Navigating Successfully into a New Frontier: PA/LTC

BILLING AND CODING IN POST-ACUTE AND LONG-TERM CARE CONTINUUM

ALVA S. BAKER, MD, CMDR, HMDC
Dr. Baker has disclosed that he has no relevant financial relationship(s).
LEARNING OBJECTIVES:

By the end of the presentation, participants will be able to:

1. Describe the differences in billing related to Place of Service
2. Delineate constraints on visit services for patients receiving Medicare Part A benefits
3. Review recent changes in billing and coding requirements
OBJECTIVE 1

Describe the differences in billing related to place of service

Billing and Coding in Post-Acute and Long-Term Care Continuum
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## PA/LTC BILLING CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>Decision</th>
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# PA/LTC Billing Codes

## Initial/Subsequent vs. New/Established Care Codes

<table>
<thead>
<tr>
<th>Initial/Subsequent</th>
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<tbody>
<tr>
<td>PA/LTC</td>
<td>Office/Hospital/etc.</td>
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<tr>
<td>Admission/episode of care</td>
<td>Longitudinal relationship</td>
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</table>

*Diagram: A sign in front of a nursing home and a cartoon illustration.*
Other recurrent troublesome concepts

- All codes apply both SNF and NF
- All require face-to-face visit
- Medical necessity must be documented
- Physician must do initial evaluation in SNF (POS 31); NPP may do in NF (POS 32)
- NPP visit in SNF prior to MD eval is billed as subsequent care
- Documentation for visit must include adequate E/M items as required for code
OBJECTIVE 2

DELINEATE CONSTRAINTS ON VISIT SERVICES FOR PATIENTS RECEIVING MEDICARE PART A BENEFITS

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SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

A. Use of CPT Codes

- “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”
- “The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”
- AMDA White Paper
30.6.13 - Nursing Facility Services

Medically Necessary Visits

“Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B”
VISITS BY QUALIFIED NONPHYSICIAN PRACTITIONERS

State Regulations, State Scope of Practice

• “All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs.”

• “General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.”
Medically Necessary Visits

• “Qualified NPPs may perform medically necessary E/M visits prior to and after the physician’s initial visit in both the SNF and NF.

• A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.”
Definition of Initial Federally Mandated Visit is:

- “the initial comprehensive visit during which the physician:
  - completes a thorough assessment,
  - develops a plan of care, and
  - writes or verifies admitting orders for the nursing facility resident.”
30.6.13 A VISITS TO PERFORM THE INITIAL COMPREHENSIVE ASSESSMENT AND ANNUAL ASSESSMENTS

Prior to/ after Initial Federally Mandated Visit:

- “other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit.”
- “Qualified NPP may perform.”
- “Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B.”

[21x491]30.6.13 A

Prior to/ after Initial Federally Mandated Visit:

1. “other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit.”
2. “Qualified NPP may perform.”
3. “Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B.”
A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.”

Definition of “readmission” unclear

Patient needs to be officially discharged from the facility to be able to use another Initial Visit code, otherwise a Subsequent Visit code should be used
B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician, or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.”

“Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.”
30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.”
30.6.13 I SNF/NF DISCHARGE DAY MANAGEMENT

- Requires a face-to-face visit
- Reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.
- 99315-99316
Death

• “may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.”
VISITS BY QUALIFIED NONPHYSICIAN PRACTITIONERS

Federally Mandated Visits

- SNF (31)
  - “Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.”
Federally Mandated Visits

NF (32)

• “Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.”
<table>
<thead>
<tr>
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<th>Admission Treatment Orders</th>
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<td>Other Medically Necessary Orders</td>
<td>Certification/Recertification</td>
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OBJECTIVE 3

REVIEW RECENT CHANGES IN BILLING AND CODING REQUIREMENTS

OBJECTIVE 3
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CODES, CODES, AND MORE CODES

Transitional Care Management (TCM)
Chronic Care Management (CCM)
Advance Care Planning (ACP)
Proposed codes
Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

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ICN 908628  March 2016
TRANSITIONAL CARE MANAGEMENT

