CPT & MEDICARE CHANGES FOR RHEUMATOLOGY

PRESENTOR: Candice Fenildo, CPC, CPMA, CPB, CENTC, CPC-I

Presented in Partnership with NORM and Crescendo Bioscience
Developed & Hosted by Acevedo Consulting Incorporated
The Mission of NORM is to be a forum by which we promote and support education, expertise, and advocacy for rheumatology practices and their patients.

NORM is a diverse community of rheumatology managers with a common goal.

NORM provides educational opportunities through webinars and during our annual conference.

NORM supports rheumatology practices, managers and staff by offering unique educational opportunities specific to rheumatology.

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Crescendo Bioscience focuses on enabling more effective management of autoimmune and inflammatory diseases by providing quantitative, objective molecular tests (such as Vectra® DA) and disease information services to rheumatologists and patients.

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Candice Fenildo holds an Associate’s Degree in Health Sciences and numerous national coding certifications through the AAPC. She is also an AAPC certified Instructor. Candice has over 15 years combined experience in coding, billing and A/R management for Multi-Specialty Physicians; including Rheumatology.

Candice is currently serving as the 2016 Chair for the AAPC Chapter Association Board of Directors (AAPCCA).

About the Firm:
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Upcoming Webinars

**PQRS for Rheumatology**
- Eastern Daylight Saving Time: Tuesday, April 12, 2016 12-1 EST
- Pacific Daylight Saving Time: Thursday, April 14, 2016 12-1 PST

**ICD-10 Documentation and Coding Tips for Rheumatology**
- Eastern Daylight Saving Time: Tuesday, May 24, 2016 12-1 EST
- Pacific Daylight Saving Time: Thursday, May 26, 2016 12-1 PST

**Infusion Coding for Rheumatology: How to Appropriately Document**
- Eastern Daylight Saving Time: Tuesday, July 26, 2016 12-1 EST
- Pacific Daylight Saving Time: Thursday, July 28, 2016 12-1 PST

**Chronic Care Management for Rheumatology**
- Eastern Daylight Saving Time: Tuesday, October 4, 2016 12-1 EST
- Pacific Daylight Saving Time: Thursday, October 6, 2016 12-1 PST
Agenda

• New & Revised Payment Policies
  • Advance Care Planning
  • Transitional Care Management
  • LCD for SNF/NF Visits

• Other Areas Needing Your Attention
  • Medicare deductible, therapy cap, etc.
  • Incident-to guidelines clarifications
  • Reporting requirements for 10- and 90-day global periods

• Pay for Performance programs
  • ....in brief
Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

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This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

**THIS PRESENTATION CONTAINS ABBEVIATED CODE DEFINITIONS, IS NOT A SUBSTITUTE FOR YOUR CODE BOOKS, AND DOES NOT INCLUDE ALL CHANGES YOU MAY NEED TO KNOW TO CODE AND BILL ACCURATELY.**
Evaluation and Management

• +99415: Prolonged clinical staff service (the service beyond the typical service time) during an E&M service in the office or outpatient setting, direct patient contact with physician supervision; 1st hour (list separately in addition to code for outpatient E&M service) (~$9.47 Medicare allowable)
  • Use with 99201-99215

• +99416: ....each additional 30 minutes (List separately in addition to code for prolonged service) (~$0.98 Medicare allowable)
  • Use in conjunction with 99201-99205, 99211-99215
  • Do not report 99415/16 in conjunction with 99354/55
• Only count face-to-face time
• Physician/NPP must be in the office suite to provide direct supervision
• Never billed alone
  • Only with 99201-99215 and any other service provided at that encounter
• Prolonged service of <45 minutes on a given date is not separately reported as the clinical staff time involved is included in the E&M code
  • Example: prolonged clinical staff services for 99214 begin after 25 minutes, and 99415 is not reported until 70 minutes of total F2F clinical staff time has been performed.
• 99415/16 may be reported for no more than 2 simultaneous patients
Clinical Example

A 52-year-old female presents with persistent vomiting. She presents with signs and symptoms of clinical dehydration.

