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Coding, Documentation, and Billing in Home-Based Care

Loyola Medicine

11/13/2024

Agenda

Topic	Time	Presenter
Welcome	1	Raabiah
CY25 MPFS Proposed Rule	3	Paul Chiang
Coding & Billing	45	Sujatha & Paul
Documentation: Foundation & Requirements / E/M Requirements		Sujatha
SDoH Risk Assessment / BHI Services		Paul
Preventive Vaccine Administration Services / CCM		Sujatha
Transitional Care Management (TCM)		Paul
Discussion/Q&A	10	All
Next Steps	1	Raabiah

CY25 MPFS Proposed Rule

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CY 25 Overview

- Advanced Primary Care Management (APCM)
- Maintain Merit-Based Incentive Payment System performance threshold at 75 points for 2025
- CMS proposes a conversion factor of $32.3562, which reflects a nearly 2.8% reduction in payment across the fee schedule
- CMS is proposing to allow the G2211 office/outpatient (O/O) E/M care complexity add-on code
- extend the telehealth flexibilities, set to expire at the end of 2024
- CMS proposes several payment changes to support its behavioral health strategy

Documentation: Foundation & Requirements

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GOLDEN RULES

- If it wasn't documented, it doesn't count
- More words do ***not*** equal better documentation
- Cloning: be careful

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Does your Documentation Support Medical Necessity?

- Why did you need to see the patient that day?
- Descriptive words that reflects the status of their chronic diseases, interventions and management plans
- What did you discuss, educate, and/or counsel the patient/caregiver about?
- What went into your decision making? (e.g. labs, diagnostic testing, speaking with other healthcare professionals)
- Medication Reconciliation or rationale for adjustments?
- Assessment/Plan details follow-up instructions and a clear treatment plan for each condition meaningful assessed.
- Any unique considerations or psychosocial issues that complicate care?
- Documentation on “paper” reflects how complex and seriously ill the patient is.

Medical Necessity is always the overarching criterion for payment regardless of the other E/M components

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E/M Requirements

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E/M Requirements

Level of decision-making is based on two out of the three elements: 1) number and complexity of problems addressed at the encounter; 2) amount and/or complexity of data to be reviewed and analyzed; 3) risk of complications and/or morbidity or mortality of patient management.

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99341 (New) 99347 (Established)	Straight-forward	99341 (15 minutes) 99347 (20 minutes)	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

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E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99342 (New) 99348 (Established)	Low	99342 (15 minutes) 99348 (20 minutes)	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) • Category 1: Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* OR • Category 2: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

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E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99344 (New) 99349 (Established)	Moderate	99344 (60 minutes) 99349 (40 minutes)	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) • Category 1: Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring independent historian(s); or • Category 2: Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or • Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99345 (New) 99350 (Established)	High	99345 (75 minutes) 99350 (60 minutes)	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) • Category 1: Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring independent historian(s); or • Category 2: Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or • Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Time-Based Billing Requirements

Time-Based Billing:

- Time statement includes total F2F time
- Documentation describes how the time was spent with the patient and or caregiver

Time Statement - Example Templates:

- I spent (X) minutes face-to-face with the patient/caregiver, discussing the patient's' medical conditions, treatment goals, and care plan to maintain and improve function." (Add specific patient details)

- I spent (X minutes) face-to-face with the patient/caregiver, counseling and coordination of care. I educated & discussed (Customize/add specific patient details)

Assessment and Plan

M **Monitor** (signs, symptoms, disease progression/ regression)

E **Evaluate** (test results, commenting on medication effectiveness, responses to treatment)

A **Assess/Address** (stable, unstable, suboptimal)

T **Treat** (Prescribing or continuing medications, therapies/ referrals, education/ counseling, monitoring)

What is their overall level of risk? Did you document why caring for the patient is complex and any contributing factors?

