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**The Most Important Billing Codes  
You May Not Be Using!**

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**Brianna Plencner CPC, CPMA**  
**Thomas Cornwell, MD; Paul Chiang, MD**

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**Webinar and Virtual Office Hours**  
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**Home Centered Care Institute (HCCI)**

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**Advancing home-based primary care to ensure that chronically ill, medically complex, homebound patients have access to high-quality care in their home.**

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**Introductions**

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**Brianna Plencner, CPC, CPMA**  
Practice Improvement Specialist,  
Home Centered Care Institute



**Thomas Cornwell, MD**  
CEO, Home Centered Care Institute  
Founder, Northwestern Medicine HomeCare Physicians



**Paul Chiang, MD**  
Chief Medical Officer, Home Centered Care Institute  
Medical Director, HomeCare Physicians

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**Objectives**

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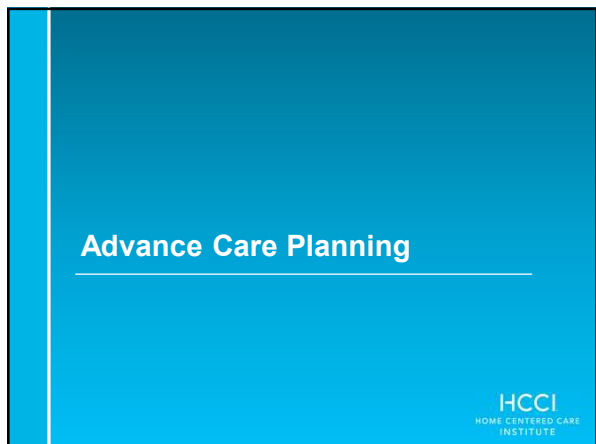
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**Objectives**

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- Identify commonly overlooked opportunities to enhance reimbursement within a HBPC practice
- Describe coding and documentation requirements for advance care planning, prolonged services non-face-to-face, anticoagulation management, and oversight of home health certifications and recertifications
- Increase revenue within your HBPC practice by appropriately coding and billing for services you may already be providing

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### What is Advance Care Planning (ACP)?

ACP means face-to-face service between physician (or other qualified health care professional) and patient discussing advance directives, with or without completing relevant legal forms

- An advance directive is a document appointing an agent and/or recording wishes of patient
- Pertains to his/her medical treatment at future time should he/she lack decisional capacity at that time

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf>

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### Who Can Bill For ACP?

ACP may be billed by:

- Physicians (specialists included)
- Nurse Practitioners
- Physician Assistants
- Clinical Nurse Specialists
- Certified Nurse Midwives

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### How Often Can ACP Be Billed?

Are there limits to how often ACP can be billed?

- CMS allows providers to bill for ACP each time there is a significant change in the patient's health status

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### Requirements For ACP

Time

- Codes are time-based. Only time spent specifically on ACP counts toward reaching billing threshold
  - CPT 99497: First 30 minutes face-to-face with the patient, family member(s), and/or surrogate (minimum of 16 minutes documented)
  - CPT 99498: Each additional 30 minutes face-to-face with the patient, family member(s), and/or surrogate (minimum of 16 minutes past the first 30 minutes documented)
- Time spent completing other portions of E/M visit or Annual Wellness Visit (AWV) may not be counted toward ACP time

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### Recommended Documentation Requirements for ACP

- Documentation of discussion with patient (or family members and/or surrogate) regarding voluntary nature of encounter
- Documentation indicating explanation of advance directives, along with completion of those forms when performed
- Documentation of who was present; and time spent in face-to-face encounter
- Documenting actual time in and out

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### NGS ACP Requirements: (MAC for IL, WI, MN)

- Documentation should reflect the provider's discussion of this planning with the patient/caregiver and an explanation of advance care directives, with or without the completion of relevant legal forms. The medical record must reflect time spent by the provider in this discussion.
- "There are no specific documentation requirements for ACP; the record should reflect that the provider had a discussion with the patient/caregiver and a summary of the patient's responses and preferences. A standard form may be used to document these details."

NGS: National Government Services  
MAC: Medicare Administrative Contractor

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### Can ACP be Billed on the Same Day as an E/M Visit?

#### Yes!

- ACP services may be billed on same day as an E/M service, during same service period as transitional care management or chronic care management services, and within global surgical periods. They may also be furnished during AWV and billed separately with modifier 33 (preventive services). The patient will not be responsible for copay/deductible when part of an AWV.
- Use modifier 25 on your E/M code, unless your carrier gives you different information.

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### Additional Billing Considerations

#### Can ACP be billed when speaking with family?

- Yes, but reason the patient is not participating in discussion must be documented, e.g., patient is incapacitated due to dementia

#### Is consent required?

- Yes. ACP is a voluntary service/discussion. The patient or family should be given the chance to decline the service. Document verbal consent within your medical record.

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### Additional Billing Considerations

#### Are there specific diagnosis codes that should be used when billing for ACP?

- No. Patient's diagnoses codes that are pertinent to discussion should be documented.

Be sure your documentation supports a separate and distinct E/M visit, and additional time spent only on the F2F ACP discussion when billing both services with modifier 25.

