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What You Should Know About 2020 Coding Updates!

Q) If a palliative care provider bills for PCM, can primary care providers still bill for CCM?
A: In the final rule, CMS indicates they anticipate there will be times when a specialty provider manages a single high-risk disease; however, the patient's primary care provider may still provide other general care management services. CMS did enforce a requirement that the PCM provider must document ongoing communication and care coordination between all practitioners to avoid fragmented care patterns.

It is important to note that PCM **cannot** be billed concurrently **by the same practitioner** for the same patients with other care management services such as CCM, behavioral health integration services, and ESRD services. In other words, if you are providing care management services you will need to decide if the patient is best suited for PCM or CCM, both services **cannot be provided by the same provider** and PCM is intended for patients with a single-high risk complex disease that requires a disease-specific care plan. Below are a few excerpts from the final rule:

"Due to the potential for duplicative payment, we proposed that PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services, and monthly capitated ESRD payments. We also proposed that PCM will not be billable by the same practitioner for the same patient during a surgical global period, as we believe those resource costs will already be included in the valuation of the global surgical code."

"Response: While we share commenters' concerns regarding care fragmentation and service duplication, we do not believe they rise to the level that separate payment should not be adopted for these services. The type of care management services that we believe are appropriately described by the PCM codes involve work intensively focused on managing a single condition and, with very few exceptions, could not be replaced by a single practitioner billing CCM services for management of multiple chronic conditions. However, we also believe it necessary to put in place some requirements so as to avoid a situation where each of a patient's individual conditions are being managed separately by different practitioners who all bill for PCM services. Therefore, we are finalizing a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record."

"We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions will continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. It is also possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously"

"Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a

single complex chronic condition requiring substantial care management. We expect that, in most instances, initiation of PCM will be triggered by an exacerbation of the patient's complex chronic condition or recent hospitalization such that disease-specific care management is warranted. We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner. For example, a typical patient may present to their primary care practitioner with an exacerbation of an existing chronic condition. Although the primary care practitioner may be able to provide care management services for this one complex chronic condition, it is also possible that the primary care practitioner and/or the patient could instead decide that another clinician should provide relevant care management services. In this case, the primary care practitioner will still oversee the overall care for the patient while the practitioner billing for PCM services will provide care management services for the specific complex chronic condition. The treating clinician may need to provide a disease-specific care plan or may need to make frequent adjustments to the patient's medication regimen. The expected outcome of PCM is for the patient's condition to be stabilized by the treating clinician so that overall care management for the patient's condition can be returned to the patient's primary care practitioner. If the beneficiary only has one complex chronic condition that is overseen by the primary care practitioner, then the primary care practitioner will also be able to bill for PCM services. We proposed that PCM services include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional."

https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

Q) Is the template for CCM for each diagnosis, or can we group them together?
A: CCM eligibility language describes this is for patients with two or more chronic diseases, which are expected to last more than 12 months; CMS does like to see disease-specific treatment plans for each chronic condition being managed. In my opinion, listing each condition and individual treatment plan is best practice from an audit standpoint. For example: for COPD or AFIB, list some specific condition guidance out separately within that care plan. The CMS FAQ describes the comprehensive care plan as "*a person-centered electronic care plan based on physical, mental, cognitive, and psychosocial, functional, and environmental (re)assessment and an inventory of resources (a comprehensive care plan for all health issues, with a particular focus on the chronic conditions being managed).*

Q) I would love to see a visual example of a care plan, as discussed with CCM billing, as well as visit note examples used for advanced billing and new codes.
A: On our **HCCIntelligence Resource Center**, we currently have an available tip sheet entitled "Chronic Care Management Care Plan Requirements," which can be used as a guide to creating your own comprehensive care plan template.

In the 2020 final rule CMS even provided guidance on the elements typically expected in a CCM care plan, see below which would be the fields used for a template. Be sure to keep checking our HCCIntelligence Tools and Tip Sheet page as we do plan to add additional resources, including a CCM Care Plan template, to provide further guidance as requested.

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CMS received in 2013 from the AMA's Complex Chronic Care Coordination Workgroup, we finalized a CCM scope of service element for a patient-centered plan of care with the following characteristics: It is a comprehensive plan of care for all health problems and typically includes, 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*
- *Medical management*
- *Environmental evaluation*
- *Caregiver assessment;*
- *Community/social services ordered;*
- *How the services of agencies and specialists unconnected to the practice will be directed/coordinated;*
- *Identify the individuals responsible for each intervention,*
- *Requirements for periodic review; and when applicable, revisions of the care plan.*

Q) What screenings are you currently doing for your homebound patients or any key quality metrics your practice focuses on?

A: HomeCare Physicians is part of a large health system, Northwestern Medicine. Metrics are being collected as a group of primary care providers. Some of the measures include blood pressure control, dilated eye exam, hemoglobin A1C, screening for depression, fall risk, tobacco screening, influenza vaccination status, and pneumonia vaccination status. Those are some of the current quality measures that are being tracked across the health system. Specifically, for our chronically ill and home limited patients in our practice, we are internally tracking measures such as advanced care planning, time to transitional care follow up, and time to new patient visits. We strive to serve our patients in a timely fashion to keep them out of the costly ER and hospital admissions and provide patients with the care and resources they need. We also track the place of death and work with our patients if it their wish to pass away at home. We use a little peer pressure where we can see how we are compared to other doctors. Often there are procedures that our patients cannot participate in due to their illnesses such as colonoscopies, and we are excluded from measuring this.

