OVERVIEW

- CPT Coding Update 2013
- E/M coding tips
- Other coding opportunities
  - Critical care
  - Prolonged services
  - CPO, HHC
- Getting ready for ICD-10
- Compliance reminders
REFERENCES FOR CODING UPDATE

- CPT ... AMA Professional Edition
- CPT Errata sheet (corrections)
  - Search “CPT Errata” and print the 2013 sheet
- CPT Changes Insider’s View
- AMA Coding Update Workshop
- Articles from various specialty organizations
CODING CHANGES THAT MAY AFFECT YOUR PRACTICE

- Reference Appendix B
  - What codes or sections do you use?

- Throughout CPT book
  - Watch for > < and green print indicating revised guidelines, cross-references
  - Watch for bullets (new codes) and triangles (revised codes)
    - Most of the E/M codes have triangles ... yikes!
      - But it’s really just a revised general concept that applies to all
INTRODUCTION

- Last year’s revision regarding “physician or other qualified health care professional”
  - CPT, Page X
  - Good reminder of difference between “other qualified health care professional” and “clinical staff”
    - Scope of practice, state licensure, facility privileges
- This year:
  - “Throughout the CPT code set the use of terms such as ‘physician,’ ‘qualified health care professional’ or ‘individual’ is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency)”
  - CPT is an equal opportunity reporting system
  - There are exceptions
    - Nursing Facility Services, page 25 CPT, instructions should read: “Physicians have a central role in assuring that all residents.....”
    - “and other qualified health care professionals” should not be included
    - Found this correction on the Errata sheet
E/M Section

- Times added to Admit/Discharge same date codes 99234, 99235, 99236
- New codes for Complex Chronic Care Coordination
- New codes for Transitional Care Management Services
Observation or Inpatient Care Services (including admission and discharge)

- Times added:
  - 99234  40 minutes
  - 99235  50 minutes
  - 99236  55 minutes

- Reminder: these codes require two face-to-face visits by the provider in the same calendar date

- Reminder: code E/M services by time as appropriate (counseling/coordination of care dominates the visit)
COMPLEX CHRONIC CARE COORDINATION SERVICES (CCCC)

- Workgroup established to give direction to CPT and RUC to address care coordination services and prevention/management of chronic disease
- CMS has declined their recommendation and considers these CCCC codes bundled and not separately payable
- What about other payors??
99487, 99488, 99489 New codes based on time with and without face-to-face visit
For patient centered management and support services to individuals at home, or in a domiciliary, rest home or assisted living facility
Require a care plan that is directed by the physician or qualified health care professional and usually implemented by clinical staff
Coordinate care being given by multiple disciplines or community service organizations
TRANSITIONAL CARE MANAGEMENT SERVICES (TCM)

- These are payable by Medicare
- Still awaiting further instructions from Medicare
  - Apparently they plan to pay for these on new patients in addition to established patients (as specified by CPT) and have made some other modifications
  - Stay tuned
- Work RVU’s
  - 99495 = 2.11
  - 99496 = 3.05
TCM

- 99495
  - Transitional Care Management Services with the following required elements
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
    - Medical decision making of at least moderate complexity during the service period
    - Face-to-face visit, within 14 calendar days of discharge
TCM

- 99496
  - Transitional Care Management Services with the following required elements:
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business dates of discharge
    - Medical decision making of high complexity during the service period
    - Face-to-face visit, within 7 calendar days of discharge
TCM

- Business days vs. calendar days
- Moderate complexity vs. high complexity
- Transition from inpatient setting (acute hospital, rehab hospital, long term acute care hospital, partial hospital, OBS status in hospital, or skilled nursing facility/nursing facility)
- Transition to patient’s community setting (home, domiciliary, rest home or assisted living)
TCM

- Non face-to-face services include a long list outlined by CPT and categorized by clinical staff vs. physician/qualified health care provider
  - Communication
  - Education
  - Assessment and support for treatment plan
  - Identification of available community and health resources
  - Facilitating access to care and services
  - Reviewing discharge information (discharge summary)
  - Reviewing need for follow-up on pending diagnostic tests and treatment
  - Interaction with other health care professionals
  - Establishing referrals

- Read the complete list in CPT and watch for further information and instructions
DIGESTIVE SYSTEM, NEW CODE FOR FMT

- Fecal Microbiota Transplant (FMT)
- New code 44705 Preparation of fecal microbiota for instillation, including assessment of donor specimen
  - For instillation by oro-nasogastric tube or enema, use 44799 (unlisted code)
- Some ID physicians are already performing this service for treatment of refractory or relapsing Clostridium difficile diarrhea
- Medicare has established a G code instead
  - G0455 for preparation of fecal microbiota for instillation, including assessment of donor specimen
CPT’S DESCRIPTION OF 44705