Description of Procedure (99415, 99416)

- Evaluation and management is performed by the physician. The decision is made to begin oral rehydration in the office. Prolonged monitoring and observation for 2 hours ensues [by the M.A.] with intermittent evaluation of the patient by the physician.
ADVANCED CARE PLANNING
Advance Care Planning*

• 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 care professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

• 99498...each additional 30 minutes (list separately in addition to primary procedure)

*Payable by Medicare, effective 01/01/2016
Advance Care Planning (continued)

• Coinsurance/deductible apply
• Unless provided with an AWV
  • Bill ACP with modifier -33 to ensure payment in full by Medicare
• No active management of the patient’s problem(s) is undertaken during the time period reported
  • 99497/98 may be billed separately if performed on the same day as most other Evaluation & Management services, as long as time is not used in the other E&M service
  • Not to be billed with critical care codes
Advanced Care Planning – Scenario

• 68 year old male with heart failure and diabetes on multiple medications is seen with wife to discuss advance care planning.

• Documentation to include: Cognitive evaluation to determine patient capacity Discussion of Risks, benefits and alternatives to the various advance directive planning tools.

• Show Patient various forms (Blank) Discussion of patients personal belief/values/goals Discuss palliative care options, ways to avoid hospitalization and the patients desire for care if decision making capacity is affected Answer Patient/caregiver questions.

• CPT code 99497 would be billed in this case.
New Medicare Payment Policy:  
Transitional Care Management (99495, 99496)

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components **must** be furnished:

- An interactive contact;
- Certain non-face-to-face services; and
- A face-to-face visit.

**2016 Medicare Change (Effective 01/01/2016):**
Date of service for TCM is the date of the face-to-face visit.
Transitional Care Management (TCM)

• New codes/Medicare benefit in 2013
• Intent: help prevent hospital readmissions
• Covers the day of discharge from an inpatient admission through the next 29 days
• Only one physician can bill
• Two CPT codes
  • 99495
  • 99496
Who can provide TCM?

Physicians (any specialty); and the following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:

- Certified nurse-midwives;
- Clinical nurse specialists;
- Nurse practitioners; and
- Physician assistants.
TCM may be provided after D/C from:

- Inpatient Acute Care Hospital;
- Inpatient Psychiatric Hospital;
- Long Term Care Hospital;
- Skilled Nursing Facility;
- Inpatient Rehabilitation Facility;
- Hospital outpatient observation or partial hospitalization; and
- Partial hospitalization at a Community Mental Health Center.
Beneficiary Must be Returned to a Community Setting Such As...

• His or her home;
• His or her domiciliary;
• A rest home; or
• Assisted living.
Component: Interactive Contact

- Must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting.
- The contact may be via telephone, e-mail, or face-to-face.
- For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver.
  - not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver.
- You may not bill the TCM if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.
Component: Non-Face-to-Face Service, Physician or NPP may provide

• Obtain and review discharge information (for example, discharge summary or continuity of care documents);
• Review need for or follow-up on pending diagnostic tests and treatments;
• Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems;
• Provide education to the beneficiary, family, guardian, and/or caregiver;
• Establish or re-establish referrals and arrange for needed community resources; and
• Assist in scheduling required follow-up with community providers and services.
Component: Non-Face-to-Face Service, Licensed Clinical Staff* may provide

- Communicate with agencies and community services used by the beneficiary;
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.

