2014 Billing & Coding Strategies

For

California Academy of Family Physicians
About This Manual

© Copyrighted 2014, The Sage Associates, Pismo Beach, California

All rights reserved. All material contained in this manual is protected by copyright. Participants who receive this book as part of a workshop presented by The Sage Associates have permission to reproduce any forms contain herein, solely for their own uses within their medical practices. Any other reproduction or use of material in this book without the permission of the author is strictly prohibited.

The material in this manual was written by practice management consultants. Any advice or information contained in this manual should not be construed as legal advice. When a legal question arises, consult your attorney for appropriate advice.

The information presented in this manual is extracted from official government and industry publications. We make every attempt to assure that information is accurate; however, no warranty or guarantee is given that this information is error-free and we accept no responsibility or liability should an error occur.

CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only. It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.
Mary Jean Sage

The Sage Associates
897-309 Oak Park Blvd.
Pismo Beach, CA 93449
Tel: (805) 904-6311
Fax: (805) 904-6313

www.thesageassociates.com
mjsage@thesageassociates.com
2014’s Biggest Challenges

• Stage 2 Meaningful Use

• ICD-10

• Affordable Care Act (ACA)
Today’s Topics:

• CPT/HCPCS Coding Update for Primary Care
  – Transitional Care Management
  – Complex Chronic Care Coordination
  – Interprofessional Telephone/Internet Consultations
  – Procedures & Other
    • Ear Wax Removal – new description
    • New Vaccine Codes

• Medicare Update
  – Deductibles, Copayments, Fee Schedules
  – New Rules / Regulations / Guidelines
  – Incentives vs Adjustments
Today’s Topics:

• Other Collection Challenges
  – New Plans / New Enrollees
  – New Collection Challenges

• The ICD-10-CM Transition
  – Get Your Systems Ready
  – Learn the Basics
  – Assess Your Documentation
  – Practice with the New Codes
  – Implement
What’s New in CPT?
Interprofessional Telephone/Internet Consultations

- New codes 99446 – 99449
  - 99446  Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 5-10 minutes
  - 99447  11-20 minutes medical consultative discussion/review
  - 99448  21-30 minutes medical consultative discussion/review
  - 99449  31 minutes or more

- Describe a scenario when the patient’s treating provider requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist in the diagnosis and/or management of the patient, without the need for face-to-face contact with the consultant

- The request for the consultation must be documented in the patient’s chart by the requesting provider and the encounter also involves a verbal and written report to the requesting provider
Interprofessional Telephone / Internet Consultations

• To be used in complex and/or urgent situations where a timely face-to-face service with the consultant may not be feasible

• Reporting by the consultant, no by the provider who requests the consult. The consultant cannot have seen the patient in the prior 14 days

• Should not be reported by a consultant who agrees to accept transfer of care or when the sole purpose of the communication is to arrange transfer of care

• No published RVUs for 2014
For the Treating Physician

- If patient is present at the time of the Interprofessional consult and accessible to the treating physician
  - Prolonged Services – direct patient contact (99354 – 99357)

- If patient is not present at the time of the Interprofessional consult
  - Prolonged Services – indirect patient contact (99358 - 99359)
Transitional Care Management Guideline Changes

• New and Established Patients

• E/M services may be reported separately if they are NOT provided on same date as the first face-to-face TCM visit

• Discharge service does not constitute the first face-to-face visit

• Same individual should not report TCM services provided in a postoperative period of service that the individual reported
  – You may report TCM in a postoperative period if you did not perform the operative service
TCM – The Requirements

• Interactive contact with the patient or caregiver within 2 business days of discharge - may be direct (face-to-face), telephonic, or by electronic means
  – Monday through Friday, except holidays

• Medication reconciliation and management no later than the date of the face-to-face visit

• A face-to-face visit with the specified time frames
  – 99495 = 14 calendar days of discharge
  – 99496 = 7 calendar days of discharge

• Medical Decision Making of Moderate or High Complexity
  – 99495 = Moderate Complexity
  – 99496 = High Complexity

• Reported once per patient within 30 days of discharge
  – Discharge day counts as day 1
TCM – The Documentation

- Obtaining and reviewing the discharge information
- Reviewing the need for or following up on pending diagnostic tests and treatments
- Interacting with other qualified health care professionals who will assume or resume care of the patient’s system-specific problems
- Educating the patient, family, guardian, or caregiver
- Establishing or re-establishing referrals and arranging for needed community resources
- Assisting in scheduling any required follow-up with community providers and services
### Medicare Reimbursement for TCM 2014

