Community-Based Palliative Care: Fee-For-Service Strategies for a Financially Sustainable Model

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Housekeeping

- All lines will be muted.
- Submit questions online at the end of this webinar.
  - You can do so at any time through the Q&A platform located at the bottom center of your screen (**NOT** the chat function).
- Session will be recorded.
- Recording and slides will be available on CHCF website within 2 weeks.

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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.

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AGENDA

Evaluation & Management Services
- Billing based on time
- Billing on “complexity” (the 3 Key Components)

Advanced Care Planning
- Who can provide
- Coding & Documentation

Non-Traditional Services
- Chronic Care Management
- Non Face-to-Face Prolonged Services
- Virtual Check-in Service (New for 2019!)

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Evaluation & Management Services

Billable encounters/visits

1. Medically necessary
2. Face-to-face

Code sets by type of service and/or place of service

- New patient vs. established patient
  - Home visits
  - ALF, domiciliary, rest home visits
- Initial care vs. subsequent care
  - Inpatient hospital
  - SNF/NF

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Evaluation & Management Services

Once the right “type” is identified:

- Location of the patient
- New vs. Established
- Initial vs. Subsequent

Must choose right “level” of service

Based on 3, 4 or 5 levels

1. Documentation of history, exam and medical decision making, or
2. Time and counseling and/or coordination of care

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7 Components Define E&M

- Key Components in selection of level
  - History
  - Examination
  - Medical Decision Making
- Ancillary elements in selection of level
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity)
  - Time

The Key Components

"Key Components"

1. History
2. Physical Exam
3. Medical Decision Making

Documentation of all three key components must meet the code's definition for

"New patient" visits

"Initial" patient visits

Documentation of 2 of the 3 key components must meet the code's definition for

"Established patient" visits

"Subsequent" visits

#1: Documentation of History

Based on 4 Types

1. Problem Focused
2. Expanded Problem Focused
3. Detailed
4. Comprehensive

History Elements

- Chief Complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family and/or social history (PFSH)

The “type” is determined based on the degree of detail in each of the history elements.

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Unobtainable History

The documentation must clearly reflect:

- The components that were unobtainable (HPI, ROS and/or PFSH)
- Circumstances that preclude obtaining the HPI, ROS, and PFSH (dementia, sedated on a vent, etc.). When using 'poor' historian the documentation must support why (e.g. dementia).
- Attempt to obtain from other resources:
  - A family member, spouse, nurse etc. was not present or was unable to provide additional information
  - The medical record (chart, ambulance run sheet, etc.) did not contain the information needed
- If patient or family can provide information at a later time, the provider may add an addendum containing this information

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#2 Physical Examination

Body Areas

- Head, including face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

Organ Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/ immunologic

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4 Levels of the Exam

Problem Focused 99231, 99341, 99347	**A limited exam of the affected body area or organ system (1+BA/OS)**
Expanded Problem Focused 99232, 99342, 99348	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/systems(s) (2-7 BA/OS)
Detailed 99233, 99221, 99343, 99349	An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) (2-7 BA/OS)
Comprehensive 99222, 99223 99344, 99345, 99350	General multi-system (8+ OS) or complete single organ system exam

#3 Medical Decision Making

(2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests and/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or possible management options
   - Each variable can be one of four levels: from minimal/none to extensive/high.

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Determining Medical Decision Making

Medical Decision Making Elements	Straight-forward	Low	Moderate	High
1. Number of Diagnoses or Management Options	< 1	2	3	4 or more
2. Amount and Complexity of Data	< 1	2	3	4 or more
3. Overall Risk	Minimal	Low	Moderate	High

MDM: _____

Two out of three elements of MDM (2 of the 3 tables) must meet or exceed to qualify for a given level of MDM.