*Beginning 1/1/15, general supervision is acceptable for the non-F2F services; all other incident-to criteria must be met
Component: Face-to-Face Encounter

• CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
  • ~$165.42 Medicare allowable (National Fee)

• CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
  • ~$233.09 Medicare allowable (National Fee)

*The face-to-face visit is part of the TCM service and is not reported separately*
TCM Documentation

Document the following information, at a minimum, in the beneficiary’s medical record:

• Date the beneficiary was discharged;
• Date you made an interactive contact with the beneficiary and/or caregiver;
• Date you furnished the face-to-face visit; and
• The complexity of medical decision making (moderate or high).
Billing TCM Services

• Only one health care professional may report TCM services;
• Report services once per beneficiary during the TCM period;
• The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported;
• Reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues should be reported separately;
Billing TCM Services (continued)

• You may not bill TCM services and services that are within a post-operative global period (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner);

• When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report the following codes during the TCM period:
  • Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and
  • End-Stage Renal Disease services: CPT codes 90951 – 90970.
Coding and Medicare Policy

Hospital Based Providers
Coding and Medicare Policy

• Hospital based providers – new POS codes
  • 19  Off campus-outpatient hospital
  • 22  On campus-outpatient hospital
CPT on Imaging Guidance*

“A written report (e.g., handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. Please see the guidelines regarding Imaging Guidance in each individual section.”

• Surgery
• Radiology
• Medicine

* CPT 2016 Instructions
Radiology – Significant Changes

• Revisions to the guidelines, code descriptors, and parenthetical notes to replace the term “film(s)” with “image(s)” to include both films and digital images.

• “A written report (e.g., handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation.”
Radiology – Hip & Pelvis Now Bundled

• 73501: Radiologic examination, hip, unilateral, with pelvis when performed; 1 view
• 73502: Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views
• 73503: Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views
• Deleted: 73500, 73510
Radiology

Hip & Pelvis Now Bundled

New Femur Codes

• 73521: Radiologic examination, hips, bilateral, with pelvis when performed; 2 views
• 73522: Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views
• 73523: Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views
• Deleted: 73520
• 73551: Radiologic examination, femur; 1 view
• 73552: Radiologic examination, femur; minimum 2 views
• Deleted: 73550
Biosimilar Products – MCR Update

• Biosimilars approved under the FDA’s abbreviated biosimilar pathway established by the Affordable Care Act, and those approved under this pathway that also are deemed interchangeable by the FDA, will be reimbursed at the biosimilars’ average sales price (ASP) plus 6% of the ASP of the reference product.
What this transmittal is telling us:

Biosimilar Products – MCR Update (continued)

• Effective Jan. 1, CMS requires that a manufacturer-specific modifier be reported with a biosimilar HCPCS code.
• Claims for a biosimilar HCPCS code that lack an appropriate modifier will be rejected.

Other Areas Needing Your Attention

- Prepayment reviews
- Medicare Deductible, therapy cap, etc.
- Incident-to guideline clarification
- Reporting requirements for 10- and 90-day global periods
SNF/NF LCD and Pre-payment Reviews

• Florida’s local MAC (FCSO) is concerned about the frequency of SNF/NF visits

• L36230 is effective 11/15/2015
  • “....Frequent visits...would then be unnecessary, particularly if the patient is medically stable. However it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness. The medical record must clearly reflect the particular circumstances requiring the increased frequency of services by documenting....”

• First Coast will be implementing a threshold audit for CPT® code 99306 and a prepayment utilization audit for CPT® codes 99307, 99308, 99309 and 99310. The new edit will be based on a predetermined percentage of claims in an effort to reduce the error rates for these nursing facility services. The audit was implemented effective February 1, 2016
Deductible and Coinsurance - 2016

• Conversion factor
  • $35.8279

• Deductible
  • Part B increased to $166.00

• Coinsurance
  • Part B 20%

• Therapy Financial Cap
  • $1,960.00 physical therapy & speech pathology
  • $1,960.00 occupational therapy
Incident-to