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### Advance Care Planning Reimbursement

CPT Code	CMS National Payment Rate	WRVU
99497	\$86.49	1.50
99498	\$76.04	1.40

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### Prolonged Services Non-F2F

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### Prolonged E/M Service Before and/or After Direct Patient Care

- CPT 99358 first hour of non-F2F services before and/or after visit
  - Minimum of 31 minutes
  - Must be directly related to the E/M visit
  - Time must be beyond the usual time a provider would spend on a service
  - May occur on a different date, before or after the E/M visit, or may occur on the same date as the visit as long as all time occurs on the same date of service
- Cannot be reported during the same service period as CCM or TCM



### Prolonged E/M Service Before and/or After Direct Patient Care

- Do not report for services without F2F time that can be described with more specific codes that have no upper time limit, such as those for care plan oversight, anticoagulant management, team conferences, or online medical evaluations
- Time based code-total time spent does not need to be continuous but must occur on the same date of service
- CPT 99359 (Add on code)
  - 76 minutes or more spent on non-F2F time (report in conjunction with 99358)



### CMS Guidance on Prolonged Services

- "CMS notes while the typical CPT threshold times are not required to bill prolonged services, we would expect that only time spent in excess of these times would be reported under CPT codes 99589-99359"
- Be sure to document the exact amount of time the provider spent, a description of how that time was spent, and consider making note of how much time was spent during the related F2F visit even if billing on documentation.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf>



### Prolonged Services Non-F2F Reimbursement

CPT Code	CMS National Payment Rate	WRVU
99358	\$113.76	2.10
99359	\$54.72	1.00



### Anticoagulation Management Services



### Anticoagulation Management

#### CPT Code 93792

Patient or caregiver training for initial set up when a patient is placed on a home International Normalized Ratio (INR) monitoring regimen. This service can be provided under the direction of a physician or QHP and billed in conjunction with a separate office visit by appending modifier 25 to the (E/M) code.

- Encounter documentation requires
  - Must be face-to-face
  - Must be for initial home INR set up and education
  - Includes education on use, care for INR monitor, obtaining a blood sample and instructions for reporting home INR test results
  - Documentation of the patient's and/or caregivers ability to perform testing and report results.



## Anticoagulation Management

### CPT Code 93793

Review and subsequent management of a home, office, or lab test once per day regardless of the number of tests reviewed. Code 93793 is not billable with an E/M service.

- Encounter documentation requires
  - Review and interpretation of INR results
  - Patient instructions and dosage adjustment as needed
  - Scheduling of follow-up INR

**Codes 93792 or 93793 are not billable with chronic care management or transitional care management services because INR monitoring is considered included in those services.**



## Anticoagulation Management Reimbursement

CPT Code	CMS National Payment Rate	WRVU
93792	\$55.08	None
93793	\$12.24	0.18



## Home Health Certifications and Recertifications



## Requirements for Home Health Certifications and Recertifications

- For certifications the patient must have not received skilled home health services within the past 60 days
- Recertifications can only be billed once every 60 days
- DOS for the claim is the date in which the MD completes and or/reviews and signs the plan of care
- Physician documentation in record of MD communicating with HHA and review of patient reports and status to affirm the implementation of the plan of care that meets the patient's needs
- HH services must be "Medicare covered" meaning cannot bill if the HH claim itself was non covered due to eligibility or insufficient documentation to support the HH benefit
- Physician who bills for the HH cert or recert must be the one who signed the plan of care, must maintain a copy of the signed plan of care within the record



## Billing for Home Health Certifications

### HCPCS Code G0180

Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets the patient's needs, per certification period



## Billing for Home Health Recertifications

### HCPCS Code G0179

Physician recertification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per recertification period



## Home Health Certification's Reimbursement

HCPCS Code	CMS National Payment Rate	WRVU
G0180	\$54.06	0.67
G0179	\$41.81	0.45

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## Additional Billing Opportunities

- **Chronic Care Management** (CPT 99490, 99487, 99489)
- **Transitional Care Management** (CPT 99495, 99496)
- **Care Plan Oversight** (HCPCS G0181, G0182)
- **Behavioral Health Integration Services** (CPT 99492, 99493, 99484)
- **Cognitive Assessment & Care Planning** (CPT 99483)
- **Smoking Cessation Counseling** (CPT 99406, 99407)
- **Brief Communication Technology Virtual Check-ins** (HCPCS G2010, G2012)

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## Virtual Office Hours: Ask the Experts

*An open forum for questions and answers*

If you have additional questions please contact  
**HCCIntelligence™ Hotline:** (630) 283-9222  
**HCCIntelligence™ E-mail:** [Help@HCCInstitute.org](mailto:Help@HCCInstitute.org)

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## Additional Education and Resources

**October 17, 2019:** AAHCM Pre-Conference presented by Home Centered Care Institute (HCCI): House Calls: Achieving Clinical Excellence and Sustainability

**December 5-6, 2019:** HCCI Advanced Applications of Home-Based Primary Care™ Workshop

**E-Learning Modules:** HCCI University™ - Featuring 12 On-demand web-based courses in both clinical and practice management topics

**Consulting Services**

**HCCIntelligence™**

- **Webinars:** Every third Wednesday of the month, free webinar on a clinical or practice management topic related to HBPC, approximately 30 minutes
- **Virtual Office Hours:** Follows the HCCIntelligence™ Webinar and provides 30 minutes of open questions with Clinical and Practice Management experts
- **Resource Center:** Contains archived webinars, materials, and tools.
- **Hotline:** (630) 283-9222
- **Email:** [Help@HCCInstitute.org](mailto:Help@HCCInstitute.org)

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