EVALUATION AND MANAGEMENT:
GETTING PAID FOR WHAT YOU DO

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Agenda

- 2014 OIG Report
- CMS Documentation Guidelines
- Gray Areas
- Modifier 25
- Medical Necessity versus Medical Decision-Making
- Preventive and Problem-Oriented Visit on Same Day
- Care Management Services
Evaluation and Management coding is the mechanism by which physician-patient encounters are expressed as CPT codes in order to quantify the service and facilitate billing.

Expressed in terms of site of service and intensity of service
“We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.”
OIG Report – May 2014

Findings –

• 55% incorrectly coded
  • 26% overcoded
  • 14.5% undercoded
  • 12% insufficient documentation for any level of service
  • 7% undocumented
  • 2% other errors (unbundling, etc.)

Average per claim overpayment - $33
OIG Report – May 2014

Recommendations –

• Consolidate 1995 and 1997 guidelines
  • CMS declines: “…there is no data or other information included in this report that suggests that the inappropriate coding observed by OIG results from having two sets of guidelines.”

• Educate physicians on correct E&M coding
  • CMS: “We already do….” – specifically mentioning extended History of Present Illness

• Encourage contractors to review “high-coding physicians”
“High-Coding Physicians”

- Average code levels in the top 1% for their specialty
- Billed the highest 2 levels at least 95% of the time
The Basics of Evaluation and Management

Documentation Guidelines

Two sets of guidelines established by CMS

- 1995 Documentation Guidelines
- 1997 Documentation Guidelines

Providers may use whichever they choose.

Auditors are instructed to audit under both sets of guidelines and allow the physician to use whichever benefits him/her.

Are there separate CPT Documentation Guidelines?
Gray Areas

- Which two out of three components for established patients?
- What is a comprehensive single specialty exam under 1995 guidelines?
- What is an “extended examination” under the 1995 guidelines?
- What is a new problem?
- What is a self-limited or minor problem?
- What is additional workup?
- ?????

Contractors have the authority to establish standards for these gray areas
Modifier 25

Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of Procedure or Other Service

- Beyond the usual preop and postop care
- Different diagnosis is not required
“In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.”

NCCI Manual
Modifier 25

Clear:

• Different diagnosis – different condition treated

• No additional diagnosis – no treatment other than procedure performed

Unclear:

• No additional diagnosis? Additional treatment rendered?
“…Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported….”
Medical Necessity versus Medical Decision-Making
<table>
<thead>
<tr>
<th>Nature of Presenting Problem</th>
<th>Level of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-limited or minor problem</strong></td>
<td><strong>Office</strong></td>
</tr>
<tr>
<td>Two or more self-limited or minor problems</td>
<td></td>
</tr>
<tr>
<td>One stable chronic illness at one or more chronic illnesses with mild exacerbation,</td>
<td></td>
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<tr>
<td>progression, or side effects of treatment</td>
<td></td>
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<tr>
<td>Two or more stable chronic illnesses</td>
<td></td>
</tr>
<tr>
<td>Two or more stable chronic illnesses</td>
<td>99212</td>
</tr>
<tr>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of</td>
<td></td>
</tr>
<tr>
<td>treatment</td>
<td></td>
</tr>
<tr>
<td>Acute uncomplicated illness or injury</td>
<td></td>
</tr>
<tr>
<td>Undiagnosed new problem with uncertain prognosis</td>
<td></td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td></td>
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<tr>
<td>Acute complicated injury</td>
<td></td>
</tr>
<tr>
<td><strong>Acute or chronic illness or injury that poses a threat to life or bodily function</strong></td>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td>Abrupt change in neurologic status</td>
<td>99221</td>
</tr>
<tr>
<td><strong>Acute or chronic illness or injury that poses a threat to life or bodily function</strong></td>
<td>99231</td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>
Progression of Services

Many contractor and ZPIC audits are being performed on a range of services – that is, multiple visits for the same patient –

• How often is a comprehensive history medically necessary?

• How often is a comprehensive physical examination medically necessary?

• What if there is no change in patient condition?
“If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, and if the problem is significant enough to require additional work to perform the key components of a problem-oriented E&M service, the appropriate Office/Outpatient code should also be reported…Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided….”
Billing Two Codes

• The components that would have been performed as part of the preventive medicine cannot be included in determining the level of service for the problem-oriented code.

• If patient is new, both codes cannot be new – the preventive medicine will be new, the problem-oriented visit will be established

• Patient will likely have a copayment responsibility for the problem-oriented code
Problem-Oriented Visit

How do you separate the “sick” level of service?

• Best practice: separate notes

• What can you separate out for HPI, ROS specific to complaint, history specific to complaint, exam specific to complaint and decision making?

• What would you report if the patient had come in just for that problem?

