



Children's National™

Health Network™

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Value Based Coding– Turning Knowledge to Payment!

21th CNHN Pediatric Practice Management Seminar

Thursday December 13, 2018

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Faculty Disclosure

Faculty Disclosure Information

In the past 12 months, we have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

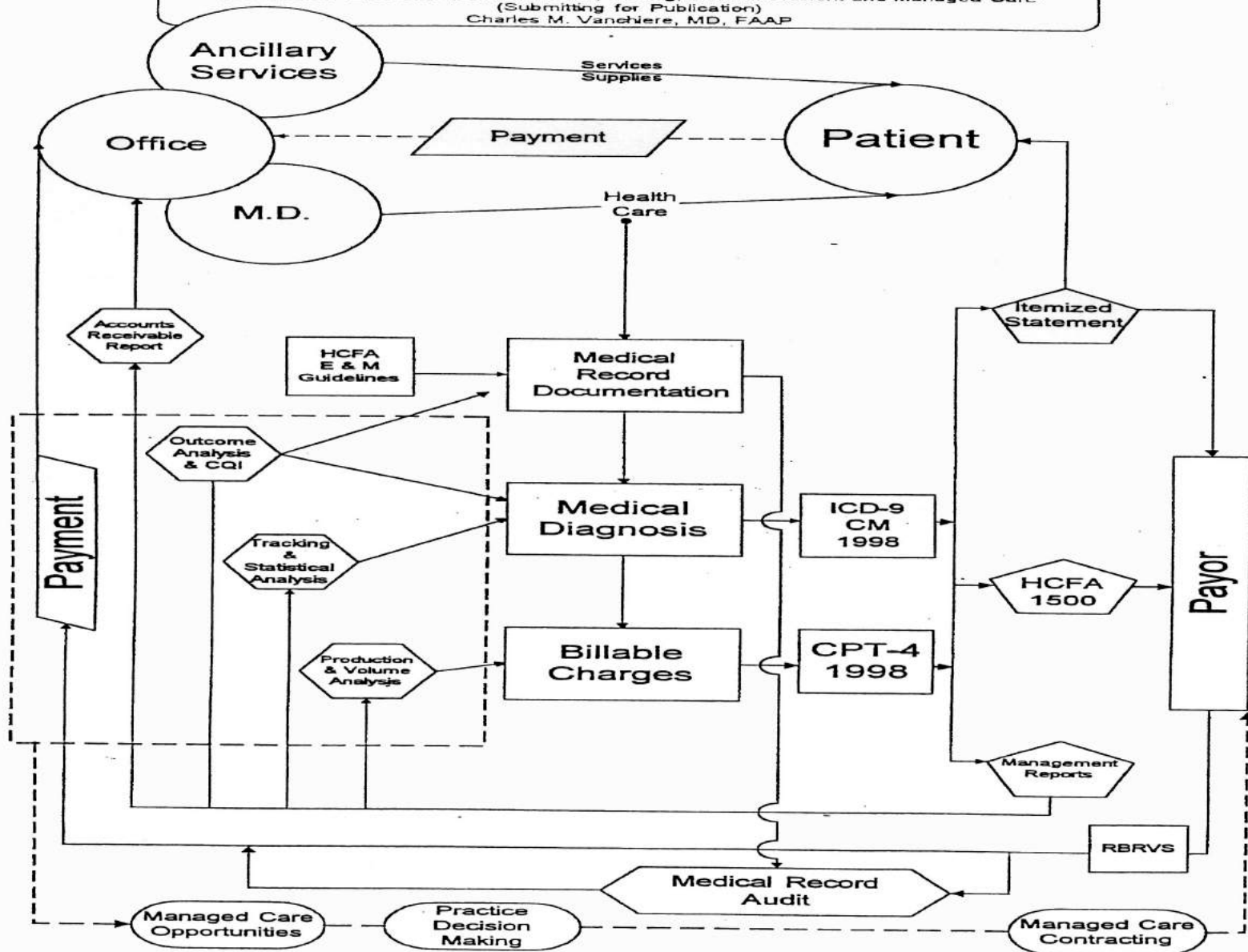
I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Learning Objectives

- Based on this presentation, changes you may wish to make in practice:
 - Beginning 1 Jan.– Use the key coding updates for 2019
 - Apply new knowledge about coding and payment to further your success in Value based payment programs
 - Learn how you can consider new care models built on concepts of population health and team based care

Medical Encounter

"The Medical Encounter—Documentation, Coding, Reimbursement and Managed Care"
(Submitting for Publication)
Charles M. Vanchiere, MD, FAAP



Terminology for “Getting Paid”

Reporting:

- the “billing” of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

Licensure:

- a state entity allowing the provider to perform a service under a “scope of practice” law, act, or regulation

Credentialing:

- certification by a public or private payer defining the services for which the provider will be paid

Current Procedural Terminology (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990's
- Tell payers what service was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
 - Nature and amount of work
 - Place and type of service
 - Patient's health and age (in some cases)

CPT Code Categories

Category I:

- Most commonly used codes for billing for patients services—numeric

Category II:

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

Category III:

- New procedures and technology
- Can be used for payment, alphanumeric

ICD-10-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification in the US is controlled by the ‘cooperating parties’
 - CMS
 - National Center for Health Statistics/CDC
 - American Hospital Association
 - American Health Information Management Association
- Tells Payers about the **Medical Necessity** of services—the **“WHY”**

Payment— The Medicare Physician Fee Schedule— Resource Based Relative Value System (RBRVS)

- Is updated each year by CMS— in October –November Federal Register – “Final Rule”
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit – “RVU”
- Each year an updated Conversion Factor (CF) is enacted by CMS – 2019 \$36.04 per rvu
- CMS Payment = rvu x cf
- Example— 99213— 2.09 rvu x \$36.04 = \$109.92

The Revenue Cycle (Getting Paid)

- Provide the services
- Find the correct billing codes
- Assign your fee to each service billed
- Report (Bill) the claim
- Receive your EOB (explanation of benefit) with payment
- Review EOB, inform your coding practice, and appeal denials

AND NEW

- Participate and succeed in Pay for Value programs

Why Code Correctly?

