Quality Insights
Quality Payment Program Support Center

Medical Record Documentation and Billing for Care Coordination and Preventive Medicine
Transcript from Live Session

Thursday, March 7, 2019

Laurie Fink: Good afternoon, everyone, and welcome to today's webinar, Medical Record Documentation and Billing for Care Coordination and Preventive Medicine. My name is Laurie Fink, and I'm the communications specialist for Quality Insights, and I will be serving as the behind the scenes host for today's session. We're so glad you are able to join us today, and for those of you watching the recording right now, welcome. Now, we will get started in just a few moments, but I'd like to first review a few housekeeping items. All participants enter today's webinar in a listen-only mode, so all lines are currently muted. Should you have a question during the presentation, we ask that you please submit it via the Q&A box on the right of your screen. We will be addressing questions throughout today's presentation, and also at the end as time allows.

Laurie Fink: Today's webinar is being recorded. The recording, along with the slide deck and a transcript of the session, will be posted on the Quality Insights website, as well as the Quality Insights QPP Support Center website, as soon as possible. These resources can be found on the Archived Events page. I will go ahead and post those links in the chat for you, so you can easily access those resources. Today's presenters, first we'll lead off with Monica Wright. She joins us from Medical Revenue Cycle Specialist, and has over 20 years' experience in medical coding, billing, and practice management. She's taught medical coding and billing at the community college level, and continues to teach physicians, managers, and staff of private medical practices and within hospital settings, and holds multiple certifications.

Laurie Fink: Also joining us later on in the presentation is Kem Tolliver. Kem has been providing strategic and operational leadership to medical practices and hospitals for over 20 years. Kem is the president of Medical Revenue Cycle Specialists, which is an organization that leads healthcare organizations in practice management and RCM improvements, coding, training, and education, payer contracting, EMR optimization, and new practice startup. So, without further ado, I will now hand over the presentation to Monica.

Monica Wright: Thanks, Laurie. Just to get started, here are ... Laurie was kind enough to introduce us, but this would be me and Kem, as she just discussed. In this presentation, we're going to go over several different topics, starting with our Medicare preventative visits, the annual wellness visits, the advanced care planning, chronic care management, transitional care management, and tele health. So there's a lot of information to be covered. We'll stop for questions at the end of each type of visit, so that if you have anything that has to do with annual wellness visits, you'll have a chance to answer early on so you don't forget as we move in through the other topics. But as Laurie said, we will take questions at the end on everything as well.

Monica Wright: Let's start off with the Medicare wellness visits, starting with the first one, the initial preventative physical exam, or IPPE. You may be more familiar with this as the Welcome to Medicare visit. This is the first visit that the Medicare beneficiary is allowed within the Medicare program, and it is a physical exam of sorts, but is not to be confused with a routine physical. Medicare never has and never will pay for a routine physical, so there is an exam component and we'll talk about in a minute, but it's not a physical that you would think of that you do with your private insurances with your other patients. There are a couple of codes that can be billed for this initial preventative physical exam.

Monica Wright: The GO402 is the exam itself, and then you are also allowed to bill an electrocardiogram in addition to the visit. Some of the codes there vary with whether or not it's the test and interpretation, the test only, or the interpretation only. Now, this code is covered once per lifetime, and it must be performed within the beneficiary's first year of Medicare eligibility. So if you miss that first 12 months, then it goes straight to the annual wellness visits. They don't get the IPPE anymore, so it has to be in that beginning of the Medicare coverage. Any diagnosis can be used along with this code, as long as it's consistent with the exam that you performed. So in this case, they will allow for those preventative codes that normally you would not bill to Medicare if there's nothing else going on with the patient. But because of some of the screenings that you're doing, there may come a diagnosis that makes more sense, and you can use the diagnosis that's appropriate to the patient.

Monica Wright: What goes into this IPPE, this Welcome to Medicare visit? What do you have to document? First, it's a review of medical and social history, and preventative services education. So you're going to get some information from the patient, and this may be done with a questionnaire that you give the patient and take the information from there. It can be done in a face-to-face conversation, but you're going to try to get the medical and surgical history, the current medications, family history, their use of alcohol, tobacco, and drug abuse, their diet, their amount of physical activity, if there's any opioid use.

Monica Wright: Again, we're tracking risk factors. What does the patient's health history look like up to this point? Then you're going to do a depression screening, and you can use any appropriate depression screening tool. Here is one, an example of a PHQ-9 screening. It doesn't matter what tool you use, but as part of this visit, a

depression screening should be done. Then you're going to review the functional ability and level of safety for the patient, so this is looking at their activities of daily living. Is there any fall risk? Is there any hearing impairment? How safe is their home? Is there anything that is concerning based on where the patient's currently living?