Transition Care Management (TCM): 99495, 99496

- for discharge from hospital, SNF, or CMHC stay; outpatient observation; partial hospitalization
- covers 30 days, starting with discharge day and ending 29 days later (date of service for billing is the 30th day)
- POS code is for the site of service of the required face-to-face visit
TRANSITIONAL CARE MANAGEMENT

Can only be billed by one provider

Covers non-face-to-face physician and non-physician time/work
TRANSITIONAL CARE MANAGEMENT

99495

- communication: by end of 2\textsuperscript{nd} business day
- face-to-face by end of 14\textsuperscript{th} day
- medical decision making: moderate

99496

- communication by end of 2\textsuperscript{nd} business day
- face-to-face by end of 7\textsuperscript{th} day
- medical decision making: high
TRANSITIONAL CARE MANAGEMENT

for both

• med reconciliation no later than date of f2f visit
• medical decision making required
TRANSITIONAL CARE MANAGEMENT

NEW IN 2016: may now submit bill on date of F2F visit and not have to wait until the 30th day

transmission and CEHRT for purposes of CCM billing. Regarding TCM services, we are adopting the commenters' suggestions that the required date of service reported on the claim be the date of the face-to-face visit, and to allow (but not require) submission of the claim when the face-to-face visit is completed, consistent with current policy governing the reporting of global surgery and other bundles of services under the PFS. We will revise the existing subregulatory guidance for TCM services accordingly.

NEW IN 2016: may now submit bill on date of F2F visit and not have to wait until the 30th day

March 17, 2016

Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

- What date of service should be used on the claim?

The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period.
TRANSITIONAL CARE MANAGEMENT

NEW IN 2016: may now submit bill on date of F2F visit and not have to wait until the 30th day. Must still track the patient for 30 days

- If the patient is readmitted within 30 days, and the practice has already billed TCM for that patient, they cannot bill for TCM when the patient is discharged the second time.
- If the patient is readmitted and the practice has not yet billed, they can wait until the patient is discharged the second time, track the patient for TCM, and bill after the second face-to-face visit.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Chronic Care Management Services

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. CPT 99490 is defined as follows:

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised, or monitored.

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ICN 509188 May 2015 1
Two or more “significant chronic conditions”

Non face-to-face work

Billed no more frequently than once per month per qualified patient

Started January 1, 2015
Services covered include

• Regular development and revision of an electronic plan of care
• Communication with other treating health professionals
• Medication management
• 24-hour-a-day, 7-day-a-week access to address a patient’s acute chronic care needs.
CHRONIC CARE MANAGEMENT (CCM)

Services covered include

• Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

• Care management for chronic conditions including systematic assessment and development of a patient centered plan of care.

• Management of care transitions within health care.
Services covered include

- Coordination with home and community based clinical service providers.
- Enhanced opportunities for a patient to communicate with the provider through telephone and secure messaging, internet or other asynchronous non face-to-face consultation methods.
CHRONIC CARE MANAGEMENT (CCM)

Electronic Care Plan - components

• establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient

• maintain an inventory of resources and supports that the patient needs
CHRONIC CARE MANAGEMENT (CCM)

Electronic Care Plan - components

• The practice must use a certified EHR to bill CCM codes.
• The electronic care plan must be directly available to anyone providing CCM services
  • fax not allowed
  • 24/7
• A copy of the electronic care plan must be provided to the patient
CHRONIC CARE MANAGEMENT (CCM)

Billing

- The practice must have the patient’s written consent
- CPT code 99490 (avg: $42.60)
- Co-pays do apply
- Only one clinician can be paid for CCM services in a calendar month
  - Duke it out
The following codes cannot be billed during the same month as CCM (CPT 99490):

- Transition Care Management (TCM) – CPT 99495 and 99496
- Home Healthcare Supervision – HCPCS G0181
- Hospice Care Supervision – HCPCS G9182
- Certain ESRD services – CPT 90951-90970
CHRONIC CARE MANAGEMENT (CCM)

Benefit

• get paid for work already being done, but not reimbursed
• billed monthly for 20 eligible patients = $10k/year

Downside

• many practices may not meet requirements
CHRONIC CARE MANAGEMENT (CCM)

Downside

• not billable for patients living in “facility”

NEW IN 2016: Clarification of “facility”

March 17, 2016

7. Can I bill CPT 99490 for CCM services provided to beneficiaries in skilled nursing facilities, nursing facilities or assisted living facilities?