The list Grows!!

- That's how you get paid for clinical activity (service–code–claim–\$)
- There is compliance risk if you don't – fraud, waste, abuse
- *There is a rapidly evolving alternative payment landscape– Value Based Payment – often additive to your fee schedule (P4P)*

Coding and Value Based Payment

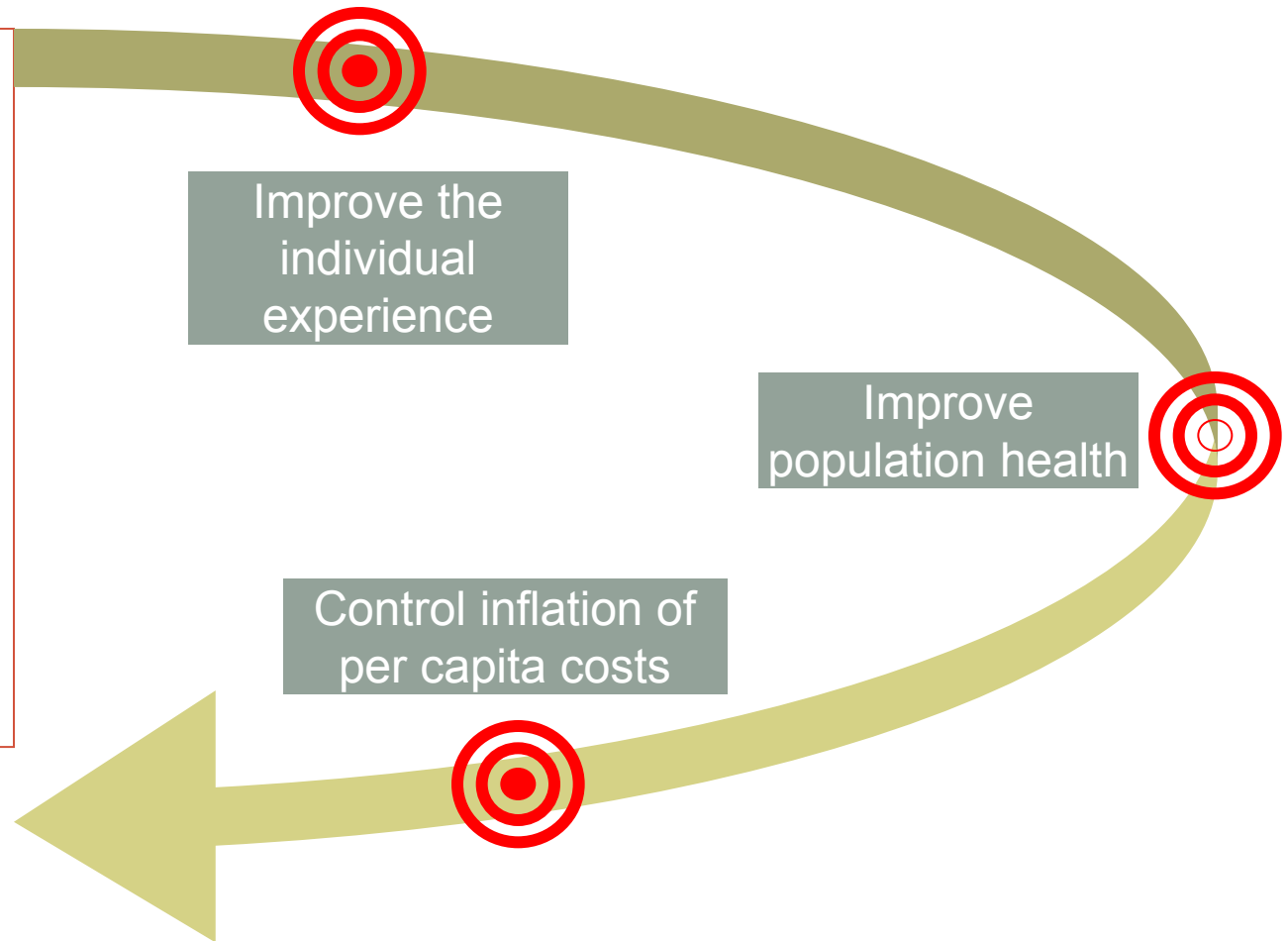
- Bundled Payments– other APM's are composed of costs defined by CPT and ICD codes
- Quality metrics– most defined by ICD and CPT codes billed
- “Narrow” or Tiered Payer Networks will have fewer providers overall, but more “higher value” providers
- Risk adjustment for cost of your patient is based on ICD coding (medical complexity – my patients are sicker)
- Population health– stratification and care gaps defined by risk (coding , utilization, EBM)

Why We Do What We Do? Achieving the “The Triple Aim”!

“The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized (given appropriate weightings on the components) simultaneously.”