Monica Wright: Then here is that exam. The exam for the preventative physical examination includes your measurements, so the height, weight, body mass index, and blood pressure, a visual acuity screening, and then anything else that's deemed appropriate based on the beneficiary's history. So you can do a respiratory exam if there's a history of COPD, but again, this isn't truly a routine exam, so it is specific to risk factors and things that you're finding where there may be a problem. There is no exam requirement like you're used to with your normal E&M codes, so it's not like you have to capture so many systems. It's just going to be specific to what is going on in the patient's history.

Monica Wright: The other things that are done in this initial preventative physical examination are end of life planning discussions, educating and counseling the patient based on any information that you find, and referring for preventative services. We'll go into that in a lot more detail with the advanced wellness visit, because some of these things do repeat when you get into those visits yearly. Once the IPPE is done, the next year we move into annual wellness visits. Again, I can't say it enough, this is not a routine physical. Medicare never covers routine physicals. The annual wellness visit has two codes, G0438, which is the first time the patient has the annual wellness visit. This will be in essentially their second year as a Medicare beneficiary, 365 days after the initial preventative exam.

Monica Wright: Now, when we talk about the year, when we're talking about these services, its calendar day. So if you see the patient on March 5th, 2019, you cannot bill this service again on March 3rd, 2020, because it will not have been a complete calendar year. You have to span 365 days. After that initial annual visit is done, every year thereafter you use code G0439, which is the subsequent visit of the annual wellness visit. We're going to talk about both together because the initial annual wellness visit is updating the IPPE, but also establishing some things, and then the subsequent visits should be adding onto what's been there yearly. Again, for the diagnosis, use the diagnosis that's appropriate to the patient's conditions and risk factors. There are no codes specifically that will be paid or won't be paid. It's patient-specific.

Monica Wright: The annual wellness visit, as I just stated, it's covered that once every 12 months. It is paid at 100%, as is the preventative visit, so there is no co-insurance to the beneficiary for these visits, and it is very similar to the IPPE, but again in this instance there is no exam and no ECG. Now, when you perform an annual wellness visit, a sick visit can be performed on the same day. So you can see the patient for their chronic condition visit if they're coming in every three months, every six months, and do the annual wellness visit while they're in the office, so they don't have to come back for a separate visit. If you do that, you

need to use the modifier 25, and the documentation has to be clear and separate.

Monica Wright: Like anything else with that 25 modifier, you have to have two distinct visits on that day that you can't cross. Don't try to document them together, but they are allowed to be performed at the same time. The first and biggest piece of the annual wellness visit is the health risk assessment. What's included in the health risk assessment? It's those activities of daily living, the shopping, housekeeping, managing medications, finances, dressing, bathing, walking, their psychosocial risks, the demographic data, the self-assessment of their health status, any behavioral risks. This is really taking a look at what's going on in the patient's life, and what are they going to be at risk for based on their behaviors? Things like smoking, obesity, unhealthy diet, physical activity, or any of those things leading to risk.

Monica Wright: Do they have medical conditions that could be indicators of other things, such as raised blood pressure or raised blood sugar, or abnormal blood lipids? Do they need to start on medications that maybe they haven't been on yet? It's really assessing these risk factors and trying to get ahead of the chronic conditions that a lot of our Medicare population has. Then you're going to establish or update the medical and family history. Look at their past medical history, their surgical history, the medications they've been taking, and any hereditary diseases in the family. Again, risks that come from that, things to be aware of, so you know what to look for in this population. Then you're going to establish or update the list of current providers.

Monica Wright: This should include any specialists currently participating in the patient's care, so it doesn't matter if they used to see the provider but they don't anymore. This should be any provider that is currently treating the patient. You should be indicating their last appointment, because you also want to help with the follow-up, if follow-up is needed, and be sure to include any suppliers so you're sure that they're getting any supply needs taken care of. It could be diabetic supplies. Maybe it's a supplier that's mailing things to the house. You want to be sure that they're not without, so make sure that that's also on this list. Then you're going to take the appropriate measurements. In this case, we are strictly looking at height, weight, BMI, blood pressure, anything the risks point towards that you may need to check.

Monica Wright: Again, not an exam, no certain number of exam requirements. This doesn't even have to have any exam requirements beyond what we would call constitutional, trying to get, you know, that height, weight, BMI. Then you're going to assess cognitive function for impairments. This can be done using direct observation and reports from the family. It can also be done using a cognitive assessment tool. Some of the tools that are out there that can be use are a Self-Administered Gero-cognitive Exam, the clock draw test, the simple word memory test, and access to these and other tests are on the Institute of Aging's website, which I give on this slide.