#### Northern California

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Area 03</th>
<th>Area 05</th>
<th>Area 06</th>
<th>Area 07</th>
<th>Area 09</th>
<th>Area 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>$188.17</td>
<td>$198.17</td>
<td>$197.75</td>
<td>$187.76</td>
<td>$196.52</td>
<td>$171.23</td>
</tr>
<tr>
<td>99496</td>
<td>$265.11</td>
<td>$279.86</td>
<td>$278.44</td>
<td>$264.57</td>
<td>$276.78</td>
<td>$241.63</td>
</tr>
</tbody>
</table>

Area 03 = Marin, Napa, Solano  
Area 05 = San Francisco  
Area 06 = San Mateo  
Area 07 = Alameda & Contra Costa  
Area 09 = Santa Clara  
Area 99 = All Other Northern CA counties
# Medicare Reimbursement for TCM

## Southern California

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Area 17</th>
<th>Area 18</th>
<th>Area 26</th>
<th>Area 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>$180.86</td>
<td>$179.44</td>
<td>$184.31</td>
<td>$171.23</td>
</tr>
<tr>
<td>99496</td>
<td>$253.00</td>
<td>$253.11</td>
<td>$259.84</td>
<td>$241.63</td>
</tr>
</tbody>
</table>

Area 17 = Ventura  
Area 18 = Los Angeles  
Area 26 = Orange  
Area 99 = San Diego, Santa Barbara and San Luis Obispo
Complex Chronic Care Coordination (CCCC) Guideline Changes

• Changes are intended to facilitate Medicare payment in 2015!
  – Become familiar with the codes now
• Commercial (Private Payers) *may* accept the codes in the interim
• Clarifies
  – Care plan – what is included
  – Patient population – adult and pediatric
• Care coordination office/practice capabilities
• Reporting requirements
Care Plan – What is Included?

- Medication Management
- Ongoing Patient Education
- Patient Self-management
- Outreach Services

Most of these services will be furnished “incident to” a physician’s service
• Provide 24/7 access to physicians or other qualified health care professionals or clinical staff
• Use a standardized methodology to identify patients who require CCCC services
• Have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
• Use a form and format in the medical record that is standardized within the practice
• Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient
• Can not be reported if the care plan is unchanged or requires minimal changes
  – “Developing, substantially revising, and implementing” a care plan under the
direction of a physician or other qualified health professional
    • i.e. Identifying a new problem that requires additional interventions

• Comprehensive plan *typically* includes:
  – Problem List
  – Expected Outcome and Prognosis
  – Measurable Treatment Goals
  – Symptom Management

• Reporting Time of Clinical Staff - “Only the time of the clinical staff of the
reporting professional is counted. Only count the time of one clinical staff
member when two or more clinical staff members are meeting about the patient”
• 99487  Complex chronic care coordination services, first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

• 99488  First hour of clinical staff time directed by a physician or other qualified health care professional with one-face-to-face visit, per calendar month

• 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)
Other CPT Changes
Ear Wax (Cerumen) Removal – CPT 69210

- Used to report unilateral removal of impacted cerumen
  - If bilateral procedure performed, apply modifier -50

- Should only be used when removal of impacted cerumen requires use of instrumentation – any of these:
  - Curette
  - Forceps
  - Suction

- If cerumen is in impacted or does not require instrumentation for removal (simple lavage) then use E/M service code to report

- Use -25 modifier on any E/M service done on the same date
Considerations

- **Visual**: Cerumen impairs the exam of clinically significant portions of the external auditory canal tympanic membrane, or middle ear condition

- **Qualitative**: Extremely hard, dry, irritative cerumen is causing symptoms such as pain, itching or hearing loss

- **Inflammatory**: Cerumen is associated with foul odor, infection, or dermatitis

- **Quantitative**: Obstructive, copious cerumen cannot be removed without magnification and multiple instrumentations requiring physician skill
New Vaccines – Flu

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

- **90685** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

- **90686** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use

- **90687** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

- **90688** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
Medicare Physician Fee Schedule (MFFS)

• The Pathway for SGR Reform Act of 2013, signed into law 12/26/2013, prevents the scheduled 2014 SGR cut January 1 through March 31, 2014
  – 2014 conversion rate during that time is $35.8228
  – 1.0 work GPCI floor extended
  – Therapy caps exceptions process extended

• Congress continues to consider options for repeal or delay of the SGR and its resulting cuts

• Changes to RVUs are now in effect

• All other “final rule” elements have gone into effect
MCR – Patient Responsibility

• Part B Deductible = $147

• Part B Co-Insurance = 20% of allowable
• Telehealth - added the two TCM services to the approved telehealth services list

• Increased therapy cap amount to $1920 (2013 = $1900)

• Requirements for billing “incident to” services – personnel performing “incident to” services must meet state law requirement for performing such services, including licensure
  – Result of 2009 OIG recommendation