CPT code and RVU

CPT Code	Total wRVUs	2024 Medicare National Fee Schedule Payment	85% of MC Allowable (NP/PA)
99341	1	$48.13	$40.91
99342	1.65	$76.29	$64.85
99344	2.87	$138.51	$117.73
99345	3.88	$196.79	$167.27
99347	.9	$44.21	$37.58
99348	1.5	$74.66	$63.46
99349	2.44	$124.10	$105.49
99350	3.6	$180.75	$153.64

Progress Note Domains

- ❑ Up-to-date
- ❑ Accurate
- ❑ Thorough
- ❑ Useful
- ❑ Organized
- ❑ Comprehensible
- ❑ Succinct
- ❑ Synthesized
- ❑ Internally consistent

https://cdn.mdedge.com/files/s3fs-public/Document/May-2018/jhm013060378.pdf

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Place of Service

Place of Service Code	Place of Service Name	Place of Service Description
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence
13	Assisted Living Facility	Location, other than a hospital or other facility, where the patient receives care in a private residence
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). (Effective October 1, 2003) (Revised, effective April 1, 2004)

https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set.html

Common Modifiers

Modifier	Description
25	Significant, separately identifiable evaluation and management (E/M) service by the same qualified provider on the same day as the procedure or other service (e.g., AWV & E/M, or ACP & E/M)
59	Distinct Procedural Service (e.g., Excisions of multiple lesions from different body areas)
GW	Service not related to the hospice patient's terminal condition, professional services provided for treatment or management of conditions **unrelated to the patient's hospice terminal diagnosis**
GV	Attending provider not employed or paid under agreement by the patient's hospice provider; or hospice-employed nurse practitioner is acting as attending physician
95	Medicare telehealth service provided via real-time interactive audio and video telecommunication system

OIG and CMS Red Flags

Visits not found medically necessary

- Routine visit, on a set schedule that are for the same stable
  diagnosis options
- Routine visits required to meet facility or state requirements

Billing for E/M code and minor procedure on same day

- Visit for a joint injection – if this is the only purpose of the visit an E/M code is not supported. The decision to complete the joint injection is included in the payment for the injection itself.

Cloning - CMS continues to expand their definition

- Documents considered cloned when each entry in the medical record is exactly like or similar to previous entries

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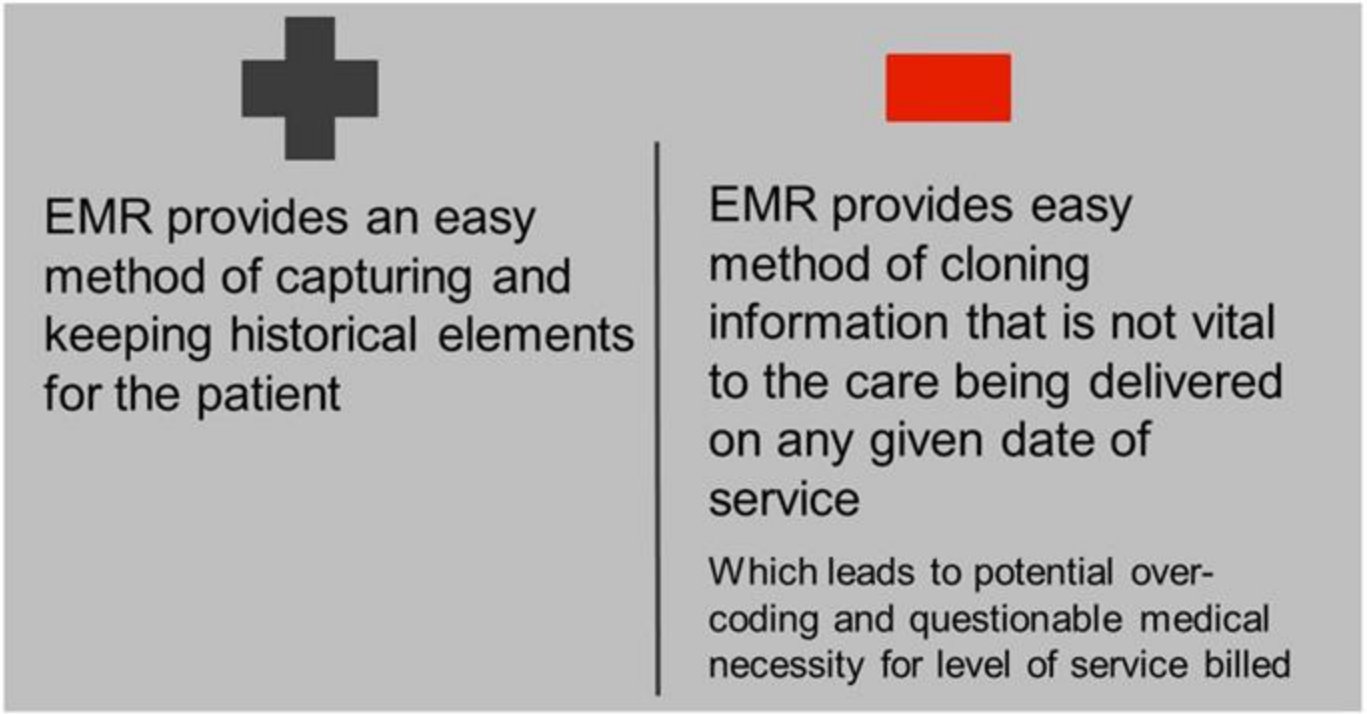
Electronic Medical Record (EMR): Friend or Foe?

