Get credit from CMS for the excellent patient care you already provide

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Objectives

- Medicare wants you to perform high-value services, incentivizes this with wRVUs.
- Understand availability of codes to get paid for what you already do
- Understand documentation needs for billing for services - “Sufficient documentation is the key to proper payment” - CMS

Disclaimer : we are not certified coders but we use these codes every day
Question

67YOF who enrolled in Medicare 6 months ago, presents for “annual exam”. She needs refills on her atorvastatin, metformin and lisinopril. She would like to discuss gradually progressive knee pain, which you evaluate, diagnose as probable osteoarthritis, order knee XR to confirm, and refer to PT. Possible wRVU for this visit:

A. Preventative (1.5) + 99214 (1.5) = 3
B. Preventative (1.5) = 1.5
C. Preventative (2.43) + 99214 (1.5) = 3.73
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C. Preventative (2.43) + 99214 (1.5) = 3.73
Billing Tips AWV

- IPPE, IAWV, SAWV - do not include any physical examination, labs.
- Any acute or chronic problem evaluation is an add-on E&M (hence add on 99212-99214)

<table>
<thead>
<tr>
<th>Service</th>
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<th>wRVU</th>
<th>Description</th>
<th>Coverage Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPPE - “Welcome to Medicare” exam</td>
<td>G0438</td>
<td>2.43</td>
<td>Includes a personalized prevention plan of service (PPS), initial visit</td>
<td>w/i 12 months of Medicare enrollment</td>
</tr>
<tr>
<td>IAWV G0402 SAWV G0439</td>
<td></td>
<td></td>
<td>Includes a personalized prevention plan of service (PPS), subsequent visit</td>
<td>After 12 months of Medicare enrollment</td>
</tr>
</tbody>
</table>
Medicare Annual Wellness Visit

What must be included:

- Health Risk Assessment (self-reported)
- Establish PMHx, FHx
- Current list of providers
- PE: Height, weight, BMI, BP, other per Med Hx
- Assess cognitive function - direct obs, caregiver report
- Screen for depression, other mood disorders
- Assess fall risk, ability to perform ADLs, home safety, hearing impairment
- Give written screening schedule for 5-10y
- Establish list on basis of above for which interventions are indicated
- Referral to community resources, education and counseling services (fall prevention, nutrition, physical activity, etc.)
- Discuss, at pt discretion, advanced care planning


ACP Tools for the Annual Wellness Visit

The following forms and templates can be customized for use in your practice:

- Practice Checklist
- Health Risk Assessment:
  - View a paper version
  - View an electronic version from HowsYourHealth.org
- Women’s Prevention Plan
- Men’s Prevention Plan
- Adult Health Maintenance Form
- Advanced Care Planning

Patient Handouts

- Patient FACTS
- Patient Letter and Checklist

https://www.acponline.org/practice-resources/business-resources/payment/medicare-payment-and-regulations-resources/how-to-bill-medicare’s-annual-wellness-visit-awv
Add-on counseling services to AWV - there are many!

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
Question

69YOF presents for “Medicare Annual”. She is a current smoker, 40 pk-y smoking history. She also has CAD and h/o coronary stent placement. You discuss tobacco cessation - she is pre-contemplative. However, when you discuss annual low dose CT Chest for lung cancer screening, she is very interested in pursuing this. You bill for this as:

A. General counseling
B. Tobacco cessation
C. Tobacco cessation + Lung cancer screening counseling
D. No additional billing, considered part of AWV.
Question

69YOF presents for “Medicare Annual”. She is a current smoker, 40 pk-y smoking history. She also has CAD and h/o coronary stent placement. You discuss tobacco cessation - she is pre-contemplative. However, when you discuss annual low dose CT Chest for lung cancer screening, she is very interested in pursuing this. You bill for this as:

A. General counseling
B. Tobacco cessation
C. Tobacco cessation + Lung cancer screening counseling (additional 0.24+0.52 = 0.76 wRVU)
D. No additional billing, considered part of AWV.
Billing Tips lung cancer screening

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<tr>
<td>Lung Cancer Screening Counseling</td>
<td>G0296</td>
<td>0.52</td>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT</td>
<td>Annually for pts age 55-77y, 30-pk-y smoking history, current smoker or quit within last 15y.</td>
</tr>
</tbody>
</table>

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#LUNG_CAN
“Patient meets the following categories, has received counseling from me and participated in shared decision making to proceed with annual LDCT for lung cancer screening:

- Aged 55 through 77
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Current smoker or one who has quit smoking within the last 15 years”
Billing Tips Counseling - Tobacco cessation

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<tr>
<td>Tobacco Cessation Counseling, Intermediate</td>
<td>99406</td>
<td>0.24</td>
<td>Smoking and tobacco-use cessation counseling; 3-10min</td>
<td>2 cessation attempts; each attempt can have 4 sessions. Code with F12.2XX nicotine dependence</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling, Intensive</td>
<td>99407</td>
<td>0.50</td>
<td>Smoking and tobacco-use cessation counseling; &gt;10min</td>
<td>As above</td>
</tr>
</tbody>
</table>

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#LUNG_CAN
Best Practices - Tobacco Cessation counseling

“At least 3 min spent in face to face counseling regarding tobacco cessation. Patient currently smokes 1PPD, and is pre-contemplative regarding quitting. She has tried NRT in the past without success. At this time, she is not interested in medications to help with smoking cessation. Will recheck readiness for change at future visits.”
Best Practices - Obesity management counseling

“At least 15 min spent in face to face counseling regarding patient’s obesity. We discussed the following plan:

Nutrition plan/goal:
Exercise plan/goal:
Medications or surgery for weight loss:
Referral to therapy for eating behaviors:
Other referrals:
Follow-up: x lbs wt loss in 4 weeks “
# Billing Tips Counseling - Obesity