Which equates to:

Straightforward	99341
Low	99221, 99231
Moderate	99222, 99232, 99344
High	99223, 99233, 99345

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#3 Medical Decision Making

(2:3 variables required)

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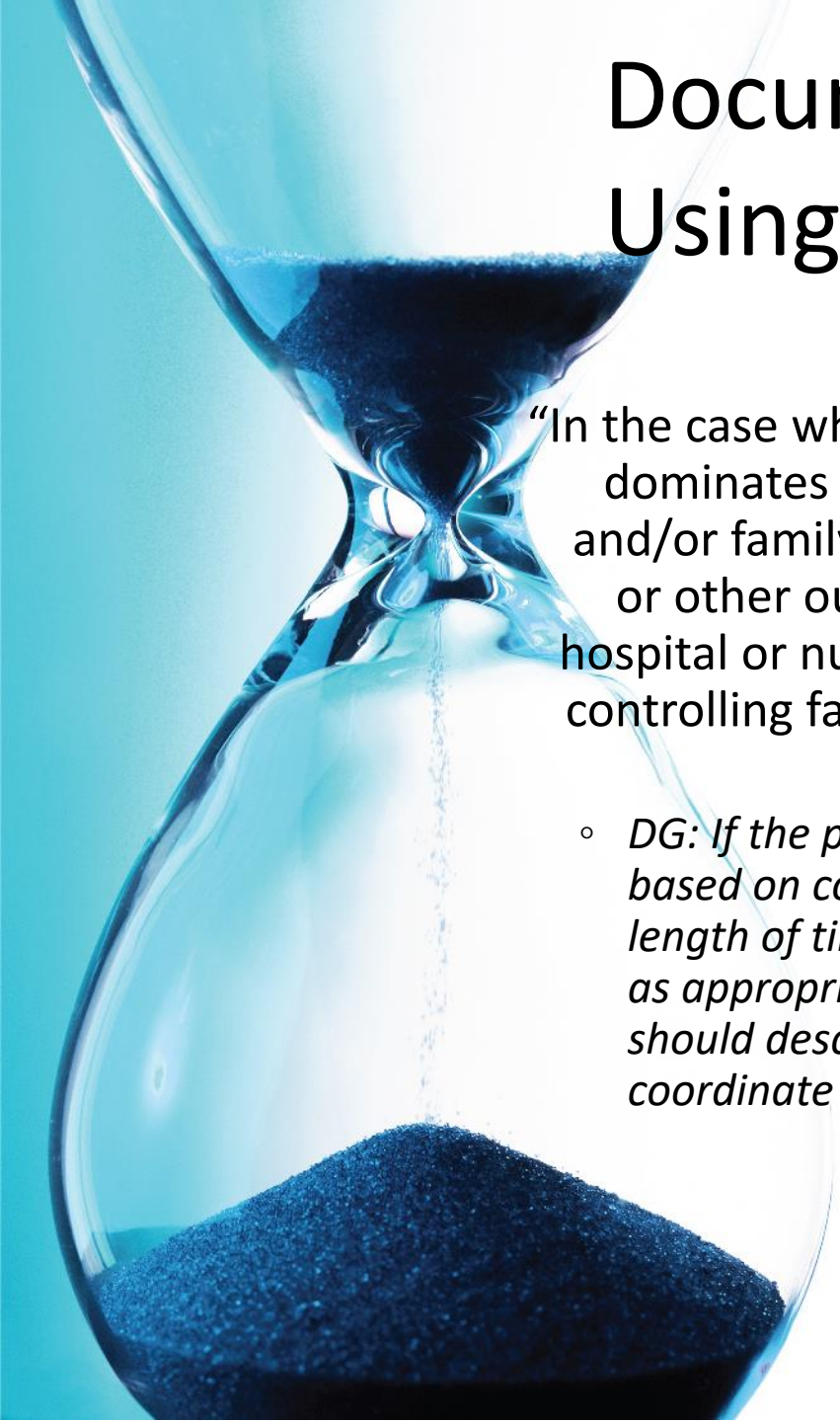

Documentation & Coding Using Time…

"In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E&M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the records should describe the counseling and/or activities to coordinate care."*

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Putting it Together

HOME CARE SERVICES
(1995 Guidelines)

New Patient

(Requires all 3 Key Components be met)

Code	History	Physical Exam[3]	Decision Complexity[1]	C/CC – Total Visit Time[2]
99341	CC; HPI (1-3)	Limited 1 Body Area/Organ System	Straightforward	20 minutes
99342	CC; HPI (1-3); ROS (1)	Limited 2-7 Body Areas/Organ Systems	Low	30 minutes
99343	CC; HPI (4+)*; ROS (2-9); PFSH (2:3)	Extended 2-7 Body Areas/Organ Systems	Moderate	45 minutes
99344	CC; HPI (4+)*; ROS (10+); PFSH (3:3)	8 or more Organ Systems	Moderate	60 minutes
99345	CC; HPI (4+)*; ROS (10+); PFSH (3:3)	8 or more Organ Systems	High	75 minutes