Tom Nolan, PhD,
Don Berwick, MD, MPH

Triple Aim



Creating Value in Your Practice

- The Triple Aim – Improving:
 - health care (delivery– eg PCMH)
 - quality of care (outcomes– eg NCQA Measures)
 - the cost of care (right care, right time, and right place)

- Creating Value

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

- **Payment Follows Value**

A New Quality— Through the Lens of the Triple Aim

- Ability to reduce variation in outcomes including cost
- Ability to provide access allowing “right care, right time, and right place”— afterhours and walk-in (patient centric)
- Ability and performance in closing “Care Gaps” – claim analytics— look at evidenced based care that has not been delivered
- Member Experience— patient activation, shared decision making, and navigation

A New Quality— Through the Lens of the Triple Aim

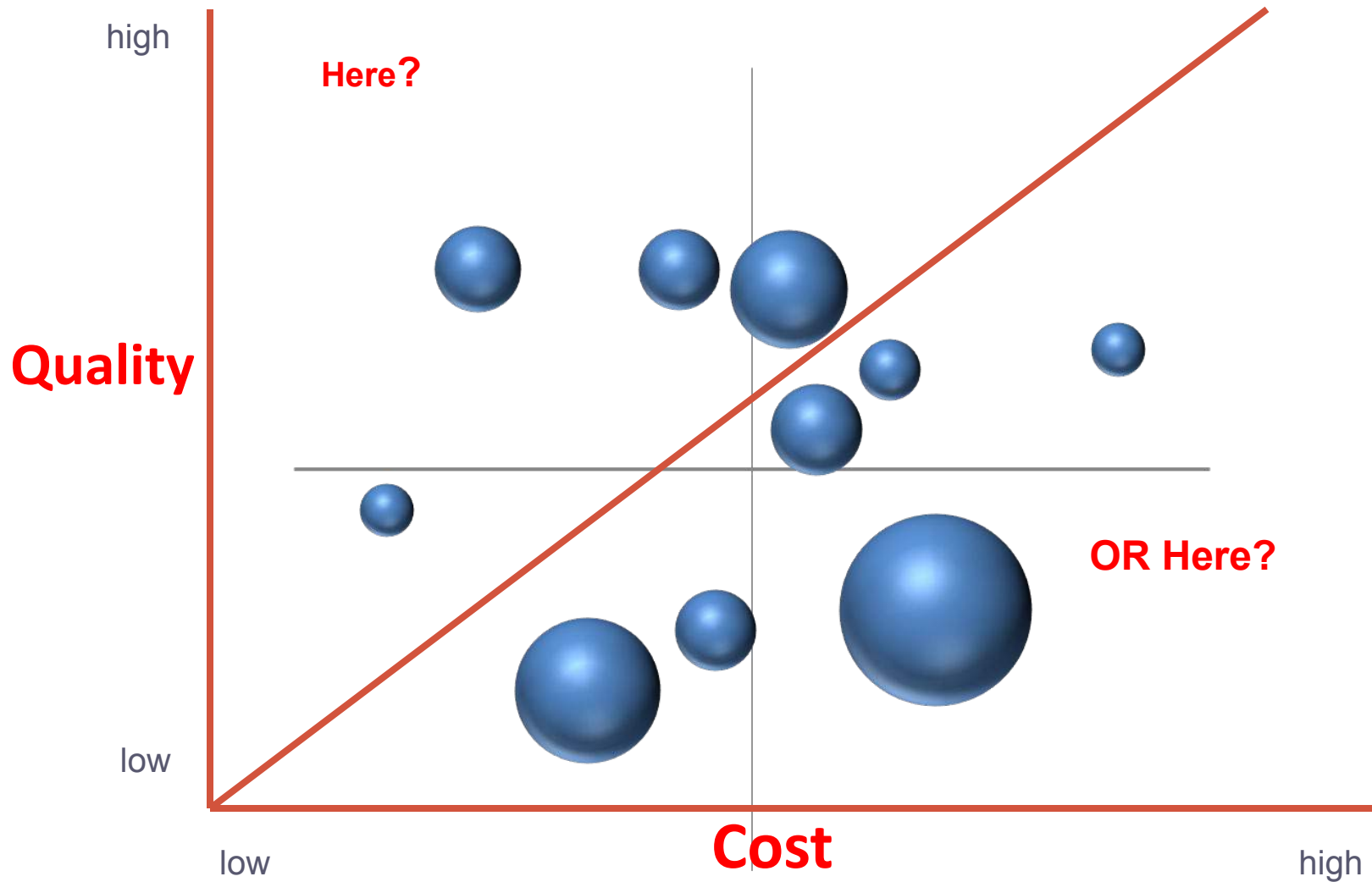
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- **Member Experience**— patient activation, shared decision making, and navigation

The New Lexicon – of Health Care

- The Triple Aim
- Accountable Care
- Variation
- Actionable Data
- The Value Equation for Health Care
- Value Based Contracting
- Value Based insurance product design
- Alternative Payment Models
- Episodes of Care
- The New Quality
- **Population Health**
- **Team Based Care**
- Care Opportunities
- Transparency
- Patient Centered Medical Home
- Health Home for **“Superutilizers”**
- Narrow Networks



Tiering—A Triple Aim “Valuegram”



Population Health

- **Once you see your population, you will see the needs and design a better care model–**
 1. **“See” your population– data analysis (claims, HRA, clinical)– risk stratified by risk or medical complexity (well, some risk, high risk)**
 2. **“See” the needs of your population – “care opportunities”**
 1. **All get Bright Futures (well care, screening, vaccines)**
 2. **Those with Risk get more intense levels of care– care coordination/care management, transitional care**

CSHCN –Children with Special Health Care Needs

- 13% of the pediatric population comprises children who meet the Maternal Child Health Bureau definition of special health care needs.
- **CSHCN (13%) account for 70% of pediatric health care expenditures.**
- Children with Medical Complexity, a subset of this population, are characterized by high service need, medical conditions associated with medical complexity, functional limitations, and high health care use.