If all the CCM billing requirements are met and the facility is not receiving payment for care management services (for example, the beneficiary is not in a Medicare Part A covered stay), practitioners may bill CPT 99490 for CCM services furnished to beneficiaries in skilled nursing facilities, nursing facilities or assisted living facilities. The place of service (POS) on the claim should be the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient) as per #5 above.
CHRONIC CARE MANAGEMENT (CCM)

Resources

• Medicare MLN

• Medicare MLN Connects: National Provider Call
CHRONIC CARE MANAGEMENT (CCM)

Resources

• ACP – toolkit
  • https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

• AAFP
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July 14, 2016

Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services

This document answers frequently asked questions about billing advance care planning (ACP) services to the Physician Fee Schedule (PFS) under CPT codes 99497 and 99498 beginning January 1, 2016.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
ADVANCE CARE PLANNING

Beginning January 1, 2016, Medicare pays healthcare providers for advance care planning (ACP) discussions with Medicare beneficiaries.

ACP: the face-to-face service between a physician or other qualified healthcare professional (QHCP) and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.
ADVANCE CARE PLANNING

Two codes

• 99497: first 30 minutes
• 99498: each additional 30 minutes

3. In what settings can ACP services be provided and billed- Inpatient? Nursing home? Other?

There are no place of service limitations on the ACP codes. As we stated in the CY 2016 PFS final rule (80 Fed. Reg. 70956), ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary. The codes are separately payable to the billing physician or practitioner in both facility and nonfacility settings and are not limited to particular physician specialties.
<table>
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<th>Description</th>
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<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.</td>
<td>1.50</td>
<td>$86 in doctor’s office $80 in hospital</td>
</tr>
<tr>
<td>99498</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physicians or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).</td>
<td>1.40</td>
<td>$75</td>
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</table>
99497 AND 99498: BILLABLE WITH

new and established patient office visits (99201-99215),

observation initial, subsequent and discharge care codes (99217-99220, 99224-99226),

initial, subsequent and discharge hospital service codes (99221-99233, 99238-99239),

observation or inpatient admit and discharge on the same date (99234-99236),

outpatient and inpatient consultations (99241-99255),

emergency department visit codes (99281-99285),

initial, subsequent and discharge nursing facility care codes (99304-99316),

annual nursing facility assessment code (99318),

new, established and discharge domiciliary or rest home visit codes (99234-99337),

new and established patient home visit codes (99341-99350),

initial and periodic preventive medicine codes (99381-99397), and

Transitional Care Management Service codes (99495-99496)
99497 AND 99498: DIAGNOSIS

9. What diagnosis must be used?

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an ICD-10-CM code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV) (see #11, 12).
PROPOSED UPDATES AND NEW CODES
PROPOSED UPDATES AND NEW CODES

New codes for primary care payments
Psychiatric collaborative care model
Four separate codes. Not pertinent to us but allows for broader application of care management benefits for those with psychiatric conditions. Temporary G codes until CPT codes/process finalized

Code for Assessment / Care Planning Services for Cognitively Impaired
SNF/NF not included – office, home, domiciliary or rest home covered. May help set a precedence for us in the future or help a dementia APM

Adjusted Payment for routine visits for those with mobility impairments
SNF/NF not included as relates primarily to need for specialty equipment needs in the outpatient setting
PROPOSED UPDATES AND NEW CODES

New codes for primary care payments

Comprehensive assessment for chronic care management

Allows for comprehensive assessment and care planning by physician or other qualified health professional for patients requiring CCM services, including assessment during the provision of a face to face service – billed separately.
PROPOSED UPDATES AND NEW CODES

CMS Recognition of CPT Codes for Primary Care Previously not Paid for

Prolonged non-face to Face Service Codes 99358/9
First 60 min, then every 30 min thereafter (2.1 and 1.0 wRVU respectively). Allows for billing of time spent before and/or after direct patient care. Vignette gives example of extensive review of subsequently received record and communication thereafter with daughter. CMS proposes to require service to be furnished on the same day by the same physician as the companion E/M code, and not on the same day as CCM or TCM codes. CMS request comment on the potential intersection of these prolonged service codes with the proposed comprehensive assessment for and care planning for patient requiring CCM service.
PROPOSED UPDATES AND NEW CODES