- Patient with refractory, relapsing C. difficile diarrhea despite multiple courses of antibiotic treatment is referred for evaluation and consideration of treatment options. After assessment (reported separately as E/M), it is elected to utilize fecal microbiota therapy. The physician has selected the potential donor, and oversees evaluation and preparation of the specimen.
SERVICES PROVIDED BY THE DONOR

- How do you get compensated for services provided to/for the donor?
  - If explanation of the procedure takes place with the patient present, consider billing an E/M code based on time, billed under the patient’s name.
  - Screening tests for donor will most likely be patient responsibility. If Medicare, suggest an ABN. Recommend explanation to the patient of potential out-of-pocket expenses.
WHAT ABOUT THE INSTILLATION?

- CPT says, “for fecal instillation by oro-nasogastric tube or enema, use 44799”
  - This is an unlisted or “dump” code without RVU’s and payment information. Need to include documentation of service with claim.
- Medicare’s special code G0455 apparently includes the instillation
- Total RVU
  - 44705  No RVU assigned per my coding resources, but according to comment letter provided by IDSA, it’s 1.42
  - G0455  Facility 1.54, Non-Facility 3.30
- Work RVU
  - 44705
  - G0455 .97
E/M Coding Tips/Reminders

- Medical Necessity
- Key elements of E/M codes
- Coding by time instead
- Consultations
- Review of grids for E/M services
- Prolonged services
- Critical care
DOCUMENTATION

- **Medical Necessity is the overarching criterion**
  - Regardless of the volume of documentation
  - How is medical necessity documented?
- To accurately reflect the service provided, the documentation should occur during, or as soon as practicable after it is provided.
  - Recommend a policy to address “timely documentation”
- Beware of the EMR
  - Cloned notes
  - Notes that make no sense
  - Conflicting information
  - Did you really do everything as reflected on the template?
TEMPLATES AND OTHER TOOLS

- History forms with past history, family history, social history, and system review
  - This information needs to be incorporated by reference appropriately
- Progress notes that prompt the provider of documentation requirements
- Charge document
  - E/M codes don’t crosswalk
  - Include all levels of E/M services
  - Include full descriptions of E/M services
  - Common procedures
- The electronic medical record
- **Medical Necessity, above all else !!!**
HISTORY

- Based on Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Past, family, social history (PFSH)
- HPI must be done by the provider
- HPI elements: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms
  - 4 of these are the most ever needed
- Or … HPI can be the status of 3 chronic conditions
REVIEW OF SYSTEMS (ROS) COMPLETE
ROS IS 10 SYSTEMS

- Constitutional
- Eyes
- ENMT
- CV
- Respiratory
- GI
- GU
- Musculo
- Integumentary
- Neuro
- Psych
- Endo
- Hem/Lymph
- All/Immun
**HISTORY**

- **ROS and PFSH**
  - Can incorporate by reference information recorded by ancillary staff or patient or information elsewhere in chart ... ROS and PFSH only
    - Update the information
    - Document date and location of that information
  - If unable to get history, say why
  - Avoid: “all others negative” for ROS
    - Recommend stating the number of systems reviewed
  - Avoid: “noncontributory” for PFSH
    - Recommend “was reviewed and is negative”
HISTORY

- Past, Family and Social History
- Only one item from an area is “required”
- For higher levels of care, some codes require something from all three history areas: past, family, and social
EXAMINATION

- 1995 guidelines are more generic by body system
  - Systems: Constitutional, Eyes, ENMT, CV, Resp, GI, GU, Musculo, Skin, Neuro, Psych, Hem/lymph
  - Problem Focused (PF) = 1 system
  - Expanded Problem Focused (EPF) = **limited** exam of 2 or more systems
  - Detailed (Det) = **extended** exam of 2 or more
  - Comprehensive (Comp) = 8 systems
  - Medicare contractors, insurance companies and internal auditing protocol may have differing definitions for Expanded Problem Focused vs. Detailed
EXAMINATION

- 1997 guidelines are very specific..the “bullets”
  - numeric requirements must be met
  - parenthetical examples are for clarification and guidance only
  - “and” really means “or”
- PF = 1-5 bullets
- EPF = 6-11 bullets
- Det = 12 bullets from at least 2 systems
- Comp = 2 bullets from nine systems for total of 18 bullets
EXAMINATION

- Hybrid (blended) approach:
  - PF = 1 system (‘95)
  - EPF = 2 systems (‘95)
  - Det = 12 bullets (‘97)
    - Or can just go ahead and do 8 systems
  - Comp = 8 systems (‘95)
MEDICAL DECISION MAKING