The simple answer is YES!



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Social Determinants of Health Risk Assessment (SDoH)

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SDoH Coding Reimbursement

The SDoH risk assessment code must be provided in conjunction with a qualifying visit, including an E/M visit, Annual Wellness visit, and in some cases behavioral health visits.

- Note: only bill once every six months

CPT2024	Description	2024 wRVU	2024 National Payment Amount
G0136	Administration of a standardized, evidence based Social Determinants of Health Risk Assessment tool, 5-15 minutes	0.18	$18.66

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SDoH Assessment

Per CMS, the tool used to render a SDoH Risk Assessment must be an evidence-based, standardized tool covering, at *minimum*, the following domains:

- Housing Insecurity
- Food Insecurity
- Transportation Needs
- Utility Difficulty

- Practitioners can choose to add other domains if prevalent or culturally important to their patient population
- SDoH Risk Assessment Tools
  - HCCIntelligence™ Premier: Social Determinants of Health (SDoH) Screening and Coding Requirements
  - CMS - Accountable Health Communities Health-Related Social Needs Screening Tool
  - AAFP – Social Needs Screening Tool

Behavioral Health Integration Services (BHI)

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Behavioral Health Integration Services (BHI)

Incorporates behavioral health care into other care to improve mental, behavioral, or psychiatric health for many patients. In addition to payment for E/M services, Medicare covers 2 types of BHI services:

General BHI services

- CPT code 99484 (wRVU: 0.93) and HCPCS code G0323 to account for monthly care integration

General BHI service elements like:

- Systemic assessment and monitoring
- Care plan revision for patients whose condition isn't improving adequately
- Continuous relationship with an appointed care team member

Collaborative Care Management (CoCM)

- Use CPT code 99492-99494

CoCM requires:

- Psychiatric consultation
- Documentation of time spent in calendar month
- Continuous relationship with an appointed care team member

Preventive Vaccine Administration Services

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Preventive Vaccine Administration

National in-home additional payment for Part B preventive vaccine administration is approximately $38 (geographically adjusted).

- Vaccinations included when administered in the patient's home:
    - Pneumococcal (G0009)
    - Influenza (G0008)
    - Hepatitis B (G0010)
    - COVID - (90480)

- HPCS Level II code M0201 to bill for the additional payment amount for administering the vaccine in the home

