Coding for the Practitioner

Jean Acevedo, LHRM, CPC, CHC, CENTC

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• This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and coding information, but is not a legal document. The official CPT® codes and Medicare Program provisions are contained in the relevant documents.

Agenda

- Payer Documentation Requirements
- Medical Necessity
  - a/k/a being able to keep the money!
- Evaluation & Management Services
- Diagnosis Coding and Paying for Value

PAYER DOCUMENTATION REQUIREMENTS

Medical Record Documentation

- Each encounter should
  - Be complete and legible
  - Every page in the chart should have the patient's name and date of service.
  - Document the reason for the encounter
    - a/k/a "medical necessity"
  - Have a documented impression
  - Have a documented plan of care/f-up
  - Be dated and have the identity of the provider
    - Sign, initial, typed name on dictation
    - All providers and staff

So, in plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is “reasonable and necessary” or be one of the preventive benefits
- Much of this is defined in NCDs and LCDs for non-E&M services provided by physicians.

Evaluation & Management Basics

CPT®: E&M Services Guidelines

- **New and Established Patient**
- "solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report [E&M] services…
- "An established patient is one who has received professional services from the physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.
- "….where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician."

7 Components Define E&M Services:

- 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

Use of Time: If a visit consists **predominantly** of counseling or coordination of care, time is the key element to assign the appropriate level of E&M service

- Office/outpatient setting
  - Face-to-face time refers to patient time with the physician only.
  - Counseling by other staff does not count.
  - Duration of c/cc may be estimated but must be recorded
  - Total duration of the visit also documented.
  - Do not round up!
    - 99214 = 25 minutes
    - 99215 = 40 minutes
    - 35 minute visit is a 99214

“Results” visit

At least 45 minutes w/patient >50% discussing lab results, lifestyle changes and medications to help manage symptoms; new diagnosis of Lupus. All patient questions answered. Long discussion regarding her desire to get pregnant.

Most visits are coded based on the 3 Key Components

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

#1: Documentation of History

- History elements
  - Chief Complaint (CC)
    - "Left knee pain for past 3 weeks" (explicit)
    - "Doing well since adding Ultram." (inference is that visit is to f/up on medication change)
  - History of present illness (HPI)
  - Review of systems (ROS)
    - Series of questions about past or present symptoms
  - Past, family and/or social history (PFSH)

#2: Documentation of Exam (1995 DG)

Comprehensive: Gen'l multi-system **(8+ OS)** or complete single system organ system exam.

Body Areas:

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

Organ Systems:

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

Documentation of Exam*

Problem Focused	A limited exam of the affected body area or organ system **(1+ BA/OS)**
Expanded problem focused	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/system(s) **(2-7 BA/OS)**
Detailed	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	Gen'l multi-system **(8+ BA/OS)** or complete single organ system exam.

*Note: there are geographic differences in these definitions

#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, &/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity &/or mortality, as well as comorbidities associated w/the patient's presenting problem(s), the diagnostic procedure(s), &/or possible management options

Each variable can be one of four levels: from minimal/none to extensive/high.

Briefly: Medical Necessity & EMRs

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information.
- Even when a "complete" note is generated, only medically necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service.
- Information not pertinent to patient's condition at time of encounter cannot be counted.
  - Patient seen in 'routine' follow-up of stable OA. History is "comprehensive" including past, family & social history. Was it "medically necessary" to repeat these history elements?

Level 3 E&M

New patient visit/consults

- 99203/99243/99253
  - Detailed history
    - HPI – 4+
    - ROS – 2-9
    - PFSH – 2:3
  - Detailed exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

3:3 Key Components

Established patient office visit

- 99213
  - Expanded problem focused history
    - HPI – 1-3
    - ROS - 1
  - Expanded problem focused exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

2:3 Key Components

99204/99244

Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
     - New problem with or w/o a work-up
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

99214

Documentation Required (2:3 Key Components)

1. Detailed History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 2- 9 systems
   - One of Past Medical/Family/Social History
     - Listing medications = medical history
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
     - 3 stable chronic conditions
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

99205/99245
Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8+ organ systems)
3. Medical Decision Making of **High** Complexity (at least 2 of the following)
   - Extensive # of diagnoses or management options
   - Extensive amount or complexity of data (to be) reviewed
   - High degree of risk

The Move From Volume To Paying for Value

Background

- On 1/26/15, HHS Sec'y Sylvia M. Burwell announced measureable goals and a timeline
- To move the Medicare program, and our health care system at large
- Toward paying providers based on the quality, rather than the quantity of care provided to patients.