Monica Wright: Then you're going to create and update their screening schedule. One of the big reasons for the annual wellness visit is to ensure that the population is getting out for their Medicare covered screenings. This is a list of some of the things that Medicare covers on these screenings, and it's probably more than you realize. Obviously, I'm sure everyone's familiar that Medicare pays for a mammogram once every 12 months, and that they pay for a colonoscopy once every 120 months, but these are all of the different screenings that are available to the Medicare population based on the different time frames and going onto the Medicare website will tell you some of them do have certain risk factor requirements.

Monica Wright: For example, the alcohol misuse screening and counseling, there obviously has to be concern for alcohol misuse before it would be paid. But once that's established and the screening determines it to be true, then you can get four brief counseling sessions per year. Here are a few more screenings that Medicare pays for. Obviously, the flu shot, the pneumococcal shot, very important to be sure the population is getting. This is just checking to make sure that the patients are up-to-date on everything they should be screened for, is anything coming up in the risk factors that indicates another screening maybe they haven't had done, and that every year, they're getting their flu shot, things that need to be repeated.

Monica Wright: Again, in the annual wellness visit, you're going to review risk factors for depression. This is that same screening we looked at under the IPPE as an example. Again, you don't have to use this screening tool. It can be whatever screening tool the provider prefers. You're going to review the functional abilities and level of safety. Again, the fall risk, the home safety, the hearing impairments, the ability to successfully perform the ADLs, are they safe in their home? Then you need to establish and update the risk factors and conditions that are currently undergoing treatment. Be sure to include mental health conditions, any risk factors or conditions that were identified initially in that IPPE or the annual wellness visit the year before, or even their most recent office visit with you that was for a sick visit two months ago. What are the conditions that were concerned with, that are undergoing treatment, that we need to be sure are managed so that they don't exacerbate and cause additional problems.

Monica Wright: And then treatment options. Are there any additional treatment options that haven't been discussed, things that the patient needs to be aware of? Especially with the mental health conditions, if dementia is worsening, they are unable to do ADLs anymore, things of that nature, then there are treatment options that can be discussed that wouldn't necessarily be brought up in a sick visit, to get the patients to where they need to be for their own safety and security.

Monica Wright: Then you're going to provide resources for education and counseling. The resources could include fall prevention, nutrition, tobacco use cessation, weight loss, cognition, and some of this might just be counseling with the patient. Some

of it might be providing handouts. Some of it might be referring to other practitioners that can be more specialized in what they need.

Monica Wright: Then you're going to offer advanced care planning services. Advanced care planning services, it's going to be up to the patient whether or not they're going to accept this at this point in time but it's the future care decisions that may need to be made, how the beneficiary can let others know about their care preferences, identifying the caregivers that the providers know who the appropriate people are and if they're allowed to talk to them and then explanation of advanced directives, including the completion of the standard forms to indicate DNR or if they want to be a full code with CPR, whatever those preferences may be. And we'll talk about this a little more with the advanced care planning services a little later.

Monica Wright: Okay, any questions thus far about Medicare and their annual wellness visits and that welcome Medicare visit?

Laurie Fink: I'm not seeing any, Monica.

Monica Wright: Okay, then we'll move on into advanced care planning. Advanced care planning is a service that's only been available for about two years now and the code for advanced care planning includes explanation and discussion of advanced directives including completion of forms by healthcare provider first 30 minutes face-to-face with patient, family member or surrogate. Now the nice thing about these codes is although they do require a face-to-face visit, they do not require the patient to be present. Because a lot of these advanced care planning visits end up happening later on with caregivers with POAs that now need to make decisions because the patient is worsening. So those conversations that you're having with those caregivers do count towards advanced care planning. Because it's a time-based code, there are two codes. The 99497, which is the first 30 minutes; and the 99498, which is each additional 30 minutes.

Monica Wright: Now these codes are not like the annual wellness visit in that they do quire the patient to pay deductibles and co-insurances, and for that reason Medicare kind of puts out there that they want you to let the patient be aware of that, that there is going to be a charge for the service and the last time I looked the co-insurance was around 18 dollars to the patient for performing the service. Some secondaries pay for it. Not every insurance is acknowledging this code though. But it is something that Medicare is paying.

Monica Wright: These codes can be billed in addition to other visits on the same day, so you can bill advanced care planning with an office visit. You can bill advanced care planning in other settings. You can bill it with a skilled nursing center visit. You can bill it with a hospital visit. You cannot bill it in addition to a code that is time-based, so for example in the hospital you can't do on a discharge day. You can't bill it with a prolonged service that would be time-based, and you can't double-dip. So if you are seeing the patient in the office, you can't use time-based billing for your visit to get it to a 99215 for the advanced care planning

discussion and then also bill advanced care planning for that same conversation. You only get it once. It's one or the other. You can't do both.