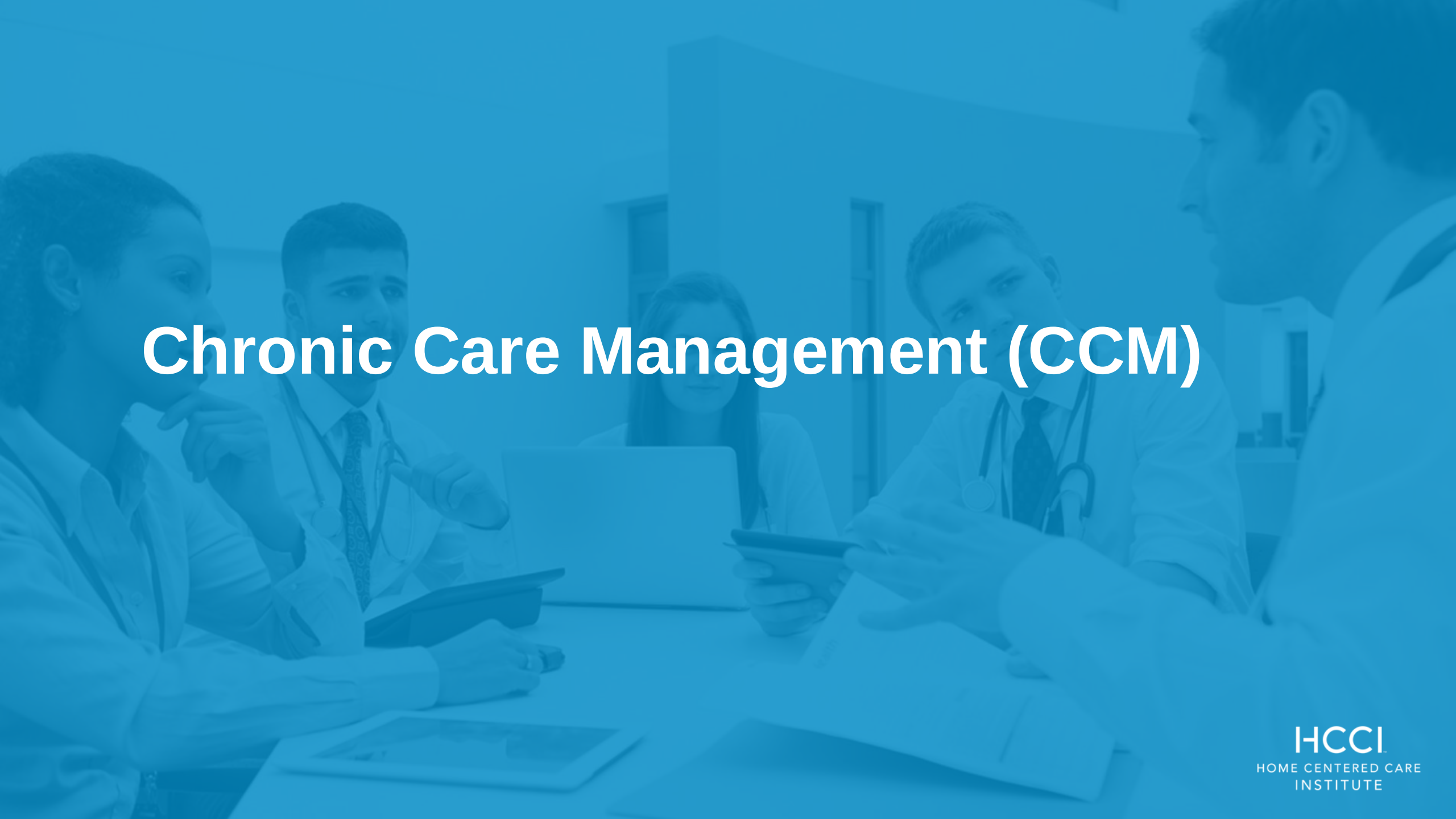
Preventive Vaccine Administration

When does the additional In-Home Payment apply?

- when the patient has difficulty leaving the home or faces barriers to getting a vaccine in settings other than their home.

Requirements for receiving additional In-Home payment:

- Medicare only pays the additional amount for administering the flu, hepatitis B, or pneumococcal shots in the home if the sole purpose of the visit is to administer 1 or more Part B preventive vaccines, including the COVID-19 shot.
- Medicare does NOT pay the additional amount if you (healthcare provider) provides another Medicare service in the same home on the same date.
  - In those situations, Medicare pays for administering the flu, hepatitis B, or pneumococcal shot at the standard amount and COVID-19.



Chronic Care Management (CCM)

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Chronic Care Management (CCM) Care Plan

- **Practices providing CCM services must utilize structured recording of patient health information using certified Electronic Health Record (EHR) technology, inclusive of maintaining a comprehensive electronic care plan, managing transitions, coordinating and sharing of patient health information promptly both inside and outside of the practice and other care management services.**

- **CMS recommends that the comprehensive care plan for all health issues include but is not limited to the following elements:**
  - Problem list.
  - Expected outcome and prognosis.
  - Measurable treatment goals.
  - Cognitive and functional assessment.
  - Symptom management
  - Planned interventions
  - Environmental evaluation
  - Caregiver assessment
  - Interaction and coordination with outside resources and practitioners and providers.
  - Requirements for periodic review
  - When applicable, revision of the care plan

Chronic Care Management (CCM) Care Plan

- CCM codes require patients to have two or more chronic conditions expected to last 12 months or until their death.
- Document verbal consent, defined as informing the patient/caregiver of the availability of the service, that only one practitioner can bill per month, the patient's right to stop services at the end of any service period, and make the patient aware of applicable cost-sharing.
- Initiating visit, which is required for new patients or patients not seen within the past twelve months. This service is separately payable.
- 24/7 access to care, defined as offering on-call services including after-hours coverage, so the patient has access to clinical advice and guidance.
- Relationship with a designated care team member to promote continuity of care.
- Comprehensive Care Management, defined as systematic needs assessment (medical and psychosocial), ensure receipt of preventative services, and medication reconciliation including management and oversight of self-management.

