Coding and Billing Strategies 2016 Update

California Academy of Family Physicians
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Learning Objectives

At the completion of this activity, attendees should be able to:

1. Improve practice documentation of visits and procedures;
2. Enhance provider understanding of changes to CPT codes, including additions, deletions and edits;
3. Discuss the recent ICD-10-CM implementation; and
4. Generate better documentation of medical decision making.
About This Manual

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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.
Today’s Topics

Coding Changes

Medicare Changes
CPT Changes

Evaluation and Management

• Chronic Care Management (CCM)
• Transitional Care Management (TCM)
• Advance Care Planning (ACP)
• Prolonged Services
• Preventive Medicine/Risk Prevention

Medicine

• Vaccines
• Inhalation Treatment
• Diabetes Prevention

Also

• Cerumen Removal
Medicare Changes

Deductibles and Co-Insurance

Medicare Physician Payment Misvalued Codes
- 103 codes finalized
- Eliminating 10- and 90-day global surgery codes – on hold

Advanced Care Planning

Telehealth Services

New POS Code

Therapy Caps

CCM and TCM – reporting guidelines are changing

Billing “Incident To”

Physician Quality Reporting System (PQRS)

Value-Based Payment Modifier (VBPM)

Medicare Enrollment Opt-Out Affidavits
HAPPY BIRTHDAY CPT

50 Years!
CPT 2016 – Celebrating 50 Years!!

1966: 3,554 codes

2016: 10,000 codes
## CPT Overview

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CPT Responding to the Changing Face of Medicine

New initiatives center around:

• Population health (Responding to IHI’s Triple Aim)
• Personalized Medicine/Pharmacogenetics – individualized therapy for more effective management of disease
• Telemedicine
• PAMA – ADLTs and CDLTs
Transitional Care Management (99495 – 99496)
  – Identification and reporting of essential services for patients moving from one care setting to another (e.g., the inpatient to outpatient care setting)

Care Management (99487 – 99490)
  – Identification and reporting of at least 20 minutes of monthly essential supervised clinical staff management services for patients with two or more chronic conditions
Prolonged Clinical Staff Services (99415 – 99416)

– Identification and reporting of essential services requiring extensive supervised clinical staff time for patients in the outpatient setting

Coordination of Care / Emerging Issues Workgroup

– CPT and RUC working on this
Emerging patterns of health care organizations characterized by payment and care delivery models (e.g., ACOs) that:

- Receive one global fee for care provided to a defined population
- Tie provider reimbursements to quality metrics
- Result in reduction of total care costs for specific patient populations

- There is still a need to account for work done by and costs on the provider network as well as outcomes
- Specific Services provided by network are defined by CPT codes
- Quality measures become more important to track outcomes (registries, Category II codes)
Paradigm Shifts in Care

• Roles of advanced practice clinics as part of a care team – each health care worker is performing at the top of his/her license.
• Medical home model provides much more coordination of care and requires more up-front investment and ongoing investment.
• Chronic disease management, when done well, requires more resources which may not be recognized in current codes and reimbursement.
• Work and cost of providing care are changing significantly; developing disease specific codes.
Paradigm Shifts in Care (cont.)

- Sites of service for care are changing → maintain patient at home, utilize SNFs rather than hospitals, home rather than SNF, use of more comprehensive home care
- Balance and interplay of coding for the above services is complex, particularly during transition
- Still need recognition of work performed
- Many advanced delivery systems have markedly refined their systems of care seeking to achieve the triple aim, and some of those care patterns are not well captured with current CPT codes
CPT in Triple Aim

- Improving the patient experience of care (quality, satisfaction)
- Improving the health of populations
- Reducing the per capita cost of care
- CPT defines the services provided (category I and III codes) and can document health status (category II codes)
- RUC valuations can be used to index the cost of physician services
Telehealth Workgroup

Telehealth has the potential to markedly reduce the cost of delivery of care, improve patient satisfaction but major impediments have slowed adoption:

- Technology
- Payment systems
- Unclear value equation for many telehealth services
Proactive movements by CPT Editorial Panel to update the code set to reflect services that are currently provided and anticipate future coding needs, while working with leaders in health care and industry to bring applications to the Panel for review:

- Evaluation of current codes to identify codes that are appropriate for reporting services using remote technology
- Definition of services to report analysis of transmitted data (e.g., physiologic monitoring)
- Definition of data types to differentiate interpretation services
- Definition and differentiation of face-to-face from remote evaluation and management services
- Definition of services for the 21st Century physical examination
Changing Modalities of Provision of Care

How will the physical examination be performed by the end of the century?