• Remember that you are billing for the “additional work” performed

• Probably not going to exceed 99213 unless based on time spent in counseling

• Different for Medicare and other payers because Medicare has different requirements for its preventive codes
Care Management Services

- Chronic Care Management – note changes for 2017
- Care Plan Oversight
- Home Health Care Certification and Re-Certification
- Transitional Care Management
- Advance Care Planning
Health and Human Services Strategic Framework on Multiple Chronic Conditions

• empower the individual to use self-care management with the assistance of a healthcare provider who can assess the patient’s health literacy level

• equip care providers with tools, information, and other interventions

• support targeted research about individuals with multiple chronic conditions and effective interventions.

http://www.hhs.gov/ash/initiatives/mcc/index.html
Complex Chronic Care Management

(Change from “Coordination” to “Management”)

Provider oversees management/care for:

- All medical conditions
- Psychosocial needs
- Activities of daily living

Patient have chronic conditions and require care/services from multiple specialties – may have social support weaknesses or access to care difficulties
Complex Chronic Care Management

CPT introduced codes in 2013, not paid until 2017

- 99487 – Complex chronic care management services, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time, per calendar month

- +99489 – each additional 30 minutes of clinical staff time per calendar month

(Originally also code 99488 that included one F2F visit in the calendar month – deleted 2015)
Chronic Care Management Services

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; comprehensive care plan established, implemented, revised, or monitored.
Which Patients?

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
2017 Changes in CCM Requirements

- Initiating visit – only required if not seen within a year
- Consent – written consent not required, document discussion and verbal consent
- Relaxed IT requirements –
  - Structured clinical summary not required
  - Can communicate by fax
- For RHCs and FQHCs, change to general supervision – allowing more flexibility in providing those services
CCM Documentation

- Documentation of discussion with patient and verbal consent
- Care plan developed and written or electronic copy delivered to patient
- Time spent in CCM and by whom
CCM Restrictions

Cannot be billed the same month as:

- Transitional Care Management
- Home Health Care Supervision
- Hospice Supervision
- ESRD monthly services

But can be separately billed with Advance Care Planning codes
New for 2017 – CCM Initiating Visit

- +G0506 – Comprehensive assessment of a care planning by the physician or other QHP for patients requiring chronic care management services, including assessment during the provision of a face-to-face service

Added to E&M, AWV, or IPPE

Only billed once per provider per patient
New for 2017 – Behavioral Health Integration

- G0507 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time

Similar to Chronic Care Management for behavioral health problems

- Initial assessment or followup monitoring, including the use of applicable validated rating scales

- Behavioral healthcare 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

- Continuity of care with a designated member of the care team.
New for 2017 – Psychiatric Collaborative Care

Captures the work of a primary care physician working with a behavioral health manager and consulting psychiatrist to manage patient psychiatric care

- G0502 – Initial psychiatric collaborative care management, first month, first 70 minutes
- G0503 – Subsequent psychiatric collaborative care management, first 60 minutes in a treatment month
- +G0504 – each additional 30 minutes in a calendar month

Requires patient entered into registry
New for 2017 – Care Planning for Patients with Cognitive Impairment

- G0505 – Cognitive and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver

Ten specific requirements -

Expected to be CPT code in 2018
G0505 Requirements

- Cognition-focused evaluation including a pertinent history and examination.
- Medical decision-making of moderate or high complexity
- Functional assessment, including decision-making capacity
- Use of standardized instruments to stage dementia
- Medication reconciliation and review for high risk medications, if applicable.
G0505 Requirements

- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instruments

- Evaluation of safety, including motor vehicle operation, if applicable

- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks.

- Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference.

- Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources needed, care plan shared with the patient and/or caregiver with initial education and support.
CCM - Other Restrictions

May not be billed by practices participating in

• Multi-payer Advanced Primary Care Practice Demonstration
• Comprehensive Primary Care Initiative

Practices affiliated with Accountable Care Organizations may be able to participate
2017 – Prolonged Services

Existing code 99354 increase by 30%

Existing codes 99358-99359 to be paid by Medicare

• 99358 – Prolonged E&M service before and/or after direct patient care, first hour

• +99359 – each additional 30 minutes
Transitional Care Management

- 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

- 99496 – 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 high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
Transitional Care Management

- The patient is discharged FROM a hospital (inpatient or outpatient observation), skilled nursing facility, community mental health center, or partial hospitalization TO a community setting such as home, domiciliary, rest home, or assisted living facility.

- Place of Service on the claim will be the location of the face-to-face visit – typically 11 or 22.
Transitional Care Management

- Obtaining and reviewing the discharge information
- Reviewing need for or followup on diagnostic tests or treatments
- Interaction with other providers who will assume or re-assume care of system-specific problems
- Communication regarding aspects of care
  - With patient and family
  - With home health and other community services
- Assessment and support for treatment regimen adherence and medication management
- Identification of available resources
- Facilitating access to care and services needed
- Medication reconciliation no later than F2F visit
Transitional Care Management

• The code is for 30 days of care
  • Billed on the date of the face-to-face visit
  • Must provide 30 days of care – not billed for less than 30 days
• Communication within 2 business days of discharge – phone, e-mail, in-person
• Face-to-face visit
  • Within 14 days for 99495
  • Within 7 days for 99496
  • Medication reconciliation/management must occur no later than the date of the face-to-face visit
• Only once per 30 days – even if subsequent hospitalization and discharge
Care Plan Oversight

