Colorado M.E.S.A. Initiative

Medicare Experts/Senior Access

Innovations in Geriatric Practice and Alzheimer's Care

Core Curriculum Training Workshop

Updated March 2017

Intro to The Colorado M.E.S.A Initiative

- The Colorado M.E.S.A. Initiative
  - **M**edicare **E**xperts / **S**enior **A**ccess
  - Be adept at Medicare coding & documentation so you are paid fairly for work
  - Be comfortable serving patients complex and comorbid geriatric syndromes
- A collaboration:
  - Donald Murphy, MD, geriatrician, MESA founder and faculty member
  - Elane Shirar, MD, founder and owner of Rocky Mountain Senior Care, MESA faculty member
  - Previously funded by The Colorado Health Foundation and others

Our Assumptions and Philosophy

- Seniors deserve access to quality medical care and most providers enjoy taking care of seniors
- Medicare patients are viewed as labor intensive and reimbursement levels are ***perceived*** as inadequate
- ***We believe*** that Medicare reimbursement ***is*** fair when you know how to document and code appropriately
- The system is changing and we don't know what tomorrow may bring
- BUT, we have a specific set of guidelines to follow today
- We must play by the rules, so we must understand the rules

Introduction to Medicare Coding and Documentation

Inappropriate Coding

- Cost of over-coding
  - Lost time and money from audits
  - Potential loss of revenue, fines, or even license

- Cost of under-coding
  - By one level in an office setting: 30 – 50%
  - By one level in a nursing home: 25 – 35%

Medicare Allowable ‘17

Minutes	Office	NH	ALF	Home
5	$21			
10	$45	$46		
15	$75	$71	$61	$56
20				
25	$110	$93	$97	$86
30				
35		$139		
40	$148		$138	$131
45				
50				
55				
60			$197	$182

Level 1

Level 2

Level 3

Level 4

Level 5

Critical Billing Success Factors

- Bill accurately
  - All providers should know how to use ICD & CPT codes
- Bill appropriately
  - Medical necessity
  - Adequate documentation
- Bill courageously
  - Bill fairly for services rendered per the rules
  - Be prepared for audits, not intimidated by them
- Document time in conjunction with medical decision making

Don’t Report All E/M Services by Time

Coding E/M services by time is simpler than reporting services according to history, exam, and medical decision making (MDM), but don’t be tempted to report ***all*** E/M services by time. Keep in mind: the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services’ (CMS) guidelines consider history, exam, and MDM to be the key components of E/M services, and allow coding by time only when 50 percent or more of the visit involves documented counseling and/or coordination of care.

The physician should include the components of history, exam, and MDM—even if cursory—in the documentation of every visit. Good medical record keeping requires documenting relevant and pertinent information. **Using time as the controlling factor to qualify for a given E/M level does not negate this requirement.**

Two Broad Paths

1. **The First Path:** Bill Based on Evaluation & Management (E/M)

2. **The Second Path:** Bill Based on Time *

** If >=50% of time is spent on Counseling and/or Coordination of Care ("C&C")*

E/M Coding

The First Path: Bill on E/M

- Evaluation & Management ("E/M")
- Key components
  1. History
  2. Physical exam
  3. Medical decision making (a.k.a., Assessment & Plan)
- New patient = all 3 components required
- Established patient = 2 of 3 components required (may not need exam, or only a limited one)

E/M 1: History

- Chief complaint
  - A concise statement, usually in the patient's own words
  - The reason for the encounter
- History of present illness
  - Description of the patient's illness from the first symptom (if focusing on one problem)
  - Often a summary of chronic conditions
  - May be a combination of chronic and acute conditions

E/M 1: History *(continued)*

- Review of systems
  - Usually an inventory to identify symptoms, but may include signs or problems past or present
- Past, Family, Social History (PFSH)
  - Past medical history (medication review is key!)
  - Family history includes diseases that may place the patient at risk
  - Social history is review of current or past activities

E/M History Tips

- History elements previously recorded
  - Provider can get credit as long as the element is relevant and referenced
- ROS and/or PFSH record
  - Can be recorded by ancillary staff or patient as long as provider documents confirmation of information
- Unable to obtain a history/ROS
  - Document the patient's condition that precludes getting the history/ROS

E/M 2: Examination

- Should be justified by the history
- May not be medically necessary
- Consider the patient's expectations
  - You may want to use the stethoscope, even if you don't ***have to***

E/M 3: Medical Decision-Making

- Common codes in a geriatric practice
  - Address at least 3 acute or chronic problems
    - 214 (office, level 4)
    - 309 (nursing home, level 3)
    - 336 (assisted living, level 3)
    - 349 (home, level 3)
- Highest level codes
  - Difficult to meet criteria unless patient is quite ill and/or very frail and medical decision-making is very complex
    - 215 (office, level 5)
    - 310 (nursing home, level 4)
    - 337 (assisted living, level 4)
    - 350 (home, level 4)

