Virginia Long-Term Care Clinician Network Monthly Forum

April 17, 2024

Welcome!

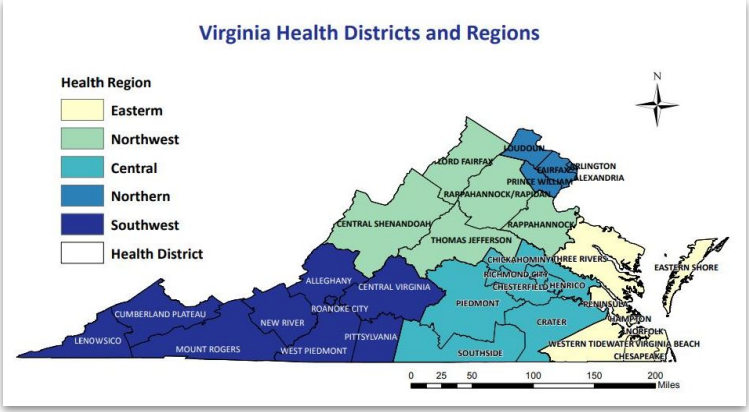
As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care. During the presentation we can mute ourselves until it is time for more interaction.

Please use the chat box:

- **Your name and region/city/town**
- **Favorite candy bar**

Welcome New Members!

Kelly Black, Administration - Central
Tracey Hairston, RN - Southwest
Hemal Patel, MD - Eastern



For great resources: look for previous slide sets and newsletters under Forums & Events and Resources on our website.

ltccn.vcu.edu

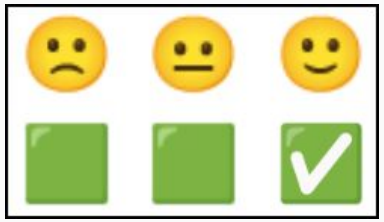
Check Your Inbox!

We are conducting a survey of our clinician members – physicians, nurse practitioners and physician assistants – on well-being and satisfaction with areas of work-life.

Participation is voluntary. Your responses will be kept confidential.

Participants will receive a $25 electronic gift card and will be eligible to enter a random drawing for a $100 gift card as a thank you. Survey responses are limited to the first 50 participants.

Check your inbox for an email with a link to take the survey today! Are there any questions?



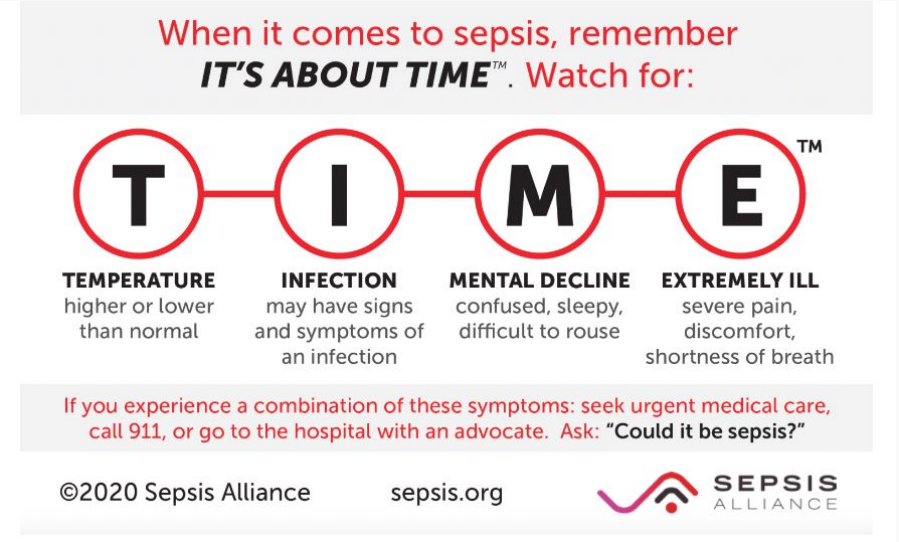
Chat Waterfall

What health/illness trends are you seeing for your LTC residents this spring?

Poll

Sepsis is often the #1 diagnosis that sends your residents to hospital. Do you think it is:

1. ***Underidentified***
2. ***Identified accurately***
3. ***Over diagnosed***



https://www.sepsis.org/about/its-about-time/

Long-Term Care Professional E/M Service Guidelines: What's on your mind?