Monica Wright: Now there are currently no limits on the number of times that this code can be used. Medicare put out that they were going to watch the service closely, but what that means is if you have a patient's family who, particularly in a more acute setting, just can't decide if they're ready to go DNR and you have the same conversation with the family three days in a row, as long as you meet the time requirement for all three days, then you can bill this code three days in a row. Now with it being a 30 minute code, we have threshold times with the CPT book. The threshold times tell us that for any time-based code we can start billing the code halfway through the time requirement. So what that means is once you've exceeded 15 minutes, then you're allowed to bill this code. Now there must be clear documentation for advanced care planning. I personally prefer it being its own note or, at the very least, in an addendum, because I've read a lot of notes from providers where they try to put it within their note and it really gets very confusing as to what the provider is trying to do. It tends to look more like they're trying to bill a time-based bill or something of that nature, rather than a separate service.

Monica Wright: Several things need to be documented when you are documenting the service. You'd have to have, first of all, who was present because it is a face-to-face code, total time spent because it's a time-based code. If you don't document the time, then you do not get credit for the service. Then just a brief discussion of what was discussed and what changes were made to those forms, to the MOLST if you're in Maryland, the POLST, a lot of other places in the country, those forms that indicate the do not resuscitation or what the family's wishes are in regard to life-saving procedures. So this is an example of something that would meet those documentation requirements, that all of those elements need to be there in order to get credit for advanced care planning.

Monica Wright: This is a list of some of the discussions that the American College of Physicians have said can be included in advanced care planning discussion. So these are the types of things that would end up in that documentation as to what was discussed. And notice it is a little bit more than just CPR and life-sustaining measures, because it's also talking about disease progression and the available treatments that help the patients and their caregivers make those decisions.

Monica Wright: Okay. Laurie, any questions before switch topics again?

Laurie Fink: Yeah, we did have a couple questions. First one is when do you bill a depression screening? Can it be billed with a wellness exam and also for alcohol screening and CT lung screening?

Monica Wright: So all of those things are going to be included in the annual wellness visit. The depression screening in particular is considered a part of it, because that's what the visit is there to do, is to do all of those screenings. So in that regard they wouldn't be separately payable. When you would bill them as something that

was payable would not be in the preventative environment. It would be when the patient comes in for a normal visit and is having symptoms that the provider feels is concerning and these things need to be diagnosed. That would be the time when it would be billed as a medically necessary service.

Laurie Fink: All right. And the next question is, after we fill out a POLST form, can we readdress and bill for 99497 every year during their annual wellness visit?

Monica Wright: Yes, as long as you're spending at least over 15 minutes on that portion.

Laurie Fink: Okay and another question. Can the subsequent annual wellness visit be performed by a medical assistant?

Monica Wright: No. It has to be performed by an MD, a PA, a nurse practitioner, a certified nurse midwife or a certified nurse specialist.

Laurie Fink: All right. I think those are all of the questions we've received so far.

Monica Wright: Okay. So I'll move on to another type of service, which is more to get paid for the things that happen in between the visits and that's chronic care management. Chronic care management was established to try to keep a closer eye or rather to get paid for the care that you are providing to these patients that have at least two chronic conditions, that have to be followed to be sure that again you don't get these severe exacerbations that put them back in the hospital. There are four different codes for chronic care management.

Monica Wright: 99490 is for 20 minutes of staff time per month. 99491 is for 30 minutes. MMA added the complex chronic care management services. 99487 has to take 60 minutes and moderate or high complexity medical decision making must be documented, and 99489 is each additional 30 minutes beyond that 60 minutes, again showing that moderate or high complexity medical decision making.

Monica Wright: So a couple of things have to be in play. Again, it's billable every 30 days. Only one provider can bill for chronic care management per month though. It can't be split. They must have the two chronic conditions that are expected to last at least 12 months and everything must be recorded in a certified EHR. So if you're not using the certified EHR technology, then you can't bill chronic care management services. It is a part of the requirements for these codes. Now these codes, the supervising provider needs to be the MD, the PA, the nurse practitioner, but these are general supervision codes for clinical staff. Now they want the services to be performed by ... medical assistant is fine, but it would be on the clinical side, clinical staff versus front office staff, in order to get credit for the time. But these services can be completed by any member of the clinical staff, as long as they're under the appropriate supervision.

Monica Wright: So, how you establish chronic care management is normally going to be during the IPPE or the annual wellness visit, but it must be established during a visit. So

if a patient has not been seen within the past 12 months, you are required to initiate the services during a face-to-face visit, so you actually have to bring the patient in for an office visit, which is payable and start the chronic care management discussion. Now if substantial time in that office visit is taken for this discussion and the planning, there is a G code, G0506, which is specific to the chronic care plan setup and management and that code can be billed in addition to the face-to-face visit, but you get that code once per lifetime. It's a setup code. It's meant for the initial getting the chronic care services started and it won't be paid again.