Population Health

- **Once you see your population, you will see the needs and design a better care model– the “right care , right place, right time” model**
 1. Your Three Populations–
 - *They come for all care– and they love you (highly engaged)*
 - *They come for acute care if convenient– they like you– mild–mod.engagement)*
 - *They don't come to your office– use ER. retail./urgent care*
 2. Develop Models– include both “outreach” and “in-reach” to close care gaps and provide access to evidenced based pediatrics
 3. The Value (\$)–
 1. Close care gaps = High Quality (HEDIS/EPSTD)
 2. Right care , place time = Cost savings (share savings) –ex.– fewer ER visits

New Care Models that Improve the care

- **Integrated care models– develop the “integrated care plan” define medical behavioral and social needs in your population , and deliver on the care and the social solutions**
 - barriers to both quality and cost savings (value) are rooted in behavioral conditions – depression, schizophrenia, bipolar, substance use– must address BEFORE medical needs are met
 - or social determinants – food, shelter, and transportation come before medical care
- **Patient “engagement or activation”**
 1. Measure “engagement” in those with risk or non compliance– tools exist – the new science of compliance
 2. Brings need for Team Care – high touch, collaborative, family centered

Defining Team Based Care

Attributes

- Care allows pediatricians to connect with their patients on key clinical issues and provide **comprehensive, continuous, coordinated care by involving more of the practice staff in patient care as appropriate to their training and capabilities**. Team-based care can also increase a practice's *efficiency and productivity*.
- Care that engages a **greater number of staff in patient care** and affords physicians, as the leader of a practice team, additional time to **listen, think deeply, and develop relationships** with patients and their families.
- Care that is highly informed— Team members **are aware of the health history, status, and unique needs of the patient and family**, and are assigned different responsibilities, which together are designed to result in continuous, comprehensive, coordinated care *during and between visits*. Team members feel engaged in their key role of caring for the patient. **THE HUDDLE**

Newer Payment Models – Evolving Risk

- **Enhanced Fee for Service**
 - Typically higher rates than “non” PCMH
 - Payment policy (afterhours care, care plan oversight)
 - Evolution to risk – capitation
- **Prospective Payments– funding infrastructure**
 - Care coordination
 - EHR
 - NCQA certification costs
 - Evolution to risk based on outcomes
- **Retrospective Payments– For Performance or Value (new)**
 - Quality Indicators
 - Patient experience
 - Evolution to risk based on a Gain Share

PCMH Reimbursement



Retrospective Payments: Pay for Performance or Value

- Payment in addition to the Fee schedule
- Based on “performance” on certain agreed upon measures
- Program designed by payer(s)
- Comes as an amendment or attachment to the payer contract
- May involve a continuum of risk

Pay for Performance: Evolution

Newer Models of Accountable Care

- Gain Sharing – (shared savings) a method for physicians and other providers to share in a defined way in **savings** a program generates for the population

Gain share may be determined by –

- Improvements compared to a past year(s) in chosen utilization metrics– ER, Inpatient
- Improvements in Total Cost of Care (Medical Loss Ratios – MLR)
- **Meeting Quality Targets – the “Gate”**

Concept of Financial Risk

- **Upside Risk** – you win– chance of getting a payment if performance targets are met or exceeded
- **Downside Risk** – you may not get a payment if targets are not met (even if you have resource costs in the effort), or in certain models you may lose payment by not hitting targets
- *Programs with downside risk typically have higher potential gains

Pay for Performance or Value— Quality Measures

- Quality Indicators
 - Generally based on national guidelines and evidenced based measures
 - NCQA, NQF, Joint Commission (JCAHO), CMS develop measures
 - Can be reported on billing forms— CPT Category I and Category II codes , ICD codes, other (pharmacy)
 - Measured from claims (administrative), or chart review , or both (hybrid),
 - Can relate to a process or to an outcome
 - Payer will define the measures, the reporting, the targets, and the payments in the contract

HEDIS Basics

- HEDIS = Healthcare Effectiveness Data and Information Set.
- Developed by the National Committee for Quality Assurance (NCQA) in 1993
- 90% of all health plans use HEDIS to measure performance, care, and service.
- HEDIS consists of 81 measures over 5 domains: Effectiveness of Care, Access/Availability, Experience of Care, Utilization & Relative Resource Use, & Health Plan Descriptive Information.

NCQA HEDIS Quality Measures

- Measure the per cent of patients who have had or not had a given health intervention
 - Measures have a denominator of the eligible patient population (*at Code level)
 - Measures have a numerator of the patients who have had the intervention (*at Code level)
-
- *CPT category 1, 2, HCPCS, or ICD 10

HEDIS Lingo

- **HEDIS Care Opportunity = a “GAP” in Care**

A HEDIS Care Opportunity means that there is an outstanding service for a patient, that once completed will result in member compliance for a particular HEDIS measure.

- **How are HEDIS Care Opportunities identified?**

Health Plan identifies Care Opportunities through claims data following the HEDIS specifications for each measure. EHR's can also identify Care Opportunities based on billings, age, etc –population health integration modules

- **How are HEDIS Care Opportunities closed?**

Care Opportunities are closed by completing the required service(s) for the identified members in the specified timeframe and submitting the appropriate codes for the service(s) provided.

