HCCI
HOME CENTERED CARE INSTITUTE

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The Most Important Billing Codes You May Not Be Using
Webinar Q & A

Q: What is the POS for non-face to face prolong service?

A: Prolonged Services is reimbursed in the office/outpatient settings (including home/domiciliary), hospital, and skilled nursing facility. It is recommended to select the place of service for where the non-face-to-face time occurred; for example, it may be POS 11 for the office if it was time spent preparing for the home visit.

Q: Can ACP be billed concurrently with a TCM visit?

A: Yes, Advance Care Planning may be billed in conjunction with AWV, E/M, TCM and/or CCM.

Q: Have you billed E/M with modifier 25 or ACP code with modifier 25? What is your experience with reimbursement? I am seeing it should be with ACP but wanted to know your experiences.

A: Past experience has taught to append modifier 25 to the E/M visit. The definition of modifier 25 is "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining the level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier."

It's important to check with your local MAC (Medicare Administrator Contractor) to determine if modifier 25 is appropriate. If this is a new service, it is recommended to monitor to ensure there are no denials.

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Q: Can G0180 be billed concurrently in the same month as TCM or in the same month as CCM?

A: You may not bill for care plan oversight services (G0181/G0182) during the same calendar month as CCM and TCM, however restrictions on billing G0180 (Home Health Certification review of the plan of care) during the same month could not be located. For additional information, please review the Medicare Claims Processing Manual, Chapter 12, Section 180.1.B, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Q: Are G0180 and G0179 only billable for Medicare and not for other payers?

A: G codes are intended for Medicare beneficiaries and these codes refer to the supervision on "Medicare-covered" home health services. Review fee schedules for your other payers to determine if payment would be made. Medicaid will **not** reimburse these services.

Q: Can APRNs be billed for G0180 or G0179?

A: Not at this time. Under the current legislation, only a physician may certify patients to receive home health services. Therefore, they are the only one who can review, sign, and bill for the monitoring of their plan of care. Current pending legislation, The Home Health Care Improvement Act of 2019, would allow Advance Practice Providers to certify patients for home health services, if passed.

Q: For recerts, does the DOS have to be the date the MD signs the recert? This might cause issues if the recert was signed before the 60 days from when the cert was signed.

A: CMS published guidance in the MLN Matter article: SE17023 that states as follows: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf. "The date of service for the Certification is the date the physician completes and signs the plan of care. The date of the Recertification is the date the physician completes the review."

Q: What about CPT code 99491?

A: CPT code 99491 is for chronic care management personally provided by a physician or other healthcare professional. This particular code must be a minimum of 30 minutes of solely provider time per calendar month and does not include the time of clinical staff such as traditional CCM CPT code 99490.

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Q: Can CCM be billed for long term custodial patients living in a SNF?

A: Per the FAQ's CMS published yes. "CCM is priced under the PFS in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

Q: To clarify – NP can be billed for CPO but not for home-health and recert, right?

A: Correct, NP's may be billed for care plan oversight services if the following guidelines are met, however they cannot bill for G0180 or G0179 at this time since they are not permitted to certify a patient for home health services.

"Non-physician practitioners can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- *The physician and NPP are part of the same group practice; or*
- *If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or*
- *If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.*

Billing may be made for care plan oversight services furnished by an NPP when:

- *The NPP providing the care plan oversight has seen and examined the patient;*
- *The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care; and*
- *The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care."*

Q: For non F2F prolonged services, can one provider in a practice review the documentation and prep the chart and bill the 99358, but then a separate provider does the actual visit and then bill for the E&M?

A: No. 99358-99359 are for prolonged services by the billing physician/NP/PA when provided in relation to an E/M service on the same or different day as the E/M service. Since they must be related to an E/M visit, it is expected the same provider to be furnishing both services.

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Q: If non-face to face is done prior to a visit and the office visit is canceled, how long do we hold the none-face to face?