Monica Wright: The patient consent has to be obtained before starting the chronic care management services. The consent may be verbal or written and it must be somewhere in the patient's chart. It's in regards to the availability of services, the cost sharing amounts. All of these things have to be documented. Again it's only one practitioner can perform per month, the same classes that I mentioned for the annual wellness visits quality, the physician assistants, the nurse practitioners, the certified nurse midwives, the clinical nurse specialists, but within that they do look at scope of practice because they say it wouldn't necessarily be medically necessary for a dentist or a podiatrist to implement chronic care management services. So this is normally done by the PCP. It doesn't have to be, but that tends to be where these services lie.

Monica Wright: The first major requirement of chronic care management is a comprehensive care plan and these are the elements that need to be included in that plan: You have to have the problem list, the expected outcome and prognosis, the measurable treatment goals, symptom management, planned interventions and identification of the individuals responsible for each intervention, medication management, any community or social services that are ordered, the description of how the services and agencies or specialists outside the practice will be directed or coordinated because you have to coordinate care and schedule periodic review and revise the care plan appropriately. So this will be kept in your certified EHR and this will be the main document that shows that you're performing that chronic care management.

Monica Wright: Other requirements: You must provide access to practitioners 24/7 for urgent needs. So the patient must always be able to get a hold of a practitioner who has access to their records and can have at least a conversation, if not a visit, regarding what's going on. You have to be able to schedule appointments within that month. They have to be able to come back in if they're having problems. You need to provide communication channels between the patient's provider, so you can use email, you can use a secure portal. Then you have to help coordinate. You have to manage the preventative services, the medication reconciliation, be sure they're managing their medications because with these chronic conditions they have to be sure they don't get worse. You have to be sure they're taking their medications appropriately. You need to coordinate care with other community providers, so any specialists. You might be doing chronic care management and one of the conditions could be congestive heart failure and if you're their PCP you want to manage that along with their cardiologist. So

you want to be sure they're seeing the cardiologist appropriately and be sure that that's documented. A lot of patients do end up in the hospital for those failed follow-ups and that's what this is about. It's about keeping those patients cared for and doing the best level possible.

Monica Wright: You need to assess the patient's medical function, psychosocial needs, again make referrals and transitional care as necessary. Now the provider cannot bill for home health supervision, transitional care management, ESRD services or prolonged services during same calendar month as the chronic care management services. All of those things are going to be included in the time that you're adding up for your chronic care management. And the time does need to be documented somewhere again in that EHR, so you can see that you met the 20, 30, the 60 minutes. And if it's a 60 minute code that you're using, then there has to be notes of the conversations and things back and forth that justify that higher level of medical decision making. And that can be things like sending them to the ER for an exacerbation. I mean, that would certainly justify it. But something would have to be documented so if the records were pulled the auditors can see what happened during the course of that month.

Monica Wright: Questions about chronic care management?

Laurie Fink: Yeah, we did have a couple questions, Monica. The first one is can a CMA perform the annual wellness visit initially and/or subsequently?

Monica Wright: They can help by getting those assessment forms, just like they would with any other visit. They can get the assessment from the patient and write it down, but the actual MD, PA, nurse practitioner actually has to see the patient as part of that and go over it with them.

Laurie Fink: Okay. Next question is does Medicare specify what edition the EHR must be certified to? For the quality payment program, CMS is requiring that all certified EHRs be updated to the 2015 edition this year if they're going to report measures in the promoting inner operability category. I'm questioning if CMS has the same requirement for chronic care management?

Monica Wright: The last I saw, the only thing I could find was 2014, but it would be my suspicion very highly that yes they will be making that change, because it's unlike them not to make the same requirement across the board.

Laurie Fink: And can a registered nurse or LPN do a wellness exam?

Monica Wright: Again, they can assist, but no because it has to be signed by one of the qualified providers that can bill for it.

Laurie Fink: And next question is can obesity counseling be done and charged at an E&M visit?

Monica Wright: Yes.

Laurie Fink: Okay.

Monica Wright: It can also be done as part of the annual wellness visit, which would be included in the annual wellness visit, but that's a risk factor and there are some screenings that can be sent out for with that, so yes it is a qualifying service.

Laurie Fink: All right. And the next question is, so we can't bill the G0179 and G0180 HCC certification with chronic care management?

Monica Wright: Yes, that is correct. They only give you one of those types of management services per month.

Laurie Fink: All right and then it looks like the final question is, can you bill CPO during CCM?

Monica Wright: I don't think so. I'm not 100% sure on that one, but in general anything else that's going to be a paid monthly service they kind of combine them all together.