Background

- The goal:
  - Tie 85% of all traditional Medicare payments to quality or value by 2016, and
  - 90% by 2018.
- The Value Modifier and Physician Feedback Programs are part of a strategy to achieve these goals

Value-Based Payment Modifier

- Current Fee Schedule payment method does not contain incentives for physicians to focus on:
  - The quality & outcomes of all the care furnished to beneficiaries,
  - The relative value of each service they furnish or order, or
  - The cumulative costs of their own services and the services that their patients receive from other providers.
- Value-Based Payment Goals:
  - Improve quality
  - Lower per-capita growth in expenditures

Physician Benchmarking: QRUR

- Quality Resource and Usage Reports
- Find yours at https://portal.cms.gov
  - Must have an IACS/EIDM account
- Care and cost data for from 2014 claims data
- Lists all Medicare FFS patients you submitted a claim for in that period of time
  - Costs incurred by you
  - Costs incurred by unaffiliated providers
- High cost/low quality, average, or Low cost/high quality?

Value Modifier Policies for 2017

- Payment at risk is -4.0%, with potential upward adjustment of up of +4.0x ('x' represents the upward payment adjustment factor)

Cost/Quality	Low Quality	Avg Quality	High Quality
Low cost	+0.0%	+2.0x*	+4.0x*
Avg. cost	-2.0%	+0.0%	+2.0x*
High cost	-4.0%	-2.0%	+0.0%

NOTE: * *Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary* ***risk score*** *in the top 25 percent of all beneficiary risk scores*

In the background, patient costs are being risk adjusted based on beneficiary health status and demographic characteristics

Risk Adjustment payment is based on what's wrong with the patient rather than what was done to the patient

- How complex a case is this, and
- Can we anticipate future costs

Proper documentation & coding of all current diagnoses impacts future payment

Chronic conditions, age, sex, original Medicare entitlement, disability & Medicaid status are included in the formula

What Diagnoses Should be Reported: ICD-10 Official Guidelines

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

Documentation Requirements

- Additional Coding Guidelines:
  - Face-to-face visit
  - Documentation must show how chronic condition is being treated, managed, or assessed
  - Each diagnosis must have an Assessment and a Plan

Sample Language

Assessment	Plan
Stable	Monitor
Improved	d/c Meds
Tolerating meds	Continue current meds
Deteriorating	Refer to/for…

Example 1: Lupus, stable well controlled. Continue Plaquenil.
Example 2: COPD, stable on Advair

Additional Documentation Tips

- Document all causal relationships
  - Coders are not allowed to make assumptions when assigning a diagnosis code
- Be descriptive
  - Think in ink
- Only document “history of” when the condition no longer exists or in no way impacts your current treatment
- Do document co-existing conditions/comorbidities that are addressed or that impact your treatment
  - Hypertension
  - Amputations
  - Diabetes Mellitus

Times they are a changing…

Ten years ago….

- There was no PQRS or EHR MU
- It was unheard of for Medicare Part B to pay for non face-to-face services
    - TCM
    - CCM
    - ACP
- ACOs were like unicorns: you may have heard about them, but no one had ever seen one.
- MSSP looked like a typo for "Medicare Secondary Payer," not Medicare Shared Savings Program
- A Modifier was a 2-digit suffix for coding, not a method for paying doctors (Value Based Payment Modifier)
- Bundled payment meant edits in the Correct Coding Initiative, rather than one payment to cover all providers involved in an episode of care
    - Total knee replacement, for example

The Future

- Phased out in 2018:
  - PQRS
  - VBM
  - EHR MU
- But rolled up into MIPS

- Merit-Based Incentive Payment System (MIPS)
- Payment in 2020 based on CY 2019 data
- 100 Point Scale
  - Quality: 30 points
  - Resource use: 30 points
  - MU: 25 points
  - Clinical Practice Improvement: 15 points
- Payment Adjustments
  - ± 4% 2020
  - ± 9% 2024

In Conclusion

- Fee For Service will still be here
  - Document and code your visits, x-rays and procedures thoroughly
    - Clinical indications and rationale: document your thought process
- As payment continues to move towards value, paint a complete picture of your patients
  - Include co-morbid chronic conditions as they impact the high quality/low cost to low quality/high cost continuum.
    1. Patient with RA is anticipated to have $x costs this year
    2. Patient with RA, DM, Hypertensive heart disease is expected to have $xxx costs this year.
    - If your patient's actual costs were $xx, in #1 you're high cost, but in #2, you were a low cost provider.


Questions
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Jean Acevedo, LHRM, CPC, CHC, CENTC
Acevedo Consulting Incorporated
2605 W. Atlantic Ave., #D-102
Delray Beach, FL 33445
561.278.9328

info@acevedoconsulting.com
www.AcevedoConsultingInc.com