– Remote devices in patient-center medicine
  • Medical care in rural areas may require this
  • Medical kiosks
  • Phone apps for ECG rhythm strip, otoscope
  • Will the hand-held echocardiogram replace the stethoscope?

– Advances in genetic analysis
  • Personalized medicine may require new personalized services
And now: A few that are important for family medicine
Evaluation and Management Services
Care Management Services
(implemented 2014 and 2015)

- Complex Chronic Care Management Services (2014)
  - 99487
- Chronic Care Management Services (2015)
  - 99489
  - 99490*

* = only one reimbursed
Chronic Care Management Services
(implemented 2015)

Code 99490
(Resequence)

Provided when medical and/or psychosocial needs of patient require establishing, implementing, revising or monitoring the care plan.

Code allows reporting for patients receiving at least 20 minutes of clinical staff time spent per calendar month.
Chronic Care Management Services Required Elements (implemented 2015)

Two or more chronic conditions expected to last at least 12 months or until the death of the patient

Chronic conditions place patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Comprehensive care plan established, implemented, revised, or monitor
Remember:

1. Not intended to be reported every month
2. Key is change or revision of plan
Transitional Care Management Services

TCM requires

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

TCM codes are

- Reported once per patient within 30 days of discharge
- Selected based on medical decision making and the date of the first face-to-face visit
- Reported by one individual
99495

- 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

- 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
Advanced Care Planning

Face-to-face between physician / QHP and patient, family, surrogate

Counseling and discussing Advance Directive

With or without the completion of relevant legal forms
Advance Directive

“A document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at the time.”

Examples:

- Health care proxy
- Durable Power of Attorney for Health Care
- Living will
- Physician Orders for Life-Sustaining Treatment (POLST)
The Codes

99497
First 30 minutes

99498
Each additional 30 minutes
Advance Care Planning

An E/M may be reported separately on the same day except for these services:

- Critical Care (99291, 99292)
- Inpatient Neonatal and Pediatric Critical Care (99468 - 99476)
- Initial and Continuing Intensive Care Services (99477- 99480)

When done at time of another E/M service, apply modifier -25 to the other E/M service code.

When done at time of another preventive service, apply modifier -33[preventive service] to the ACP code.
Prolonged Services – New Codes

Prolonged Service Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

– New title and subsection guidelines in CPT
– New timed codes to identify prolonged clinical staff time of one hour (99415) and each additional half hour (99416)
– Reported for prolonged clinical staff services (beyond the typical service time) during an evaluation and management service
What Has Changed for Prolonged Services?

Prior to 2016, codes 99354 and 99355 were the only codes that could be reported for prolonged services provided face-to-face with the patient.

These services, however, implied that the physician or qualified health care professional was providing the service.

The new prolonged services codes now allow a method for reporting face-to-face services that are not provided by the physician/QHP.

Development of the new codes allow for such reporting under specifically noted circumstances that only require face-to-face observation by clinical staff under the supervision of a physician/QHP.
Reporting 99415 and 99416

• The typical face-to-face time of the primary service is used to define when the prolonged service time begins
• Less than 45 minutes is not reported separately
• When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff
• Used once per date of service
Prolonged Services – The Codes

**99415** - Prolonged clinical staff service (the service beyond the typical service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour

**99416** - Each additional 30 minutes

Use with 99201 – 99215

Do not use in conjunction with 99354 or 99355
Example

99214

- Prolonged services begins AFTER 25 minutes (typical time listed in 99214)

99415

- Code 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed

Why?

- Because 45 minutes of prolonged services must be performed beginning AFTER the typical time
  - $25 + 45 = 70$
### Total Duration of Prolonged Services Table

<table>
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<th>Total Duration of Prolonged Services</th>
<th>Code (s)</th>
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<tr>
<td>less than 45 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>45-74 minutes (45 minutes – 1 hr. 14 min.)</td>
<td>99415 X 1</td>
</tr>
<tr>
<td>75 – 104 minutes (1 hr. 15 min. – 1 hr. 44 min.)</td>
<td>99415 X 1 and 99416 X 1</td>
</tr>
<tr>
<td>105 minutes or more (1 hr. 45 min or more)</td>
<td>99415 X 1 and 99416 X 2 or more for each additional 30 minutes</td>
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Preventive Medicine Services: Guideline Revision

The Preventive Medicine Services and the Counseling Risk Factor Reduction and Behaviour Change Intervention guidelines have been revised:

