CPT Coding in the Nursing Home

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1

1

Disclosures

- Dr. Zorowitz is an employee of Optum and a stockholder of UnitedHealth Group
- Otherwise no conflicts/disclosures

2

2

Learner Objectives

- Understand the use of cognitive codes available to report services provided in the nursing home
- Understand the basic requirements for documentation and reporting Chronic Care Management Services, Transitional Care Management Services, Prolonged Non-Face-to-Face Services and other recently introduced codes
- Recognize the controversies and opportunities in reporting services not originally intended for the nursing home setting
- Know where to find further information on reporting services performed in the nursing facility

3

3

Which service(s) cannot be reported in the nursing facility?

a) Transitional Care Management Services
b) Chronic Care Management Services
c) Cognitive Impairment Assessment and Care Plan Services
d) Advance Care Planning Services
e) a and c
f) b and c

4

4

But Bob, I'm not going to remember a blasted thing you say!

The Official CPT Manuals—Indispensable Primary Source

5

5

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

https://paltc.org/product-store/guide-post-acute-and-long-term-care-coding-reimbursement-and-documentation

6

6

The 2021 Office Code Revisions

CPT® E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes

- https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

CPT® E/M Office Revisions Level of Medical Decision Making (MDM)

- https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Office Evaluation and Management (E/M) CPT Code Revisions—Learning Module

- https://edhub.ama-assn.org/module/2736085

7

7

What do payers want?

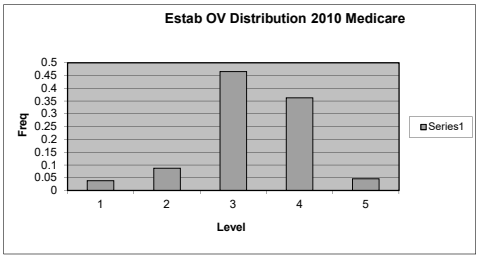
Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- **the site of service;**
- **the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or**
- **that services provided have been accurately reported.**

8

8

Profiling Pattern



9

9

Coding is based not only on what you do, but what you DOCUMENT

10

10

CPT Codes take into account:

- Work
- Practice expense
- Malpractice insurance expense

11

11

Advance Care Planning Services

- Voluntary—get and document permission/consent
- Billed in addition to other E/M and CPT codes
- No limit on how many times can be billed
- Physician/NPP can bill (incident-to rules apply)
- Must be face-to-face (with either patient or decision-maker)
- Remember 20% copay by beneficiary or secondary insurer
  - Except when doing Annual Wellness Visit, modifier -33, no copay
- Does not require any specific template or completion of any legal documents like **POLST**/AHCD; document time and content
  - For primary care physicians can be an add-on to an Annual Wellness Visit with modifier -33 (in this case no 20% co-pay)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

12

Advance Care Planning Services

99497 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

+ 99498 each additional 30 minutes (List separately in addition to code for primary procedure)

CPT Changes: An Insider's View 2015

CPT Assistant Dec 14:11

(Use 99498 in conjunction with 99497)

13

National Rates 2019

Code	Short Description/ CMS Posted Typical Time(s)	2019 NF MPFS National Rate	2019 F MPFS National Rate
99497	**Advncd care plan 30 min**	**$86.49**	**$80.37**
99498	**Advncd care plan addl 30 min**	**$76.04**	**$75.68**

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

14

How often can ACP be billed?

- Per CPT language, there is no limit
- CMS has declined to establish frequency limits at this time
- BUT—if billed multiple times, CMS would expect to see "a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care."

15

Where can ACP be billed?

- There is no place of service limitation in the CPT code descriptors
- CMS has no place of service limitation in its final rule (80 Fed. Reg. 70956)
- ACP codes may be used in any setting, facility or non-facility (although not in the ICU if critical care codes are used)

16

Who can submit ACP claims?

- As per CPT coding convention, 99497-8 may be submitted by any "Physician or other qualified health care professional"
- There is no limitation as to physician specialty
- Nonphysician practitioners (NPP), e.g. nurse practitioners, physician assistants, etc., may submit ACP claims

17

Are there rules governing who may actually perform the service?