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NCQA Quality Measures

1. Appropriate Testing for Children With Pharyngitis (CWP) Ages 2-18 years

- Diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
- *Commercial, Medicaid (Admin.)*

2. Appropriate Treatment for Children With Upper Respiratory Infection (URI) Ages 3 months–18 years

- Given a diagnosis of URI and were NOT dispensed an antibiotic prescription.
- *Commercial, Medicaid*

Pediatric Well Care Visits

Preventive service E&M

- **Well Care Visits in the First 15 months of Life (W15)**
- **Well Care Visits in the 3rd, 4th, 5th and 6th years of Life (W34)**
- **Adolescent Well Care (AWC)***
- **Exploit EHR documentation prompts & coding for well care coordinated compliance**
 - BMI percentile, physical activity and nutritional counseling (WCC)
 - Completed, timely UTD immunization documentation (CIS/HPV/IMA)
 - Lead screening (LSC) – document date and result if in history+**(ACC contract)**
 - Chlamydia Screening (CHL) for sexually active 16-24 yo females

Important Points to Remember :

- Utilize age appropriate preventive service/health check CPT and ICD 10 codes
- Include age appropriate documentation supported ICD 10 codes for BMI and activity/nutrition counseling code

AAP– 2018 – Seven Child Health Measures

- Key attributes– evidenced based, representative of what pediatrician do, ability to measure, reflect diversity of care and patient complexity
- Developmental Screening in the first 3 years of life
- Well Child visits in adolescents
- Childhood immunization status
- Adolescent immunization status
- Appropriate treatment of URI
- Child and adolescent suicide risk assessment
- Weight measurement and counseling for nutrition and physical activity

Reporting CPT Cat 2 Codes

Codes Minimize record reviews for Hybrid Measures

From	To	POS	TOS	Procedure	Diagnosis	Charges	Units
11/07/2013	11/07/2013	11	NCSV	0502F	V221	\$0.01	

Consd Chg	\$0.01	Deductible	\$0.00	Discount Amount	\$0.00
Allowed Units	0	Copay	\$0.00	Supplemental Discount	\$0.00
Allowed	\$0.00	Coinsurance	\$0.00	COB Adjustment	\$0.00
Cons Allowed	\$0.01	Cons Benefit	\$0.01	Withhold	\$0.00
Benefit	\$0.00	Disallow	\$0.01	Patient Liability Disallow	\$0.00
HRA Paid	\$0.00			Total Patient Liability	\$0.00
FSA Paid	\$0.00				
Provider Specialty	OBSTETRICS AND GYNECOLOGY				
Procedure	Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal				
Add'l Modifiers					
National Drug Code		NDC Units			
Diagnosis	Supervision of Other Normal Pregnancy				

New CPT for 2019

- Published in late September (new vaccine can be July or Jan on AMA website)
- Implementation date under HIPAA is 1 Jan 2018
- Payer “claim readiness” – payment policy and pricing should be in effect by 1 January but check websites and contact payers for any high volume/revenue code changes you want to make

New CPT for 2019

- EM Coding Changes Coming!
- Telehealth Coding Evolves
- Care Management– New Code for Physician
- Developmental Testing
- Vaccines

2019– CMS and EM Guidelines

- For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:
 - Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
 - For established patient office/outpatient visits, 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 that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;

2019– CMS and EM Guidelines

- For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient
....Cont'd
 - Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and
 - Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

CMS and EM – 2021(Proposed)

- Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation. **Specifically for CY 2021, CMS is finalizing the following policies:**
- Reduction in the payment variation for E/M office/outpatient visit levels by **paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;**

CMS and EM – 2021(Proposed)

- Permitting practitioners to choose to **document E/M office/outpatient level 2 through 5 visits using medical decision-making or time** instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;
- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, we will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, we will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making;

CMS and EM – 2021(Proposed)

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary;
- **Implementation of add-on codes** that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements; and
- Adoption of a new “**extended visit” add-on code** for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

2019 –Telehealth – Code Expansion

- Telehealth– expansion (by CMS and AMA)
 - Interprofessional Consultations
 - CMS– Electronic touch base and review of patient data (pictures)
 - Remote Data Monitoring

New Telehealth Codes 2019– CMS–Virtual Check -In

- Brief Communication Technology Based Services
- Patient checks in with Physician to see if an appointment is needed
- Telephone, email or EHR messaging
- CMS– (Final Rule for Medicare Fee Schedule Nov1)
- Bill Code– G2012
- Payment – Medicare– \$14.78
- Private payers and Medicaid now Reviewing Coverage

New Telehealth Codes Value by CMS— 2019

- Remote evaluation of patient recorded data—
- Video or images submitted by an established patient
- CMS— (Final Rule for Medicare Fee Schedule Nov1)
- G2010
- Payment – Medicare— \$12.61
- Private payers and Medicaid now Reviewing Coverage

New Telehealth Codes— Remote Patient Monitoring

Digitally Stored Data Services—Remote Physiologic Monitoring

Codes – for 30 days using an FDA approved device (scales, BP, oximeter, glucose)– physiologic data

99453– for set up /education of patient

99454– for supply of the device and programmed alerts and transmission

99091– For the MD who collects and interpretation the incoming data– minimum of 30 min each 30 days

New Telehealth Codes– Remote Patient Monitoring

- Digitally Stored Data Services–Remote Physiologic Monitoring –Treatment Management Services
- Codes – for 20 minutes per calendar month
- 99457– requires interactive communication with the patient or caregiver

Telehealth Face to Face Care – OLD, NEW, and Newly Valued

- Code are in the EM, Non Face to Face section
- Three Categories
 - Telephone Services (OLD) 99441– 99413
 - Online Medical Evaluation (Old) 99444
 - Interprofessional Telephone/Internet/Electronic Health Record Consultation (New)

Interprofessional Telephone/Internet/Electronic Health Record Consultation (New)

- Consultant should use codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/Internet/electronic health record consultations.
- record consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise

Telehealth Face to Face Care— NEW and Newly Valued— E-Consults

- The written or verbal request for the advice by the treating/requesting physician should be documented in the patient's medical record, including the reason for the request.
- Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion
- report and written report from the consultant to the treating/requesting physician or other qualified health care professional.