Laurie Fink: All right, I think that's all the questions for now.

Monica Wright: So let's take a look at transitional care management. And again, this is included in the chronic care management if you're already performing that service for the patient. It wouldn't be billed separately. Transitional care management, again, has two codes. It's sort of a monthly code because it has to do with the timeframe right after the patient gets discharged from a facility. The two codes are based on the complexity and the medical decision making of the required face-to-face visit. We'll look at that in detail in just a minute.

Monica Wright: So transitional care management can be furnished after discharge from any of these facilities. So it doesn't just have to be a hospital. It can be a skilled nursing facility. It can be a rehab center. It can be observation. But the patient must have returned to home in the community. So this isn't a patient that's still in long-term care. This is someone that's back home after they've been treated in a facility for some type of illness and now it's making sure that they get that aftercare that they need so that they don't end up right back in the hospital.

Monica Wright: So you've got during the first 30 days from discharge, there are a couple of things that have to be done to bill that transitional care management. The first is there has to be an interactive contact. Within two business days of discharge, you must contact the patient via phone, email or face-to-face, and this contact must be made by a clinical staff who can address the patient's status. So this is the initial how are you doing from discharge? And to set up the appointment to meet the face-to-face requirement. The other non-face-to-face services that are included in transitional care management is reviewing discharge information, following up on any tests that were pending from when they left the hospital,

coordinating with other healthcare providers to be sure they get all of the follow-up care that they need post hospitalization, provide patient education and arrange those referrals to be sure that the patient is in complete understanding of what needs to be done to keep their health on track.

Monica Wright: Then there is a face-to-face requirement, and this can be furnished via tele health which, by the way, as can the annual wellness visit. The level of service, the 95 or 96, is dependent upon the medical decision making. So you'd have those two codes and this is how you're choosing your visit. It's going to be based on what's documented in this face-to-face visit. So you do not get to bill the face-to-face visit separately from transitional care management. The payment is included in that transitional care management code. This would also include medication reconciliation and management with the patient. You must document the date of discharge, the date of that first interactive contact, the date of the face-to-face visit and then the actual documentation from the face-to-face visit which would include the medical complexity, the assessment and plan of what happened during that visit.

Monica Wright: Now generally, again, the services can be done by a PCP so that once this is done, then they would come back for their regular follow-ups with the office, but again it does not have to be. There can be other types of providers that can perform these services to be sure that the patients are then getting out to their PCPs. There are a lot of discharge clinics around that are kind of focusing in on this type of service for patients that don't tend to have PCPs in the community to get them out to the physicians that they need to see once they've been discharged.

Monica Wright: Any questions about transitional care management?

Laurie Fink: Yes. Who can perform the transitional care management?

Monica Wright: So again it's that general supervision for the phone call and for the things that are going on and making the referrals and doing all the coordination, so it can be any clinical staff, but for the physical face-to-face visit it would have to be an MD, a PA, an NP, the certified nurse midwife or the certified nurse specialist.

Laurie Fink: Okay. And how does complexity play a role in these visits?

Monica Wright: So, you've got the two codes. The 99495 and the 99496. You choose the code based on the documentation of the face-to-face visit. So the 99495, the assessment and plan would have to show moderate medical decision making, so prescription drug management or an acute illness with systemic symptoms, all those things from our table of risk. And the 99496 would have to show high complexity medical decision making, which would mean the drugs requiring monitoring for toxicity or parenteral controlled substances or a severe exacerbation or an acute illness with threat to life or bodily functions. All of those things, again, meet our table of risk requirements.

Laurie Fink: Okay we do have another question. I'm not quite sure ... I'll read it to you, but I'm not quite sure what she's asking. It says, "He is seven days or less than 14 days visit. What is the difference? The medication reconciliation list, patient preference?" Does that make sense, Monica?

Monica Wright: I'm not entirely sure. The idea of the transitional care management visit is to get their ... within that first 30 days from the hospital to be sure that the patients pick up their medications upon discharge. We have a lot of issues when patients don't do that, they end up back in the hospital. Be sure they understand what they're supposed to be doing to keep up the treatment in the field. So within two business days, that phone call needs to be made to be sure that this gets established. Then you've got that 30 days which would make the visit, which would include that medication reconciliation. It's not that it has to be done this week or next week. You have that little bit of leeway in time, as long as it's done within that first 30 days.

Laurie Fink: All right. I think that's it for now.

Monica Wright: The other type of services we're going to take a look at are tele health services. Now tele health services, there's some vocabulary to be aware of. The originating site is where the patient is physically located. The distant site is where the provider is located. Asynchronous tele health means that transfer images are forwarded, so it's not live. This is not happening in real-time. This is someone taking the imaging and then getting it to the provider and then the provider responding back. This is compared to synchronous, which would be real-time interaction like a Skype video type thing between provider and patient.

