CPAs & ADVISORS

experience **access //**

CODING AND DOCUMENTATION INTEGRITY IN CRITICAL ACCESS HOSPITALS – AUGUST 25, 2016

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OBJECTIVES

- Health Care-Acquired Conditions (HCAC) and Impact
- Chronic Care Management
- Medicare Wellness Visits
- Advanced Care Planning
- Documentation and Compliance
- Final Thoughts

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

- Critical Access Hospitals are *not* Subject to Hospital Acquired Conditions (HAC) under *Medicare's* Inpatient Prospective Payment System (IPPS)
- Missouri Critical Access Hospitals *are* Subject to Missouri *Medicaid's* Health Care-Acquired Conditions (HCAC)
- Missouri Critical Access Hospitals are also Subject to Medicaid Payment Adjustments for Provider-Preventable Conditions or "Never Events"

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

// Provider Preventable Conditions Falls Under the Umbrella of the HCACs (Category 2)

- For Any Healthcare Setting
- Wrong Surgical Procedure Performed on a Patient
- Surgical Procedure Performed on Wrong Body Part
- Surgical Procedure Performed on the Wrong Patient

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

In accordance with the *Federal Register, Vol. 76, No. 108,* dated June 6, 2011, HCACs for state Medicaid agencies apply only to the inpatient hospital setting and are defined as the full list of Medicare's Hospital-Acquired Conditions, with the *exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients.* *Effective July 1, 2012*

HCACs are defined as "conditions that could reasonably have been prevented by the health care establishment, as well as through implementation of appropriate policies, procedures and protocols by a hospital" – MO Dept. of Social Services, Provider Bulletin, Volume 34, Number 29, May 31, 2012

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

// Present on Admission (POA) Indicator Reporting

Required to report all inpatient diagnosis codes to the MO HealthNet Division (MHD). The HCAC diagnosis code and corresponding POA indicator must be populated within the first five (5) diagnosis positions on the claim.

For a complete listing of Medicare's hospital acquired conditions, go to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

// To find the list of International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) codes on the POA exempt list, refer to http://www.cms.gov/Medicare/Coding/ICD10/Downloads/Detailed-List-of-Codes-Exempt-from-POA.zip on the CMS website

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

Valid POA Indicator Values:

Y = Yes, present on admission

N = No, not present at time of IP admission

U = Unknown, documentation is insufficient

W = Clinically undetermined, provider unable to determine whether present on admission or not

POA defined – Present at the time the order for inpatient admission occurs. Conditions that develop during a previous outpatient encounter prior to admission (ER, observation, OP surgery) are considered POA.

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

// Claims that have HCACs billed with a “N” (not present on admission) in the POA indicator are subject for post-pay review

// Upon review, claims with reported HCACs may be reduced or payment recouped

// May self-report on claims the “non-covered” days or the days when the HCAC occurred or was still being treated

HEALTH CARE-ACQUIRED CONDITIONS (HCAC) AND IMPACT

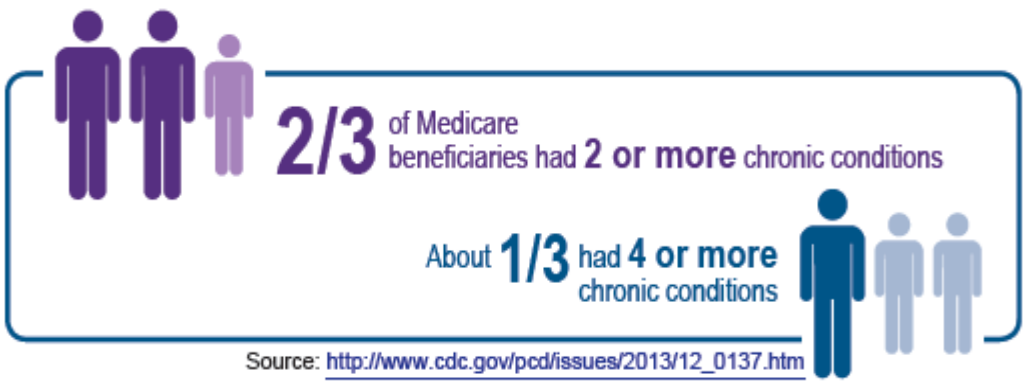
// IMPACT AND WHAT TO DO

1) Reimbursement
2) Penalties
3) Timely appeals
4) Coding POA correctly is imperative
5) Following correct coding guidelines is imperative
6) Physician documentation, specific, is imperative

CHRONIC CARE MANAGEMENT

POPULATION HEALTH – WHY CHRONIC CARE MANAGEMENT?