Common E/M Codes With Seniors

Minutes	Office	NH	ALF	Home
5	211			
10	212	307		
15	213	308	334	347
20				
25	214	309	335	348
30				
35		310		
40	215		336	349
45				
50				
55				
60			337	350

Level 1

Level 2

Level 3

Level 4

Level 5

"Common" Codes

"Highest" Codes

E/M Documentation Tips

- Update problem status - do not just use "stable"
- Be specific – do not just state "continue present treatment"
- Summarize discussions with interested parties (patient, family, staff)

Know a 214

A typical geriatric patient with multiple problems

1. History
    a. Brief chief complaint
    b. History of present illness
        1) Summary of 3 chronic problems
        2) OR elaborate on one acute problem
        3) OR a combination of chronic & acute
    c. Past medical history
        1) Often a medication list update
    d. Review of systems (ROS)
        1) Brief, minimum of 2

Know a 214

2. Examination: targeted, if necessary at all
3. Medical decision-making
    a. Summary of 3 chronic problems
    b. OR elaborate on one acute problem
    c. OR a combination of chronic & acute

An E/M 215 is Challenging

- A high hurdle compared to a 214
  - 10 ROS instead of 2-9
  - A social history instead of none
  - Comprehensive vs. targeted exam
  - Criteria for medical decision-making is more complex
- Exceptions
  - Patient is quite ill and/or very frail and medical decision-making is very complex
  - History justifies an extensive ROS & comprehensive physical exam (e.g. progressive weight loss, worsening fatigue)

Time-Based Coding

The Second Path: Bill Based on Time

- >=50% of the encounter spent on counseling and/or care coordination (C&C)
- Great patient care
- Fair compensation
- E/M detail not necessary
- Must meet a certain complexity of visit

Counseling & Coordination Visit

- Time is the key factor in selecting the level of service when counseling and/or coordination of care dominates (>=50% of) the encounter
  - Estimate an actual percentage
  - Follow the "typical time" standards set by the AMA and published in the CPT book
  - Time approximation must meet or exceed the specific CPT code billed
  - Time should ***not*** be "rounded" to the next higher level
  - Document time in conjunction with medical decision making

Definitions by Location: Outpatient

- Outpatient: clinic, home, ALF
  - Includes activities such as:
    - Teaching and/or planning
    - Coordinating care
  - ***Requires*** *that time be spent directly with the patient, "Face-to-Face"*

Definitions by Location: Inpatient

- Inpatient: SNF, Nursing Home
  - Includes activities such as:
    - Patient/family teaching
    - Patient/family discussion
    - Reviewing old records
    - Discussing case with other providers
    - Coordinating discharge planning, etc.
  - *Time can be spent in the patient's room or at the nursing station, but must be on the premises of the patient's unit (i.e., "Floor Time")*

C&C Documentation Requirements

- Continuous visit: document total time spent (actual number of minutes)
  - Example: “8:00 – 8:40, >=50% C&C”
- Discontinuous visit: document that the duration of the visit was scattered over a longer period of time
  - Example: “Time of visit was 40 minutes, scattered over a two-hour period, >=50% C&C”
  - Each note should have a start time

C&C Documentation Requirements

- If in an outpatient setting, confirm through documentation that time was spent face-to-face
- Outline what was done and/or discussed during time spent
  - Treatment and/or alternatives
  - Importance of compliance with treatment
  - Risks and morbidities
  - Prognosis and recommendations
  - Summarize discussions
  - Patient and/or family education
  - Instructions for management and follow-up care

Which Path?

E/M or Time-Based Billing?

- When billing E/M services, make a decision about whether or not time spent counseling and coordinating (C&C) care dominated the encounter
- Document the chief complaint and a detailed problem list & plan in either case; this establishes medical necessity for the visit and sets the stage for billing E/M should this be the end result

Be Prepared to Take Either Path

- **Construct your note to go either way**
- Start Down 1st Path: E/M
  - Relatively brief and focused (213, 307, 308, 334, 335, 347, 348)
  - Review of several stable conditions (214, 309, 336, 349)
- Jump to 2nd Path if Appropriate: Time
  - You see that visit will be long (family meeting, multiple issues, counseling and/or care coordination)
- Include components of history, exam, and medical decision making—even if cursory

Prolonged Care Services

Rules for adding a prolonged service care code:

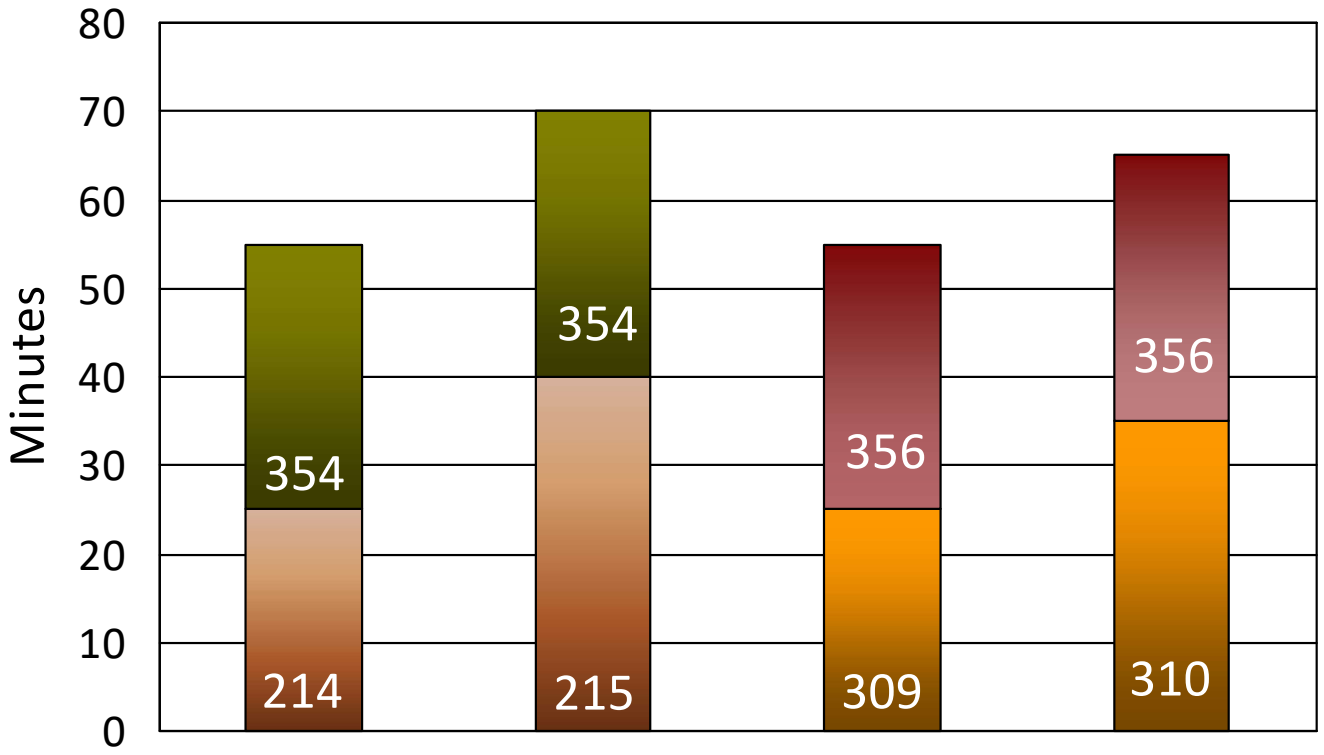
- Prolonged care services are billed separately when a provider spends >30 minutes more than the typical time allotted for any E/M encounter
- Applies to physician or midlevel
- Outpatient (clinic) = face-to-face time
- Inpatient (nursing home) = face-to-face time for the above typical time capture

Prolonged Care Services

Select E/M code **first.**

- Visit level selected based on history, exam, and MDM
  - Add prolonged care code when the total time exceeds the CPT typical time by at least 30 minutes
- Visit level based on time
  - Add prolonged care ***only*** if you meet or exceed the time threshold for the highest code level in that family of codes (i.e., 99310, 99306, 99337, 99328, 99350, 99345, 99215, 99205)
- Floor time counts for the initial selection of the level of service based on time, but the prolonged care service time must be face-to-face

Prolonged Care Services



The threshold ***must*** be met!