- Clarify that these codes (99406 – 99409) are appropriately reported separately, in addition to, the Preventive Medicine codes (99381 – 99397)
- Align them with the original intent of the Behavior Change Intervention codes’ edits in 2008, which was to allow separate reporting of an E/M service, which include the Preventive Medicine codes
- Includes instructions to append modifier 25 when reporting E/M services on the same day as the Counseling Risk Factor Reduction and Behavior Change Intervention codes
Medicine Services
ACIP Abbreviations

- The AMA’s Vaccine Coding Caucus (BCC) recommends that the Advisory Committee on Immunization Practices (ACIP) vaccine abbreviations be included in the CPT vaccine code descriptions to adequately describe the vaccine product to capture standardized vaccine abbreviations.

- Large-scale revisions (45 codes) standardize the CPT nomenclature with the terminology recommendations of the ACIP.
  - Example – 90632 Hepatitis A vaccine (HepA), adult dosage, for intramuscular use.
Obsoletes Vaccines

Deletion of 17 codes for outdated vaccines
No longer available in the United States

Deleted codes for 2016:

90645, 90646, 90692, 90693, 90704, 90705, 90706, 90708, 90712, 90719, 90720, 90721, 90725, 90727, 90735
90625  Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use
  • 90725 Cholera administered subcutaneously, has been deleted

90697  Diphtheria, tetanus, acellular pertussis (DTaP), poliomyelitis (IPV), Haemophilus influenza type b (Hib) and hepatitis B (HepB)
  • Hexavalent vaccine = vaccines for six diseases combined into a single vaccine
  • No ACIP abbreviation assigned yet

* Both are pending approval by the Food and Drug Administration (FDA) - ✔
Other Vaccines

Appeared last year, but have now received FDA approval:

- **90630** – Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
- **90651**  Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonvalent (HPV), 3 dose schedule, for intramuscular use
Revision to clarify **94640** is appropriate to use for both:

- Therapeutic purposes, and/or
- Diagnostic purposes
- Do not report with
  - **94060** (bronchodilator responsiveness)
  - **94070** (bronchospasm provocation evaluation)
  - **94000** (breathing response to CO2)
Diabetes Prevention

0403T - Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day:

- For non-physician educators
- For individuals at high risk of developing type 2 diabetes but do not have diabetes yet (this is a preventative service)
- Assignment of Category III code allows for tracking
Diabetes Prevention (more)

• Uses a standardized curriculum recognized by the Centers for Disease Control and Prevention (CDC)
• Community-based, peer-led groups
• Program may consist of 16 weekly sessions, followed by monthly sessions for up to eight months
• Time-based
Cerumen Removal

Please do not!
Impacted Cerumen

- **Visual considerations:** Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- **Qualitative considerations:** Extremely hard, dry, irritating cerumen causing symptoms such as pain, itching, hearing loss, etc.
- **Inflammatory considerations:** Associated with foul odor, infection, or dermatitis.
- **Quantitative considerations:** Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skill.
Cerumen Impaction Removal: New Code and Parentheticals

69209  Removal impacted cerumen using irrigation / lavage, unilateral
- Do not report 69209 in conjunction with 69210 when performed on the same ear
- For bilateral procedure, report 69209 with modifier 50
- For removal of impacted cerumen requiring instrumentation use 69210
- For cerumen removal that is not impacted, see E/M service code

*Is intended to be done by staff - no Physician Work Value assigned - only Practice Expense*
Updates ... Changes ... Adjustments

Medicare 2016
Medicare Changes

Deductibles and Co-Insurance

• 2016 Deductible = $166
• 2016 Co-insurance = 20%
• Some services are exempt from deductible, co-insurance or both
SGR went away; target was established (imposed)

Reductions **IF** Target is Not Met

- **CY 2016** – **CY 2018** payment rates reduced across the board if target established by statute not met
- **Target** = 1% for 2016, 0.5% for 2017 & 2018
- If don’t meet target, then reduce payments by an amount equal “target recapture amount”
- **Target recapture amount** = target for year – net reduction
- **For CY 2016**
  - Net reduction in expenditures was 0.23%
  - Overall reduction was 0.77%
Conversion Factor Changes

December 31, 2015 = $35.9335
January 21, 2016 = $35.8279

• About a .29% decrease from 2015
  • +0.5% update due to MACRA
  • -0.77% change due to the target
  • -0.02% budget neutrality adjustment
CMS finalized list of 103 potentially misvalued codes based on high expenditures by specialties

- They are now seeking recommendations from RUC and other stakeholders before finalizing

