Strategies for Coding, Billing and Getting Paid Appropriately

2013 Supplement

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STRONG MEDICINE FOR CALIFORNIA

Every new calendar year brings important changes in coding, billing and reporting services and the receipt of payment for those services. Family physicians can manage these changes in three steps. First, review them and assess their impact on your practice. Next, plan the change implementation and, if necessary, update your practice. Finally, consider data reporting requirements that may not, at first glance, have any impact on your immediate reimbursement, but, on further examination, could have a direct impact on future reimbursement.

Medicare's Current Procedural Terminology (CPT)/Coding Update for Family Medicine:

Let us look at a few coding changes that will have a direct effect on family medicine practices in 2013. Two new sets of CPT codes are especially important. The first set of codes (CPT Codes 99487 - 99489) is for Complex Chronic Care Coordination (CCCC) services:

- 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 professional, per calendar month *(This is an add-on code, so report separately in addition to the code for the primary procedure).*

Specifically, these codes

- Are reported **once** per calendar month;
- Include all non-face-to-face CCCC services;
- Include no or one face-to-face office or other outpatient, home or domiciliary visit;
- May only be reported by the single physician or qualified health care professional (QHP) who assumes the coordination role with a particular patient for the calendar month; and
- Require determining the time:
    - Do not count any clinical staff time on the first date or the date of another E/M visit.
    - Use the 50 percent rule when deciding which code to use.

CCCC services are:

- Patient centered management and support services provided by physicians, other QHPs and clinical staff;
- Provided to an individual residing in a home or in a domiciliary, rest home or assisted living facility (no skilled nursing facility and no hospice);
- A care plan directed by a physician or QHP and typically implemented by clinical staff; or
- Services that address the coordination of care by multiple disciplines and community service agencies.

The reporting individual (physician or QHP) provides or oversees the management and/or coordination of services, as needed, for:

- All medical conditions;

- Psychosocial needs; and
- Activities of daily living

Coordination of care is an important factor. Note that the reporting provider does not have to actually provide the care for all of the above, but he must be coordinating that care!

Some important elements of CCCC services and patients:

- Patients requiring CCCC may be identified by:
    - Algorithms that utilize reported conditions and services (e.g., predictive modeling risk score or repeat admissions or emergency department use);
      OR
    - Clinical judgment.

- CCCC patients:
    - Typically have one or more chronic, continuous or episodic health conditions;
    - Commonly require the coordination of a number of specialties and services,
    - May have medical and psychiatric behavioral co-morbidities complicating their care; and
    - May have social support weaknesses or difficulties accessing care.

Now, here is the BAD news about these new codes: The Centers for Medicare and Medicaid Services (CMS) currently considers CCCC services **bundled** services. In other words, they are grouped with the services to which they are incident and are not separately payable. Therefore, a practice may not bill the patient directly for these services when they are denied by Medicare. There is a ray of light, however. CMS has indicated they will continue to explore payment approaches and they are developing proposals to promote primary care within a fee-for-service payment structure. Also, as CMS continues to explore payment for primary care services in future rulemaking, they are considering adoption of the complex care coordination codes developed by the AMA for CPT.

What does this all mean? CCCC is an important aspect of health care delivery – especially for family physicians. If you are doing this type of coordination/management, then you should begin tracking and reporting the services to support the need for CMS to develop payment approaches for the services.

A second set of new codes that are especially important for family physicians in 2013 is the set of codes for Transitional Care Management services (TCM). TCM services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care. TCM services address any needed coordination of care performed by multiple disciplines and community service agencies.

Transitional Care Management services are the transition in care:

From: Health care facilities:

- Inpatient Hospital
- Partial Hospital
- Observation Status
- Skilled Nursing Facility / Nursing Facility

To: The patient's community setting:

- Home
- Domiciliary
- Rest Home
- Assisted Living

Transitional Care Management services require:

- A face-to-face visit within the specified time frames;
- Interactive contact with the patient or caregiver within two business days of discharge and may be direct (face-to-face), telephonic or electronic; and
- Medicare reconciliation and management no later than the date of the face-to-face visit.