- Besides the CPT descriptor, there is no introductory language nor are there explanatory notes governing the performance of the service
- According to the final rule (80 Fed. Reg. 70956), "99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, NPPs and other staff under the order and medical management of the beneficiary's treating physician."

18

More on who may perform ACP

- CMS expects the billing physician or NPP to "meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision."
- "Incident to" service rules apply
  - May be of particular relevance in the NH
- All applicable state law and scope of practice requirements must be met

19

Must the beneficiary be present?

- According to the code descriptor, the service is "face-to-face with the patient, family member(s) and/or surrogate"
- Cannot be reported if performed by phone or via telehealth services
- According to CMS, if beneficiary is not present, must document that the beneficiary is impaired and unable to participate effectively
- Must still be face-to-face with family member(s) and/or surrogate

20

Is consent necessary?

- Important, because copays and deductibles apply (except in the case of Annual Wellness Visit)
  - AWV can technically be done in the NH
- ACP services are voluntary
- No formal consent is required, but beneficiaries (or family members/surrogates) should be given opportunity to decline or receive ACP services, good idea to document

21

What must be documented?

- No requirements in the CPT code descriptor
- Consult Medicare Administrative Contractors (MACs)
- CMS recommends documentation of:
  - Voluntary participation (consent)
  - An account of the discussion
  - Who was present
  - Explanation of advance directives, including any completed forms
  - Time spent in the encounter *(definitely include this)*

22

- Completed Advance Directive forms are not, by themselves, sufficient to document the service for the purposes of reporting the ACP code(s)
- Completion of Advance Directive(s) or other documents (e.g., POLST Paradigm forms) is not necessary to report ACP services

23

Can ACP be reported in addition to other services?

- May be reported in addition to E/M codes, including all nursing facility services
  - But need to keep time separate
- May be reported during same service period as Transitional Care Management or Chronic Care Management
- May be reported during global surgical periods
- May not be reported on same date as certain critical case services, including neonatal and pediatric critical care

24

(Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480)

- Critical care services 99291-99292
- Neonatal critical care services 99468-99469
- Pediatric critical care services 99471-99476
- Neonatal intensive care services 99477-99480

Advance care planning included in the time requirements of these codes, so do not bill ACP

25

Are specific diagnoses required?

- No specific diagnoses required
- HOWEVER, as for all services, appropriate ICD-10 code(s) required, preferably that on which the physician is counseling the beneficiary
- Diagnosis necessary for 99318 annual NF exam
- May use well exam diagnosis when ACP furnished as part of the Medicare Annual Wellness Visit (AWV)
  - Append modifier -33

26

Do deductibles and copays apply?

- YES, except when reported as element of the Annual Wellness Visit (G0438 or G0439); use modifier -33
- YES, when reported in addition to Introductory Preventive Physical Examination ("Welcome to Medicare Exam")
- Recommend that practitioners let beneficiaries know

27

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

28

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- In response to comment to the CY 2016 proposed rule, for 2017 CMS established separate payment for non-face-to-face prolonged E/M service codes that are currently considered to be "bundled." The codes are:

99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

29

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- Used to report extended non-face-to-face time by physician or other qualified healthcare professional
- Does not overlap with CCM or Behavioral Health Integration codes
- Must be directly related to a face-to-face service
- Adopted as written in CPT

30

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- Requirements much like the Face-to-face Prolonged service, BUT
- May be performed on a different day, so long as it is directly related to the face-to-face service

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf

31

Chronic Care Management Services:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

32

Chronic Care Management (CCM)

CPT 99490

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

Assumes 15 minutes of work by the billing practitioner per month.

CPT 99491

Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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

33

33

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
- May be provided by physicians or
  - Nurse practitioners
  - Physician assistants
  - Nurse midwifes
  - Clinical nurse specialists

34

Chronic Care Management (CCM)

- Services covered include
  - Regular development and revision of an electronic plan of care using certified EHR
  - 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
  - Transitional Care Management

35

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.
  - 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.