- CMS recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.



- According to the Center for Disease Control (CDC), about 2/3 of Medicare beneficiaries – 117 million people – have 2+ chronic diseases.

- Focusing on patients with 2 or more chronic conditions by providing CCM services can help improve their health care quality and reduce cost.

[1]Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. Prev Chronic Dis. 2014;11:130389.
[2]Centers for Disease Control and Prevention. Death and Mortality. NCHS FastStats Web site.http://www.cdc.gov/nchs/fastats/deaths.htm. Accessed December 20, 2013.
[3]Robert Wood Johnson Foundation. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation; Accessed December 23, 2013.

CCM CARE APPROACH

According to CMS, providing chronic care management to beneficiaries with multiple chronic conditions requires a multidisciplinary care approach that can be implemented in any setting

WHO IS ELIGIBLE TO BILL FOR CCM?

- Physicians
- Certified Nurse Midwives
- Clinical Nurse Specialists
  - Note: are not eligible core providers in a RHC setting
- Nurse Practitioners
- Physician Assistants

CCM SCOPE OF SERVICE REQUIREMENTS

- Must be initiated during an annual well visit (AWV), Initial Preventive Physical Exam (IPPE) or comprehensive E/M visit that is billed separately
- Provider cannot bill for CCM services unless he/she secures a written consent from beneficiary

MEDICARE BENEFICIARY CONSENT

- Beneficiary must acknowledge provider has explained (list not all inclusive)
  - CCM program
  - Manner in which CCM services will be provided
  - Health information will be shared with other practitioners
  - Only one practitioner can provide these services during a calendar month
  - Beneficiary has right to stop CCM services at any time

// Patient consent form(s) should include how to revoke service

CCM SCOPE OF SERVICE REQUIREMENTS

- At least 20 minutes of non-face-to-face care management services must be provided in a calendar month
- Non-face-to-face services are provided by ancillary staff
  - Under ***general supervision*** *in a non-RHC or non-FQHC setting*
  - Under ***direct supervision i****n a RHC or FQHC setting*
  - **2017 MPFS proposed rule** – will allow services to be provided under general supervision in the RHC or FQHC setting

NON-FACE-TO-FACE SERVICE DOCUMENTATION

- Documentation must include
  - Date & time
  - Person furnishing services
  - Description of services
    - //Performing medication reconciliation, oversight of beneficiary self-management of medications
    - //Ensuring receipt of all recommended preventive services
    - //Monitor beneficiary's condition (mental, physical & social)

CCM OVERVIEW

- CCM Patient agreement requirements
  - Structured data recording
  - Electronic care plan
  - Access to care management services 24/7
  - Management of care transitions
  - Coordination & sharing of patient information with other providers
- Medicare patients will be charged a coinsurance for CCM services

COMPREHENSIVE CARE PLAN

- Create a patient-centered care plan based on physical, mental cognitive, psychosocial, functional & environmental (re)assessment & inventory of resources (a comprehensive plan of care for all health issues)
- Provide patient with a written or electronic copy of care plan & document its provision in medical record
- Ensure care plan is available electronically at all times to anyone within practice providing CCM service
- Share care plan electronically outside practice as appropriate

CCM CERTIFIED TECHNOLOGY

- Requires use of certified EHR technology to satisfy many CCM scope of service elements
- Technology used to furnish CCM services beginning on January 1, 2016, would be required to meet, at a minimum, requirements included in 2014 certification criteria edition(s)
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

CCM TECHNOLOGY REQUIREMENTS

- Provider must be able to transmit summary record for purposes of care coordination
- House beneficiary consent of CCM services
- House beneficiary receipt of care plan
  - Must have ability to provide a copy to beneficiary
- Document communication to & from home-based & community-based providers
- Plan must be accessible 24/7 to all care team members & other providers caring for beneficiary

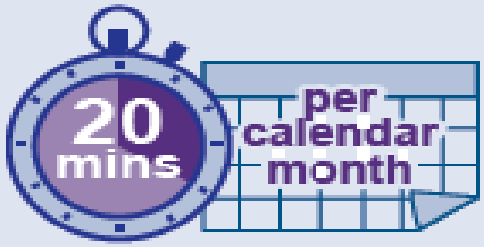
CCM BILLING & CPT CODE REQUIREMENTS

Chronic Care Management (CPT 99490)

According to the CMS Chronic Care Management Fact Sheet, CPT 99490 is defined as

99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, 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.

