Strategies for Coding, Billing + Getting Paid Appropriately

2014 Supplement

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It is the beginning of a new year and time to take a look at what every family medicine practice needs to do to make the most of the reimbursement environment for the coming year.

As our system for reporting service, Current Procedural Terminology (CPT), becomes more mature, there are fewer and fewer new codes added each year and hence fewer opportunities to increase revenue by reporting a new service. However, that doesn’t mean that we should not look at the changes made. We still need to ensure that every practice is capturing all services done and reporting them correctly. Capturing all services done and reporting them correctly will help avoid any possibility of a third party payer requesting money back from a physician because of the inappropriate use of a code. Let’s begin by going over some of the coding changes for 2014 and then discuss some of the other things practices should be doing to ensure they maintain or increase their revenue for 2014.

CPT/Coding Update for Family Medicine – 2014:
Changes are few, but important, and some of them are quite subtle.

CPT 69210
Removal of impacted cerumen, has been revised to clarify that this code should be used to report unilateral removal of impacted cerumen. The descriptor was further revised to clarify that 69210 should be used only when removal for impacted cerumen requires use of instrumentation. If a bilateral procedure is performed, then the modifier 50 should be appended to the code to indicate the service was performed on both ears. Additionally, a cross-reference was added directing users to report Evaluation and Management (E/M) service codes when cerumen removal is not impacted or does not require instrumentation. In other words, a simple ear wash or lavage, often done by a medical assistant, is considered part of an E/M service and should be reported using an E/M service code.

While the new description reflects what has been the intent of this code for some time, it has previously been somewhat vague in description and never reflected that instrumentation was required. This is a code that third party payers could watch closely in the coming year, and they may request medical record documentation to support that the code is being used properly.

Remember that this is considered to be a surgical procedure and as such falls within the global surgical concept, even though there are no (00) days assigned. In this case a -25 modifier should be appended to any E/M service done the same day as the cerumen removal to support the need for both the E/M service and the surgical service. Appropriate diagnosis codes should be used to support the medical necessity of doing both services.

Hospital Discharge Day Management
To conform with the CPT Nomenclature Reporting Neutrality initiative, the note following code 99329, (which pertains to both CPT 99328 and 99239, was revised to adhere to the policy of neutrality in identifying who may perform a procedure or a service. In addition, a note was added to address concurrent care services. Here is what it means for the family physician who sees inpatient hospital patients:
1) One physician or provider, only, should report discharge day management services and that should be the physician who does the discharge summary for the patient.

2) If another physician also sees the patient on the day of discharge and reviews his or her discharge instructions with that patient, they should code their service using the subsequent hospital care codes (99231 – 99233). If necessary it would be appropriate to select that code based on the amount of unit/floor time spent on that patient if the time spent on counseling/coordination of care is adequately documented.

**Interprofessional Telephone/Internet Consultations**

Four (4) new codes, designated by time, have been developed to report this service.

**What is it?**
- A non-face-to-face assessment and management service by a physician with specific specialty expertise.
- Typically provided in complex and/or urgent situations that do not allow for a timely face-to-face service (e.g., geographical distance).

**Who reports it?** The physician with specific specialty expertise who:
- Has not had a face-to-face encounter with the patient within the last 14 days.
- Cannot accept transfer of care until after the telephone/internet consultation.

**Who is the patient?**
- New patients to the consultant.
- Established patients to the consultant with new problems or exacerbation of existing problem.
- If established patients, then they should not have been seen by the consultant in last 14 days.

**What is Included?** Review of:
- Pertinent records;
- Laboratory studies;
- Imaging studies;
- Medication profile; and/or
- Pathology specimens.

Greater than 50 percent of the time reported must be devoted to medical consultative verbal/internet discussion.

**What is documented?**
- Written or verbal request of treating physician/qualified health care provider (QHP);
- Reason for the request;
- Verbal opinion report; and
Written report from the consultant to the treating physician/QHP.

When is the code not reported?

- If it is an immediate transfer of care to the consultant;
- If it is an “other” face-to-face service within the next 14 days or next available appointment date of the consultant;
- If the patient has been seen by the consultant within the last 14 days;
- If it is a telephone/Internet consultation of less than five minutes; or
- If the sole purpose of the call is to transfer care.