If you're not already familiar with the work that Dr. Christine Ritchie and Dr. Bruce Leff are doing to create meaningful quality metrics for the field of Home Care Medicine, I'd encourage you to visit the National Home-Based Primary and Palliative Care Consortium.

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Q) When the situation does not meet the insurance company's definition for medical necessity for a home visit, how should one bill if the visit still occurs in the person's home? Or can one not bill for the visit?

A:If we go back to the definition of medical necessity, CMS describes this as – a service that is reasonable and necessary for the treatment of the patient's conditions that are being addressed on that date of service, is not primarily for convenience, and meets standards of good medical practice.

Prior to 2019, there used to have to be an additional necessity as to why the patient was being seen at home in lieu of an office visit. That requirement went away as of last year. The guidance CMS provided is that the **justification for a home visit is left to the provider and the patient if the encounter itself is medically necessary.** You no longer need to include a template explaining the additional necessity for a home visit within your documentation; however, practices are still going to care for the population that needs the care most and aligns with your organization's mission or unmet community need.

Some examples of when I would see medical necessity denials – one red flag is if you are seeing all of your patients on the same visit frequency. Visits should be personalized to each individual patients' needs. Generally, if you are going out and making a house call, you can make a case for the high-quality care you're providing by documenting the complexity and complications for caring for these patients, which helps support your medical decision making and supports the necessity of the visit. Be sure to document all the work you do, and each patient's unique risks and complexity to support the visit. Do not use an across the board blanketed visit frequency.

Q) We see all our discharges within 7 days, can we bill high complexity based on that? Or is it based on MDM?

A: It is based on both. If you are within the 7 days, that is great, but you also need to meet high medical decision making/complexity to support CPT code 99496. If you're not familiar with an audit or education tool that reviews how MDM is calculated, I would suggest reviewing how MDM is scored. Three elements determine MDM – 1) the number of diagnosis and treatment options, 2) the amount and/or complexity of data reviewed, and 3) the overall risk of complications and/or morbidity or mortality using the table of risk.

Some examples of gaining credit for the amount of data reviewed is documenting if you ordered or reviewed labs or diagnostic testing, if you had to speak with someone other than the patient to obtain history, or if you discussed treatment with another healthcare professional involved in care for the patient.

House call patients are complex and typically have at least 4 chronic conditions, so by listing each chronic condition in your assessment and plan and documenting your specific clinical judgment and treatment plan for each condition, that leads to credit for the number of diagnoses and treatment options.

First Coast has an interactive E/M worksheet, which is another great resource to understand how the overall level of service is appropriately determined.

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Q) What advanced coding opportunities is Dr. Chiang currently utilizing in his practice? Was it difficult to implement these?

A: Currently, Dr. Chiang is billing for prolonged services before and after a face to face visit (CPT code 99358). There were some initial challenges with the templates being used, and per an auditor's suggestions, updates were made and are now supported. You need to document start and stop times of the non-face-to-face work. You cannot include time reviewing your own personal notes – however, this service works well for new patients that may require extensive medical record review. Patients tend to be frail, complicated, and need ongoing care. My updated template includes past medical history, relevant data, relevant laboratory studies that were reviewed, imaging that was reviewed, pathology results, cardiac studies reviewed, EKG, list of some of the providers that have been involved with the patient. Include names and treatment notes relevant to your prep work for the visit. We also bill for Advance Care Planning (CPT 99497), Anticoagulation Management (93793), and home health certifications and recertifications (G0180 & G0179).

Q) For 99358, if you prepopulate your note, how do you bill for it?

A: You would bill 99358 on the same claim as the face-to-face visit it's related to. It is going to be situational based on your current billing structure and how that works. You may use a non-face to face encounter, then once the face to face visit occurs, you bill those visits out together or select the charge capture option and route it to your billing department to bill out on the appropriate claim. The billing process is something you can work with your billing department or whoever handles billing in your practice to determine the best process for you. You do need to make sure that face to face visit happens to bill 99358. In any EMR, you are going to have a charge capture option.

Q) Startup house call and telemedicine practice, what are some of the common codes that they will use?

A: HCCI is here to help and be a resource. Be familiar with the home visit codes and the domiciliary code requirements, think about the care management opportunities, whether CCM or technology-based services that you may be able to take advantage of. There are new opportunities for remote patient monitoring; although reimbursement is limited, it does add up. House call patients require significant care management and non-face to face work, be sure you are using the right opportunity to be reimbursed for your time. I'd also suggest working with your EHR vendor to personalize templates and MACROs to promote efficiency. Get familiar with what features may be available to save you time, such as favorite buttons that can also assist in reducing the amount of stress and documentation to capture and get appropriately paid for your work.

Q) Are there any updates on EPIC assisting with scheduling?

A: HCCI is participating in an expert panel with an objective to develop a Home-Based Primary care module within Epic. This is very exciting work, although currently, Epic does not plan to include a scheduling feature. On our HCCIntelligence webinar page, you can find archived materials from a webinar we have on geographic scheduling, which may be beneficial.