Chronic Care Management (CCM) Care Plan

- Comprehensive electronic care plan, requirements described earlier in this resource. CMS also requires the care plan is timely available within and outside of the practice (e.g., fax), a copy of the care plan provided to the patient/caregiver (format not prescribed), and that the care plan is established, implemented, monitored, and revised, as appropriate.
- Management of care transitions (e.g., follow up post-discharge and ED visits) and referrals, defined as creating and exchanging care documents in a timely manner. Following up on the need and execution of referrals for other services.
- Home and community-based care coordination, defined as coordination with any home and community-based clinical service-based providers, and documenting communication with those professionals regarding psychosocial and functional deficits.
- Enhanced communication opportunities, defined as offering non-face-to-face methods other than telephones, such as secure email or patient portals.

Chronic Care Management (CCM) Care Plan

Available CCM CPT Codes

CPT Code	Descriptor
99487	Complex chronic care management services, 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, establishment or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99489	Complex chronic care management services, 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, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure).
99490	Chronic care management services 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; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of a physician or other qualified healthcare 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.

Chronic Care Management (CCM) Care Plan

New CCM CPT Codes

A new code was created for physicians and qualified providers, reimbursing for an additional 30 minutes of provider-delivered CCM services. This code is an add-on to the original 99491 code.

CPT Code	Descriptor
99437 (add-on) to 99491)	Additional 30 minutes of a physician or qualified professional time each month for patients with two or more chronic conditions.

Chronic Care Management (CCM) Coding

CPT Code	2024 wRVU	2024 CMS National Payment
99490 (Traditional CCM, 20 mins per calendar month, clinical staff & billing provider time)	**1.00**	**$61.56**
99439 (Traditional CCM add-on code, each additional 20 mins)	**0.70**	**$47.15**
99491 (Provider CCM, 30 minutes per calendar month by the billing provider)	**1.50**	**$83.17**
99437 (**New CPT code**, Provider CCM add-on, each additional 30 mins)	**1.00**	**$58.61**
99487 (Complex CCM, 60 minutes per calendar month)	**1.81**	**$131.96**
99489 (Complex CCM add-on code, each additional 30 mins)	**1.00**	**$71.06**

Chronic Care Management (CCM) Implementation Considerations

Clinical Staff
Does your practice have designated clinical staff to support CCM efforts (Care Plans, capturing time, main point of contact.)

Time
How will you track your time

MACRO
Develop care plan template and other customizations such as MACRO for documenting patient consent

Care Plan
Process to provide a copy of care plans to patients/caregivers

Billing Process
To capture month end revenue

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Transitional Care Management (TCM)

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Transitional Care Management (TCM)

99495 - TCM services with moderate Medical Decision Making complexity

- Domiciliary (ALF), rest home, or custodial care services are billed with home and residence services codes.
- Report this Evaluation and Management (E/M) code for the post-discharge face-to-face visit.
- The patient must be seen within 14 calendar days of discharge.
- The visit must require **moderate** Medical Decision Making (MDM).
- Interactive contact by a clinical staff member must occur within two business days of discharge.
- 2024 CMS National Payment Amount $203.34; wRVU 2.78

99496 - TCM services with high Medical Decision Making complexity

- Report this Evaluation and Management (E/M) code for the post-discharge face-to-face visit.
- The patient must be seen within 7 calendar days of discharge.
- The visit must require **high** Medical Decision Making (MDM).
- Interactive contact by a clinical staff member must occur within two business days of discharge.
- 2024 CMS National Payment Amount $275.05; wRVU 3.79

Transitional Care Management (TCM)

Service must meet or exceed two of the three medical decision-making elements to qualify as an established type of medical decision-making. Providers should not report an E/M code in addition to the TCM CPT code. CMS requires, at a minimum, the following information be documented in the beneficiary's medical record:

- The date on which the patient was discharged.
- The date on which the provider's office contacted the patient and/or caregiver.
- The date on which the provider furnished the face-to-face visit.
- The documentation must support the overall complexity of MDM being moderate or high.