These 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; and
- May be reported by one individual.

There are two new codes used to report these services:

- 99495 - Transitional Care Management Services with the following required elements:
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
        - *This will require good coordination with the hospital about the discharge date;*
    - Medical decision making of at least moderate complexity during the service period; and
    - Face-to-face visit, within 14 calendar days of discharge.

      The work RVU established for this service is 2.11 and the intra-service time is 40 minutes.

- 99496 - Transitional Care Management (TCM) Services with the following required elements:
    - Communication (direct contract, telephonic, 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.

      The work RVU established for this service is 3.05 and the intra-service time is 50 minutes.

CMS will recognize these codes effective 1/1/2013, and they should be reported, rather than the proposed G code (HCPCS) for post-discharge transitional care management. CMS has also modified some of the CPT instructions for these services:

- They will allow physicians to bill these codes for **new** patients, not only established patients as specified in CPT.
- The physician who reports a global procedure should not be permitted to report the TCM service also (i.e., TCM services cannot be provided in a post-operative period by the same physician).
    - CMS did clarify that the same physician may bill the discharge day management for the patient and the TCM for the patient, but, you cannot use the discharge day management code and the TCM-included **E/M visit** on the same day. The discharge day management cannot be considered the face-to-face visit.

Under the proposed Medicare Physician Fee Schedule (MPFS) for 2013, the reimbursement ranges from $125 to $144 for CPT 99495 and from $150 to $203 for CPT 99496, depending the on the location of the practice.

Some Coding Tips for both CCCC and TCM:

The CCCC and TCM codes include:

- Care plan oversight services;
- Prolonged services without direct patient contact;
- Anticoagulant management;
- Medical team conferences; and
- Education and training.

These services/codes should not be reported separately when providing either CCCC or TCM.

The CCCC and TCM codes include:

- Telephone services;
- End stage renal disease services;
- On-line medical evaluation;
- Preparation of special reports;
- Analysis of data;
- Medication therapy management;
- TCM (when reporting CCCC); and
- CCCC (when reporting TCM).

These services are mutually exclusive and should not be reported together.

There is one last CPT modification that family physicians should be mindful of. For physicians who provided hospital inpatient or observation services, typical times have not been added to codes 99234 through 99236. The times are:

99234 – 40 minutes
99235 – 50 minutes
99236 - 55 minutes

With the addition of these typical times, physicians are now allowed to add prolonged services to that set of observation or inpatient hospital services when the care (unit or floor time) exceeds the typical time.

Medicare 2013:

Deductible: The 2013 deductible for Medicare Part B is $147.00. Every practice should start to collect toward the deductible when patients are being seen for the first time each calendar year. If the patient has Medicare secondary or supplemental insurance then ask them to relay the specifics of that plan, so you can discover whether or not that plan will be responsible for a portion or all of the deductible. Failure to collect towards a deductible at the time of service only delays payment to the practice at a time when reimbursement from third party payers is limited. Remember, when collecting deductible amounts, those amounts should be based upon what you expect the payer to reimburse, not necessarily on the amount of the practice fee schedule.

The co-insurance for Medicare Part B services continues to be 20 percent of the Medicare allowed amount, after the deductible has been fully met. Many Medicare patients now have Medicare

Advantage Plans rather than the traditional Medicare Part B coverage and those deductibles may vary. In fact, many do not have a deductible, but instead have a co-payment that is due at each visit. The beginning of the year or the first time you see the Medicare patient each year is a good time to verify the type of Medicare coverage they have. Medicare patients are allowed to change coverage throughout the year, so do not forget to continue to ask what plan they have when they visit the practice.

Preventive Services: Medicare has not added any new preventive medicine services to the beneficiary's coverage this year, but does continue to cover all the previously legislated preventive medicine services, in addition to the Initial Preventive Physical Examination (IPPE - Welcome to Medicare) exam and the Annual Wellness Visit (AWV) – both initial and subsequent. These services provide revenue for the practice, so every family physician practice should consider providing these services to the Medicare patient on an annual basis.