• 2016 MPFS rule makes two things clear:
  1. “Where the supervising physician [the doctor in the office suite] is not the same as the referring, ordering or treating practitioner, only the supervising practitioner may bill Medicare for the incident-to service.”
    • Do not bill under the patient’s physician if s/he is not in the office suite when services are provided.
  2. “New requirement” that auxiliary personnel who have been excluded or revoked from Medicare and Medicaid are prohibited from providing incident-to services.
Changes to Appeal Review Scope

• MLN Matters SE1521: Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims:
  • MACs and QICs must now limit their review to the reason(s) directly associated with the initial denial.
  • Previously, they had discretion to develop additional, new issues related to coverage for a submitted appeal; e.g., claims denied for lack of documentation and then denied for a new reason at the next level of appeal.
  • Applies only to claims denied in post-payment review or audit.
    • Does not apply to prepayment review claims.
  • Effective for redeterminations and reconsideration requests received by the MAC or QIC on or after Aug. 1, 2015.
Section 1848(c)(8)(B)(i) of the Act* requires CMS to develop, through rulemaking, a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Section 1848(c)(8)(B)(iii) of the Act specifies that the Inspector General will audit a sample of the collected information to verify its accuracy. Section 1848(c)(8)(C) of the Act requires that, beginning in CY 2019, we must use the information collected as appropriate, along with other available data, to improve the accuracy of valuation of surgical services under the PFS. Section 523(b) of the MACRA adds a new paragraph at section 1848(c)(9) of the Act that authorizes the Secretary, through rulemaking, to delay up to 5 percent of the PFS payment for services for which a physician is required to report information under section 1848(c)(8)(B)(i) of the Act until the required information is reported.

*MACRA
PQRS Highlights

• No major changes
• Impact on Value Based Modifier significant
• 2016 reporting methods looks much like 2015
• Penalty for not reporting 2016 PQRS is 4% for solo providers and groups with 2-9 providers: 2% value modifier penalty + 2% PQRS penalty
• Penalty for not reporting 2016 PQRS is 6% for groups with ten or more providers: 4% value modifier penalty + 2% PQRS penalty
Meaningful Use

Patient Access and Medicare Protection Act, Pub. L. No. 114-115, enacted December 28, 2015:

• Creates the ability to submit a hardship exception for EPs who will not be able to meet the 2015 requirements of MU at the group practice level.
  • Rather than submit an individual form for each physician in the group.
• EPs obtaining the hardship would not be hit with a penalty in PY 2017.
• Would need to apply by 07/01/2016.


While we do recommend that your goal be to attest, for anyone having one of the accepted hardships, this could be important.
Value Based Payment

• The VM is one of many tools CMS is using to shift the basis for Medicare payments from volume to value. On January 26, 2015, Health and Human Services (HHS) Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.
Value Based Payment (continued)

• The three cost/quality tiers for which a group receives an upward adjustment are: low cost/average quality; average cost/high quality; low cost/high quality.

• Groups that treat beneficiaries with an average beneficiary risk score in the top 25 percent of all beneficiary risk scores, receive an additional +1.0x VM payment if they are eligible for an upward adjustment based on their cost and quality performance.
### VBPM Results for 2015

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<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
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<td>Low Cost</td>
<td>+0.0% (0)</td>
<td>+1.0x = 4.89%</td>
<td>+2.0x = 9.78%</td>
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<td>Average Cost</td>
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<td></td>
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<tr>
<td>High Cost</td>
<td>-1.0% (3)</td>
<td>-0.5% (1)</td>
<td>+0.0% (0)</td>
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Useful Websites

• Value-Based Payment Modifier
  www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html

• PQRS
  www.cms.gov/pqrs

• Physician Feedback Program:
  www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/index.html

• Physician Compare
  www.medicare.gov/physiciancompare
Useful Websites (continued)

• Search for Meaningful Use, PQRS, VBP Modifier, etc. at www.cms.gov

• Provider Compliance http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp

• HIPAA Enforcement www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/index.html
There’s a lot going on..... Questions?
We Thank You for Joining Us!