Times 99456 (5-10 m), 99457 (11-20 m), 99458 (21-30 m); 99459 (31 or > m)

Interprofessional telephone/Internet/electronic health Consult– NEW 2019

Were converted from CMS language

99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a **consultative physician**, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time CMS- \$ 37.48 Once per 7 days

99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a **treating/requesting physician** or other

qualified health care professional, 30 minutes (>16) CMS- \$ 37.48

Telehealth – the Path to Payment

- Services and Payments for Telemedicine services will take two paths–
 - **Billing fees for service–volume** – fee is tied to the relative value of the service(s) . Parity laws help .
 - **Services provided as part of a more global service** and payment– or payments come from outcomes in a value based programs (improved quality and or cost of care outcomes)

CMS and Telemedicine

<http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

- The primary payment policy for TH services
- Many private payers and Medicaid payer adopt some version
- Defines most elements— covered services, geographic areas, billing codes/payments, allowed origination sites
- Focus is on expanding Access
- CMS has made recommendation to expand or change in the July Proposed Rule for the 2017 Medicare Fee Schedule

CMS and Telemedicine –Key Payment Areas

<http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

- Definitions of Telehealth
- The Origination Site and Distant Site
- Practitioners who can bill
- Geographic Areas– HRSA shortage area, outside MSA
- Covered Services
- Coding and Billing

CMS Policy—Originating Site

- **An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs.**
- **Location-** Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
 - A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or a county outside of a MSA
 - The Health Resources and Services Administration (HRSA) determines HPSAs, and the United States (U.S.) Census Bureau determines MSAs

CMS TH Policy – Allowed Origination Sites

The originating sites authorized by law are:

- The offices of physicians or practitioners;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC)

CMS Policy Allowed Provider Types

DISTANT SITE PRACTITIONERS – Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians; Nurse practitioners (NP); Physician assistants (PA);
- Nurse-midwives;
- Clinical nurse specialists (CNS);
- Certified registered nurse anesthetists;
- Clinical psychologists (CP) and clinical social workers (CSW). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
- Registered dietitians or nutrition professionals

CMS payment Conditions- Billable Telehealth Services

As a condition of payment, you must use –

- an interactive audio and video telecommunications system
- that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.
- Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii.
 - Newly enacted legislation –

CMS payment Conditions – TH Covered Services

- Telehealth consultations, emergency department or initial inpatient HCPCS codes G0425–G0427
- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs HCPCS codes G0406–G0408
- Office or other outpatient visits CPT codes 99201–99215
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days CPT codes 99231–99233
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days CPT codes 99307–99310
- Individual and group kidney disease education services HCPCS codes G0420 and G0421
- Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training HCPCS codes G0108 and G0109
-

CMS Payment Conditions – Covered Services

- Individual and group health and behavior assessment and intervention CPT codes 96150–96154
- Individual psychotherapy CPT codes 90832–90834 and 90836–90838
- Telehealth Pharmacologic Management HCPCS code G0459
- Psychiatric diagnostic interview examination CPT codes 90791 and 90792
- End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
- Individual and group medical nutrition therapy HCPCS code G0270 and CPT codes 97802–97804
- Neurobehavioral status examination CPT code 96116
- Smoking cessation services HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407

CMS Payment Conditions – Covered Services

- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services HCPCS codes G0396 and G0397
- Annual alcohol misuse screening, 15 minutes HCPCS code G0442
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes HCPCS code G0443
- Annual depression screening, 15 minutes HCPCS code G0444
- High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes HCPCS code G0445
- Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes HCPCS code G0446
- Face-to-face behavioral counseling for obesity, 15 minutes HCPCS code G0447
- Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) CPT code 99495

CMS Payment Conditions – Covered Service

- Family psychotherapy (without the patient present)
(effective for services furnished on and after January 1, 2015) CPT code 90846
(effective for services furnished on and after January 1, 2015) CPT code 90847
- Prolonged service in the office or other outpatient setting
requiring direct patient contact beyond the usual service; first hour
(effective for services furnished on and after January 1, 2015) CPT code 99354
- Prolonged service in the office or other outpatient setting requiring direct
patient contact beyond the usual service; each additional 30 minutes
(effective for services furnished on and after January 1, 2015) CPT code 99355
- Annual Wellness Visit, includes a personalized prevention plan of
service (PPPS) first visit
(effective for services furnished on and after January 1, 2015) HCPCS code G0438
- Annual Wellness Visit, includes a personalized prevention
plan of service (PPPS) subsequent visit
(effective for services furnished on and after January 1, 2015) HCPCS code G0439

CMS Billing and Payment– GT Modifier (OLD as of 2017)

- You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service
- CMS– Before 2017– Use the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT).
- By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service.
- Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for covered telehealth services.
- **Many private payers use the GT**