CMS issued final rates for approximately 220 codes that were CY 2015 interim final.
Established interim final rates for about 81 services
Did not change values of 10- and 90-day global surgical services – continues to examine payments and will consider comments for future rulemaking:

- MACRA prohibited CMS from moving forward with its previously finalized plan to eliminate the use of 10- and 90-day global surgical codes

- MACRA requires agency to begin collecting data to value these services in 2017

- Must improve payment accuracy of these services by 2019
Medicare and Advanced Care Planning

CPT codes 99497 and 99498 will be separately payable, beginning January 1, 2016

• When reasonable & necessary for the diagnosis or treatment of injury or illness
  o Add 25 modifier to E/M
• As voluntary, separately payable part of Annual Wellness Visits (AWV)
  o Add 33 modifier to AWV

50% time criteria applies

No limitations on frequency per CMS – provide as needed, but not excessively
Deductible / Coinsurance

- Deductible / coinsurance applies when reasonable and necessary for the diagnosis or treatment of injury or illness
- **NO** deductible / coinsurance applies when as voluntary, separately payable part of AWV

Incident to:

- Can be furnished incident to when reasonable and necessary
- Incident to doesn’t apply to AWV, but can be delivered under “team” approach
- Need direct supervision in both cases

- National payment rates
  - **99497** = $85.99
  - **99498** = $74.88
Medicare and Telehealth

Added the following services to the list of Medicare telehealth services:

• Prolonged service inpatient CPT codes 99356 and 99357
• ESRD related services for home dialysis CPT codes 90963 – 90966
• Complete list on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html
New Place of Service (POS) Code

Physician Services in Off-Campus Provider-Based Department

• New Place of Service Code for CY 2016
• POS 19: Off Campus-Outpatient Hospital
• POS 22 Revised: On Campus – Outpatient Hospital
• For more information, see Medicare Claims Processing Manual, Chapter 12, Section 20.4.2

NOTE: Increasing focus on physicians using wrong place of service codes.
Therapy Caps

Physical Therapy (PT) and Speech-Language Pathology (SLP)
  – $1,960 (2015 = $1,940)

Occupational Therapy (OT)
  – $1,960 (2015 = $1,940)

Extended exceptions process
CCM and TCM Reporting Guidelines

- Did not finalize any changes to reduce onerous administrative requirements for billing CCM and TCM – did indicate will take steps in future years
- Will clarify CCM rules regarding use of fax
- Will revise existing guidance for TCM services to specify that the required date of service on the claim form should be the date of the face-to-face visit
- Established payment for CCM and TCM furnished in a rural health center (RHC) or federally qualified health center (FQHC) beginning in 2016
Incident To Billing

- Physician / practitioner who bills must be supervising physician / practitioner
  - Does not have to be physician who initiated plan of care
- Services can’t be provided by individual who has been excluded from Medicare, Medicaid or other federal program
- Services can’t be provided by individual who has had Medicare enrollment revoked
- Compliance with state law – only provide services within licensure
PQRS

Reporting Mechanisms

• Claims
• Individual Measures or Measures Groups via a Qualified Registry
• EHR data via direct submission or through a submission vendor
• Individual measures submitted via a QCDR

Avoiding 2018 2% penalty

• Individuals – 9 measures across three domains or one measures group (via registry)
Measures Changes

Cross-cutting measures
• Added four new cross-cutting measures – total of 23

Individual measures
• Added 37 and removed 12 individual PQRS measures
• Changed the NQS domain of five individual measures
• Changed the mechanism by which 17 individual measures are reported
• Added three new and amended three existing measures groups

GPRO Web Interface measures
• Added one new measure - total of 18
• Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Value-Based Payment Modifier (VBPM)

2018 VBPM payment levels based on 2016 PQRS participation

- Those who have not successfully met PQRS requirements in 2016 will receive an automatic 2% VBPM penalty in 2018

Application of the VBPM to non-physician EPs in 2018 based on 2016 performance

- MACRA sunsets current VBPM on 12/31/2018, and new MIPS will take effect 1/1/2019
MACRA stipulates that any valid Medicare opt-out affidavits filed on or after June 16, 2015 will automatically renew every two years. CMS confirms this change in the PFS, which is a departure from previous policy in which EPs were required to file new affidavits every two years. EPs who do not want their opt-out status to automatically renew at the end of this two-year period can cancel their renewal by notifying in writing all MACs with whom they have an affidavit on file at least 30 days prior to the start of the new opt-out period.
Thank you and now ...

Questions