What does the treating physician/QHP report? (This is IMPORTANT for family physicians!)

- Face-to-face Prolonged Services (99354-99357) if time exceeds 30 minutes beyond typical E/M time and the patient is present (on-site) and accessible. *Medicare may pay for this service if you have documented the circumstances and the time.*
- Non-face-to-face Prolonged Services (99358 – 99359) if time exceeds 30 minutes beyond typical E/M time and the patient is not present. *Medicare considers this a “bundled” service, will not pay for it and the provider may not bill the patient for it.*

What are the potential concerns? *There is a proven track record!*

- The patient/caregiver may not be aware of the service.
- It is important for the patient/caregiver to be made aware.
- This service has been successfully implemented in child psychiatry supporting primary care.

The new CPT codes for these services are:

- 99446 – 5-10 minutes of medical consultative discussion and review.
- 99447 – 11-20 minutes of medical consultative discussion and review.
- 99448 – 21-30 minutes of medical consultative discussion and review.
- 99449 – 31 minutes or more of medical consultative discussion and review.

Practices should check with their payers to see if these services are covered before they begin billing for them.

Complex Chronic Care Coordination Services (CCMS)

Let’s revisit this service, because Medicare has proposed to begin covering and paying for it in 2015. Any time and frequency limits or other requirements for CMS to pay for this service is expected to be addressed in the Final Rule for 2015.

CMS expects this service to be most frequently billed by primary care physicians, though specialists who meet the requirements may also bill for these services. CMS believes that nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives are the only non-physician qualified health care professionals that may furnish the full range of these
services under this Medicare benefit, but only to the extent permitted by applicable limits imposed by state scope of practice laws. While clinical psychologists are not permitted to bill for CCMS, practitioners furnishing the service may refer patients to mental health professionals as part of chronic care management when necessary.

CMS expects that many CCMS will be furnished “incident to” a physician’s services. If provided in compliance with applicable state law, time spent by a clinical staff person furnishing aspects of CCMS outside the practice’s normal business hours during which there is no direct physician supervision would count toward the time requirement to bill for the service, even though the services do not meet the direct supervision requirement for “incident to” services.

There are several other requirements that CMS makes as well:

1) Before a practitioner can furnish or bill for CCMS, eligible beneficiaries must be informed about the availability of these services, how they are accessed, how the patient’s information will be shared with other providers in the care team and that cost-sharing applies to CCMS even when they are not delivered face-to-face (i.e., the Medicare patient may have some financial responsibility).

2) A written or electronic copy of the care plan is required to be provided to the beneficiary and this also must be documented in the patient’s electronic medical records. Further, CMS recommends that a practitioner furnish an annual wellness visit (AWV) or initial preventative physical examination (IPPE) prior to furnishing CCMS.

3) Beneficiaries must provide consent at the outset to receive CCMS and practitioners are required to document in the medical record that the CCMS were explained and offered to the patient, noting the patient’s decision to accept the services. While revocation of the agreement to provide CCMS is not effective until the end of a current 30-day period, a beneficiary may do so at any time. Subsequent to revocation, a beneficiary may choose to seek CCMS from a different practitioner, who would then need to fulfill all of the requirements for billing this service.

In addition to the required CCMS components, CMS will require that providers meet certain standards that will require additional investments in staff training and technology, such as a certified Electronic Health Record (EHR) that meets the most recent regulatory standard for meaningful use, that is, an EHR that practitioners could access 24 hours a day, seven days a week.

CPT made several editorial guideline revisions to the subsection on Complex Chronic Care Coordination Services for 2014 to clarify:

- Care plan – what is included;
- Patient population – adult and pediatric;
- Care coordination office/practice capabilities; and
- Reporting requirements.

As clarified by CPT, care coordination activities performed by clinical staff typically include:
Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care.

Communication with home health agencies and other community services utilized by the patient.

Collection of health outcomes data and registry documentation.

Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.

Assessment and support of treatment regimen adherence and medication management.

Identification of available community and health resources.

Facilitation of access to care and services needed by the patient and/or family.

Development, communication and maintenance of a comprehensive care plan.