Putting it Together

HOME CARE SERVICES
(1995 Guidelines)
Established Patient
(Requires 2 of 3 Key Components be met)

Code	History	Physical Exam[3]	Decision Complexity[1]	C/CC – Visit Time[2]
99347	CC; HPI (1-3)	Limited 1 Body Area/Organ System	Straightforward	15 minutes
99348	CC; HPI (1-3); ROS (1)	Limited 2-7 Body Areas/Organ Systems	Low	25 minutes
99349	CC; HPI (4+)*; ROS (2-9); PFSH (1:3)	Extended 2-7 Body Areas/Organ Systems	Moderate	40 minutes
99350	CC; HPI (4+)*; ROS (10+); PFSH (2:3)	8 or more Organ Systems	Moderate to High	60 minutes

Advance Care Planning

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ACP: The Codes

CPT® Code	Description
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	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; each additional 30 minutes (List separately in addition to code for primary procedure)

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Care Management Services

Transitional Care Management

- Prevent inpatient readmission within 30 days of discharge
- Only 1 provider can bill
- F2F and non-F2F services

Chronic Care Management

- Avoid trips to the ED and hospital admissions
- Only 1 provider can bill
- No F2F service

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Chronic Care Management

- Effective January 1, 2015
- No face-to-face services required
- May be provided by the Physician, NPP or clinical staff

Incident-to direct supervision criteria has been waived for CCM

- 24/7 access is required

➢ Organization/practice must use a certified EHR

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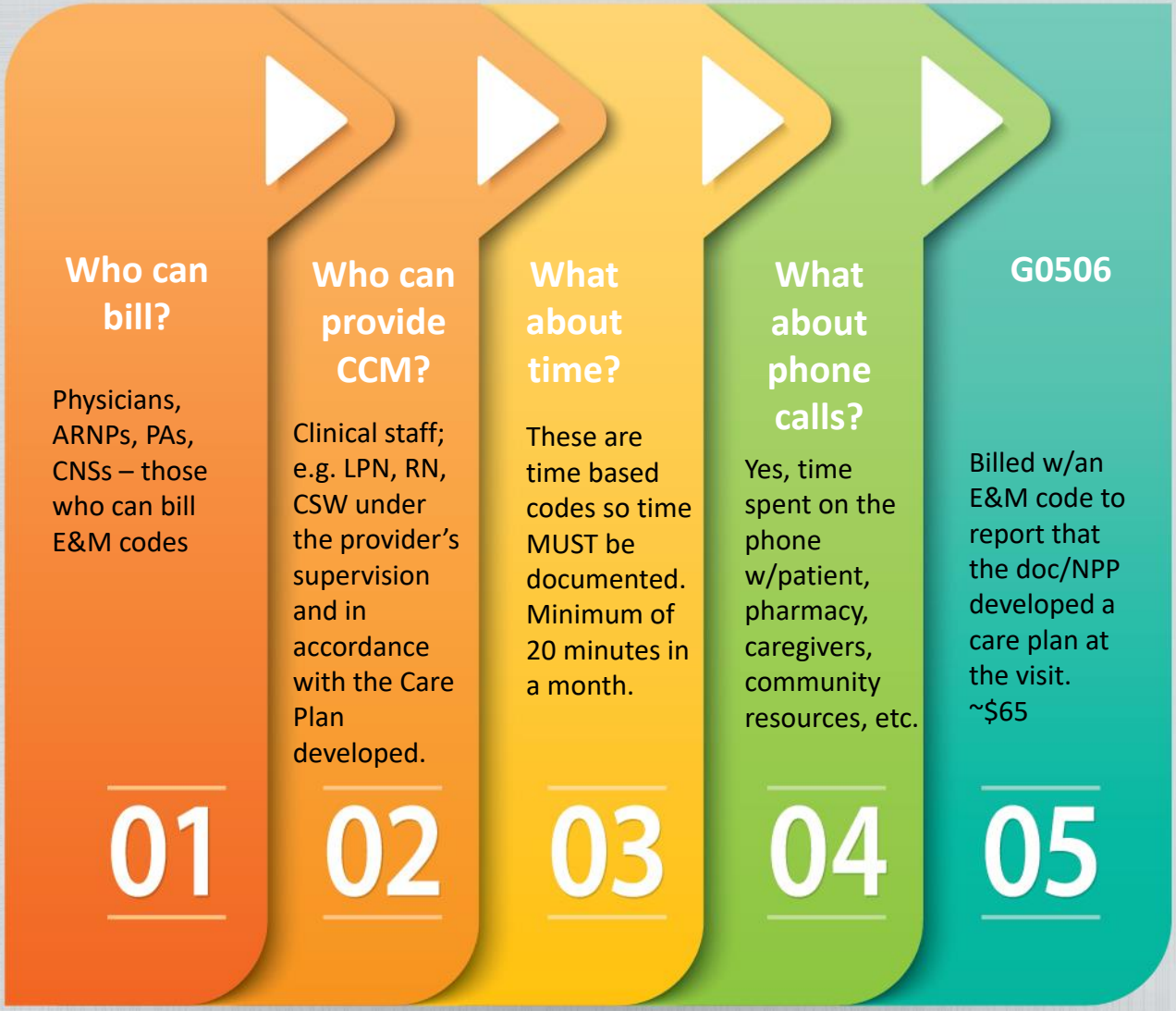
Chronic Care Management



