Billing and Coding Update in the Nursing Home 2014

Charles Crecelius MD PhD FACP CMD
Agenda

- Review of nursing home basic coding requirements
- Use of NPP
- New Transition of Care code
- Ancillary CPT codes, common conundrums in the nursing home
- Billing patterns the last several years
All Evaluation and Management codes require which one of the following:

A. A physical exam
B. A medical history
C. Medical decision-making
D. A face-to-face encounter
E. C and D
Regulations for subacute care allow:

A. Weekly visits for physicians
B. Monthly visits for physicians
C. Weekly visits for NPP if not employed by a NF
D. Payment for two visits in one day, if medically necessary
E. None of the above
## Initial Visit NH CPT Codes

<table>
<thead>
<tr>
<th></th>
<th>99304</th>
<th>99305</th>
<th>99306</th>
</tr>
</thead>
<tbody>
<tr>
<td>History &amp; Exam</td>
<td>Detail</td>
<td>Detail</td>
<td>Comp</td>
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<tr>
<td>Comp</td>
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<tr>
<td>Decision making</td>
<td>StrFwd</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Problem Severity</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
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<tr>
<td>Time minutes</td>
<td>20</td>
<td>45</td>
<td>75</td>
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## Subsequent NH CPT Codes

<table>
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<tr>
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<tbody>
<tr>
<td><strong>History</strong></td>
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<td>Exp prob focused</td>
<td>Detailed</td>
<td>Comp</td>
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<tr>
<td><strong>Exam</strong></td>
<td>Problem focused</td>
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<td>Comp</td>
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<td>Mod</td>
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<tr>
<td><strong>Problem Severity</strong></td>
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<td>Low Mod</td>
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<td><strong>Time minutes</strong></td>
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<td>15</td>
<td>25</td>
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NH Annual Visit

• **99318** (Need all three)
  – Detailed interval history
  – Comprehensive exam
  – Medical decision making:
    • Low to Moderate
  – 30 minutes

• Used for:
  – Annual exam - takes the place of regulatory visit
  – Usually, the patient is stable, recovering, or improving.
All of the following Nursing Home Discharge Code claims are true except:

A. Need a Face-to face encounter
B. Need to be seen on day of discharge
C. Can bill for discharge upon death only if death personally pronounced by the provider
D. Can cover activities over a period of time
E. Billing date is date of actual visit, even if discharge is a different date
NH Discharge

- 99315 - 30 minutes or less
- 99316 – More than 30 minutes

- TOTAL DURATION OF TIME

- USED FOR:
  - Final Exam
  - Instructions for continued care
  - Preparation of discharge paperwork
  - Prescriptions
  - Referral forms
Time as a component

• For office visits, ALFs, and home visits, *time is face-to-face* with the patient and/or family. Time spent before and after the visit (reviewing records, arranging consults, telephone conversations) *does not count*. Supposedly this non face-to-face time was already included in the codes.

• For hospital, nursing home (institutions), *time is floor time*, not face-to-face. This includes chart review, writing notes, communicating with other professionals, etc.

• MDs, PAs and NPs can bill based on time.
Billing for Time

• More than 50% of the time must be spent in counseling or coordination of care.
• Round to the nearest time
• “Let go” of the E & M requirements when billing based on time.
• Example:
  – NH, established pt, spent 28 minutes, including 18 minutes counseling patient and family.
    → Round to 25 minutes, Code 99309
The maximum number of NH visits that a physician can perform in one day is:

A. 20
B. 30
C. 40
D. Not defined
## Comparison NH Reimbursement

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## Comparison Discharge Codes Parity with Different Sites 2012

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<td>$69.78</td>
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<td>99238</td>
<td>Hosp. &lt; 30 min discharge</td>
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<td>99316</td>
<td>NH ≥ 30 min discharge</td>
<td>$100.78</td>
<td>2%</td>
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<tr>
<td>99239</td>
<td>Hosp. ≥ 30 min discharge</td>
<td>$103.13</td>
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</table>
Nurse Practitioners can do all of the following except:

A. See SNF patients before the physician
B. Perform an initial comprehensive visit on a non-skilled (NF) patient if the state allows
C. Make SNF regulatory visits if facility employed
D. Make NF regulatory visits if facility employed
NPP must work with Physician

• The long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations ensure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

• Required physician tasks, such as verifying and signing orders in an NF, may be delegated to a PA, NP, or CNS who is not an employee of the facility, but who is working in collaboration with a physician.

MLN MATTERS NUMBER: SE1308
# NPP Authority to Make Visits / Write Orders

<table>
<thead>
<tr>
<th></th>
<th>Initial Comprehens. Visits / Orders##</th>
<th>Other Required Visits</th>
<th>Other Medically Necessary Visits/Orders</th>
<th>Certification / Recertification</th>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Alternate Visits</td>
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<td>No</td>
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<tr>
<td>NP, CNS &amp; PA not a facility employee</td>
<td>No</td>
<td>Alternate Visits</td>
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<td>Subject to State</td>
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<tr>
<td><strong>NF</strong></td>
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<tr>
<td>NP, CNS &amp; PA Facility-employed</td>
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<td>No</td>
<td>Yes</td>
<td>N/A</td>
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<tr>
<td>NP, CNS &amp; PA not a facility employee**</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
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</tbody>
</table>

##Medically necessary visits may be performed prior to the initial comprehensive visit.