CMS Recognition of CPT Codes for Primary Care Previously not Paid for

Complex Chronic Care Management Codes 99487 / 89

CMS noted that in order to more accurately pay for services based on the relative resources required, that the original somewhat more stringent CCCM codes would now be paid for. These codes require the patient be at significant risk of death, acute exacerbation/decompensation or functional decline, and requires the establishment or substantial revision of a comprehensive care plan or moderate or high complexity medical decision making, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. 99487 is for the first 60 minutes per month, 99489 is for each additional 30 minutes.
PROPOSED UPDATES AND NEW CODES

Telehealth Codes

Advance Care Planning – added to telehealth on basic AWE allowed, although no formal request was made.
Rural/underserved areas only
PROPOSED UPDATES AND NEW CODES

Telehealth Codes

ICU consultative visits – added to telehealth. May help form basis for allowing specialty consultations in PA/LTC in the future. CMS is considering such requests on a yearly basis. Submitted evidence requires a description of relevant clinical studies that demonstrate the service provided by telehealth improves the diagnosis or treatment of illness or injury or improves the functioning of a malformed body part.
Billing and Coding in Post-Acute and Long-Term Care Continuum

ICD-10 CONSIDERATIONS
ICD-10

The Devil is in the Details
**ICD-10**

<table>
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<th>Differences Between ICD-9-CM and ICD-10 Code Sets</th>
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<th>ICD-10 Code Structure Changes (selected details)</th>
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<tr>
<td><strong>Old</strong></td>
</tr>
<tr>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>• 3-5 characters</td>
</tr>
<tr>
<td>• First character is numeric or alpha</td>
</tr>
<tr>
<td>• Characters 2-5 are numeric</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Old</strong></td>
</tr>
<tr>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>• 3-4 characters</td>
</tr>
<tr>
<td>• All characters are numeric</td>
</tr>
<tr>
<td>• All codes have at least 3 characters</td>
</tr>
</tbody>
</table>

http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm
ICD-10: WHAT DETAILS:
Laterality
Severity
Complexity
Injuries (cause, how, where happened)
Pregnancy trimester
Operative (intra-, post- complications)
New concepts not in ICD-9 (under dosing, blood type, the Glasgow Coma Scale, and alcohol level.)

http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm
HOW DETAILED??

16. V97.33XD: Sucked into jet engine, subsequent encounter.
15. W51.XXXA: Accidental striking against or bumped into by another person, sequela.
14. V00.01XD: Pedestrian on foot injured in collision with roller-skater, subsequent encounter.
11. Y92.146: Swimming-pool of prison as the place of occurrence of the external cause.
10. S10.87XA: Other superficial bite of other specified part of neck, initial encounter.
  9. W55.41XA: Bitten by pig, initial encounter.
HOW DETAILED??

5. Y93.D: V91.07XD: Burn due to water-skis on fire, subsequent encounter.
4. W55.29XA: Other contact with cow, subsequent encounter.
3. W22.02XD: V95.43XS: Spacecraft collision injuring occupant, sequela.
2. W61.12XA: Struck by macaw, initial encounter.
1. R46.1: Bizarre personal appearance.

TOP CODING CHALLENGES
(AHIMA, JULY 2016)

Incorrectly applying 7th character for trauma and fracture

Improperly using procedure codes that drive a diagnostic related group

Misidentifying respiratory failure

Mistaking the use of guidance tools

Insufficiently documenting devices, components, and grafting material
ICD-10: BILLING IMPLICATIONS

Correct code
Adequate level of detail
Initial/subsequent encounters
Staff training
Timely response to rejections
A DREAM DOESN'T BECOME REALITY THROUGH MAGIC; IT TAKES SWEAT, DETERMINATION AND HARD WORK.

- COLIN POWELL
Billing and Coding in Post-Acute and Long-Term Care Continuum

SUMMARY
SUMMARY

Differences in billing related to Place of Service

Constraints on visit services for patients receiving Medicare Part A benefits

Recent changes in billing and coding requirements

Impact of ICD-10 implementation
Billing and Coding in Post-Acute and Long-Term Care Continuum

Thank You