Prolonged Care Services

Office Services				
	E&M Code	Typical Time	Threshold Time to Bill 99354	Threshold Time to Bill 99354 and 99355
New Patient	99201	10	40	85
New Patient	99202	20	50	95
New Patient	99203	30	60	105
New Patient	99204	45	75	120
New Patient	99205	60	90	135
Established Patient	99213	15	45	90
Established Patient	99214	25	55	100
Established Patient	99215	40	70	115

Nursing Home Services				
	E&M Code	Typical Time	Threshold Time to Bill 99356	Threshold Time to Bill 99356 and 99357
New Assessment	99304	25	55	100
New Assessment	99305	35	65	110
New Assessment	99306	45	75	120
Subsequent Care	99307	10	40	85
Subsequent Care	99308	15	45	90
Subsequent Care	99309	25	55	100
Subsequent Care	99310	35	65	110
Annual Assessment	99318	30	60	105

Note: *99356 and 99357 are frequently not paid.*

Miscellaneous Coding

Transitional Care Management

- Services provided to an established patient whose medical or psychosocial problems require moderate or high complexity medical decision making during the transition in care from an inpatient hospital setting to the patient's community setting
- Services provided within 30 days of discharge

Transitional Care Management

- One face-to-face visit in combination with non-face-to-face services
- May be performed by the physician or midlevel
- All pre-and post-encounter non-face-to-face care management work is included in the total work for E&M services and bundled into one payment

Transitional Care Management

- Transition FROM: Inpatient Hospital Setting ("Med A")
  - Acute care hospital
  - Rehab hospital
  - Long term acute care hospital
  - Partial hospital
  - Hospital observation status
  - SNF
- Transition TO: Community Setting (Outpatient)
  - Home
  - Domiciliary
  - Rest home
  - Assisted living

Transitional Care Management

CPT Code	Communication with Patient or Caregiver *(direct, phone, or electronic)* Within	Medical Decision Making Complexity	Face-to-Face Visit Within	Reimbursement
99495	2 business days of discharge	At least moderate	14 calendar days of discharge	$167.03
99496	2 business days of discharge	High	7 calendar days of discharge	$236.21

Chronic Care Management

- Non face-to-face services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions
- Chronic conditions expected to last at least 12 months
- This service includes:
  - Communication with the patient and treating health professionals
  - Medication management
  - Care coordination (both electronically and phone)
- Refer to downloadable PDF on website titled, “Chronic Care Management Services 2017” for more details

Advance Care Planning

Effective January 2016, CMS pays for voluntary Advance Care Planning to enable Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it.

- ACP is a time-based code
  - Document total amount of time spent face-to-face with the patient, family members, and/or surrogate
  - Discussions may include the following (first 3 required)
    - **With whom the conversation was held (patient and/or surrogate)**
    - **Types of medical care preferred**
    - **Comfort level preferred**
    - How the patient wishes to be treated by others
    - What the patient wishes others to know

Advance Care Planning

- ACP Codes
  - 99497: First 30 minutes (minimum of 16 minutes)
  - 99498: each additional 30 minutes

- Refer to the downloadable PDF on the MESA website titled, “Advance Care Planning” for more details

Incident-to Qualifications

- Clinic only (not ALF or nursing home)
- Under “incident-to” billing, NPs/PAs are paid at 100% if:
  - Established patient
  - Physician has seen patient
  - Physician initiated plan of care
  - Physician is in clinic during visit
- Otherwise, NPs/PAs earn 85% of Medicare allowable

Incident-to Conditions

- Physician must:
  - Remain actively involved in patient care
  - "Periodically" see the patient
- No "incident-to" with a new illness or problem
- Billing is under the billing number of the physician actually "on-site"

Preventive Care – IPPE

- The Initial Preventive Physical Exam ("IPPE"), also known as the "Welcome to Medicare Visit"
- Must be done within the first 12 months after the effective date of becoming a Medicare patient
- This is a one-time benefit (use it or lose it)
- Download the CMS Quick Reference Guide from the MESA website

Preventive Care – AWV

- CMS allows for a preventive physical exam called the Annual Wellness Visit ("AWV")
- Initial AWV can be done any time (so long as it has not already been performed by another provider) with annual follow-ups
- Download the document, "The ABCs of the Annual Wellness Visit" from the MESA website for more information

Home Care

- Home Care Certifications/Recertifications
  - G0180: certification
  - G0179: recertification, every 60 days
- Care Plan Oversight
  - G0181: Home Hospice or Home Care
  - A minimum of 30 minutes of work during a calendar month

Home Visits – OIG 2017 Work Plan

- Rules changed for 2017
- Must be necessary, not a just a convenience to patient or provider (must document medical necessity)
- Beneficiary does not need to be confined to their home
- Must clearly document how the visit was initiated and what circumstances prevent the patient from traveling to the provider's place of service

Audits

- Be prepared for an audit, not afraid of one!
  - Know the rules and guidelines
  - Have confidence
  - Show proper intent
- If you've done your daily work properly, you've got nothing to worry about
- Regularly audit yourself to be sure

Other MESA Resources

MESA Resources

www.ColoradoMESA.org

- Downloadable supplemental materials
  - Complete PowerPoint version of this presentation
  - CMS documents and coding tools
- Archived webinars on various topics
- Clinical discussion forum
- Clinical Pearls & Protocols for senior patients

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