CCM BILLING & CPT CODE REQUIREMENTS

- Codes/services that cannot be reported during same month as CCM
  - Transitional care management (CPT codes 99495 - 99496)
    - // TCM & CCM services may be provided in same calendar month if furnished service periods do not overlap
  - Home health & hospice care supervision (HCPCS codes G0181 - G0182)
  - End-stage renal disease service (CPT codes 90951 - 90970)
  - Overlap with CMS demonstration or other initiatives that pay for similar services

2016 CMS PAYMENT

- Payment for CCM services will be “based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services”
- Rate will be updated annually
- No geographic adjustment
- Coinsurance & deductible apply
- **2016 payment rate = $40.82**

ADVANCED CARE PLANNING

WHAT IS ADVANCED CARE PLANNING (ACP)?

- Making advanced plans for patient-desired care when facing a serious illness
- Discussions between patients & providers about
  - Future care decisions that may need to be made
  - How beneficiary can let others know about care preferences
  - Explanation of advance directives & other legal documents
  - May also involve completion of standard forms

ADVANCED CARE PLANNING

- Care decisions may include, but not be limited to
  - Choosing or refusing diagnostic testing, invasive procedures &/or medication
  - Whether to perform or continue life-sustaining treatment
  - Stating who is allowed to make care decisions when patient cannot

ADVANCED CARE PLANNING – COVERAGE & BILLING

- Effective January 1, 2016, ACP will be a stand-alone billable visit
  - CPT code 99497
- Performed by a physician or qualified health professional
  - Physician
  - Nurse Practitioner
  - Physician Assistant

ADVANCED CARE PLANNING – COVERAGE & BILLING

- ACP services may be furnished on same day as another billable medical visit
  - Coinsurance & deductible will apply
  - Paid under AIR in RHC setting
  - Paid under fee schedule in non-RHC setting
- In the RHC setting, ACP services may be furnished on the same day as an Annual Wellness Visit (AWV)
  - Only one AIR will be paid and coinsurance/deductible waived

ADVANCED CARE PLANNING – RHC BILLING EXAMPLE

ACP Furnished as a Stand-alone Billable Visit

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
52x	99497	01/01/2016[1]	1	$XX.XX[2]	AIR	Yes

[1]Any date of service on or after 1/1/2016

[2]Enter charge amount

ADVANCED CARE PLANNING – BILLING EXAMPLE

ACP Furnished as Part of an AWV

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
52x	G0438 or G0439	01/01/2016[1]	1	$XX.XX[2]	AIR	No
52x	99497	01/01/2016[1]	1	$XX.XX[2]	Included in the AIR	No

[1]Any date of service on or after 1/1/2016 through 3/31/2016

[2]Enter charge amount

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

- The goal of the IPPE, which includes an optional electrocardiogram (EKG), is health promotion and disease detection and includes education, counseling and referral to screening and preventive services also covered under Medicare Part B

IPPE REQUIRED COMPONENTS

- The IPPE consists of the following seven components:
  1. A review of an individual's medical and social history with attention to modifiable risk factors
  2. A review of an individual's potential (risk factors) for depression
  3. A review of the individual's ability and level of safety

IPPE REQUIRED COMPONENTS

4. An examination to include an individual's height, weight, blood pressure measurement, visual acuity screen and body mass index, optional performance of and interpretation of an EKG
5. End-of-Life Planning
6. Education, counseling & referral based on the results of the review and evaluation services described in the previous five elements

IPPE REQUIRED COMPONENTS

7. Education, counseling & referral, including a brief written plan such as a checklist for obtaining the appropriate screening and/or other preventive services