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Typical CCM Services

- Assessment of the patient's medical, functional, psychosocial needs;
- Medication reconciliation with review of adherence and potential interactions; and
- Oversight of patient self-management of medications.
- Provide follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordinate care with home and community based clinical service providers.

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Non Face-to-Face Prolonged Services…

+99358 – Prolonged evaluation and management service before and/or after direct patient care, **first hour**.

~$118

+99359 – Prolonged evaluation and management service before and/or after direct patient care, **each additional 30 minutes** (List separately in addition to code for prolonged service).

~$60

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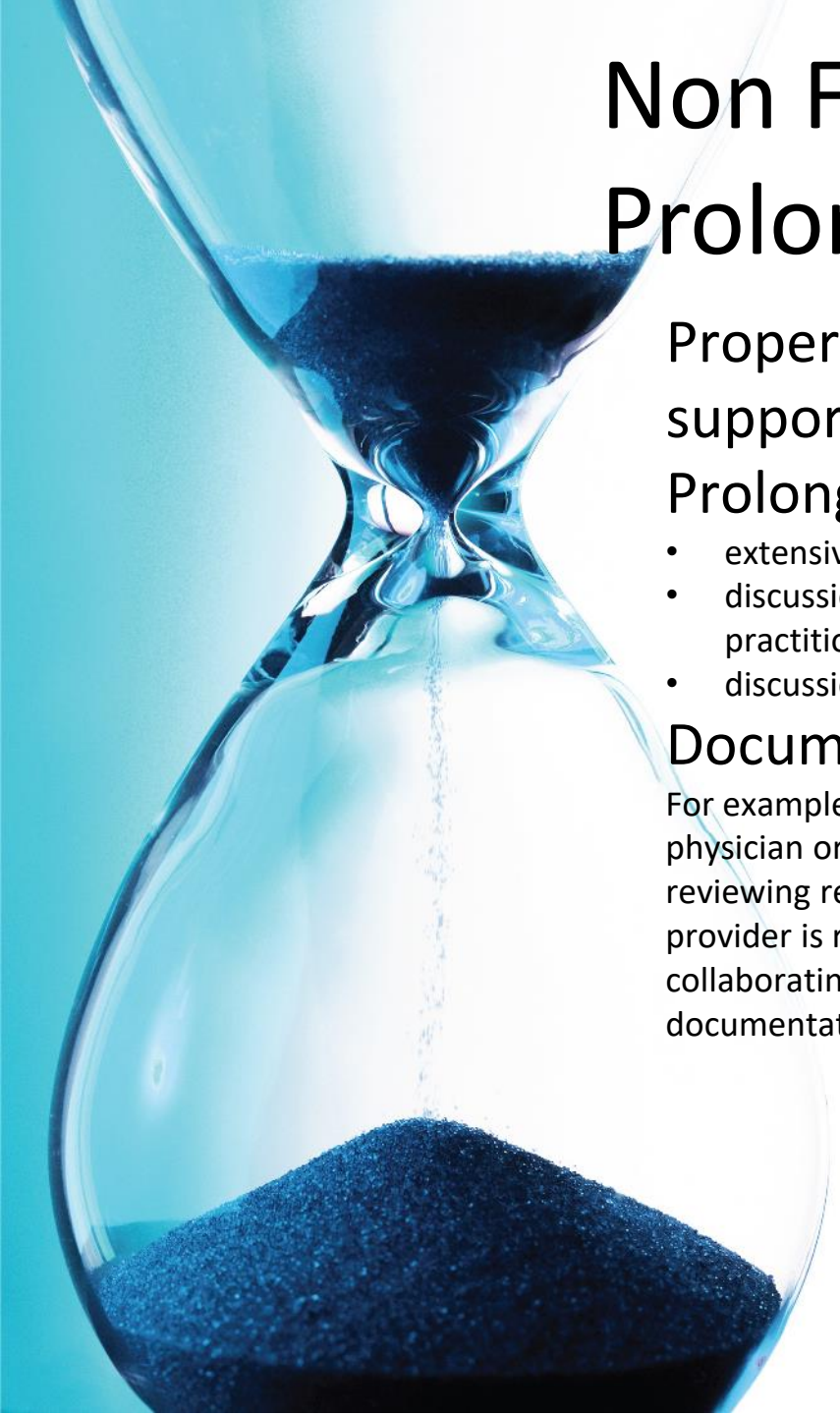