CMS TH Policy – New 1-1-17 Reporting by Place of Service

- For professional services furnished on or after *January 1, 2017 for CMS*, to indicate that the billed service was furnished as a telehealth service from a distant site, submit claims for telehealth services using Place of Service (POS) 02: Telehealth:
- Use POS 02 for the location where health services and health related services are provided or received, through telehealth telecommunication technology.
- **So– POS 02 largely replaces the GT modifier**
- **Medicaid or private payers – if they want 02 or the POS that defines the location (eg, 11 – office)**

CMS TH– Asynchronous Services Billing and payment GQ Modifier

- For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, you should submit claims using the appropriate CPT or HCPCS code for the professional service
- Use the telehealth modifier GQ if you performed telehealth services “via an asynchronous telecommunications system” (for example, 99201 GQ).
- By using the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.
- Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for covered telehealth services.

CMS Billing and Payment – Originating Site Q3014

- Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014
- Pays for the practice expense at the hosting site-check in, facilitator, room
- **Most private payers do not cover.**

New for 2017– CPT Coding for Telemedicine

- CPT Telehealth Workgroup – Regular meetings since late 2015
- Large multi-stakeholder group
- Defines Structure and definitions
- Reviews Code Change Proposals
- Makes recommendations to the CPT Panel

New for 2017– CPT Coding for Telemedicine

- Major changes have been made to the 2017 code manual
- New Appendix (P)
 - This appendix was developed to list codes that are applicable to the new telemedicine modifier
- New symbol (a star ★)
 - This symbol next to the CPT code denotes codes that are listed in appendix P
- New Modifier (95)
 - The new modifier to denote when a service was provided via real-time interactive telecommunications system

New for 2017– CPT Codes for Telemedicine – Modifier 95

- Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System.
- Modifier **95** may only be appended to the services listed in Appendix P.
- Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real time (synchronous) interactive audio and video telecommunications system.

New for 2017– CPT Codes Allowed for Telemedicine – Appendix P ★

- Appendix P includes codes for services commonly performed by most pediatric physicians, including–
 - New and established patient office or other outpatient evaluation and management services (**99201–99205, 99212–99215**)
 - New and subsequent hospital care (**99231–99233**)
 - Inpatient and outpatient consultations (**99241–99245, 99251–99255**)

New for 2017– CPT Codes for Telemedicine – Appendix P

- Prolonged services in the office or outpatient setting (**99354, 99355**)
- Individual behavior change interventions (**99406–99409**)
- Transitional care management services (**99495, 99496**)
- Remote real-time interactive video-conferenced critical care codes (**0188T, 0189T**)

New for 2017– CPT Codes for Telemedicine – Modifier 95

- Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.
- The totality of the communication of information exchanged between the provider or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction

Telemedicine –Where are the Payment Gaps in Pediatrics?

- Infrastructure – CPT and Medicare Fee Schedule
 - Establish TH Codes for new technology or new clinical models delivered by TH
 - Appendix P additions – add CPT codes for pediatric services with proven efficacy by TH
- Infrastructure – Payment Policy (Coverage)
 - CMS – TH policy (for Medicare)sets national standard
 - State Medicaid – Can vary from CMS to reflect local needs
 - Managed Medicaid – Variants of CMS coverage
 - Private Payers – Variants of CMS coverage

Telemedicine – Medical Record Documentation

- Documentation by the physician providing the telemedicine service from the distant site will include that which would be required for reporting the service if provided in person
- For EM services, the CMS Evaluation and Management Documentation Guidelines 95/97. (New for 2019 – can use Medical Decision Making or Time)
- For other services, describe the activity

2019 – Care Management – Physician

99491

- Chronic care management services, provided **personally by a physician** or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored
- Do not report **99491** in the same calendar month as **99487**, **99489**, or **99490**
- Do not report **99340**, **99339** with **99491**

The Care Management Family– 11 Codes!

Physician Care Management

99491	Physician CCM		2 Disease	30 Min/mo	CMS - \$ 83.97
99339	Care Plan Oversight		Chronic Illness	30 Min/mo	CMS - \$ 78.20

Nursing Staff Care Management

99484	BH CCM			20 min/mo	CMS - \$ 32.80
99490	CCM	Staff	2 Diseases	20 min/mo	CMS - \$ 32.44
99487	CCCM	Staff	2 Diseases	60 min/mo	CMS - \$ 52.98
99489	CCCM	Staff	2 Diseases	+30 min/mo	CMS - \$ 26.67

Physician + Nursing/Behavioral staff

99495	TCM	MD/staff		no time req	CMS - \$ 112.08
99496	TCM	MD/staff		no time req	CMS - \$ 162.54

Behavior Integration-Psych Collaborative Care

99492	PCCM	MD/staff		> 35 min/mo	CMS - \$ 90.46
99493	PCCM	MD/staff		> 30 min/mo	CMS - \$ 81.81
99494	PCCM	MD/staff		+30/mo	CMS - \$ 43.97

2019 – Care Management – The Care Plan

- Care Plans in Chronic Care Management and Care Plan Oversight
- In the prefatory instructions for chronic care management, CPT instructs that a care plan for chronic care management addresses all health concerns and “typically includes, but is not limited to, the following elements:
- CPT does not provide a separate description of a care plan in the context of care plan oversight, but the documented care plan should address any acute or chronic illness or injury and the required complex and multidisciplinary care modalities rather than chronic conditions