Monica Wright: Now the requirements for tele health vary greatly based on the insurances and the type of services. For Medicaid, providers must register in order to perform tele health services. For Medicare, the originating site, where the patient is, must be in a health professional shortage area. So if you meet those requirements then, as I just said, the annual wellness visits, the transitional care visits, and your basic office visits are all things that would be covered using tele health as long as that requirement is met. When you meet all of those and all of the requirements of a face-to-face visit must exist, so you have to be able to perform all of the components you normally would for the type of service that you're billing through tele health versus being face-to-face. So you have to be able to get an exam. If that means having someone at the originating site that can get vitals or there's certain things that they have to do, or having the Skype so that the provider can ask the person, whoever it is, on site to do certain things and they can make the exam assessment. You have to be able to do that in order to bill this visit.

Monica Wright: When you meet all of those requirements, then the provider would bill a standard code, whatever that code would happen to be. If it was an annual visit, you'd do the GO438 with the modifier GQ. That modifier says, "I have performed this service via tele health." Now with Medicare, the originating site

also gets paid a little bit for providing the service, for having someone there to be with the patient and provide the technical equipment to make the tele health visit happen. And that code is Q3014. That would be billed by the originating site. It's just a small stipend. It's not a huge payment but it's something for the originating site to be able to bill and get paid because they're participating in the tele health service.

Monica Wright: So questions about tele health? I know that's a confusing one. The problem is because the requirements vary so greatly, it's really hard to give an in-depth look at it unless we devoted a whole hour or so to it to look at what each individual insurance company is requiring.

Laurie Fink: Yeah we do have a couple questions. They were actually about the previous topic. I didn't notice them on the screen, but the first question is, does the face-to-face have to be within seven days.

Monica Wright: No. No, I believe you have that first 30 days. You've got to make that initial contact by two days, and then within the first 30 days of the hospital stay. You have that much time to get a face-to-face.

Laurie Fink: Okay. The next questions asks, is it okay to bill when we do the face-to-face visit or do we bill the last date of the 30 day period?

Monica Wright: As long as you've met all of those other requirements within the 30 day period, when you get to the face-to-face visit and everything is done, then you can bill the service. It's just a matter of that's how much time you have. It can't go beyond that. And all of those things have to be included. But the face-to-face is really the second piece of it. Most of the non-face-to-face are things that are going to be done before the patient is seen. After is just going to be following up on those referrals.

Laurie Fink: When TOC is performed, is it billed immediately? Or does it need to be billed at the face-to-face/tele health encounter?

Monica Wright: It would be ... you'd wait until the face-to-face encounter.

Laurie Fink: Okay and a follow-up on that question we were a little unsure about. She provided a little bit more information. She said, "For example, if it is a lower complexity visit, but the patient is seen within seven days, can we bill?"

Laurie Fink: She said can we bill 99496? I'm sorry. Can they bill with that code?

Monica Wright: No. The time does not override the medical complexity requirement. It would be the 99495 for that level of service.

Laurie Fink: All right. Next question. So when we start with the first phone call for transition of care, are we billing that day or does the physician bill the transition of care code when they see the patient for follow-up.

Monica Wright: I would do it when they see the patient for the follow-up visit because that will be the full circle, the completion of that entire transitional care package. Because the face-to-face visit is part of it and that is how you determine your level of service. Without that face-to-face, you can't determine which code to use.

Laurie Fink: And is it the complexity that determines the code for TOC, or the timing of the TOC visit?

Monica Wright: The complexity. It's the complexity of that visit, which will come from that assessment and plan.

Laurie Fink: Okay. Next question. Can we bill the 99495/99496 on the day we have the face-to-face visit or do we bill it on the last day of the 30 day period?

Monica Wright: It can be done at the face-to-face visit. You don't have to wait the full 30 days if the whole service was done before that 30 day period is over.

Laurie Fink: Okay. Next one is, I have psychiatrists who each perform remote visits, however the patient isn't far away. What is the distance criteria?

Monica Wright: That really depends on the insurance, because with Medicare there is that health Professional shortage area requirement, so that is really what determines it, is if the patient is in that health professional shortage area. I know with the psychiatric codes a lot of the insurances have a lot of different rules for it because there are several different ways those codes can be billed via tele health. So, unfortunately, I'm sorry I can't be more specific than that, but it really is insurance dependent.

Laurie Fink: All right, and there was a follow-up question with that. Also, these psychiatrists perform at length follow-up with family members via telephone and for numerous times via telephone without patient present. How does the psychiatrist bill these phone calls?