Supervision of a (home health, hospice, nursing facility) patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month.
Care Plan Oversight

CPT codes –

• 99374 – home health agency – 15-29 mins
• 99375 – home health agency – 30 mins or more
• 99377 – hospice – 15-29 mins
• 99378 – hospice – 30 mins or more
• 99379 – nursing facility – 15-29 mins
• 99380 – nursing facility – 30 mins or more
CPO - Medicare

G0181 – home health agency – 30 mins or more

G0182 – hospice – 30 mins or more

No Medicare coverage for CPO for patient in nursing facility
CPO Requirements for Medicare

- Cannot have a significant financial arrangement or be an employee or medical director of the home health agency or hospice. Only one physician per month may bill CPO.
- Must be the physician who signed the certification for the HHA or hospice services.
- Face-to-face service within the past six months.
- Must have personally provided at least 30 minutes of service in one calendar month.
What Counts for CPO Time?

• Reviewing charts, reports and treatment plans
• Reviewing diagnostic studies if the review is not part of an E/M service
• Phone calls with health care professionals who are not employees of the practice and are involved in the patient's care
• Conducting team conferences
• Discussing drug treatment and interactions (not routine prescription renewals) with a pharmacist
• Coordinating care if physician or nonphysician practitioner time is required
• Making changes to the treatment plan
What DOES NOT Count for CPO Time?

- Renewing prescriptions
- Talking with fellow employees/partners
- Travel
- Preparing and submitting claims
- Talking to the patient’s family
- Work performed as part of discharge services
- Interpreting test results at a visit
CPO Documentation

- Log of time spent and activities performed to support 30 minutes or more
- Face-to-face visit within 6 months

Tools available through specialty societies – may also be available from your EMR vendor

Internet search “care plan oversight documentation”
Certification/Re-Certification

- G0180 - Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period

- G0179 – per re-certification period

Care must be certified by a physician – not NPP
Certification/Re-Certification Documentation

More than just signing the CMS-485 form

• Face-to-face visit within 90 days prior to home health services or 30 days after start for the condition requiring home health care

• Documentation must support
  • Need for services
  • Homebound status
Certification/Re-Certification

- The place of service code should represent the place where the majority of the plan development and review work was performed.

- The date of service is the date the service was performed, i.e., the date the plan was signed. A span of dates is not appropriate.

- No other services may be billed on the same claim as the physician services for certification or recertification.
Advance Care Planning

- 99497 – Advance care planning; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- 99498 – each additional 30 minutes
Advance Care Planning

Payment for CPT codes 99497-99498

- With or without completing forms
- Must be performed by physician or NPP
- Deductible or cost-share applicable if performed by itself or same day as E&M
- No deductible or cost-share if performed same day as Annual Wellness Visit
- Not billable with IPPE – Welcome to Medicare – as end-of-life planning is required part of that visit.
Advance Care Planning

- Subject to Local Coverage Determinations
- No limitation as to specialty or frequency
- “other qualified health care professional”
  - Incident-to guidelines apply
- CPT time rules apply
- May not be billed with critical care codes 99291-99292, 99468-99476, 99477-99480
CPT Time Rule

CPT 2016 Professional, page xv –

“A unit of time is attained when the midpoint is passed.”

Regarding Advance Care Planning codes –

99497 – requires documentation of at least 16 minutes face-to-face with patient.

99498 – as an add-on to 99497, requires documentation of at least 46 minutes face-to-face with the patient.
ACP – same day as E&M

• “reasonable and necessary for the diagnosis and treatment of illness or injury”
• Same diagnosis as office visit

Example –

72yo female with end-stage Parkinson’s with dementia is seen for visit at which she also wishes to discuss her wishes for future care. An advance directive is completed and executed according to applicable state law.

Documentation: “In addition to the time spent in evaluation and management of Mrs. ----’s Parkinson’s disease, we spent 45 minutes discussing her wishes regarding nursing home care as her condition progresses as expected.”
ACP – same day as E&M

• Billed with same diagnosis as E&M

• Patient cost-share and deductible apply

Example – Physician bills 99214 with primary dx code G31.83 and 99497 with same dx code

Patient (or her secondary insurance) will be responsible for deductible and 20% cost-share.

Cannot bill additional time with 99498 – CPT time rule: time spent must be more than half that defined in the code.
Example Documentation –

“Aside from the time spent in performing Annual Wellness Visit, I spent 30 minutes discussing the patient’s wishes regarding end-of-life care. Forms for advanced directive were discussed, and she will complete them after discussing with her children.”

• Billed with modifier 33
ACP – same day as AWV

• Physician bills G0439 with dx code Z00.00 and 99497-33 with dx code Z71.89 - other specified counseling (watch for LCDs for other specified codes to use)

• Patient has no financial responsibility

• May be included as part of care plan on which CCM rests
Which Services?

- Advance Care Planning can be billed in conjunction with any of these other care management services.

- Otherwise, must choose which code best captures the work/service performed – cannot bill CCM, TCM and/or CPO for the same time period.
Questions?
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