House Calls Coding 101

Beth Carlson, Health Dimensions Group
Shawna Ramey, Health Dimensions Group
Gary Swartz, Associate Executive Director for Public Policy and Practice Management, AAHCM

Today's Session

• Identified Coding Risks
• Elements of Documentation: House Calls and Assisted Living Evaluation and Management (E/M)
  • CPT Codes
  • Documentation Requirements
• Additional Opportunities Overview
• Questions
• Wrap-up
• Next Sessions

Objectives

Delineate CPT codes used by house calls practices
Define documentation requirements to support E/M codes
Develop in-depth understanding of the basics, minimizing risks, and optimizing additional revenue opportunities

2016 OIG Focus on “Reasonableness and Necessity” of Physician Home Visits
NEW Physician home visits—reasonableness of services:
We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made $559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, §1862(a)(1)(A) (OAS; W-00-15-25794; expected issue date: FY 2016)
OIG and CMS Red Flags

- Visits not found medically necessary:
  - Routine visits required to meet facility or state requirements
  - Routine visits that do not take into consideration emergent visits and are repetitive

- Billing for E/M code and minor procedure on same day
- Podiatry visit for nail treatment not supporting E/M code
- Cloning—CMS continues to expand their definition:
  - Documents considered cloned when each entry in medical record is exactly like or similar to previous entries

Elements of Documentation
Telling the Story to Get Paid for Services Provided

CPT Codes for Home Visits E/M

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Typical Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99341</td>
<td>20</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
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<tr>
<td>99342</td>
<td>30</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Low</td>
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<tr>
<td>99343</td>
<td>45</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99344</td>
<td>60</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99345</td>
<td>75</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
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</table>

<table>
<thead>
<tr>
<th>Follow-up</th>
<th>Typical Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99347</td>
<td>15</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99348</td>
<td>25</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99349</td>
<td>40</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99350</td>
<td>60</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate to High</td>
</tr>
</tbody>
</table>

POS 12

Definition of Medical Necessity

According to the settlement agreement for “medically necessary” or “medical necessity”: Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for patient’s illness, injury or disease; and

c. Not primarily for the convenience of the patient, physician, or other health care provider, and less costly than alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease. For these purposes, “generally accepted standards of medical practice” means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with standards set forth in policy issues involving clinical judgment.
Where Does the Process of Showing Medical Necessity Begin?

At intake:
- Who is calling?
- Why do they need to be seen?
- Where do they live?
  - Place of service impacts coding choice
  - It is vital that this basic element is correct!

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Documentation Components Behind the Billing Code

- Chief complaint (CC)
- History of present illnesses (HPI)
- Review of systems (ROS)
- Past medical, family and social history
- Levels of examination
- Medical decision-making
- Number of diagnoses and/or management options

Chief Complaint (CC)

- Concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter
- CC is usually stated in the patient's own words; for example:
  - Patient complains of upset stomach, aching joints, and fatigue

Document the Need for a Home Visit

There should be a documented statement indicating the medical necessity for a home visit, including home limited status

History of Present Illness (HPI)

Chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present; HPI elements are:
- Location (e.g., left leg)
- Quality (e.g., aching, burning, radiating pain)
- Severity (e.g., 10 on a scale of 1 to 10)
- Duration (e.g., started three days ago)
- Timing (e.g., constant or comes and goes)
- Context (e.g., lifted large object at work)
- Modifying factors (e.g., better when heat is applied)
- Associated signs and symptoms (e.g., numbness in toes)
- OR: Status of three chronic conditions

Review of Systems (ROS)

Inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced—this information can be completed by intake and then verified by the provider; following systems are recognized for ROS purposes:
- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
Past Medical/Family/Social History (PMFSH)

Complete PMFSH consists of a review of three areas:

- Past medical history, including experiences with illnesses, operations, injuries, and treatments
- Family history, including review of medical events, diseases, and hereditary conditions that may place the patient at risk
- Social history, including age-appropriate review of past and current activities—does the patient live alone?

Levels of Examination

General multi-system examination involves examination of one or more organ systems or body areas

<table>
<thead>
<tr>
<th>Examination Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Include performance and documentation of 1 to 5 elements, identified by a bullet, in 1 or more organ system(s) or body area(s)</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Include performance and documentation of at least 6 elements, identified by a bullet, in 1 or more organ system(s) or body area(s)</td>
</tr>
<tr>
<td>Detailed</td>
<td>Include at least 8 organ systems or body areas. For each system/area selected, performance and documentation of at least two elements, identified by a bullet, is expected. Alternatively, may include performance and documentation of at least 6 elements, identified by a bullet, in 2 or more organ systems or body areas.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Include at least 9 organ systems or body areas. For each system/area selected, all elements of the examination, identified by a bullet, should be performed, unless specific directions limit the content of the examination. For each anatomic system, documentation of at least 2 elements, identified by a bullet, is expected.</td>
</tr>
</tbody>
</table>

Code Selection: Medical Decision-Making

Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option, determined by considering the following factors:

- Number of possible diagnoses and/or number of management options that must be considered
- Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- Risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Assessment and PLAN

Important points when documenting the number of diagnoses or management options:

- For each encounter, document an assessment, clinical impression, or diagnosis which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation
- Paint a picture of the patient’s health:
  - Improved, well controlled, resolving, or resolved; or
  - Inadequately controlled, worsening, or failing to change as expected

The assessment and plan is NOT the patient’s problem list and should only contain diagnosis options treated on that day!