Non Face-to-Face Prolonged Services…

Proper documentation is critical to support 99358 & 99359.

Prolonged service activities:

- extensive review of medical records,
- discussion of patient's case with other health practitioner,
- discussion with family/surrogate.

Document as specific as possible.

For example, start by documenting the time you (the physician or other nonphysician practitioner) began reviewing records — say, 11:05 a.m. Note which records the provider is reviewing; document phone calls with collaborating physicians and list their practices; and end the documentation with the time — say, 12:15 p.m.

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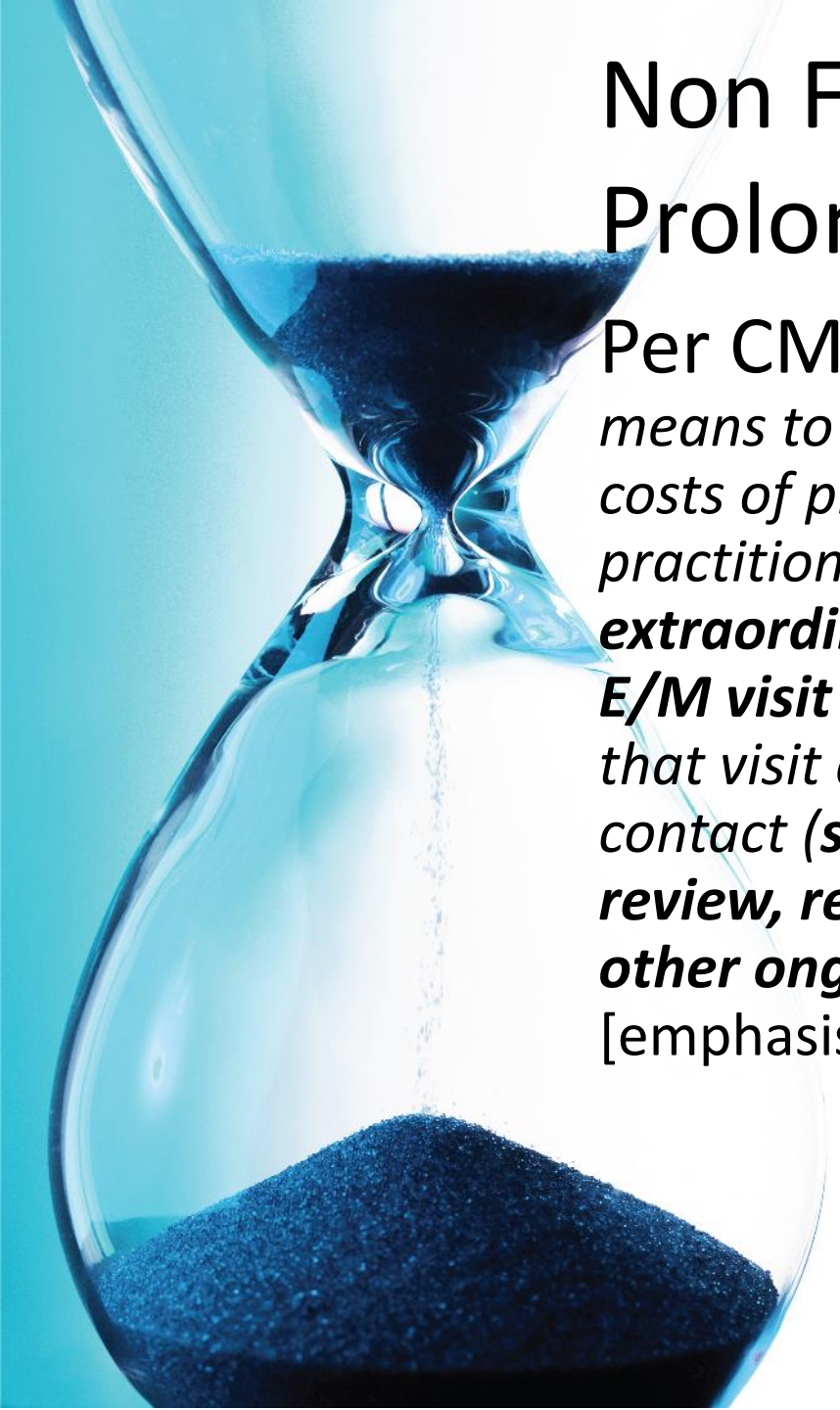