36

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

37

Chronic Care Management (CCM)

- Electronic Care Plan - components
  - The practice must use a certified EHR to bill CCM codes.
  - The care plan must be available to anyone providing CCM services in a timely fashion
  - A copy of the electronic care plan must be provided to the patient

38

Chronic Care Management (CCM)

- Billing
  - The practice must have the patient's consent
  - CPT code **99490**
  - Co-pays do apply
  - Only one clinician can be paid for CCM services in a calendar month

39

Chronic Care Management

- 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

  Although not intended to be used in nursing facilities, CMS allows the service to be performed and reported in nursing facilities, so long as all the requirements are met and the patient is not on a Part A stay

40

So what's new since 2017?

- Increased payment and additional codes
- Reduced requirements associated with initiating care, and increased payment when extensive initiation work is necessary
- Significantly reduced administrative burden (reduced payment rules for billing the services)
- General supervision in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

41

CCM – **New since 2017**

- Initiating Visit: now only needed for new or patients not seen >1 year; extra payment for extensive initiating services
- Certified EHR: no longer required for ALL CCM documentation (but still for SOME); now can fax care plan; coverage no longer needs access to EHR; removed standards for formatting and exchanging continuity of care documents; continue to encourage advanced technology, but acknowledgement that practitioners will increase technology better based on incentives

42

CCM – **New since 2017**

- Continuous Relationship with Designated Care Team Member: align better with CPT language
- Comprehensive Care Management and Care Planning: align better with CPT language; no longer specify the format of the care plan copy that must be given to the patient; technology use standards relaxed
- Transitional Care Management: align better with CPT language; clinical summaries for managing transitions renamed "continuity of care document(s)"; technology use standards relaxed

43

CCM – **New since 2017**

- 24/7 Access to Address Urgent Needs: align better with CPT language; clarify the required access is for urgent needs
- Advance Consent: verbal instead of written consent allowed

44

Complex Chronic Care Management Codes 99487 / 89

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

- Requires the patient be at significant risk of death, acute exacerbation/decompensation or functional decline
- Requires the establishment or substantial revision of a comprehensive care plan
- Requires moderate or high complexity medical decision making
- Based on clinical staff time directed by a physician or other qualified health care professional
- 99487 is for the first 60 minutes per month, 99489 is for each additional 30 minutes.

45

Complex Chronic Care Management

CPT 99487

Complex chronic care management services, 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
- Establishment or substantial revision of a comprehensive care plan
- 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

CPT 99489

Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

CCM (sometimes referred to as "non-complex" CCM) and complex CCM services share a common set of service elements (summarized in Table 1). They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed.

46

46

Total Duration of Staff Care Management Services	Complex Chronic Care Management
Less than 60 minutes	Not reported separately
60 to 89 minutes (1 hour - 1 hr. 29 min.)	99487 X 1
90 - 119 minutes (1 hr. 30 min. - 1 hr. 59 min.)	99487 X 1 and 99489 X 1
120 minutes or more (2 hours or more)	99487 X 1 and 99489 X 2 and 99489 for each additional 30 minutes

From AMA, CPT Professional 2020

47

Chronic Care Management (CCM)

- Resources
  - ACP – toolkit
    - **https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf**
  - AAFP
    - **https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/chronic-care.html**

48

48

National Rates 2019

Code	Brief Description	2019 NF MPFS National Rate	2019 F MPFS National Rate
99490	Chron care mgmt srvc 20 min[1]	$42.17	$32.44
99491	Chron care mgmt srvc 30 min[2]	$83.97	$83.97
99487	Cmplx chron care w/o pt vsit[1]	$92.98	$52.98
99489	Cmplx chron care addl 30 min[1]	$46.49	$26.67
G0506	Comp asses care plan ccm svc[2]	$63.43	46.49

[1] Counts staff time
[2] Counts physician/qualified healthcare provider time

49

Proposed CMS Rule for 2020

- Chronic Care Management (99490)
- Complex Chronic Care Management (99487, 99489)
- Principal Care Management (?)

50

50

Chronic Care Management

(Under proposed rule for 2020)

- CMS Proposing Temporary Replacement of 99490
- Would use 2 'G' Codes
  - 'GCCC1' --Initial 20 minutes
  - 'GCCC2' –Each additional 20 minutes
- Limit the number of 'GCCC2s?'