Transitional Care Management (TCM): Elements of Medical Decision Making

Along with the face-to-face visit, CMS expects the following services to be rendered as part of TCM unless the provider determines they are not medically necessary. The clinical staff may assist with certain non-face-to-face services:

- Obtain and review discharge information, such as the discharge summary or inpatient records.
- Complete a comprehensive medication reconciliation, inclusive of a review of all medications to reconcile discharge medications with home medications, ensure necessity, and to check for interactions. Clinical staff may begin the process during the interactive contact, which occurs within two business days of discharge, however, the provider is responsible for completing the process during the visit.
- Review the need for follow-up on any pending orders such as diagnostic tests or treatments.
- Communicate with other healthcare professionals who also have a responsibility in the patient's care.
- Provide education to the patient and/or caregiver.
- Establish or re-establish referrals to any needed community resources.
- Assist with scheduling required follow-up with community services or providers.

Additional Opportunities

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Additional Opportunities

Telehealth

- Home-Based Medical Care: Telehealth Guidelines & Coding Requirements

Caregiver Training

- Home-Based Medical Care: Advanced Coding Opportunities

Community Health Integration

- Home-Based Medical Care: Advanced Coding Opportunities

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Q&A

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Next Steps

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The Illinois House Call Project: Foundations of House Calls Coursework Series

Session 3

November 14th, 2024

9:30 am – 11:00 am CST

Courses:

- Advanced Coding and Billing: Beyond E/M for House Calls
- Optimizing Efficiency in House Call Operations
- Legal Compliance for Home-Based Primary Care
- Risk Adjustment and HCC Coding for House Calls

For any questions, please contact Raabiah Ali, Program Manager
RAli@hccinstitute.org

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HCCIntelligence™ Community

HCCIntelligence™ Community members receive ***exclusive*** access to a wealth of resources tailored for home-based medical care professionals.

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- **1-on-1 Office Hours with HCCI Experts**
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The John A. Hartford Foundation

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HCCIntelligence™ Community Webinar Series

Expanding Home-Based Primary Care: Uncovering Referral Channels, Attracting New Patients, and Partnering with Providers

Objectives:

- Explain the process of identifying patient referral sources.
- Explore strategies for recruiting and communicating with potential new patients, including talking points and scripting examples.
- Outline key discussion topics for engaging with providers when reaching out to new referral sources.

November 20, 2024
3 pm - 4 pm CT

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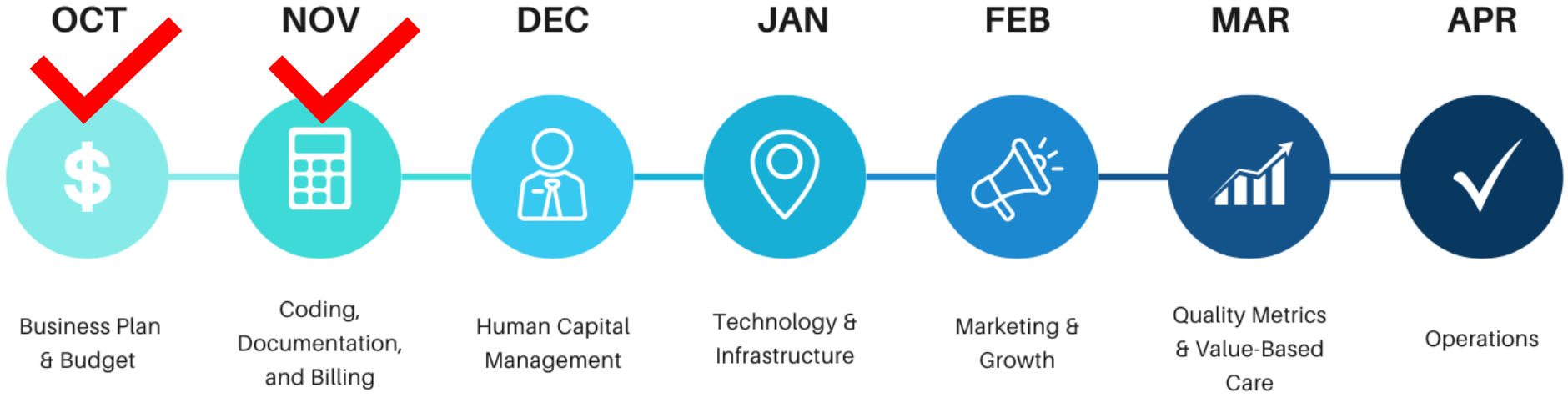
UPCOMING MONTHLY TOPICS



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