Monica Wright: So for those services, it's going to be a little bit different from what we talked about in these services today because a lot of times there are codes for within the psychotherapy for family psychotherapy, but the initial assessment that includes gathering information from lots of sources and those things come into play. It's just like kind of we've been told since the beginning of time with the evaluation and management visits, if it's something that happens in between the visits, it's normally considered something that is included and billable the next time you see the patient. So it all comes into play in the complexity and the records review and everything within the next visit.

Laurie Fink: All right. The next question asks, can we use transitions of care and the EM code on the same day?

Monica Wright: No. Because the transitional care code includes the E&M.

Laurie Fink: All right. Next question. Can advanced care planning and chronic care management be billed under rural health clinics?

Monica Wright: Yes.

Laurie Fink: Okay. Also if the patient gets admitted to a hospital after being seen for face-to-face for transitional care visit, but within 30 days of hospital discharge, will the TOC code be denied by Medicare?

Monica Wright: I actually haven't seen that in practice but I wouldn't think it would be denied, as long as all of the requirements of the transitional management were met. So if you called them within two days, you saw them within the appropriate length of time, then you had met the requirements of the visit. If the patient was so sick they went back in ... there's always going to be some outliers for what they're trying to do. I can't see how they would fault you for that. It'll be a readmission for the hospital because that is what it is. I haven't seen it in practice, but I would think you'd get paid.

Laurie Fink: All right. Next one. I bill for a 45 minute visit. If the visit goes over 90 minutes due to follow-up calls in between visits, am I only allowed the max minutes on the psychiatry med management and/or therapy at the max time limit?

Monica Wright: I'm going to have to look into that in a little more detail. Generally, yes, you are limited to the max. They won't go beyond those maximum times with the time-based codes.

Laurie Fink: Okay. I believe we've captured all the questions. Some great questions.

Monica Wright: So just kind of in summary, those annual wellness visits can be performed once every 365 days. Make yourself a note, watch the EMR and be sure that you're scheduling them 365 days post and not before so it's paid. Refer the patients for the Medicare-covered preventative services. Take a look at the full list. Be sure you're utilizing all the services Medicare has to offer. Advanced care planning can be billed when performed face-to-face and it can be billed in addition to the office visit. Chronic care management can be billed every month, as long as you're continuing to provide those services to those patients. And transitional care management is there after a facility stay. Be sure to review your carrier requirements when you're looking to make the decision to do tele health.

Monica Wright: So Laurie, have we exhausted all the questions at his point.

Laurie Fink: Yeah. There was a follow-up to the psychiatric visits. She said, "So essentially I have to write off any overage?"

Monica Wright: Again, I haven't looked at those psychiatry laws or rules in a little while so I'm a little rusty on it. I'm not 100% certain but generally in the world of time-based billing and those time codes. If the codes give you ... some of them will be each additional 30 minutes and then you can keep adding that code to cover all of your time. But the ones that don't do that, then yes in those instances we do get cut off.

Laurie Fink: Okay and another question is, in regards to the annual wellness visit, does it have to be once every 365 days or can it be in the same month the following year? So, for example, if it was done on January 15, 2018, could it be done on January 10, 2019.

Monica Wright: It has to be a full 365 days.

Laurie Fink: All right. I think that's it for the questions.

Monica Wright: Okay. Then I can turn the next part of the presentation over to Kem here.

Kem Tolliver: Hi, everyone. I've been on mute. Can you hear me?

Laurie Fink: Yeah.

Monica Wright: Yep.

Kem Tolliver: I just wanted to thank quality insights and thank all of your for participating today. We really hope that you've gotten some useful information that you can take back to your practices to improve any coding and documentation practices that you have. Just a little bit about medical revenue cycle specialists. Our goal is to assist private practices with education and making sure that your practices remain viable.

Kem Tolliver: In the next slide, I just give a brief graphic about the process that we use when we do revenue cycle assessments in practices. The following slide also kind of includes some of the services that we provide. We are available to provide you with any support that you need in terms of practice operations analysis, helping with fee schedules and payer contracting, but there is a list here and I believe everyone who has participated today will get copies of these slides. Our contact information is located on the last slide and if you have any additional questions after this program, feel free to reach out to us and we'd be happy to answer them for you. Thank you.

Laurie Fink: Well, thank you so much Monica and Kem. And thank you everyone who was able to join us today. We had a lot of great questions. Hope we got all the answers to you that you needed, but as Kem mentioned, her email address is on

this last slide. So if you have any additional questions, please feel free to reach out to her. Now, when you sign out of today's webinar, we remind you that there is a very quick evaluation we ask that you complete. We're anxious to get your feedback and comments about the session. Thanks again for joining us today. Have a great rest of the day. This session is now concluded.

Quality Insights
Quality Payment Program Support Center

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