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Foundations of Coding and Billing for House Calls – Discussion Guide with Facilitator Notes

Thank you for leading a group discussion regarding key learning points from the HCCI online education activity, *Foundations of Coding and Billing for House Calls.* This guide is intended to help you prepare to facilitate this discussion.

OVERVIEW

Purpose: The discussion's purpose is to reinforce your practice's commitment to creating documentation that will result in positive audit outcomes.

Audience: This discussion is intended for learners who have successfully completed the online education activity, *Foundations of Coding and Billing for House Calls.* The discussion should take no longer than 75 minutes to complete.

Materials:

- Hard copies of the *Next Steps* handout from the Resources screen in the course.
- Hard copies of the three case studies provided: Ralph, Betty, and MJ
- Hard copies of *HCCI Superbill Coding Exercise*. Distribute three copies for each participant.
    - Access the HCCI Superbill Coding Exercise here.
- *Optional:* A flipchart to capture comments and ideas to help focus discussions and/or save for future consideration.

Instructions: Use the question prompts provided to initiate group discussions.

Learning objectives:

- Explain "medical necessity" as defined by the Centers for Medicare & Medicaid Services.
- Describe the required documentation components for house call visits and avoid common documentation mistakes.
- Apply billing and coding best practices to avoid red flags that send negative messages to auditors.

AGENDA

#	Topic	~Minutes
1	Introduction	5 min
2	Define Medical Necessity	10 min
3	Documentation Components	20 min
4	Billing and Coding	10 min
5	Case Study Activity	20 min
6	Debrief	5 min

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TOPIC 1: INTRODUCTION

Question prompts:

- Medicare only covers health-related services that they determine to be "medically necessary." Do you think a home-based setting is more prone to documentation problems than in an outpatient/office setting? Why or why not?

TOPIC 2: DEFINE MEDICAL NECESSITY

Question prompts:

- The course discusses three elements that are required to prove medical necessity. Explain each and/or provide an example.
    - Generally accepted standards
    - Clinically appropriate
    - Not primarily for convenience

TOPIC 3: DOCUMENTATION COMPONENTS

Question prompts:

- At what point does quality documentation start to prove the case for medical necessity?
    - *(When the appointment is scheduled, documentation must include who requested the visit and the reason for the request.)*
- What are the documentation components discussed in the course? Provide an example of what each might look like in practice.
    - Scheduling
    - Chief Complaint
    - Statement of Necessity
    - History of Present Illness (HPI)
    - Review of Systems
    - Levels of Examination
    - Medical Decision-Making
    - Number of Diagnoses and/or Management Options

  NOTE: You may want to have the group work in smaller groups or with partners to discuss each component. Then debrief together.

- Which documentation components present the biggest challenges for home-based primary care providers? What are these challenges, and do you have any strategy ideas to make them easier?
- What is "cloning" and how can this be avoided?
- If using a coder to submit billing, how can we ensure that they understand our practices in determining what is medically necessary?

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TOPIC 4: BILLING AND CODING

Question prompts:

- The course recommended training in the guidelines, understanding the required elements, and consistent documentation as important strategies for accurate documentation. What are some resources you can use to help you with this?
    - *(You may wish to reference participants to any training resources available.)*
- What are examples of when you should bill for time spent?
- What did the course indicate as documentation "red flags" for CMS auditors? Provide an example of what each might look like in practice, and this can be avoided.
    - Stable patient visits
    - Billing for Evaluation and Monitoring AND a minor procedure on the same day
    - Visits that are not medically necessary
    - Cloning

TOPIC 5: CASE STUDY ACTIVITY

- Read each case study and then use the *HCCI Superbill Coding Exercise* handout to circle the most appropriate codes for each case.
- What observations did you have about the documentation for each case?

NOTE: You may want to have the group work in smaller groups or with partners on each case. Then debrief together and discuss the reasons why they chose their answers. An answer key is provided.

TOPIC 6: DEBRIEF

Question prompts:

- Are there any documentation practices that you don't think we as providers are currently doing that we should start (or we should start to do better/more consistently)?
- Are there any strategies that this course confirmed for you that we, as providers in our practice, should continue doing?
- Refer to the *Next Steps* handout. Review and mark which steps you would like to commit to taking next. Share your ideas for implementation.

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Documentation for House Calls: Avoiding Negative Audit Outcomes – Case Study Answer Key

Ralph

Codes

- 99350-25 base E/M code with modifier
- 99354 – prolonged service
- 99406 – smoking cessation

Observations

- The provider clearly documents time and counseling.
- Modifier 25 is used due to CPT code 99406 being used on the same day as an E/M code. If smoking cessation is not being billed, then modifier 25 is not needed for billing prolonged services.
- When billing for smoking cessation, utilize the ICD10 code for Nicotine Dependence or History of Tobacco Use.

Betty

Codes

- Under 95 guidelines this note would code as a 99350.
- Under 97 guidelines this note would code as a 99349.
- NOTE: Both sets of guidelines as permissible; however, the 97 guidelines are much more regimented and tend to be easier to defend in an audit.

Observations

- The provider does not document time and counseling, so coding should be based on the documented elements.
- The provider documented a detailed history, a Comprehensive Exam (if utilizing the 95 guidelines or a detailed if utilizing the 97 guidelines), and MODERATE medical decision making.

MJ

Codes

- This visit would code at 99496 – Transitional care visit, high complexity.

Observations

- This is a transitional visit with the required elements completed. The patient is at high risk due to multiple documented issues.