An updated reference chart of Medicare preventive services is available at www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

To access templates that will help document the elements of the AWV, as well as the IPPE, visit the AAFP website at http://www.aafp.org/online/en/home/publications/journals/fpm.html.

Bonus Programs:

Primary Care Incentive Program (PCIP): Once again in 2013 Medicare will provide a quarterly incentive payment to augment the Medicare payment for primary care services as authorized by the Affordable Care Act. The incentive payment is equal to 10 percent of the Medicare paid amount for primary care services as defined in the Medicare statute. Those services are:

- New and established patient office or other outpatient services (CPT 99201 – 99215);
- Nursing facility care visits and domiciliary, rest home or homecare plan oversight services (CPT 99304 – 99340); and
- Patient home visits (CPT 99341 – 99350).

There is no need for a physician to apply for this program; eligibility is determined automatically by this criteria:

1. The provider must have a Medicare specialty designation of family medicine, geriatric medicine, pediatric medicine, internal medicine, nurse practitioner, clinical nurse specialist or physician assistant.
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 *PCIP incentive payment year, i.e., CY 2011 c*laims for CY 2013 eligibility.

If you do not automatically receive a quarterly bonus payment in April, 2013, contact the Medicare carrier (MAC) to verify eligibility - www.palmettogba.com/J1.

Physician Quality Reporting System (PQRS): Eligible Professionals (EPs) who successfully report on quality measures in PQRS are eligible for a 0.5 percent incentive payment for years 2013 – 2014. Beginning in 2015, EPs who do not satisfactorily report PQRS quality data will receive a 1.5 percent **reduction** under Medicare, which will increase to 2 percent in 2016 and beyond. To ease the experience for providers who have not previously participated in PQRS, CMS states that satisfactory reporting in 2015 and 2016, the first years of payment adjustments, includes the option of reporting only one applicable measure or measures group using the claims, registry or EHR-based reporting mechanisms.

For the 2015 payment adjustment, CMS had previously adopted CY 2013 (1/1/13 – 12/31/12) as the reporting period. For the 2015 payment adjustment, CMS has added a six-month reporting period from July 1, 2013 to December 31, 2013 for reporting measures groups via a registry. The six-month reporting period is only available for individual EPs and **through a registry**.

This "bonus" program could turn into a payment adjustment for your practice if you do not participate in 2013! Now is the time to review the possible measures to be reported and start to plan the collection of data and reporting process for PQRS if your practice has not reported previously.

For CY 2013 CMS has added 13 new individual measures and retired 14 measures. The 13 new individual measures address conditions such as stroke, diabetes and cardiovascular disease as well as coordination of care. CMS finalized 21 measures groups previously available for reporting in CY 2013 and added a new oncology measures group. CMS retired the community-acquired pneumonia and coronary artery disease measures groups in 2013. One of the easiest measures groups for family physicians is the Preventive Measures group.

E-prescribing: The Medicare Final Rule maintains many of the current e-prescribing criteria for earning a 2013 and 2014 bonus and avoiding the 2014 penalty. However, there are several key changes to the rule, including the addition of the following two new hardship exemptions for avoiding e-prescribing penalties:

1. EPs who achieve meaningful use during the respective six or 12 month payment adjustment reporting periods.

2. EPs who have registered to participate in the EHR Incentive Program and adopted Certified Electronic Health Record Technology (CEHRT) prior to the application of the respective payment adjustment.

For a full explanation of these two hardship exemptions access the final rule on the CMS website: www.cms.gov; search under 2013 Final Rule.

Medicaid (Medi-Cal) 2013:

A change in Medicaid (Medi-Cal) rates is coming in 2013 for primary care services. In November 2012 CMS released the final regulation that implements Section 1202 of the Affordable Care Act. This section increases Medicaid payments for specified primary care services to Medicare levels for certain

primary care physicians in 2013 and 2014. Physicians practicing in a Federally Qualified Health Center or Rural Health Center (FQHC or RHC) are excluded from this increase.