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<tr>
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<tbody>
<tr>
<td>Obesity Counseling</td>
<td>G0447</td>
<td>0.45</td>
<td>Behavioral counseling for obesity, 15min</td>
<td>BMI ≥ 30. Bill with both Z code for specific BMI and E66.01 code for obesity</td>
</tr>
</tbody>
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https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#LUNG_CAN
You are scheduled to see a patient who has CHF and type 2 diabetes, both of which are sub-optimally controlled. She has both Medicare and Medicaid insurance. The team RN has been working with her on insulin and diuretic management and spending about 15 minutes every week on the phone with her. She has a documented care plan in the chart and you are in close contact with her endocrinologist and cardiologist. Are there available CPT codes to reimburse the non-face-to-face care this patient receives?
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Yes, this patient is likely eligible for Chronic Care Management Services.
# Chronic Care Management

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Requirements</th>
<th>wRVUs</th>
</tr>
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<tbody>
<tr>
<td>99490</td>
<td>20 min care management by care team</td>
<td>0.61</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM - 60 min timed service by care team, mod-high MDM</td>
<td>1.00</td>
</tr>
<tr>
<td>99489</td>
<td>Each additional 30 min care management by care team</td>
<td>0.50</td>
</tr>
<tr>
<td>99491</td>
<td>CCM services provided personally by physician or APP &gt;/= 30 min</td>
<td>1.45</td>
</tr>
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CCM Pearls

- Consent
- Copays
  - Medicaid and Medicare supplements generally will cover the 20% cost sharing and patients with these plans will not get charged
- Time tracking
- CCM components
  - Comprehensive Care Plan
  - Certified EHR
  - Access and continuity
  - Comprehensive care management
  - Management of care transitions
Table 1. CCM Service Summary

Initiating Visit – Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services.

Structured Recording of Patient Information Using Certified EHR Technology – Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.

24/7 Access & Continuity of Care

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients/caregivers with means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments

Comprehensive Care Management – Care management for chronic conditions including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

Comprehensive Care Plan

- Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
- Must at least electronically capture care plan information and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient’s care.
- A copy of the plan of care must be given to the patient and/or caregiver.

Management of Care Transitions

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers
Proposed Changes in Physician Fee Schedule - CCM

- Principle Care Management (PCM)
- Complex Chronic Care Management (CCCM)
A patient is scheduled with you following hospital discharge 5 days ago for community acquired pneumonia. The team RN called the patient day after discharge and reviewed medications and functional status. You review the discharge summary and find admission was uneventful and the patient improved quickly on antibiotics. During the visit, the patient feels much improved. What CPT code should you use to bill this visit?

A. 99213
B. 99214
C. 99495
D. 99496
Question

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A. 99213
B. 99214
C. 99495
D. 99496
Transitional Care Management

- Total costs of care and mortality were significantly lower in patients who received TCM services compared to those who did not in the 31-60 days following discharges.
- TCM services billed in 3.1% eligible discharges in 2013, 5.5% in 2014 and 7.0% in 2015.

Source: Bindman AB and Cox DF. Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries. JAMA Internal Medicine. 2018; 178:1165-1171
## Transitional Care Management

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Requirements</th>
<th>RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>Initial contact within 2 business days of discharge and face-to-face visit within 14 days of discharge, at least mod MDM</td>
<td>2.11</td>
</tr>
<tr>
<td>99496</td>
<td>Initial contact within 2 business days of discharge and face-to-face visit within 7 days of discharge, high MDM</td>
<td>3.05</td>
</tr>
</tbody>
</table>

TCM Pearls

- Patients eligible for TCM services who have been discharged from hospital (inpatient or observation) and/or SNF
- Patients receiving CCM, home health services with care plan oversight (G0181), hospice services and ESRD currently not eligible for TCM
- Patients readmitted within 30 days of initial discharge not eligible for TCM services (charges held until 30 days post-discharge)
- Initial contact is generally a phone call - often by RN - reviews medications and functional status within 2 business days of discharge
  - If visit within 2 days of discharge, no phone call needed
  - If patient is contacted twice but not reached, can still bill TCM for visit (make sure attempts documented!)
- TCM services can be billed via telehealth visit
Proposed Changes in Physician Fee Schedule - TCM

- Proposed wRVU increase to 2.36 (from 2.11) for 99495 visit
- Expanded eligibility - home health services with care plan oversight (G0181), hospice services and ESRD
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<tr>
<td>Annual Wellness</td>
<td>G0438</td>
<td>2.43</td>
<td>Welcome to Medicare, IPPE Initial AWV</td>
<td>Medicare, 1st visit 1st AWV</td>
<td>Z00.01 - Encounter for well adult exam with abnormal findings</td>
</tr>
<tr>
<td></td>
<td>G0402</td>
<td>2.43</td>
<td></td>
<td>1st AWV Subsequent AWV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G0439</td>
<td>1.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Ca screening</td>
<td>G0296</td>
<td>0.52</td>
<td>Counseling + shared decision making, lung cancer screening</td>
<td>Annual, 55-77yo, &gt;/= 30 pk-yr smoking hx, current/ quit in last 15 yr</td>
<td>Z87.891 Personal hx of nicotine dependence</td>
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<td>Tobacco cessation</td>
<td>99406</td>
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<td>TCM</td>
<td>99495</td>
<td>2.11</td>
<td>14 day f/u, mod/high MDM</td>
<td>Inpt, obs or SNF discharge; not eligible if readmit within 30 days</td>
<td>(discharge dx(s))</td>
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<td></td>
<td>99496</td>
<td>3.05</td>
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<td>20 min care management</td>
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Work with your coding team to create auto-texts which satisfy documentation needs for billing for these services
Recap and questions