Medicare Billing and Coding Update

Doing It Right to Get the Best Results

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Speaker Disclosures

• Dr. Baker has disclosed that he has no relevant financial relationships.

Learning Objectives

By the end of this session, participants will be able to

– Correlate billing codes with visit-determined place of service
– Define recently approved billing codes for use in the geriatric care continuum.
– Define the documentation requirements for billing these codes.
– Discuss advance care planning as it pertains to frail older persons.
PART 1: CORRELATE BILLING CODES WITH VISIT-DETERMINED PLACE OF SERVICE

Which of the following is not true regarding billing for patients visited in their homes:

THIS SLIDE IS FOR ARS QUESTION #1

In a nursing facility, residents considered to be “skilled” must be receiving Medicare Part A benefits.

THIS SLIDE IS FOR ARS QUESTION #2
30.6.13 – Nursing Facility Services
(Codes 99304- 99318)

Nursing Facility (e.g., Skilled Nursing Facility
[SNF], or Nursing Facility [NF])
• 99304 – 99306 : initial visit codes
• 99307 – 99318 : subsequent visit codes

• Place of service (POS) codes :
  – 31 (SNF: receiving Part A benefits)
  – 32 (NF: no Part A benefits)

30.6.14 - Home Care and Domiciliary Care Visits
(Codes 99324- 99350)

Domiciliary, Rest Home (e.g., Boarding Home),
or Custodial Care Services
• 99324 – 99328 : new patient codes
• 99334 – 99337 : established patient codes

“Residents residing in a facility which provides
room, board, and other personal assistance
services, generally on a long-term basis.”

• Place of service (POS) codes :
  – 13 (Assisted Living Facility)
  – 14 (Group Home)
  – 33 (Custodial Care Facility)
  – 55 (Residential Substance Abuse Facility).
**30.6.14 - Home Care and Domiciliary Care Visits (Codes 99324-99350)**

Home Care
- CPT 99341 through 99350, Home Services codes
  - 99341 – 99345: new patient codes
  - 99347 – 99350: established patient codes
  
  “Used to report E/M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes.”

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**30.6.14 - Home Care and Domiciliary Care Visits (Codes 99324-99350)**

Home Care
- CPT 99341 through 99350, Home Services codes
  - 99341 – 99345: new patient codes
  - 99347 – 99350: established patient codes
  
  “The Home Services codes apply only to the specific 2-digit POS 12 (Home). Home Services codes may not be used for billing E/M services provided in settings other than in the private residence of an individual as described above.”

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**30.6.14.1 - Home Services (Codes 99341 - 99350)**

B. Homebound Status
- “Under the home health benefit the beneficiary must be confined to the home for services to be covered.
- For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home.
- The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.”
Homebound Status

Homebound Status Policy
• Effective Date September 2, 2014 attempts to clarify the definition of the patient “confined to the home.” CMS states they removed such “vague terms” as “generally speaking” to “ensure clear and specific requirements of the definition.” There is a clear attempt to reduce confusion and provide more definitive guidance in order to “foster compliance.”

Homebound Status
Per the MBPM Chapter 15, 60.4.1, CMS expects the following definition of homebound to be followed:
• “For a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home”. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Homebound Status
• Criterion One
  – The patient must either:
    • Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
    OR
    • Have a condition such that leaving his or her home is medically contra indicated.”
Homebound Status

If the patient meets Criterion One conditions, then the patient must ALSO meet the two additional requirements defined in Criterion Two:

- **Criterion Two**
  - There must exist a normal inability to leave home AND
  - Leaving home must require a considerable and taxing effort

Homebound Status

CMS has identified that a patient may leave the home “for absences attributable to the need to receive health care treatment including, but not limited to:

- Attendance at adult day care centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy

http://www.selectdata.com/homebound-status-requirements/

PART 2: DESCRIBE RECENTLY APPROVED BILLING CODES FOR USE IN THE GERIATRIC CARE CONTINUUM
You see a female resident for a routine regulatory visit. The resident has hypertension and diabetes, both of which are controlled.

**THIS SLIDE IS FOR ARS QUESTION #3**

One of your longstanding office patients sustained a hip fracture, underwent ORIF, and has been your patient in the nursing home.