Treatment Options

- Document initiation of, or changes in, treatment
- Treatment includes wide range of management options, including:
  - Patient instructions
  - Nursing instructions
  - Therapies
  - Medications
- If referrals are made, consultations requested, or advice sought, the record should indicate:
  - To whom or where the referral or consultation is made, or
  - From whom advice is requested

Time Based

- Counseling statement: “Greater than 50% of the visit was spent in counseling/coordinating care”
- Time must be documented:
  - Preferred method is showing time in/time out
  - Documentation must contain specific content of information covered during counseling
Additional Opportunities Overview
Highlights of Upcoming Session Deep-Dives

Prolonged Services – Additional Time to Evaluation and Management Service

- CPT 99354 – Medicare will pay for prolonged physician services with direct face-to-face patient contact that requires one hour beyond the usual service, when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes:
  - MD/DO $101.03
  - NP/PA $85.88
- CPT 99355 – The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code; you should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services:
  - MD/DO $98.17
  - NP/PA $83.44
- Paid in conjunction with house call codes as required “companion code”

Care Plan Oversight Services (CPO)

- Medicare Benefit Policy Manual, Chapter 15, contains requirements for coverage for medical and other health services including those of physicians and non-physician practitioners
- Care plan oversight (CPO) is the physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency or Medicare-approved hospice
- Home health care supervision – G0181
  - MD/DO $108.56
  - NP/PA $92.27
- Hospice care supervision – G0182
  - MD/DO $109.28
  - NP/PA $92.88

Care Plan Oversight Services (CPO) (continued)

- CPO services require complex or multidisciplinary care modalities involving:
  - Regular physician development and/or revision of care plans;
  - Review of subsequent reports of patient status;
  - Review of related laboratory and other studies;
  - Communication with other health professionals not employed in the same practice who are involved in the patient’s care;
  - Integration of new information into the medical treatment plan; and/or,
  - Adjustment of medical therapy

Care Plan Oversight Services (CPO) (continued)

- CPO services require recurrent physician supervision of a patient involving 30 or more minutes of the physician’s time per month, services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to:
  - Time associated with discussions of the patient and/or his or her family or friends to adjust medication or treatment;
  - Time spent by staff getting or filing charts;
  - Travel time; and/or,
  - Physician’s time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies
- Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient’s care with the home health agency or hospice during the month for which CPO services were billed; the physician who bills for CPO must be the same physician who signs the plan of care
- Nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of state law, may bill for care plan oversight; these non-physician practitioners must have been providing ongoing care for the beneficiary through evaluation and management services and these non-physician practitioners may not bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service
Transitional Care Management

- CPT 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
  - MD/DO $165.17
  - NP/PA $140.39

- CPT 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
  - MD/DO $233.24
  - NP/PA $198.25

Chronic Care Management (CMS)

CPT 99490 – At least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored
  - MD/DO $40.84
  - NP/PA $34.72

Advance Care Planning (ACP)

- CPT code 99497 – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
  - MD/DO $85.99
  - NP/PA $73.09

- CPT code 99498 – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (list separately in addition to code for primary procedure)
  - MD/DO $74.52
  - NP/PA $63.34

Improving Payment for Primary Care Services

- ACP – coverage and payment effective 2016
- TCM – reducing administrative burden; can now submit claim after face-to-face encounter
- CCM – advocacy to reduce administrative burden and coverage and payment now in FQHC and RHCS
- Establishing separate payment for collaborative care and interactive complexity
- Other non face-to-face services – non face-to-face services during acute illness for non-facility-based patients
- Academy involvement in proposing/advocating for codes, and coverage and payment

Clinical Practice Leaders Have Already Charted Pathway to Practice Transformation

<table>
<thead>
<tr>
<th>Traditional Approach</th>
<th>Transformed Practice – Moving to Value-Based Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s chief complaints or reasons for visit determines care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem/time available today</td>
<td>Care is determined by a proactive plan to meet patient needs</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory/attitude of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates a patient’s care</td>
</tr>
<tr>
<td>Clinicians know they deliver high-quality care because they are well trained</td>
<td>Clinicians know they deliver high-quality care because they measure it and make rapid changes to improve</td>
</tr>
<tr>
<td>It is up to the patient to tell us what happened to them</td>
<td>You can track tests, consults, and follow-up after the emergency department and hospital discharge</td>
</tr>
</tbody>
</table>

CPT 99490 Elements of Service

- Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with healthcare providers in the practice to address his or her urgent care needs regardless of the time of day or day of the week)
- Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments
- Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications
- Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental/assessment and an inventory of resources and support; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers
- Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care
- Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
- Beneficiary consent – Inform the beneficiary of the availability of CMS services and obtain his or her written agreement to have the services provided; including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary’s medical record that all of the CMS services were explained and offered, and note the beneficiary’s decision to accept or decline services
- Beneficiary consent – Inform the beneficiary of the right to stop the CCM services at any time effective at the end of the calendar month and the effect of a revocation of the agreement on CCM services

CMS CPT 99490 Elements of Services

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House Calls Coding 101

February 16, 2016
What to Do Next

• Develop practice to document the range of services you are rendering—E/M, CPO, CCM, TCM and now ACP
• Develop practice to participate in alternative payment models
• Share best practices with your colleagues
• Participate with Academy in response to proposed legislation and regulation
• Attend Annual Meeting to learn, share, and network

Wrap-up

Next Sessions

Compliance: A Simple Equation of Continuous Education and Auditing