A: The only guidance CMS has provided is that it is the non-face-to-face time must directly relate to an E/M visit; the language I've seen is within a reasonable amount of time. I would recommend deciding on an audit policy for a set time period you feel is reasonable.

Q: How many times per day can non-face to face be billed? What about CPC Code 99491?

A: Prolonged services cannot be reported during the same service period as complex chronic care management or transitional care management. The time does not need to be continuous however it must occur on the same date of service so add your total non-face to face time for that day and ensure the CPT threshold time for the visit is met or exceeded.

Q: Can I bill 99358 with or without a house call?

A: Prolonged services non-face to face can be provided in the office/outpatient, inpatient, or nursing facility setting if they are related to an evaluation and management service and is beyond the usual provider time for the professional service time.

Q: How do you correctly bill home health certification and recertification using the codes G0180 and G0179?

A: Below are the requirements:

- For certifications, the patient must not have 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 the record of MD communicating with HHA and review of patient reports and status to affirm the implementation of the plan of care that meets patient's needs
- HH services must be "Medicare-covered" meaning cannot bill if the HH claim itself was not 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 POC within a record

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Q: How do you correctly bill for completing paperwork and forms without seeing a patient?

A: Explore services such as Chronic Care Management, Psychiatric Collaborative Care Management Care Services, Care Plan Oversight, Transitional Care Management Services, General Behavioral Health Management Services, and Prolonged Services. Some practices charge a flat fee for completing forms depending on nature; however, you would be unable to charge cash/additional fee for Medicare patients.

Q: When documenting 99358, can you document in your E&M visit notes or should it be documented as a separate note?

A: It is recommended a separate encounter to document the none-face to face time to clearly identify it was separate and distinct from the E/M service provided.

Q: What about G0181 and G0182 – Can APRN bill (this is CPO)?

A: Yes. APRN's may bill for Care Plan Oversight.

Q: When is TCM supposed to be billed? I read in the CMS regs on day 30 of TCM period, my biller says immediately.

A: You must furnish one face-to-face visit within certain time frames for Transitional Care Management, so it is recommended to report 99495/99496 on the date of your face-to-face post discharge visit with the patient. 99495 must occur within 14 calendar days of discharge and 99496 must occur within 7 calendar days of discharge. CMS tells us we should not report the TCM face-to-face separately. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf.

Q: Just to clarify, home visit documentation no longer requires the reason why the patient is homebound or needs a home visit as opposed to a clinic visit?

A: Correct, as of 1/1/19 providers are no longer required to include documentation in their progress notes as to why the patient was seen in the home in lieu of an office visit. Medicare announced in the 2019 Medicare Physician Fee Schedule that the justification for the home visit is now up to the provider and the patient as long as the visit itself is medically necessary.

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Q: For home-based primary care practices that have an IDT, can we bill for the IDT time discussing the patients or would that fall under the CCM?

A: If your IDT team meeting were regarding the patient's enrolled in chronic care management, you would not bill for your time separately. CPT indicates medical team conferences may not be billed during the same calendar month as complex chronic care management and transitional care management.

Q: Regarding ACP documentation, I suggest my providers note some individualized distinct details while using the smart phrase; what are your thoughts?

A: While Macro's or smart phrases are a great way to standardize documentation to meet requirements and promote efficiencies providers should always customize their documentation as it relates to that specific patient on that particular date of service to support medical necessity. It does not need to be multiple paragraphs but document the details of the conversation, what are the patient's preferences, who was involved in the discussion, and what counseling was provided.

Q: How do we confirm where the POS was done for an office visit done in POS 12 or 33?

A: POS 12 is for the home, which is defined as a location other than a hospital or other facility, where the patient receives care in a private residence. POS 33 is a custodial care facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component. It is suggested to report the place of service for where the provider performed the work or if you don't have an office, POS report where the provider would typically see the patient face-to-face.