Non Face-to-Face Prolonged Services…

Per CMS: *"these codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners, when they spend an* ***extraordinary amount of time outside of an E/M visit*** *performing work that is related to that visit and does not involve direct patient contact (****such as extensive medical record review, review of diagnostic test results or other ongoing care management work****)."* [emphasis added]

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Virtual Check-in Service
a/k/a
“Telemedicine Lite”

Changes to E&M Requirements

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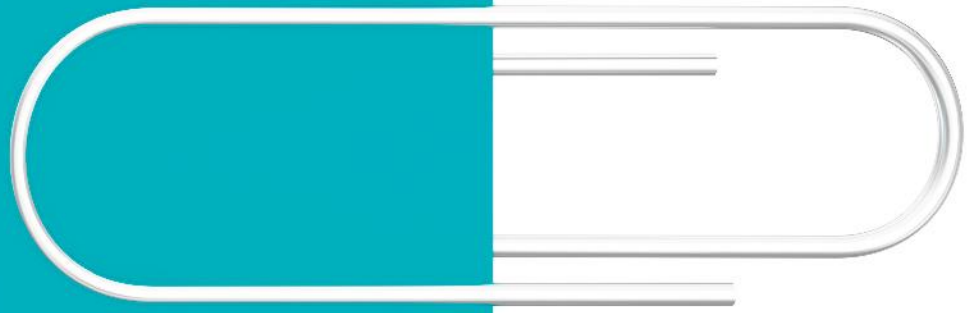
NOTES:

HCPCS G2012: (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).



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What Technology Will be Allowed?

01

Phone

Audio-only real-time telephone interactions.

02

Video

Synchronous, 2-way audio interactions that are enhanced with video or other kinds of data transmission.

03

NOTE:

G2012 explicitly only allows direct interaction between the patient and the billing provider – no other clinical staff.

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Other Requirements

→Contact must be initiated by the patient
- →Co-insurance applies
  - →~$14 allowable
- →Patient should be advised of cost sharing with verbal consent noted in the medical record

→Service can only be billed for an established patient

→Must be medically reasonable and necessary in order to be paid by Medicare.

Watch for more info
from CMS in 2019

Home vs. Office Visits

Effective Jan 1, 2019:
The physician/NPP will no longer be required to document the medical necessity of a home care visit versus an office visit.

Up till then, must continue documenting why the patient could not have gone to an office/clinic for care.

Eliminating Redundant Documentation

Effective Jan. 1, 2019 for established patient E&M Office/Outpatient Visits:
(CPT® 99201-99215)

"When relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence…the practitioner reviewed the previous information and updated it as needed."

Note: not home, ALF, hospital, nursing home, just office visits

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Recommended Reading

Evaluation & Management Services Guide
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html

Advance Care Planning
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

Chronic Care Management
https://go.cms.gov/ccm

Look for the companion palliative care FFS billing handbook in early 2019 to fill in the detail for much of this presentation's topics.

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