- Point system for number of dx/management options
  - More credit for new problems vs established problems
  - More credit for worsening established problem vs stable established problem

- Point system for data
  - Order or review: lab, X-ray, EKG, etc.
  - Extra credit if personally review image or test
  - Additional credit for discussing test results with another dr or obtaining hx from other than patient

- Table of Risk
  - Nature of presenting problem, diagnostic procedure(s) ordered, management option(s) selected
  - Expand list of examples, especially high risk
POINT SYSTEM FOR MDM

- Dx/management options
  - 1 point for each stable or improving established problem
  - 2 points for each worsening problem
  - 3 points for each new problem w/o additional work-up
  - 4 points for each new problem with additional work-up
POINT SYSTEM FOR MDM

Data ordered/reviewed
- 1 point for lab test(s)
- 1 point for radiology test(s)
- 1 point for medicine test(s)
  - EKG, pulm function, EMG, etc
- 2 points to personally review imagine, tracing, specimen
- 2 points to review AND summarize old records
- 2 points to obtain history from someone other than the patient
**Point System for MDM**

- **Risk (table of risk)**
  - Examples of Minimal/Low
    - One stable chronic illness or acute uncomplicated illness/injury
    - OTC meds, PT or OT
    - Minor surgery w/o identified risk factors
  - Examples of Moderate
    - One chronic illness with exacerbation or two or more stable chronic illnesses
    - Undiagnosed new problem or acute complicated injury
    - Prescription drug management
    - Elective major surgery w/o identified risk factors
  - Examples of High
    - One chronic illness with severe exacerbation
    - Acute or chronic illness that could pose a threat to life or bodily function
    - Abrupt change in neurological status
    - Drugs requiring intensive monitoring for toxicity
    - Parenteral controlled substances
    - Elective major surgery with identified risk factors or emergency major surgery

- Reference the IDSA coding resources
Coding Based on Time

- Time becomes the overriding factor when greater than 50% of the encounter is counseling or coordination of care
  - Face-to-face time for outpatient
  - Unit/floor time for inpatient
- Documentation must identify:
  - Total length of time (in minutes)
  - Counseling time (in minutes)
  - Brief description of what was discussed
- Might be a good option for daily hospital visits
- Using time to document critical care and prolonged services will be discussed later
CONSULTATIONS – OTHER THAN MEDICARE

- What is the intent?
  - If it’s to manage a portion of the patient’s care, then it’s not a consultation and most likely, a subsequent hospital visit

- Documentation for request
  - Might be in the requesting physician’s progress note or could be in the orders
  - Needs to be specific

- Render an opinion
- Send a report
- Are you still billing consultations to payors who accept them?
ADMIT AND DISCHARGE SAME DATE

- **Same date**
- Can be used for OBS or inpatients
- Medicare guidelines require that the patient be there at least 8 hours if using these codes
- Patient could be inpatient status or OBS status ... codes are the same, place of service would be different
- Require two face-to-face visits
  - Why? The RVU for these codes = admit + discharge
  - Face-to-face for one and phone call for other won’t work
    - If only seen once, then bill for the service rendered, which might be the admit (inpatient or OBS) or it might be the discharge
CRITICAL CARE

- Patient must meet critical care criteria
  - “Critical care is the direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition” ....

- Reference the CPT book and Medicare resources for further information on what are considered “critical care services”
CRITICAL CARE

- 99291 for first 30-74 minutes; 99292 for each additional 30 minutes
  - 75-104 min. = 99291, 99292
  - 105-134 min. = 99291, 99292 x 2
  - 135-164 min. = 99291, 99292 x 3

- Need to combine critical care time within a calendar day
- If procedures done during critical care, the time doing the procedure needs to be backed out of critical care time
- Can bill “regular” E/M additionally IF visit was earlier in day and later the patient required critical care. E/M code will need –25 modifier.

- Only one provider at a time
  - Documentation of time is very important to “prove” there is no overlap with another physician
**Prolonged Services**

- Add-on codes to your “regular” E/M service to indicate additional time spent with patient
  - For office and outpatient, it’s face-to-face time
  - For hospital or nursing facility, it’s unit/floor time per CPT. However, Medicare still refers to it as face-to-face time.
  - Time does not need to be continuous
  - Multiple providers need to add their time together within a calendar day
PROLONGED SERVICES

- Office/Outpatient 99354 and 99355
  - 30-74 minutes = 99354
  - 75-104 minutes = 99354, 99355
  - 105+ minutes = 99354, 99355 x 2 (plus additional units of 99355 as appropriate)

- Inpatient 99356 and 99357
  - 30-74 minutes = 99356
  - 75-104 minutes = 99356, 99357
  - 105+ minutes = 99356, 99357 x 2 (plus additional units of 99357 as appropriate)