• Ultrasound screening for abdominal aortic aneurysms (AAA) – removes the requirement that a beneficiary receive a referral for AAA screening as part of his/her IPPE
  – Eliminates the one year time limitation
• Liability for Overpayments
  – Increases timeframe from which provider is deemed to be without fault, absent any evidence to the contrary from three years to five years

• Physician Compare Website
  – Contains information about healthcare provider enrolled in Medicare
  – Mandated by ACA and CMS must add more information in the coming years
    • Participation in Meaningful Use
    • Satisfactory Reporting on Quality Programs - GPRO
Incentive vs Adjustments

• Primary Care Incentive Program (PCIP)
  – Continues one more year
  – 10% incentive – paid quarterly

• Medicaid (Medi-Cal) Primary Care Payments Parity (with Medicare)
  – Need to Self-Attest to being Primary Care on Medi-Cal website – www.medi-cal.ca.gov
  – E/M services and vaccine administration
Federal Quality Reporting Programs
This is a critical year for practices to avoid penalties under Medicare’s biggest quality reporting programs

<table>
<thead>
<tr>
<th>2014 Program Participation</th>
<th>Penalty / year levied</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-prescribing</td>
<td>2% penalty / 2014</td>
</tr>
<tr>
<td>PQRS</td>
<td>2% penalty / 2016</td>
</tr>
<tr>
<td>EHR Meaningful Use</td>
<td>2% penalty / 2016</td>
</tr>
<tr>
<td>Value-Based Payment Modifier</td>
<td>2% penalty 2016</td>
</tr>
</tbody>
</table>
Incentives & Adjustments

• Physician Quality Reporting System (PQRS)
  – 2014 Incentive - 0.5%
    • Must report nine PQRS measures covering at least three National Quality Strategy (NQS) domains for at least 50% of the EP’s Medicare Part B fee-for-service patients seen during reporting period
      – Alternatively, report one measures group for at least 20 patients – via registry
  
  – Avoiding 2016 Penalty
    • Report at least three measures for at least 50% 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
Incentives & Adjustments

• Meaningful Use

  – 2014 last year to begin participating to avoid financial penalties that begin in 2015

  • 1% → 5%
Incentives & Adjustments

• Expansion of Value-Based Payment Modifier (VBPM)
  
  – Directly tied to PQRS participation and performance

  • 2016 VBPM will impact group practices with 10 or more eligible professionals

  • All physicians in 2017

    – Based on 2014 performance

  – Groups who do not successfully participate in PQRS in 2014 will receive a 2% payment adjustment in 2016
Other Reimbursement Challenges
ACA Implementation

• New Plans

• New Enrollees

• New Administrative Challenges

• New Collection Efforts / Strategies
Accommodates ICD-10 and aligns some additional requirements

- Indicator in Item 21 to identify the version of the diagnosis code set reported (ICD-9 or ICD-10)
- Expansion of the number of diagnosis codes that can be reported in Item 21 (increased from 4 to 12)
- Ability to identify the role of the provider reported in Item 17 and the specific dates reported in Item 14
Transition Timeline

• January 6, 2014  Payers begin receiving and processing paper claims submitted on the revised 1500 claim form (version 02/12)

• Jan. 6 – March 31, 2014  Dual-use period during which payers continue to receive and process paper claims submitted on the old 1500 claim forms (version 08/05)

• April 1, 2014  Payers receive and process paper claims submitted only on the revised 1500 claim form (version 02/12)

• Visit www.nucc.org to review new 1500 form and manual
• Health plans required to offer practices option of accepting electronic funds (EFT) sing new standards and operating rules

• Health plans required to offer newly standardized electronic remittance advice (ERA)

• Moving to EFT and ERA will automate an important component of the claims revenue cycle and could provide a significant return on investment

• Discuss these and other administrative simplification opportunities with your software vendors
Heightened Emphasis on Compliance

- HIPAA – more comprehensive rule for guarding patients’ protected health information (PHI) – and more stringent penalties for failing to do so
  - Began 09/2013 – but will be monitored closely in 2014

- Risk Analysis for PHI – required in 2014
  - Conduct and document
  - Review practices and procedures for when PHI lost or stolen

- Show you have the ability to send health information to patients electronically

- Update Notice of Privacy and Ensure its Availability to Patients
Penalties for Violations

- HIPAA Omnibus rule establishes four “tiers” of violations, based on “increasing levels of culpability”, with a range of fines for each tier