**At the option of the State
Transitional Care Management Services Codes (99495 and 99496)

• As of January 1, 2013, Medicare pays for combined face to face and non-face to face physician and staff service of complex patients recently discharged from hospital, LTAC, or skilled nursing facility.

• Medicare will pay between $164 and $231, depending on the complexity of the patient, for care during the 29 days after the discharge date.

• Can bill other medically necessary visits
Transitional Care Management Services Code 99495

• 99495 - Moderate complexity patients
  – Requires physician / staff to make direct contact, by phone or electronically, with the patient or caregiver within 2 business days of discharge.
  – A face-to-face visit with the patient is required within 14 calendar days of discharge.
Transitional Care Management Services Code 99496

- 99496 - High-complexity patients
  - Requires direct contact with the patient or caregiver within 2 business day
  - Face-to-face visit within 7 calendar days
- Both codes billable by only one party (PCP or specialist) in the outpatient setting
- Requires medication reconciliation and any needed coordination of care
Transitional Care Management Services Codes (99495 and 99496)

- Non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction:
  - Staff services: medication adherence, education of patients / caregivers e.g. self-management, HHA communication, facilitating access to care.
  - Physician services: discharge information review, diagnostic test follow up, community resources referrals, educating patients / families, interaction with other health professionals
Complex Chronic Care Coordination

• CPT codes established and will be paid for in 2015 at present—*details still not set*
• Home, AL and residential based codes
• Patient has at least 2 chronic condition placing them at risk of higher level of care, requires significant services and coordination of care
• Includes non-face to face physician & staff work
• Not billed with care plan or TCM codes
Advance Care Planning Code

- CPT has made code / RUC has set value, but CMS has not decided whether to pay for it (death squad part 2)
- One-half hour practitioner time to discuss ACP, ensure appropriate forms filled out
- Only for complicated cases requiring practitioner (not staff time)
- 2016 payment at earliest, all sites of service eligible
Telehealth

- Telehealth NOW allowed under distinct conditions – most still not billable
- ONLY non-regulatory required subsequent visits are allowed (99307-10)
- ONLY can be made every 30 days
- MUST be located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area
Telehealth continued

• As a condition of payment, an interactive audio and video telecommunication system must be used that permits real-time communication between a physician or practitioner at the distant site and the beneficiary at the originating site.

• Will be expanded to Annual Wellness exam – *may set a trend*
Home Health Care and Nursing Home Discharge

- CPT G0180  MD Certification of Home Health Care Services
  - Can be billed if had contact with HHC, review pertinent reports as part of discharge planning – usually SNF
  - Affirm the initial implementation of the plan of care that meets patient's needs
  - LTC Frequency - about 13,000
  - 2012 reimbursement: $52.76
Home Health Care Supervision & LTC

- CPT G0181 Home Health Care Supervision
  - Can be done if continue to engage in HHC outside the NH and PCP is not
  - $101.76/month, ≥ 30 min by physician
  - Complex and multidisciplinary, regular physician plan and revision, communication
  - LTC Frequency ~ 2,000
Medicare pays the physician for which one of the following in the nursing home?

A. Care plan oversight
B. Inpatient consultations
C. Telephone calls
D. Specialist care
E. Interdisciplinary team meetings
Medical Team Conferences

- Medicare does not pay for MTC meetings in NH
- “Bundled” into NH visits
  - 99366: MTC w/ face to face
  - 99367: MTC w/o face to face w/ MD
  - 99368: MTC w/o face to face w/ NPP
- Suggestion: document meeting, add into progress note that day (But no official policy)
Telephone Calls

• **Medicare does not pay separately for telephone calls**

• CPT Codes: 99441-99443

• “Bundled” into NH visits

• Suggestion: 1) make family calls on unit 2) document calls, add to next progress note
  • Not delineated by CMS

• Preservice (24hrs)/postservice (7 days)
Assuming Care from Another Provider

• Current suggestion:
  • Need to use subsequent E&M code
  • Usually 99309 level
  • Need to document appropriately
  • Can not use 99304-6 codes unless newly admitted into facility
Assuming Care from Another Provider 2

- Is this suggestion correct?
  - Descriptor 99304-06
    “Initial nursing facility care, per day, for the evaluation and management of a patient”
  - Multiple requests to CMS still have not provided answer
Use of Templates for Visits

- Caveat 1: must perform all items checked or delineated in chart record – or clearly identify that which was actively done and which is historical
- Caveat 2: bill only for what was actually done
- Suggestions: 1) have nurses document briefly extent of your visit 2) avoid copying notes esp. HPI and medical decision making
Medicare pays the same physician on the same date for the following services combinations