The codes for billing the IPPE and the screening EKG are below:

HCPCS Code	Code Descriptor
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report
G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

IPPE PAYMENT

- Both deductible & copay are waived for the IPPE
- Payment is made at the all inclusive rate (AIR) in RHC setting
- Payment is made under 100% of allowance in the non-RHC setting

ANNUAL WELLNESS VISITS (AWV)

AWV CRITERIA

- Benefit allows for an initial AWV and subsequent wellness visits annually
- Coinsurance and deductible are not applicable
- Initial AWV must occur after the initial 12 months of Medicare eligibility (during which the IPPE should be performed)
- Subsequent AWV can take place 12 months after the initial AWV and so forth

AWV CRITERIA

- HCPCS codes:
  - **G0438 (Initial) and G0439 (Subsequent)**
- RHCs will report according to detailed billing guidelines
- May be performed in addition to a medical E/M encounter on the same date of service

Reference: CMS, MLN Matters, MM7079

AWV ELIGIBLE PROVIDERS

- Physicians
- Non-physician practitioner
- Medical professional or a team of such medical professionals, working under DIRECT supervision of an eligible physician
- *NOTE: In the RHC, a RN may record data under direct supervision but **may not** perform the entire service and/or report a billable encounter if performed without physician participation*

AWV – INITIAL CRITERIA

- Medical/family history
- A working list of current providers and suppliers that are regularly involved in the patient's care
- Measurement of height, weight, BMI (or waist circumference), BP, and other routine measurements as appropriate
- Detection of cognitive impairment
- Review of potential risk factors for depression
- Review of functional ability and level of safety based on direct observation
- A written screening schedule and list of risk factors and conditions for which interventions are recommended or are underway
- Provision of referrals to health education or preventive counseling

ACP PERFORMED AS PART OF AN ANNUAL WELLNESS VISIT

- Voluntary advanced care planning (ACP) may be performed an optional part of the AWV
- Report CPT 99497 (First 30 minutes)
- CPT 99498 for each additional 30 minutes

Reference: CMS, MLN Matters MM9271

AWV - SUBSEQUENT

- Must include all of the required elements from the initial visit
- The provider must update the written screening schedule
- The provider must update the list of risk factors and conditions and recommended interventions

AWV HEALTH RISK ASSESSMENT

- Initial and subsequent visits will need to include completion of a Health Risk Assessment (HRA)
- Must be completed prior to the visit (by the patient) or during the encounter (with the RN or provider)
- Will be updated at each subsequent visit
- Will include list of all prescription and OTC medications
- Form is not currently developed by Medicare. Providers should develop a form that is user friendly, can be completed on paper or electronically

Reference: CMS-1524-FC, Page 738

HRA COMPLETION

- Collection of self-reported information
- Can be administered independently by the patient or with the assistance of a nurse or provider during the encounter
- Is tailored to communicate the needs of any underserved populations, persons with limited English proficiency, and/or persons with health literacy needs

Reference: CMS-1524-FC, Pages 745-746

HRA COMPLETION

- Should take no more than 20 minutes to complete
- Addresses at a minimum:
  - Demographic data (i.e., age, gender, race, ethnicity)
  - Self assessment of health status, frailty, and physical functioning
  - Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue
  - Behavioral risks (i.e., tobacco use, physical activity, nutrition, oral health, alcohol consumption, etc.)

HRA COMPLETION

- Activities of daily living
  - Dressing, feeding, toileting, grooming, ambulation, balance/risk of falls, and bathing
- Instrumental activities of daily living (ADLs)
  - Shopping, food preparation, using the telephone, housekeeping, laundry, taking medications, handling finances, etc

Centers for Disease Control and Prevention (CDC), Interim Guidance for Health Risk Assessments and their Modes of Providion for Medicare Beneficiaries

DEPARTMENT OF HEALTH AND HUMAN SERVICES • Centers for Medicare & Medicaid Services