2019– Developmental Testing

Developmental testing– code family revised

- 96111 – deleted
- 96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
- **+** 96113 each additional 30 minutes (List separately in addition to code for primary procedure)
 - Developmental screening – 96110 is not changed
 - Behavioral screening – 96127 is not changed

2019 – New Vaccines

90689 Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use

- A new code, 90689, will be used to report an adjuvanted, preservative-free, 0.25-mL dose of quadrivalent influenza vaccine after the US Food and Drug Administration (FDA) approves the vaccine for use. The lightning bolt symbol () will be removed from the code when an FDA approval notice is received by the AMA.
- [Vaccine Updates – https://www.ama-assn.org/practice-management/category-i-vaccine-codes](https://www.ama-assn.org/practice-management/category-i-vaccine-codes)

Supporting Behavioral Health Integration

- Behavioral Care integration with Physical Health
- Supporting evolving care models with 4 new CPT codes for psychiatric collaborative care and general behavioral care management.
- Evidence— better Adult care, higher quality and cost outcomes
- May be more defined than pediatric models
- Medicaid and Private Payers deciding coverage now— CMS covers both for Medicare

Psychiatric Collaborative Care Management (COCM)

Three codes for TEAM based integrated care

- 99492
- 99493
- 99494

Reflects a New BH integration Care model

Very Specific Requirements

CMS covers – move from G codes to CPT 2018

Psychiatric Collaborative Care Management – Requirements

- Services are provided under the direction of a treating physician or other qualified health care professional (QHP)
- Patient has a diagnosed psychiatric disorder that requires a behavioral health care assessment and establishing, implementing, revising, or monitoring a care plan; and provision of brief interventions
- Reported by the treating physician or other QHP

Psychiatric Collaborative Care Management – Requirements

- Include the services of the treating physician or other QHP consultant who has contracted directly with the treating physician or other QHP, to provide consultation.
- Patients directed to the behavioral health care manager typically have newly diagnosed conditions, may need help in engaging in treatment, have not responded to standard care delivered in a non psychiatric setting, or.....
- Require further assessment and engagement, prior to consideration of referral to a psychiatric care setting.

Defining the Model in CPT

The Episode of Care

- Begins when the patient is directed by the treating physician or other QHP to the behavioral health care manager
- Ends with attainment of targeted treatment goals, resulting in the discontinuation of care management services, OR failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment; or
- Lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive six month calendar

Defining the Model in CPT

The Provider Definitions

Health care professionals – the treating physician or other QHP who directs the behavioral health care manager and continues to oversee the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.

- Evaluation and management (E/M) and other services may be reported separately by the same physician or other QHP during the same calendar month.

Defining the Model in CPT

The provider Definitions

- **Behavioral health care manager** refers to clinical staff with a masters-/doctoral-level education or specialized training in behavioral health who provides care management services as well as an assessment of needs, including the administration of validated rating scales, the development of a care plan, provision of brief interventions, ongoing collaboration with the treating physician or other QHP, maintenance of a registry, all in consultation with a psychiatric consultant.
- Services are provided both face-to face and non-face-to-face and Psychiatric consultation is provided minimally on a weekly basis, typically non-face to-face.

Psychiatric Collaborative Care Management

99492

- Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities,
- In consultation with a psychiatric consultant, and
- Directed by the treating physician or other qualified health care professional, with the following required elements:

Psychiatric Collaborative Care Management

99492– Required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or QHP
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

Psychiatric Collaborative Care Management

99493

- **Subsequent psychiatric collaborative care management**, first 60 minutes in a *subsequent month* of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP

Psychiatric Collaborative Care Management

99493 – required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;

Psychiatric Collaborative Care Management

99493 – required elements:

- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

Psychiatric Collaborative Care Management

99494

- **Initial or subsequent psychiatric collaborative care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

COCM– Medicare Fee Schedule

2018 CPT Code	Medicare G Code 2017	2018 Relative Value Units	2018 Allowed Amount
99492	G0502: initial PCCM \geq 70 minutes per calendar month	3.98	\$142.84
99493	G0503: subsequent PCCM \geq 60 minutes per calendar month	3.52	\$126.33
+99494	G0504: each additional 30 minutes	1.84	\$66.04

CPT midpoint rule applies

General Behavioral Care Management

#99484

Care management services for behavioral health conditions, at least **20 minutes of clinical staff time**, directed by a physician or other qualified health care professional, per calendar month

- Moved into CPT from HCPCS code G0507 with 2017 Medicare payment of \$46.07

Behavioral health Care Management

Required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes.
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
- Continuity of care with a designated member of the care team

Behavioral health Care Management

- Behavioral health integration care management (99484) and psychiatric collaborative care management (99492, 99493, 99494) may not be reported by the same professional in the same month.
- Behavioral health care integration clinical staff are not required to have qualifications that would permit them to separately report services (eg, psychotherapy), and
- if qualified and they perform such services, they may report such services separately, as long as the time of the service is not used in reporting 99484

Behavioral Health Care Management

- General behavioral health integration care management services (99484) are reported by the supervising physician or other qualified health care professional.
- The services are performed by clinical staff for a patient with a behavioral health (including substance use) condition that requires care management services (face-to-face or non-face-to-face) of 20 or more minutes in a calendar month.
- A treatment plan as well as the specified elements of the service description is required. The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
- Code 99484 may be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.

ICD-10-CM: New codes for 2018

Clinical need → code development

The October 1, 2017 release is the culmination of 5 years worth of meetings/proposals

<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-PCS-Update-Summary.pdf>

total ICD codes— 78,705

- 3562 New codes
- 1821 Revised codes
- 645 deleted*