51

51

Complex Chronic Care Management
(Under proposed rule for 2020)

- CMS Proposing Temporary Replacement of 99487-99489
- Two 'G' Codes:
  - 'GCCC3' –Initial 60 minutes
  - 'GCCC4' –Additional 30 minutes
- Would remove requirement for "substantial revision of care plan"

52

52

Complex Chronic Care Management
(Under proposed rule for 2020)

The comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list.
- Expected outcome and prognosis.
- Measurable treatment goals.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan.

53

53

Principal Care Management (PCM)
(Under proposed rule for 2020)

- Care Management for ***ONE*** Serious Condition
- Expected to be used more often by specialist (e.g. diabetes, cystic fibrosis, cancer, etc.)
- Proposing two 'G' Codes:
  - 'GPPP1' Initial 30 minutes by physician/QHP
  - 'GPPP2' Initial 30 minutes by clinical staff

54

54

Principal Care Management (PCM)

(Under proposed rule for 2020)

"Due to the potential for duplicative payment, CMS proposes that PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services, and monthly capitated ESRD payments. CMS also proposes that PCM would not be billable by the same practitioner for the same patient during a surgical global period, as CMS believes those resource costs would already be included in the valuation of the global surgical code."

55

55

Behavioral Health Integration Care Management

56

Behavioral Health Integration Care Management

- Established for care management of behavioral health conditions
- Similar in structure to Chronic Care Management
- Does not require comprehensive care plan, but requires initiating E/M visit
- Does not require all the practice attributes of 99490 Chronic Care Management
- Uses same simplified consent

57

General Behavioral Health Integration Care Management

 # 99484 Care management services for behavioral health conditions, 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:

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- continuity of care with a designated member of the care team.

CPT Changes: An Insider's View 2018
CPT Assistant Feb 18:7, Mar 18:5

(Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month)

58

Question

- Q: Can the same provider report CCM (99490) and Behavioral Health Integration Care Management (G0507)?
- A: Yes. CMS advises selecting the most appropriate code, but if they are each independently eligible to be reported, they both may be reported in the same month. CMS will be monitoring utilization.

59

Psychiatric Collaborative Care Management Services

60

Psychiatric Collaborative Care Management Services

In February 2016, the CPT Editorial Panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from CMS to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM).

CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts:

1)Patient-Centered Team Care/Collaborative Care;
2)Population-Based Care;
3)Measurement-Based Treatment to Target; and
4)Evidence-Based Care.

61

Psychiatric Collaborative Care Management Services

- Involves a primary care physician working with
  - Behavioral health manager
  - Consulting psychiatrist
- CMS opted to provide a 'G' code for reporting the service in 2017
- It has now been replaced with CPT codes

62

Psychiatric Collaborative Care Management Services

99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;
- entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

63

Psychiatric Collaborative Care Management Services

99493 **Subsequent psychiatric collaborative care management,** first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation;
- participation in weekly caseload consultation with the psychiatric consultant;
- ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;

64

99493, Subsequent psychiatric collaborative care management (Cont'd.)

- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

65

Psychiatric Collaborative Care Management Services

99494 **Initial or subsequent psychiatric collaborative care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

(List separately in addition to code for primary procedure)

(Use 99494 in conjunction with 99492, 99493)

66

Payment for New Behavioral Health Codes

Code	Brief Description	2019 NF MPFS National Rate	2019 F MPFS National Rate
99484	Care mgmt svc bhvl hlth cond	$48.65	$32.80
99492	1st psych collab care mgmt	$162.18	$90.46
99493	Sbsq psyc collab care mgmt	$129.38	$81.81
99494	1st/subsq psyc collab care	$67.03	$43.97

67

To find the Medicare physician fee schedule look-up:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/02_pfssearch.asp

68

Other Common Services

Code	Brief Description	2019 F MPFS National Rate	2019 NF MPFS National Rate	Bill in NF?
G0402	Welcome to Medicare Visit (IPPE)[1]	$129.02	$169.02	Yes
G0438	Annual wellness exam[2], initial	$174.43	$174.43	Yes
G0439	Annual wellness exam, subseq.	$118.21	$118.21	Yes
99318	Annual nursing fac assessmnt	$97.92		Yes

[1]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

[2]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

69

Where can I bill these codes?