CPT further identifies that the office/practice must have the following care coordination capabilities:

- 24/7 access to physicians or other qualified health care professionals or clinical staff;
- A standardized methodology to identify patients who require chronic complex care coordination services;
- An internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
- A form and format in the medical record that is standardized within the practice; and
- The ability to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

For a further discussion of CCMS and a description of its general components, access the 2013 Update of Strategies for Coding, Billing and Getting Paid Appropriately at www.familydocs.org/resources/coding-billing.

CPT Clarification of Transitional Care Management Services

We saw an increase in the provision of this service in 2013 and expect it to increase even more in 2014. This is a service often provided by the family physician. There is greater specificity around the transitional care management (TCM) codes. Specifically, the TCM services are not applicable to new patients, as indicated in the revised CPT guidelines. Other revisions to the TCM guidelines provide further clarification of the use of these services:

1. Additional E/M services reported separately should be on subsequent dates after the first face-to-face visit.
2. The physician must specify that the discharge service may not constitute the required face-to-face visit.
3. TCM is not reportable in the postoperative period of a service by the same individual who reported the operative service.

This clarification means that the day of discharge counts as day one of the 30-day period, but the two business days for contacting the patient begin after the discharge.

To review the elements required for billing this service, here is what is required for each code:
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge;
Medical decision making of at least moderate complexity during the service period; and
Face-to-face visit, within 14 calendar days of discharge (included in the service and not billed separately).

Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge);
Medical decision making of high complexity during the service period; and
Face-to-face visit, within seven calendar days of discharge (included in the service and not billed separately).

To access the AAFP 30-day worksheet for documenting TCM services go to: http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCM30day.pdf

New Vaccine Codes
There are several new CPT codes for influenza virus vaccine, some of which are awaiting FDA approval (as indicated with the ✅ symbol). Several of them were released mid-year 2013 and are just appearing in CPT 2014 as new, fully usable codes. They are:

90673 Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.

90685 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children six to 35 months of age, for intramuscular use.

90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals three years of age and older, for intramuscular use.

90687 Influenza virus vaccine, quadrivalent, split virus, when administered to children six to 35 months of age, for intramuscular use.

90688 Influenza virus vaccine, quadrivalent, split virus, when administered to individuals three years of age and older, for intramuscular use.

2014 – A Year of Bonus Versus Adjustment/Penalty:

A very important reimbursement strategy for every medical practice, but especially for family medicine and other primary care providers in 2014, will be to take advantage of a few remaining bonus programs that are offered. Just as important, those practices will want to avoid any payment adjustment or penalty when possible. Most of the adjustment programs are based
upon a physician’s nonparticipation in a few federally mandated programs. Here is an update on some of those programs.

**Primary Care Incentive Program**

The Affordable Care Act (ACA) gave select Medicare primary care services a 10 percent bonus between the years 2011 and 2015 and set Medicaid primary care payments on par with those of Medicare in 2013 and 2014. There is movement to continue these pay increases, which could come in legislation that repeals Medicare’s sustainable growth rate (SGR) payment formula. That legislation faces a tough battle, however, as a budget conscious Congress works to keep the SGR repeal price tag low. In the meantime, each physician should assure that he or she is receiving these incentive payments when entitled.

There is no need for a physician to apply for the Medicare program; eligibility is determined automatically by the following:

1. The provider must have a Medicare physician specialty designation of family medicine (08), geriatric medicine (38), pediatric medicine (37), internal medicine (11), or a nonphysician provider (NPP) designation of nurse practitioner (50), clinical nurse specialist (89), or physician assistant (97).
2. Primary care services must account for at least 60 percent of the practitioner’s total allowed charges under the physician fee schedule in the qualifying calendar year.
   a. Medicare claims data from the calendar year that is two years prior to the Pre-existing Condition Insurance Plan (PCIP) incentive payment year (e.g., CY 2012 for CY 2014 eligibility).

If you do not automatically receive a quarterly bonus payment, contact the Medicare carrier (MAC) to verify eligibility – [www.noridian.com](http://www.noridian.com).

To assure that you receive the additional payment from Medicaid/MediCal to which you are entitled, you must self-attest to being a primary care physician. You can do that on the MediCal website at [http://files.medi-cal.ca.gov/pubsdoco/aca/aca_form_landing.asp](http://files.medi-cal.ca.gov/pubsdoco/aca/aca_form_landing.asp).