Presented by Teri Molsbee, CPCO, CPC, CDEO, CRC

Disclaimer

- This document is provided solely for educational purposes.
- Answers and comments are based on information that is available at the time of this presentation.
- The AMA, CMS, and private payers may all provide additional information in the future that may contradict the interpretations provided in this presentation.
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Hot Topics

- Medical Decision Making versus Time
- New Initial visit versus Subsequent Visit
- Transitional Care Management
- Chronic Care Management
- Annual Wellness Visits vs Annual History & Physicals vs Annual Preventive visits
- Advanced Care Planning
- G2211
- Split-Shared Visits
- Incident-To Services
- Hospice – understanding GV and GW Modifiers
- Billing Trends
- Audit Risks

Place of Service Matters

While in Evaluation and Management (E/M) certain guidelines remain the same regardless of the place of service, such as the guidelines for determining Level of Service, some guidelines differ based on place of service. Knowing these differences is key to accurate documentation and coding assignment for billing.

- New versus established patient or Initial versus Subsequent visit
  - SNF (POS 31) and NF (POS 32) utilize Initial versus Subsequent visit guidelines
  - AL (POS 13) and Office/Outpatient (POS 11 or 12) utilize New versus Established patient guidelines
- Program or Service Availability
  - CCM program available in all places of service
  - TCM program available in Office/Outpatient (POS 11 or 12) and Assisted Living (POS 13)
  - Split-Shared Visits per CMS cannot be done in Office (POS 11)
  - Incident-To Services available in Office/Outpatient (POS 11 or 12) and Assisted Living (POS 13)
- Scope of Practice Guidelines
  - SNF (31) Initial visit can only be provided by physician

Let's Talk MDM vs Time

- The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis.
- Documentation should always support the medical necessity of the visit regardless of which element is utilized to determine the level of the visit.
- AMA guidance is to utilize the element that is to the best advantage of the provider.
  - Time spent on encounter is greater than MDM level based on various reasons, such as prolonged time spent reviewing test results and patient and family with multiple questions (documentation should support this time spent, i.e. "patient and family had multiple questions regarding results of coagulation profile and decision to treat with Coumadin")
    - Time would be especially essential in a case such as the above if a great amount of time was spent in discussion leading to prolonged service code assignment in addition to base code
- Time is often the criteria for certain services, such as chronic care management and advanced care planning
- Question – Prescription drug management billing based on time versus MDM? It depends!

MDM Review

- Levels of MDM –
  - Straightforward
  - Low
  - Moderate
  - High
- Determining MDM - To adequately determine the level of visit, the MDM is selected based on 3 components (2 of 3 must be met at the same or higher level)
  1. The number and complexity of **problems addressed** at the encounter;
  2. The amount and complexity of **data** to be reviewed and analyzed; and
  3. The **risk** of complications and/or morbidity or mortality of patient management.

TIME

- Time - Time can be an element of code selection for a variety of E/M services. It is important to review any instructions and code descriptions in each category of E/M services as they vary within each category and level of service.
- The E/M Guidelines in the CPT® code book outline activities performed by the provider that are included in the time as follows:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other healthcare professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)
- When time is the basis for code assignment, time spent **must** be documented.

Patient/Visit Type

- New versus established patient
  - AL (POS 13) and Office/Outpatient (POS 11 or 12)
    - New Patient – Has not received any professional services from the provider or a provider of the same group of the **exact** same specialty or subspecialty within the past three years.
    - Established Patient – Has received professional services from the provider or a provider of the same group of the **exact** same specialty or subspecialty within the past three years.
      - This does not mean that every 3 years the patient would be eligible for a new patient CPT code and would pertain to 3 years or greater lapse in care with group.