Description	LTC	Ambulatory	Home
CCM (Chronic Care Management), 20-59 min	Yes	Yes	Yes
CCCM 60 minutes	Yes	Yes	Yes
CCM, each additional 30 minutes to 99487	Yes	Yes	Yes
CCM initial care plan creation	Yes	Yes	Yes
TCM - 14 days (Transitional Care Management)	No	Yes	Yes
TCM - 7 days	No	Yes	Yes
ACP - 1st 30 min (Advance Care Planning)	Yes	Yes	Yes
ACP - each additional 30 min	Yes	Yes	Yes
Home Care Re-certification	No	Yes	Yes
Home Care Certification	No	Yes	Yes
CPO (Care Plan Oversight)	No	Yes	Yes
CPO-hospice	No	Yes	Yes
Prolonged Service non F2F with E/M , 1st 60 min	Yes	Yes	Yes
Each additional 30 min	Yes	Yes	Yes
Behavioral Health Integration Care Management	Yes	Yes	Yes
Psychiatric Collaborative Care Management Services	Yes	Yes	Yes
	Yes	Yes	Yes
	Yes	Yes	Yes
Cognitive assessment, outpatient	No	Yes	Yes
New, outpatient	No	Yes	Yes

70

70

Which service(s) cannot be reported in the nursing facility?

a) Transitional Care Management Services
b) Chronic Care Management Services
c) Cognitive Impairment Assessment and Care Plan Services
d) Advance Care Planning Services
e) a and c
f) b and c

71

71

Name of Service	Where to find the information
Chronic Care Management Services	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.pdf
Cognitive Assessment and Care Services	https://www.alz.org/careplanning/downloads/cms-consensus.pdf
Advance Care Planning Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
Non-Face-to-Face Prolonged Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf
Care Management Services in Rural Areas	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

72

Name of Service	Where to find the information
The Initial Preventive Physical Exam ("Welcome to Medicare Visit")	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
Annual Wellness Exam (AWV)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/awv_chart_icn905706.pdf
Transitional Care Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Behavioral Health Integration Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

73

JAMA Network

From: **Medicare's Approach to Paying for Services That Promote Coordinated Care**

JAMA. 2019;321(2):147-148. doi:10.1001/jama.2018.19315

Table. Fee-for-Service Codes for Promoting Coordinated Care[a]

Code	Description	Approximate Medicare Reimbursement Rate in 2019, $
New codes in 2019		
G2012	Virtual patient-clinician check-ins	15
G2010	Asynchronous video or image review and storage	13
99451, 99452, 99446-99449	Interprofessional consultations (provider-to-provider e-consults)	18-73
99453, 99454, 99457	Chronic care remote physiologic monitoring	19-64
Existing codes (introduced 2014-2018)		
99497, 99498	Advanced care planning	76-87
99495, 99496	Transitional care management	167-235
99490, 99487, 99489	Chronic care management	42-93
99483	Cognitive assessment and care plan services	264
99492, 99493, 99494, 99484	Behavioral health integration	49-162
99091	Remote patient monitoring	58

[a] Sources for data in this table from the Centers for Medicare & Medicaid.[1,2]

Table Title:
Fee-for-Service Codes for Promoting Coordinated Care[a]

74

QUESTIONS????

75

75

Evaluation/Management (E&M) Codes:

- Initial Nursing Facility Care (New OR Established Patient)
  - 99304
  - 99305
  - 99306
- Subsequent Nursing Facility Care 99307
  - 99308
  - 99309
  - 99310
- Nursing Facility Discharge Services
  - 99315
  - 99316
- Annual Nursing Facility Assessment
  - 99318

76

76

Sample nursing facility codes

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- **A detailed or comprehensive history;**
- **A detailed or comprehensive examination; and**
- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A detailed interval history;**
- **A detailed examination;**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

77

77

Work activities incorporated into E&M codes:

- History
- Examination
- Medical-Decision Making

- To a lesser extent
  - Nature of presenting problem
  - Counseling
  - Coordination of care
  - Time

78

78

Number of work activities required

- For assessment codes 99304-99306
  - All 3 work activities
- For subsequent care codes 99307-99310
  - 2 out of 3 work activities
- For Nursing Facility Discharge Services, codes 99315 and 99316
  - Governed by TIME