PREVENTIVE SERVICES

HTTP://WWW.CMS.GOV/MEDICARE/PREVENTION/PREVNTIONGENINFO/DOWNLOADS/MPS_QUICKREFERENCECHART_1.PDF

SELECT A SERVICE FOR CODES AND BILLING INFORMATION

Alcohol Misuse Screening & Counseling	Annual Wellness Visit
Bone Mass Measurements	Cardiovascular Disease Screening Tests
Colorectal Cancer Screening	Counseling to Prevent Tobacco Use
Depression Screening	Diabetes Screening
Diabetes Self-Management Training	Glaucoma Screening
HBV Vaccine & Administration	Hepatitis C Virus Screening
HIV Screening	Influenza Virus Vaccine & Administration
Initial Preventive Physical Examination	IBT for Cardiovascular Disease
IBT for Obesity	Lung Cancer Screening
Medical Nutrition Therapy	Pneumococcal Vaccine & Administration
Prostate Cancer Screening	Screening for STIs and HIBC to Prevent STIs
Screening Mammography	Screening Pap Tests
Screening Pelvic Examinations	Ultrasound Screening for AAA
Frequently Asked Questions	Resources
Disclaimers	Open & Print All Services

Some of the services listed include codes that you may provide via telehealth – this symbol designates these services.

This educational tool provides the following information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare). For additional guidance on the use of diagnoses codes, go to Pub. 100-04 Claims Processing Manual, Chapter 18.

ICN 006559 October 2015

MEDICARE PREVENTIVE RESOURCES

- Interactive Preventive Services Tool
  - https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- IPPE
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf
- AWV
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

DOCUMENTATION AND COMPLIANCE

CLINICAL DOCUMENTATION IMPROVEMENT AND INTEGRITY

- Clinical Documentation Improvement (CDI)
  - "A service that Physicians can use to help their quality of care-not how they provide it, but how they project it (in their documentation)."

Reference: Association for Clinical Documentation Improvement Specialists (ACDIS)

WHY IS DOCUMENTATION SO IMPORTANT?

- Compliant documentation supports the complexity of work performed or acuity of illness treated
- Supports and drives “medical necessity”
- Detailed clinical documentation
  - Improves quality data reporting
  - Supports length of stay
  - Prepares your organization for pay for performance models
  - Supports coding and charge capture

MEDICAL NECESSITY DEFINED

- "Services or procedures that a prudent physician would provide to a patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is:
  - In accordance with the generally accepted standard of medical practice.
  - Clinically appropriate in terms of frequency, type, extent, site and duration.
  - Not for the intended or the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider."

Reference: American Medical Association

MEDICAL NECESSITY DEFINED

- "No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Reference: Title XVIII of the Social Security Act, Section 1862 (a) (1) (a)

DOCUMENTATION REMINDERS

- Indication of medically necessary evaluation and treatment of the coded sign, symptom or condition
- Status or severity of acute or chronic conditions
- Association with diagnostic results
- Causal statements
- Progress of treatment, response to treatment, any changes to treatment on date of service or throughout episode of care
- Specific to each date of service for professional service coding

ELECTRONIC MEDICAL RECORD AREAS OF RISK

- Cloned notes
- “Inflated” documentation
- Signatures without credentials
- Contradictions in documentation
  - HPI states -
    - “Patient presents with shortness of breath and chest pain”
  - Review of systems negates this by stating –
    - “Respiratory – negative for SOB”

FINAL THOUGHTS

// **New and Revised Place of Service (POS) Codes for Professional Claims to Identify Where Services Were Rendered**

CR Transmittal #: R3315CP, Effective January 1, 2016

- Add new POS code 19 for “off-campus hospital provider based department” and revise language for POS code 22 from “outpatient hospital to “on campus-outpatient hospital”

FINAL THOUGHTS

// Mandatory Facility Reporting of Modifier – PO, January 1, 2016

Indicates services, procedures and surgeries provided at off-campus provider based outpatient departments.

This modifier is to be reported with every HCPCS code for outpatient hospital services furnished in an off-campus provider-based department of a hospital.

CMS will capture information related to the services provided in off-campus, provider-based departments and the effect on payments and patient cost-sharing

FINAL THOUGHTS

- Explore the opportunities for providing CCM, ACP or other Medicare preventive services
- Implementation and maintenance of an environment of compliant clinical documentation is a team effort
  - Physicians, Non-Physician Practitioners
  - Clinical Documentation Improvement team
  - Administrative support
  - Coding Department
- Internal and external audits are recommended for monitoring and training

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DISCLOSURE

Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.

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