**THIS SLIDE IS FOR ARS QUESTION #4**

**Codes for Discussion**

- Chronic Care Management (CCM)
- Transitional Care Management
- Advance Care Planning
CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM)

- 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

Chronic Care Management (CCM)

- 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

Chronic Care Management (CCM)

• Billing
  – 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
  - not billable for patients living in “facility”

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](https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf)
  - AAFP
TRANSITIONAL CARE MANAGEMENT (TCM)

Transitional Care Management

- Transition Care Management (TCM): 99495, 99496
  - for discharge from hospital, SNF, or CMHC (Counseling and Mental Health Center) 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

- 99495
  - communication: by end of 2nd business day
  - face-to-face by end of 14th day
  - medical decision making: moderate
- 99496
  - communication by end of 2nd business day
  - face-to-face by end of 7th day
  - medical decision making: high
Transitional Care Management

- for both
  - med reconciliation no later than date of f2f visit
  - medical decision making required

Transition of Care Codes

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and family/caretaker education to support self-management, independent living, and activities of daily living.
### Transition of Care Codes

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources.
- Facilitating access to care and services needed by the patient and/or family.

### Transition of Care Codes

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems.

### Transition of Care Codes

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.
Transition of Care Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Days</th>
<th>Non-Facility Price</th>
<th>Facility Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>14 d.</td>
<td>$163.99</td>
<td>$134.73</td>
</tr>
<tr>
<td>99496</td>
<td>7 d.</td>
<td>$231.36</td>
<td>$197.67</td>
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</tbody>
</table>

ADVANCED CARE PLANNING

Advance Care Planning

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

99497 and 99498

- Medicare decided to NOT pay for these codes in 2015
  - For 2016, Medicare has proposed advancing the codes to “Active” status
    - if so, implementation expected July 1, 2016
    - fee assigned
    - may or may not make national coverage determination
    - final information and decision expected around November 1
- Commercial insurers may pay

PART 3: DEFINE THE DOCUMENTATION REQUIREMENTS FOR BILLING THESE CODES
DOCUMENTATION GUIDELINES

• **DO NOT UNDERDOCUMENT**
  — OVERALL STATUS OF THE PATIENT

• MULTIPLE DIAGNOSES
• CO-MORBIDITIES
• OTHER COMPLICATING ISSUES
• FAMILY ISSUES
• FACILITY ISSUES

Chronic Care Management

• 99490
  — certified EHR required
  — patient’s written consent required
  — electronic care plan accessible to practice AND coverage 24/7; copy provided to patient
  — billed monthly
  — non F2F work
  — two or more “significant chronic conditions”
Transitional Care Management

- **99495**
  - communication: by end of 2nd business day
  - face-to-face by end of 14th day
  - medical decision making: moderate

- **99496**
  - communication by end of 2nd business day
  - face-to-face by end of 7th day
  - medical decision making: high

Transitional Care Management

- for both
  - med reconciliation no later than date of f2f visit
  - medical decision making required

- Covers 30 days: bill on day 30 using POS code of where F2F visit was done
  - Reminder: day of discharge counts as Day 1

- Includes non-F2F care by physician/provider and clinical staff under their direction

Advance Care Planning

- Two codes
  - 99497: first 30 minutes
  - 99498: each additional 30 minutes
PART 4: DISCUSS ADVANCE CARE PLANNING AS IT PERTAINS TO FRAIL OLDER PERSONS

Physician participation in advance care planning requires which of the following:

THIS SLIDE IS FOR ARS QUESTION #5
Advance Directives

• Living Will – desires for care if any of three conditions exist (terminal illness; persistent vegetative state; end-stage condition)
• Agent – appointment of a person or persons authorized to make health care decisions for you if you cannot make them yourself
• Counseling for these is billed using 99497 and 99498

Process: Advance Care Planning

Getting to POLST

• Education
• Counseling
• PROGNOSTICATION
Longevity Prognostication

- Not a matter of luck
- We are educated, experienced, rational, and sentient health care providers
- We know our patients
- We should not be afraid to offer prognostication
Barriers to Prognostication

- Knowledge
- Experience
- Length of provider-patient relationship
- Fear of being wrong: what then???

But, we have help!

Resources

- Case study: https://palliative.stanford.edu/prognostication/
- CAPC Fast Fact on prognostication https://www.capc.org/fast-facts/30-prognostication/
- ePrognosis: Estimating Prognosis for Elders http://eprognosis.ucsf.edu/
Summary

- Correct place of service code must be assigned by patient location
- Recent CMS-authorized CPT codes must be billed correctly in order to capture historically non-billable revenue
- Advance care planning incorporates both the science and the art of medicine.