79

79

Work Activities

- History
- Examination
- Decision-Making (Assessment and Plan)

- NOTE THAT FULL DOCUMENTATION IS A "SOAP" NOTE. NOTES SHOULD BE WRITTEN IN THIS FORMAT

80

80

Initial NF Services and NPP

(Note correlation in MDM and NPP)

Code (3/3)	Nature of Presenting Problem
99304 *(D,D,SF or Low)*	Low severity ("Level 2")
99305 *(C,C, Mod)*	Moderate severity ("Level 3")
99306 *(C,C,High)*	High severity ("Level 4 or 5")

81

81

Subsequent NF Services and NPP

Code (2/3)	Nature of Presenting Problem ("Usually")
99307 *(Pf, Pf, SF)*	Minor severity ("Level 1") "Stable, recovering or improving"
99308 *(Epf, Epf, Low)*	Low severity ("Level 2") "Responding inadequately to therapy or minor complication"
99309 *(D, D, Mod)*	Moderate severity ("Level 3") "Developed significant complication or new problem"
99310 *(C,C,High)*	High severity ("Levels 4 or 5") "Unstable or requires immediate physician attention

82

82

Medical Decision-Making Takes into account:

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity/mortality

83

83

Need at least two elements to determine level of decision-making:

Type of Decision	Number of Diagnoses and Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Morbidity and Mortality
Straightforward	Minimal (1-2)	Minimal (0-2)	Minimal (1-2)
Low complexity	Limited (1-2)	Limited (1-2)	Low (1-2)
Moderate complexity	Multiple (3-4+)	Moderate (3-4+)	Moderate (3-4)
High complexity	Extensive (3-4+)	Extensive (3-4+)	High (3-4)

84

84

Documentation of Risk

- Comorbidities
- Underlying conditions/diseases
- Invasive Procedures
- Tables of risks

- The highest level of risk in any one category determines the overall risk

85

85

To simplify the MDM Component

(Levenson SR. Practical E/M, 2nd Ed. AMA, 2008)

1. Levels of Risk: SUBJECTIVE
   - Risk of morbidity
   - Risk of mortality
   - Risk of functional impairment
2. Number of diagnoses or treatment options: OBJECTIVE

86

86

Assigning Numerical Values

CPT Description of Amount or Number	Numerical Value
Minimal (Level 1 or 2)	1
Limited (Level 3)	2
Multiple or Moderate (Level 4)	3
Extensive (Level 5)	4 or more

87

87

Assessing Level of Risk

- Only one of three risk categories needs to equal or exceed the severity of risk warranted by the Nature of the Presenting Problem
- Therefore, focus on documenting the risk of the patient's presenting problem(s)

88

88

Level of Risk	*Presenting Problem*	*Diagnositc Procdure(s) Ordered*	*Management Options Selected*
Minimal	•One self-limited or minor problem eg. Cold,insect bite, tinea corporis	•Laboratory tests •Chest x-rays •EKG/EEG •Urinalysis •Ultrasound, eg. Echocardiography •KOH prep	•Rest •Gargles •Elastic bandages •Superficial dressings
Low	•Two or more self-limited or minor problems •One stable chronic illness, eg. Well controlled hypertension, DM, cataract, BPH •Acute uncomplicated illness eg. Cystitis, etc	•Physiologic tests not under stress, eg. PFT •Non-cardiovascular imaging studies with contrast •Superficial needle biopsies •Clinical lab tests requring arterial puncture •Skin biopsies	•Over the counter drugs •Minor surgery with no identified risk factors •Physical therapy •Occupational therapy •IV fluids without additives

89

89

Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Moderate	•One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment •Two or more stable chronic illnesses •Undiagnosed new problem with uncertain prognosis, eg. Lump in breast •Acute illness with systemic symptoms, eg. Pyelonephritis, pneumonitis, colitis •Acute complicated injury, eg. Head injury with brief loss of consciousness	•Physiologic tests under stress, eg. Cardiac stress test •Diagnostic endoscopies with no identified risk factors •Deep needle or incisional biopsy •Cardiovascular imaging studies with contrast and no idetnified risk factors, eg. Arteriogram, cardiac cath •Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	•Minor surgery with identified risk factors •Elective major surgery with no identified risk factors •Prescription drug management •Therapeutic nuclear medicine •IV fluids with additives •Closed treatment of fracture or dislocation without manipulation