A. Office visit and initial NH visit
B. Hospital admission and NH visit
C. ER visit and NH visit
D. Hospital discharge and initial NH visit
E. Hospital visit and NH visit
Multi-site Visits which include Nursing Facility Visit
Same Physician, Same Day

• Medicare NEVER pays a practitioner for both a visit in the nursing home and at another site of service with one exception:
  Hospital discharge and nursing home admit

• Bundle E/M services on the same date into the higher level of service (e.g. initial nursing home and office = initial nursing home code)
Physicians in Group Practice

• Same Group - Same Specialty
  • Bill and be paid as though they were single MD
  • One E&M code per day per problem
  • Can combine same day visits and submit appropriate code

• Same group – Different Specialty
  • Bill / be paid without regard to membership in group
Growth in utilization of Medicare Fee Schedule Services
Increase in E/M Frequency

• CMS & OIG have expressed concern for the increased utilization of higher level codes and increased total visits in several sites of service including nursing homes
  – What groups are making more visits?
  – What codes are being used more?
  – Are patterns changing in NF vs. SNF?
  – Does increased visits equal better value?
# Summary, Nursing Facility Family E/M Services 2009-2013

<table>
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<tr>
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<th>2009</th>
<th>2011</th>
<th>2013</th>
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<td>Services</td>
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<td>24,873,607</td>
<td>26,294,294</td>
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<td>Charges</td>
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<td>1,905,820,590</td>
<td>2,193,727,594</td>
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<tr>
<td>Increase</td>
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<td>Service 9.4% Charge 20%</td>
<td>Service 15.4% Charge 38.2%</td>
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Source: CMS Website: Research and Statistics, Medicare Part B Utilization,
## SNF vs. NF 2009-2011
### Frequency of Visits

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<tr>
<th>POS</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>22,600,847</td>
<td>24,873,607</td>
<td>26,294,294</td>
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<tr>
<td>SNF</td>
<td>59.3%</td>
<td>58.5%</td>
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<tr>
<td>NF</td>
<td>40.7%</td>
<td>41.5%</td>
<td>40.0%</td>
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</table>
Who Billed Nursing Home Visits
2007 - 2013

Percent

2007 2008 2009 2010 2011 2012 2013

IM FP NP GER PMR PA PSYCH
Allowed NH Services 2009-2013

Code

0 2 4 6 8 10 12
Millions of Services


99318 99316 99315 99310 99309 99308 99307 99306 99305 99304
## Increase in Total Visits by Specialty 2009-2013

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2009</th>
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<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Gen Prac</td>
<td>654.9</td>
<td>588.9</td>
<td>516.1</td>
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<td>Fam Prac</td>
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<td>668.9</td>
<td>881.8</td>
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<td>Geriatric</td>
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Total visits in thousands
# Increased Visits by Provider Types

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<th>Group</th>
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<th>2013</th>
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<tbody>
<tr>
<td>Traditional PCP IM+FP+Ger+GP</td>
<td>14,049,175 (68.8)</td>
<td>13,984,964 (61.6)</td>
<td>13,991396 (57.2)</td>
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<tr>
<td>“Nontraditional” NP+PA+PMR</td>
<td>4,824,787 (23.6)</td>
<td>7,052,548 (31.1)</td>
<td>8,351758 (34.2)</td>
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<td>Ancillary Psych+Pod</td>
<td>1,556,917 (7.6)</td>
<td>1,648,784 (7.3)</td>
<td>2,113,129 (8.6)</td>
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Trends in Initial Visit NH Code Billing Frequency 2006-2013

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<th>2012</th>
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Thousands of visits
Distribution of 2011 Initial Nursing Facility Care Visits

![Bar Chart]

- **Percent of Visits**
- **CPT Code**:
  - 99304
  - 99305
  - 99306

Legend:
- GER
- IM
- FP
- NP
Distribution of 2013 Initial Nursing Facility Care Visits

Percent of Visits

CPT Code

99304
99305
99306

GER
IM
FP
NP
## Trends in NH Subsequent Code Billing Frequency

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<td>20,920</td>
<td>21,760</td>
<td>22,269</td>
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<td>2008</td>
<td>19,295</td>
<td>21,760</td>
<td>22,269</td>
<td>22,954</td>
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Thousands of visits
Distribution of 2011 Subsequent Nursing Facility Care Visits

![Bar chart showing the distribution of visits by CPT code and provider type.](chart.png)
Distribution of 2013 Subsequent Nursing Facility Care Visits

CPT Code

Percent of Visits

Ger
IM
FP
NP

99307
99308
99309
99310
Conclusion

• More types of professionals are billing more often in both SNF and NF
  – NP / PA are playing an increasing role
  – Is Quality Improving?
• It is imperative to know how to bill and code correctly
• CMS is developing new codes which may help the FFS world in PA/LTC
  – Most will assist in new models of care