- The typical time specified for the base CPT code needs to be subtracted from the total time (threshold time)
# Prolonged Services Threshold Time

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<th>Code</th>
<th>Typical Time</th>
<th>Threshold for 99356</th>
<th>Threshold for 99356, 99357</th>
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</tr>
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<td>99223</td>
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</tr>
<tr>
<td>99233</td>
<td>35</td>
<td>65</td>
<td>110</td>
</tr>
</tbody>
</table>
MEDICARE RESOURCES

- Prolonged Services
  - MLN Matters MM5972 7/1/08

- Critical Care
  - MLN Matters MM5993 7/7/08
For medical review purposes, Medicare requires that services provided/ordered by authenticated by the author ... handwritten or electronic ... no stamp signatures


CARE PLAN OVERSIGHT

- Services within a 30-day period (calendar month)
- Only one physician may report for a given period of time
- Services require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of reports, lab, etc, communication for purposes of assessment or care decisions with healthcare professionals, family members ...
CARE PLAN OVERSIGHT

- Domiciliary, Rest Home (e.g., Assisted Living Facility) or Home Care Plan Oversight Services
  - 99339 for 15-29 minutes
  - 99340 for 30 minutes or more
CARE PLAN OVERSIGHT

- Patient under care of home health agency
  - 99374 for 15-29 minutes
  - 99375 for 30 minutes or more
- Hospice patient
  - 99377 for 15-29 minutes
  - 99378 for 30 minutes or more
- Nursing Facility patient
  - 99379 for 15-29 minutes
  - 99380 for 30 minutes or more
MEDICARE CARE PLAN OVERSIGHT

- G0181  Patient under care of home health agency
- G0182  Patient in hospice

- Both codes are for 30 minutes or more
HOME HEALTH CERTIFICATION

- G0180 Certification
- G0179 Recertification

Effective 2011, “prior to certifying a patient’s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed NPP has had a face-to-face encounter with the patient”
  - To support homebound status and need for skilled services
  - Must occur within 90 days prior to start of care or within 30 days after

- Research Medicare website
TRANSITIONING TO ICD-10

So, what are you doing to get ready for the transition in October, 2014?

- EHR
- Claims processing software
- Learning new codes yet?
  - When do you plan to get training?
  - How will you educate your providers?
Benefits

- Incorporates much greater specificity and clinical information
- Improved ability to measure health care services
- Increased refining of reimbursement methodologies
- Decreased need to include supporting documentation with claims
- Updated medical terminology and disease classification
- Better date for measuring patient care, tracking public health, conducting research, etc.
ICD-9 vs. ICD-10

- ICD-9
  - 3-5 digits
  - Some codes are alpha numeric (V and E codes)
  - Digits 2-5 are numeric

- ICD-10
  - 3-7 digits
  - Digit 1 is alpha
  - Digit 2 is numeric
  - Digits 3-7 are alpha or numeric
ICD-10-CM OFFICIAL GUIDELINES

- Conventions
  - NEC and NOS
  - Brackets and Parentheses
  - Includes and Excludes

- General Coding Guidelines
  - How to locate a code, using alpha index and tabular list

- Chapter-Specific Coding Guidelines
  - Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, NEC (R00-R99)
    - When a definitive diagnosis has not been established

IMPLEMENTATION

- Reality check
  - Based on size of practice
  - Vendors
  - Payers
- How soon?
  - Do something now
  - List of your top ten diagnosis codes, compare to ICD-10 to see what additional specificity will be needed
- Cost?
  - Staff training
  - Physician training
  - Implementation
COMPLIANCE

- More and more emphasis on correct E/M coding
- Use of templates, cut and paste, cloned records
- Appropriate use of modifier -25
  - RAC audits
- Ongoing CERT audits of E/M services
- OIG “hit” list (a few things that are included)
  - Incident-to billing; shared visits
  - POS (place of service) errors
  - E/M coding
BILLING FOR PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

- PA or NP
  - For Medicare, can bill under their own provider numbers or under the physician’s number
    - Own numbers = 85% reimbursement
    - Physician’s number = 100% reimbursement
      - Incident-to rules apply in office (next slide)
      - Shared visits apply in hospital
        - Both must see the patient (face-to-face visit)
        - Both must document
  - Always and never or on a case-by-case basis?
  - Other insurance companies may or may not credential these individuals ... know the rules
INCIDENT-TO CRITERIA

- Clinical Staff must meet incident-to criteria
  - RN, LPN, CMA, etc.
- PA or NP billing in physician’s name must meet incident-to criteria
- Incident-to means:
  - Provider on premises
  - Already established care plan, so no new patients or established patients with new problem
  - Appropriate employer/employee relationship
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