90

90

Level of risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
High	•One or more chronic illnesses with severe exacrbation, progression or side effects of treatment •Acute or chronic illnesses or injuries that pose a threat to life or bodily function eg. Multiple traum, acute MI, pulmonary embolus, severe respiratory distress, progressive severe RA, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure •Abrupt change in neurologic stats, eg. Seizure, TIA, weakness, sensory loss	•Cardiovascular imaging studies with contrast with identified risk factors •Cardiac electrophysiologic al tests •Diagnostic endoscopies with identified risk factors •Discography	•Elective major surgery (open, percutaneous or endoscopic) with identified risk factors •Emergency major surgery •Parenteral controlled substances •Drug therapy requiring intensive monitoring for toxicity •Decision not to resuscitate or to de-escalate care because of poor prognosis

91

91

Summary: Initial Nursing Facility Care

Must meet all 3	**Level 1**	**Level 2**	**Level 3**
CPT (E&M) code	99304	99305	99306
History: • HPI • ROS • PFSH	Detailed: • 4 elements • 2-9 Body systems • 1 element (or comprehensive)	Comprehensive • 4 elements • 10 body systems • all 3 elements	Comprehensive • 4 elements • 10 body systems • all 3 elements
Examination	Comprehensive	Comprehensive	Comprehensive
Decision-Making (2 of 3) • Number of diagnoses/options • Data complexity/amount • Risk	Straightforward/low complexity: Minimal-limited 1-2 Minimal-limited 1-2 Minimal-low 1-2	Moderate complexity: Multiple 3 Moderate 3 Moderate 3	High complexity: Mult-ext 3-4+ Mod-ext 3-4+ Mod-high 3-4+

92

92

Summary: Subsequent NF Care (Must meet 2 out of 3 components)

Must meet 2 of 3	**Level 1**	**Level 2**	**Level 3**
CPT (E&M) code	99307	99308	99309
History: • HPI • ROS • PFSH	Problem focused: • 1 elements • N/A • N/A	Exp. Prob Focused: • 1 elements • 1 body systems • N/A	Detailed: • 4 elements • 2-9 body systms • 1 element
Examination	Problem-focused	Exp. Problem-focused	Detailed
Decision-Making (2 of 3) • Number of diagnoses/options • Data complexity/amount • Risk	Straightforward (minimal) Minimal-limited 0-1 Minimal-limited 0-1 Minimal-low 0-1	Low complexity: Minimal-limited 1-2 Minimal-limited 1-2 Minimal-low 1-2	Moderate complexity: Mult-ext 3-4+ Mod-ext 3-4+ Mod-high 3-4+

93

93

Additional Codes

- The "Level 4" code: 99310
  - Comprehensive interval history
  - Comprehensive examination
  - Medical decision making of high complexity
  - Must meet 2 out of 3 components
- Annual Nursing Facility Assessment: 99318
  - Detailed Interval History
  - Comprehensive Physical
  - Medical Decision Making of Low to Moderate Complexity
  - MUST MEET ALL THREE COMPONENTS

94

94

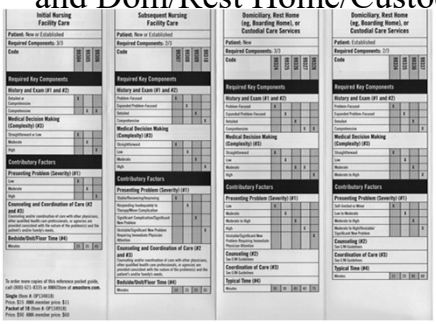
Hints

- You are reimbursed for what you document, not just what you do
- Record must be legible- 3 people must be able to read it
- All encounters must be signed and dated
- All monthly notes must include
  - Medical record review
  - Noting of changes since previous visit
  - Reviewing and signing orders

95

95

CPT Codes for Nursing Facility and Dom/Rest Home/Custodial



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96

96

Thank you!

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97