**Physician Quality Reporting System (PQRS)**

Eligible professionals (EPs) who successfully report on quality measures are eligible for a 0.5 percent PQRS incentive payment for 2014, the last year a bonus will be made available through this Medicare program. Penalties will be applied in this program in 2015 and 2016. CMS will apply a two percent penalty in 2016 for non-participation.

**Reporting to earn a 2014 incentive:** In most cases, to earn a 2014 incentive, EPs will be required to report at least nine PQRS measures covering at least three National Quality Strategy (NQS) domains for at least 50 percent of the EP’s Medicare Part B fee-for-service (FFS) patients seen during the reporting period to which the measure applies. Alternatively, EPs can report one measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. There is a single six-month reporting period option for 2014: reporting a measures group via registry from 7/1/2014 – 12/31/2014. Detailed PQRS reporting requirements for earning a 2014 incentive are found on the CMS website: [www.cms.gov/pqrs](http://www.cms.gov/pqrs).
Reporting to avoid a 2016 penalty: To avoid a 2016 PQRS penalty, in most cases, EPs will be required to report at least three measures for at least 50 percent of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Alternatively, those EPs who meet the criteria to earn a 2014 incentive will also avoid the 2016 PQRS penalty. CMA did not finalize the Administrative Claims option for the purposes of avoiding the 2016 penalty. Detailed reporting requirements for avoiding a 2016 penalty are also found on the PQRS page on the CMS website: www.cms.gov.

Meaningful Use – Incentive or Adjustment?
2014 is the last year in which doctors who have not previously participated in Meaningful Use (MU) can do so and avoid financial penalties that begin in 2015. The penalties can be substantial, so it is important that each physician weigh the ramifications of not participating very carefully and make an informed decision. Payment adjustments for nonparticipation begin at 1 percent and can potentially be as high as 5 percent if a physician does not participate in this program to adopt and use an electronic health records system.

For physicians who have successfully attested to MU1 previously, they can choose any 90-day period in 2014 to meet their MU2 objectives and qualify for the next round of incentive payments. Start now to review the MU2 objectives and prepare to qualify.

ICD-10: A Speeding Locomotive Heading toward Your Practice – ETA: October 1, 2014!
The transition to using ICD-10 to report diagnosis will undoubtedly be one of the biggest challenges facing medical practices in 2014. While the implementation or compliance date is not until October 1, 2014, every practice needs to start now to get ready for this massive change. Many organizations have been preparing for several years for the transition, but it may still be premature for most physicians to become familiar with all of the nuances of the new coding system. After all, until you regularly use ICD-10, it is unlikely that you will retain much of what you learned too early.

However, there are a number of things every practice should be doing at this time to get ready for this big change:

1. Identify the areas of impact in your practice - where do you use diagnosis codes – processes, people, systems, paperwork, forms and templates?
2. Get started on your plan for transition - what needs to be done; who will do what; what results are expected; what is the timeline for each?
3. Communicate with your vendors and partners – what are each of them doing to help you with the transition; when will you be able to test; what will the costs be to you?
4. Plan for education – who needs to be trained, at what level, how will the training be done, what will the education cost?
5. Identify the costs and budget for the transition – system upgrades, templates, forms and other paper products, education, contingency plans, delayed or reduced revenue.
Here are additional steps every physician and other providers can take now:

› Familiarize yourself with the basic structure of ICD-10.
› Practice documenting a more complete diagnosis, including details such as site, laterality, complications and any other specific characteristics such as episode of care.
› Develop more detailed templates to ensure that your documentation will meet coding and billing requirements.
› Convert your current most commonly used ICD-9 codes to ICD-10 codes keeping in mind that there is not a one-to-one match for each code.

The more any physician and his or her practice can do at the beginning of 2014 to get ready for the transition to ICD-10 in the latter half of 2014, the greater the likelihood that the practice will have a successful and less stressful transition to the new diagnosis coding system. The practice will also be less likely to have dramatic fluctuations in revenue.

The year 2014 promises to be a busy year for family physicians. With every challenge there is opportunity. Make the most of these opportunities by being well educated about each of them. Be prepared to face the challenges and you will then be in a position to reap the benefits of each opportunity.