The final rule provides for higher payment in both the fee-for-service and managed care settings for specific primary care services furnished by:

- Practicing physicians who self-attest that they are board certified with a specialty designation of family medicine, general internal medicine or pediatric medicine;
- Subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association or the American Board of Physician Specialties who also self-attest that they are board certified;
- Physicians related to the specialty categories of family medicine, internal medicine and pediatrics who self-attest that at least 60 percent of all Medicaid services they bill or provide in a managed care environment are for the specified E&M and vaccine administration codes; or
- Advanced practice clinicians when the services are furnished under a physician's personal supervision.

In addition to the increases in Medicaid payments, this regulation also updates vaccine administration fee maximums that had not been updated since the Vaccines for Children (VFC) program was established in 1994.

The specified primary care services are:

- E&M codes 99201 – 99499
- Vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474
- New Patient/Initial Comprehensive Preventive Medicine – CPT 99381 – 99387
- Established Patient/Periodic Comprehensive Preventive Medicine – CPT 99391 – 99397
- Counseling Risk Factor Reduction and Behavior Change Intervention – CPT 99401 – 99404, 99409-99409, 99411 – 99412, 99420 and 99429
- E&M/Non Face-to-Face physician services – CPT 99441 – 99444

Inclusion of a code on this list does not require a state to pay for the service if it is not already covered under the state's Medicaid program; it only requires the state to pay for the service at the Medicare rate if covered. All other state coverage and payment policy rules related to the service also remain in effect.

This is good news for family physicians and their Medi-Cal patients, whether it is a Medi-Medi patient, a Managed Care Medi-Cal patient or a straight Medi-Cal patient. However, the good news is tempered by the time limit (2013 and 2014) and the state's on-going efforts to cut all Medi-Cal provider payments by 10 percent retroactively to June 2011.

Getting Ready for ICD-10 – *Yet another Thing to Do in 2013!*

Physicians are being hit with a slew of major changes affecting their billing and practice habits. Among them are meaningful use of electronic health records, electronic prescribing requirements, Medicare

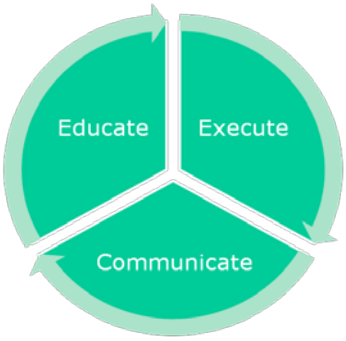
quality modifiers and electronic claims requirements. And, there is one more to add to the list of things to do – get ready for the transition to International Classification of Diseases (ICD)-10.

Although the implementation date is not until October 1, 2014, transitioning to ICD-10 is a complicated task and one that requires a great deal of planning, education and change implementation before the practice can be ready to "go live" on October 1, 2014. **NOW,** is the time to start. Taking simple, small steps early on and throughout the process will make the difference between a successful transition and a transition filled with challenges and possibly decreased or lost revenue. Health and Human Services (HHS) is being firm that there are no additional delays expected and no grace period from the ICD-10 deadline.

The Simple Way to Build a Path to ICD-10 is to Communicate, Educate and Execute.

Your plan for the next two years should be to

1/1/13 – 6/30/13	Communicate (Start Now)
7/1/13 – 3/31/14	Communicate and Educate
4/1/14 – 10/1/14	Educate and Execute
10/1/14 – 12/31/14	Execute



The goals of your first communications should be to:

- Identify "What" has to change in your practice:
- Identify "Who" has to understand those changes;
- Find out "When" these things are changing;
- Create a task list to address the "What and Who"; and
- Make a plan based on "When."

You can begin today to prepare your practice for the transition to ICD-10 by considering these seven simple steps:

1. Identify the areas of impact;
2. Get started on a project plan;
3. Collect information from vendors / partners;
4. Plan for education;
5. Outline transitions of people, documents and systems;
6. Identify the costs and budget impacts; and
7. Validate the results as you go.

This calendar year promises to be a busy one for the family physician.