Patient/Visit Type - continued

- Initial versus Subsequent visit/service
  - SNF (POS 31) and NF (POS 32) – This one gets tricky as it is determined by the stay (admission and/or re-admission), but can also be determined by new or established to practice and specialty within practice
    - Initial Visit/Service – Patient has not received any professional services from the provider or a provider of the same group of the **exact** same specialty or subspecialty during the nursing facility admission and stay.
      - Admission to facility for first time
      - Re-admission to facility following hospitalization (if patient previous stay was discharged and new stay established typically following 3-midnight hospital stay)
      - Patient is new to practice during an existing admission
    - Subsequent Visit/Service – Patient has received professional services from the provider or a provider of the same group of the **exact** same specialty or subspecialty during the nursing facility admission and stay.
      - Transition from skilled services to nursing services during same admission
      - During skilled services (part A stay), APP visit even if prior to physician initial visit

Services and Programs

- **Transitional Care Management**
  - TCM is for patients with medical and/or psychosocial problems requiring a moderate or high level of medical decision making during transitions in care **from** an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility **to** the patient's community setting (eg, home, rest home, or assisted living).
  - Commences upon the date of discharge and continues for the next 29 days.
  - Requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services provided on subsequent dates after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
  - Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date of discharge and there must be a high level of medical decision making. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and there must be at least a moderate level of medical decision making.
  - Only one individual may report these services and only once per patient within 30 days of discharge.

Services and Programs - Continued

- **Chronic Care Management**
  - These services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan.
  - Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
  - Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities. Code 99439 is reported in conjunction with 99490 for each additional 20 minutes of clinical staff time spent in care management activities during the calendar month up to a maximum of 60 minutes total time (i.e., 99439 may only be reported twice per calendar month).
  - Code 99491 is reported for at least 30 minutes of physician or other qualified health care professional time personally spent in care management during the calendar month. Code 99437 is reported in conjunction with 99491 for each additional minimum 30 minutes of physician or other qualified health care professional time.
  - If reporting 99437, 99491 do not include any time devoted to the patient and/or family on the date that the reporting physician or other qualified health care professional also performed a face-to-face E/M encounter.
  - Cannot bill for both clinical staff time and provider time within same month (if both exist, can bill for one or the other or account for the provider time as part of the clinical staff time.
  - There must be documentation of total time spent for each code with supporting documentation for activities as part of total time.
  - Medicare program, some Payers will not cover CCM services (Tricare is one who will not reimburse for service)

Annual Visits – 3 Types

1. **Annual History & Physical (Nursing Facility only)**
   - Nursing Home Regulatory Visit annually from date of admission/initial visit date
   - Billed as subsequent visit (99318 – annual history and physical was deleted in 2023)
   - Covered by all payers
2. **Annual Wellness Visit**
   - Annual preventive visit for Traditional Medicare beneficiaries only regardless of POS
   - Eligibility requirements are present –
     - From 0-12 months of enrollment, beneficiary eligible for IPPE (“Welcome to Medicare”) visit
     - Following 12 months of enrollment, beneficiary becomes eligible for initial AWV(G0438) and every year thereafter is eligible for subsequent AWV (G0439)
     - Is on a monthly calendar, not a day calendar, so if an AWV is done any day in December of one year, the following December they would be eligible for their AWV
     - Can be performed on same date of service as routine E/M visit by same provider
3. **Annual Preventive visit**
   - Annual Physical exam for patients seen in outpatient setting to include office, assisted living, and home, covered by most Medicare Advantage and Commercial payers (Traditional Medicare will not cover as this would be their AWV)
   - On a day calendar, so not payable until 365 days have elapsed from last billed annual preventive

Advance Care Planning

- The face-to-face service between a provider and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).
- When using codes 99497, 99498, no active management of the problem(s) is undertaken during the time period reported.
- Can be performed on the same day as another evaluation and management service
- 99497 – must be 16+ minutes documented for ACP including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the provider
- 99498 – added to 99497 if at least 46 minutes spent on ACP services on DOS; and additionally added at every subsequent 30-minute mark, i.e. 76 minutes would be 99497+99498+99498
- When done at the same time as an E/M visit, add modifier 33 (If done as stand-alone service, no modifier)
- When done at the same time as an AWV, no copay for the beneficiary (and add 33 modifier)
- When done via telephone only conversation with patient/family, add modifier 93 (if done via video