<table>
<thead>
<tr>
<th>Category</th>
<th>Fine Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not know of breach</td>
<td>$100 to $50,000</td>
</tr>
<tr>
<td>Had reasonable cause to know</td>
<td>$1,000 to $50,000</td>
</tr>
<tr>
<td>Willful neglect, corrected</td>
<td>$10,000 to $50,000</td>
</tr>
<tr>
<td>Willful neglect, not corrected</td>
<td>$50,000</td>
</tr>
</tbody>
</table>
THE ICD–10–CM TRANSITION 10/01/2014
Historically, physician practices have been paid based on the CPT codes reported, not the complexity or acuity of the patient being treated. For example, a level-three new patient visit for a healthy patient with allergies pays the same as a level-three new patient visit for a chronically ill patient with pneumonias. A documented higher level of history and exam may change the level of service; however, the number of diagnosis codes reported on a claim form or the health status of the patient does not directly affect payment.

As the health care system moves from fee-for-service to value-based payment that reward providers for meeting quality and efficiency measures, the acuity of a practice’s patient population will affect year-end payment reconciliation. For example, Medicare’s shared savings program uses acuity as one of the factors that determines whether an accountable care organization shares in any monetary savings or is assessed a penalty. Medicare or a third-party payer can get this information from claims data. Thus, it will become increasingly important for family physicians to accurately and completely report diagnosis codes if they currently participate or intend to participate in these programs.

\[\text{\ldots} \quad \text{(Family Practice Management, January/February 2014, page 10)}\]
The Five (5) Things You Should Be Doing NOW

1. Identify the Areas of Impact in Your Practice
   1) Where do you use diagnosis codes
      a. Processes
      b. People
      c. Systems
      d. Paperwork
      e. Forms
      f. Templates

2. Get Started on Your Plan for Transition
   1) What needs to be done?
   2) Who will do what?
   3) What results are expected?
   4) What’s the Timeline for each?
Five Things for NOW

3. Communicate with Your Vendors & Partners
   1) What are each of them doing to help you with the transition?
   2) When will you be able to test?
   3) What will the costs be to you?

4. Plan for Education
   1) Who needs to be trained?
   2) At what level?
   3) How will training be done?
   4) What will it cost?

5. Identify the Costs and Budget for the Transition
   1) Systems Upgrades
   2) Templates
   3) Forms
   4) Other Paper Products
   5) Education
   6) Contingency Plans - Delayed or Reduced Revenue
Ten (10) Practical Steps to Take to Get Ready

1. Order the ICD-10-CM Book
   a. Draft – but both ICD-9 and ICD-10 are frozen except for new illnesses – but comfortable with the draft

2. Orient Yourself to the New Code Set
   a) Start with alpha and are 3-7 characters
   b) New Rules for Sequencing
   c) New Includes & Excludes Instruction - Excludes 1 and Excludes 2

3. Crosswalk your ICD-9 codes to ICD-10 codes
   a) Translation software can help – but BEWARE – the can be helpful and are a good starting point, but are not meant to result in accurate coding and should not be used for code selection
   b) Be SPECIFIC
Ten (10) Practical Steps to Take to Get Ready

4. Start using more specific ICD-9 codes NOW
   a) Stop using ICD-9 unspecified codes
   b) ICD-10 has unspecified codes, but payers may not accept them on every claim
   c) If documentation is not specific enough for code selection, it will result in delayed claim submission

5. Do a Gap Analysis
   a) Will help identify what is missing in clinical documentation
   b) Identify top 30 most commonly used codes
   c) Identify patient charts that use these codes and evaluate the documentation – try to assign ICD-10 codes based on the documentation in each medical record
   d) Make list of missing clinical information and begin physician education on these topics
Ten (10) Practical Steps to Take to Get Ready

6. Educate Staff
   a) Billers / Coders
   b) Other Clinical Staff
   c) Administrative Staff – pre-authorization, referrals, data reporting

7. Educate Physicians
   a) Prioritize most frequently used codes
   b) Short, focused intervals
   c) Refresh close to Implementation
   d) After Implementation for questions
Ten (10) Practical Steps to Take to Get Ready

8. Talk with your vendors
   a) Practice management (billing)
   b) Clearinghouse
   c) EHR vendors
   d) Payers
   e) When can you upgrade?
   f) When can you test?

9. Have cash on hand (or line of credit)
   a) May take longer to pay claims
   b) More claims may need to be appealed
   c) May take longer to get your claims out the door
Ten (10) Practical Steps to Take to Get Ready

10. Decide on a “go live” process
   a) Paper encounter forms that list most common codes WILL NOT work
   b) If translation software is used – review code selection and sequencing
   c) Coding staff should be available to answer questions from clinicians during early days
Thought of the Day!

It is going to be a BUSY year - just make sure you keep on top of things; starting NOW!
YOUR QUESTIONS

1.
2.
3.
4.
5.
6.