Other Services

- **G2211**
  - G2211 is payable starting January 1, 2024 (by CMS, commercial payers may not cover).
  - G2211 is an add-on code that may be reported with new and established patient **office/outpatient** evaluation and management (E/M) services (CPT codes **99202-99215**). So per these guidelines, not allowable in assisted living/home setting.
  - Use the add-on code when you are the continuing focal point for all health care services the patient needs. Per CMS, the relationship between the patient and the physician is the determining factor of when the add-on code should be billed.
- **Split-Shared Services**
  - Per CMS, cannot be done in the office setting (POS 11); SNF (31) can be split-shared except physician initial visit; NF visits do not meet the definition of split (or shared) services; must append modifier FS
  - If the level is selected using time, the practitioner that spends the most time (more than 50% of total time) reports the service (and can only report the time of the billing provider).
  - If MDM is used to select level, bill under the practitioner NPI who performed the substantive portion of the visit; that provider must also sign and date the medical record.
  - Documentation should clearly identify both providers and who performed each portion of the visit

- **Incident-To Services**
  - Not allowable in institutional setting, including assisted living
  - Only allowable in office setting

- **Hospice – GV or GW?**
  - Attending physician not employed or paid under arrangement by the patient's hospice provider.
    - Tips: A patient, who opts for hospice coverage, waives his Medicare Part B payment for any treatment of terminal illness during the hospice period. However, there is an exception for the provider who attends the patient, referred to as attending physician in the modifier descriptor, who is not an employee of the hospice and is in no way attached to the hospice. The attending provider may also include a nurse practitioner, besides specific specialty providers.
  - Service not related to the hospice patient's terminal condition.
    - A provider appends modifier GW when the provider delivers a service, not related to the problem for which the patient was admitted into the hospice. This provider is not a part of the hospice or an employee of the hospice and provides the services independently.

    - Tips: For Medicare payment, report modifier GW, if the patient's condition for hospice care is not related to the service.

Billing Trends and Audit Risks

Have billing trends changed since E&M changes last year? Has Nationwide coding usage changed?

- Increase in encounters billed by time
- Increase in validation errors based on changes in AL codes and deletion of Nursing annual physical exam code
- Slight increase in some of the higher-level new and established/initial and subsequent visit codes
- National Increase in additional service utilization, such as CCM and TCM

Audit Risks – What billing practices would send off alarms?

- Under-coding and over-coding are equally discouraged and higher utilization of one set of codes in either direction is a red flag for an audit.
- Excessive billed visits per day per provider
- Ongoing increased visit frequency for a patient
- Billing provider differing from rendering provider on claim in POS where incident-to and split-shared are not allowable
- Duplicate billing

Resources

CMS MLN 906764 - 08.28.2023_MLN906764_E_M_Services_Guide_2023_08_508.pdf

AMA E/M Resources:
https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

AMA 2023 E/M Guidelines
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

CMS 2023 Proposed Rule
https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule

https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

AAPC Website https://www.aapc.com/evaluation-management/em-coding.aspx

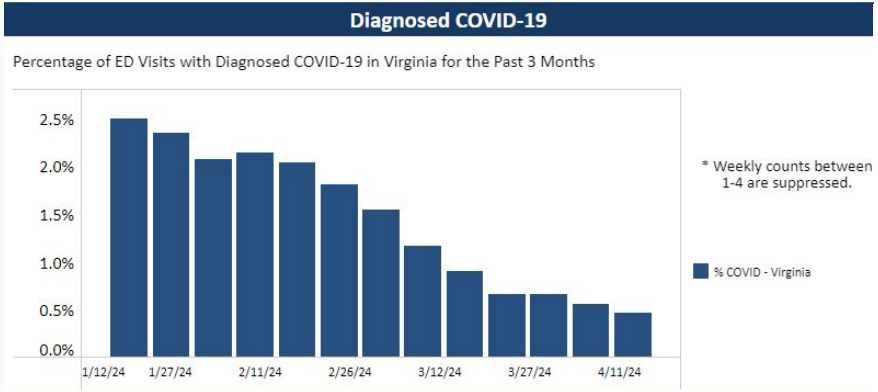
AAPC **2024 E/M Audit Worksheet**

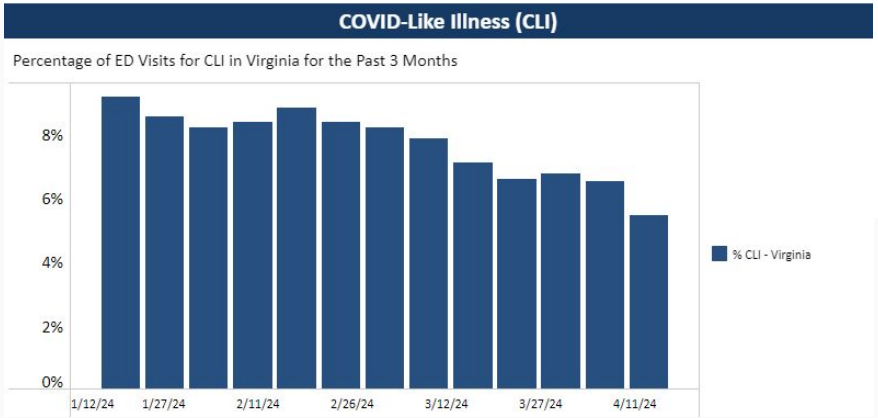
Open Forum

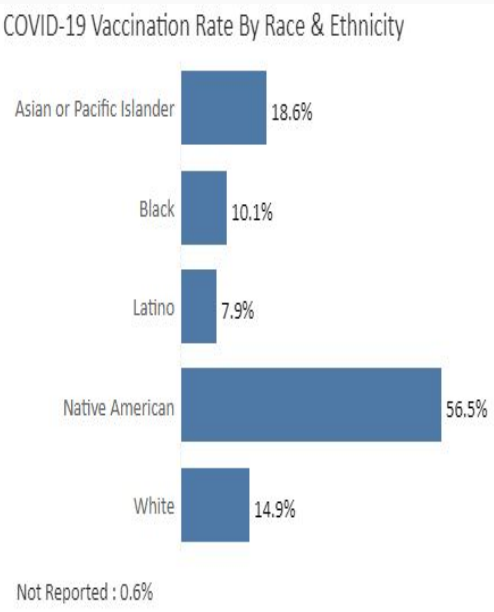
Any questions or ideas from the talk?

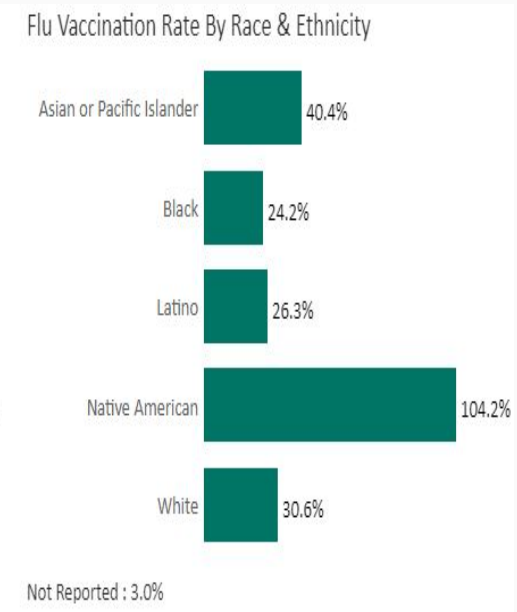
Share an idea!
Anything you need help with?
What's new in your Virginia Health District?
Any announcements?

VDH Dashboard Snapshot









https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-in-virginia/

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of ***1.00 AMA PRA Category 1 Credits***^{TM}. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for ***1.00 AAPA Category 1 CME credits***. PAs should only claim credit commensurate with the extent of their participation.

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Disclosure of Commercial Support:

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   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
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   b. The course code for today's event is: **33036** *(within **5** days of the event)*

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

Thank you for joining us!

Next Newsletter - coming to you in **May**

Next Monthly Forum: **Wednesday, May 15, 2024, 4-5 pm, Dr. Aabha K. Jain, TOPIC: Sepsis in LTC**

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at ltccn@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu

Disclosures

The speakers and presenters for today have no relevant financial conflicts of interest.

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Virginia Long-Term Care Infrastructure Pilot Project (VLIPP) funding will be utilized in nursing homes and long-term care facilities to assist with the ongoing COVID-19 response and to bolster preparedness for emerging infections. The projects are based on identified needs that align with funding objectives.