SA4- Billing and Coding in PA/LTC: How to do it Right!

Saturday, March 24
11:00 AM- 12:30 PM

Session Description
This session will provide details about billing for services that have recently been approved by the Centers for Medicare & Medicaid Services. Participants will learn the peculiarities of the billing changes for these codes. The session will also review and explore the finer points of some classical billing and coding enigmas that continue to be challenging for many PA/LTC practitioners.

Learning Objectives
Discuss details of billing complexities for recently approved billing codes used in the geriatric care continuum.
Review details of some recurrently perplexing PA/LTC coding and billing issues.

Presenter(s): Alva Baker, III, MD, HMDC, CMDR

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Billing and Coding in PA/LTC:
How to Do it Right!

Alva S. Baker, MD, CMDR, HMDC

Speaker Disclosures
Dr. Baker has disclosed that he has no relevant financial relationship(s).

Learning Objectives:
By the end of the presentation, participants will be able to:
• Discuss details of billing complexities for recently approved billing codes used in the geriatric care continuum.
• Review details of some recurrently perplexing PA/LTC coding and billing issues.

PA/LTC Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>Decision</th>
</tr>
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<tbody>
<tr>
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<tr>
<td>99304</td>
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<td>Det/Comp</td>
<td>Det/Comp</td>
<td>Str/Low</td>
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<td>99308</td>
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<td>Exp. PF</td>
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<td>Low</td>
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<tr>
<td>99309</td>
<td>25</td>
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<td>Detailed</td>
<td>Moderate</td>
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<tr>
<td>99310</td>
<td>35</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
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<td>xxx</td>
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<td>xxx</td>
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<tr>
<td>99318</td>
<td>30</td>
<td>Detailed</td>
<td>Comp</td>
<td>Low/Mod</td>
</tr>
</tbody>
</table>

PA/LTC Billing Codes
• Initial/Subsequent vs. New/Established care codes

<table>
<thead>
<tr>
<th>Initial/Subsequent</th>
<th>New/Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/LTC</td>
<td>Office/Hospital/uc.</td>
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</tbody>
</table>

Pre-session Review

REVIEW OF BASIC PA/LTC BILLING AND CODING
PA/LTC Billing Codes

- Other recurrent troublesome concepts
- All codes apply both SNF and NF
- All require face-to-face visit
- Medical necessity must be documented
- Physician must do initial evaluation in SNF (POS 31); NPP may do in NF (POS 32)
- NPP visit in SNF prior to MD eval is billed as subsequent care
- Documentation for visit must include adequate E/M items as required for code

Billing and Coding in PA/LTC: How to Do it Right!

Objective 1

Codes, codes, and more codes

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Advance Care Planning (ACP)
- Prolonged Services
- Behavioral Health Integration

Transitional Care Management

- Coming from
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Long Term Care Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Hospital outpatient observation or partial hospitalization
  - Partial hospitalization at a Community Mental Health Center

- Going to
  - His or her home
  - His or her domiciliary home
  - A rest home
  - Assisted Living

Transitional Care Management

- Three components
  1. interactive contact by telephone, email, or f2f; by physician or clinical staff, within 2 business days following discharge
  2. non f2f services by physicians or NPPs
    - review discharge info
    - follow-up on pending tests and treatment
    - interact with others who will assume or resume system-specific care
    - provide education
    - establish or re-establish referrals/needed community resources
    - assist in scheduling required follow-up with community providers/services
Transitional Care Management

- Three components
  - 2. non f2f services by clinical staff supervised by physicians or NPPs
    - communicate with agencies and community services
    - provide education to support self-management, independent living, and activities of daily living
    - assess and support treatment regimen adherence and medication management
    - identify available community and health resources
    - assist in accessing needed care and services

- 3. Face to Face visit
  - moderate medical decision making complexity – within 14 days of discharge
  - high level of decision making complexity – within 7 days of discharge
  - the f2f is part of TCM and is not billed separately
  - may be done via telehealth (if telehealth services authorized)
  - med reconciliation no later than date of f2f visit

Transitional Care Management: Billing

- 99495
  - communication: by end of 2nd business day
  - face-to-face by end of 14th day
  - medical decision making: moderate

- 99496
  - communication by end of 2nd business day
  - face-to-face by end of 7th day
  - medical decision making: high

- Can only be billed by one provider
- Covers non-face-to-face physician and non-physician time/work
- Required F2F visit - if not done by physician must meet “incident to” rules; included in TCM – is not billed separately
- Other E/M medically necessary services are billed separately
- Covers 30 days, starting with discharge day and ending 29 days later (bill may be submitted when f2f is done)
- POS code is for the site of service of the required face-to-face visit

- Minimum documentation must include
  - Date of discharge
  - Date of Interactive Contact
  - Date of f2f
  - Complexity of medical decision making (moderate or high)

- The discharging provider can bill TCM, but required f2f cannot be done on the day of discharge
- Cannot bill if any TCM days fall within post-operative global period
- Cannot bill concurrently with
  - Care Plan Oversight Services
  - Home Health/Hospice supervision (G0181, G0182)
  - ESRD services (90951-90970)
  - Chronic Care Management Services
  - Prolonged E/M services without direct patient contact

- Cannot bill if any TCM days fall within post-operative global period
- Cannot bill concurrently with
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Transitional Care Management

• **2016 Update**: may now submit bill on date of F2F visit and not have to wait until the 30th day. Must still track the patient for 30 days
  • If the patient is readmitted within 30 days, and the practice has already billed TCM for that patient, they cannot bill for TCM when the patient is discharged the second time.
  • If the patient is readmitted and the practice has not yet billed, they can wait until the patient is discharged the second time, track the patient for TCM, and bill after the second face-to-face visit (as long as no other provider billed for TCM subsequent to the first discharge).

Chronic Care Management (CCM)

• Two or more "significant chronic conditions"
• Non face-to-face work
• Billed no more frequently than once per month per qualified patient
• Started January 1, 2015

Chronic Care Management (CCM)

• Services covered include
  • Regular development and revision of an electronic plan of care using certified EHR
  • Communication with other treating health professionals
  • Medication management
  • 24-hour-a-day, 7-day-a-week access to address a patient’s acute chronic care needs
  • Transitional Care Management

Chronic Care Management (CCM)

• Services covered include
  • Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
  • Care management for chronic conditions including systematic assessment and development of a patient centered plan of care.
  • Management of care transitions within health care.
  • Coordination with home and community based clinical service providers.
  • Enhanced opportunities for a patient to communicate with the provider through telephone and secure messaging, internet or other asynchronous non face-to-face consultation methods.

Chronic Care Management (CCM)

• Electronic Care Plan - components
  • establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient
  • maintain an inventory of resources and supports that the patient needs
Chronic Care Management (CCM)

- **Electronic Care Plan - components**
  - The practice must use a certified EHR to bill CCM codes.
  - The care plan must be available to anyone providing CCM services in a timely fashion
  - A copy of the electronic care plan must be provided to the patient

- **Billing**
  - The practice must have the patient’s consent
  - CPT code 99490 (avg: $43)
  - Co-pays do apply
  - Only one clinician can be paid for CCM services in a calendar month
  - Duke it out

- **Benefit**
  - get paid for work already being done, but not reimbursed
  - billed monthly for 20 eligible patients = $10k/year

- **Downside**
  - many practices may not meet requirements

- **2017 – Major Updates:**
  - Less Hassle, More Money

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7. Can I bill CPT 99490 for CCM services provided to beneficiaries in skilled nursing facilities, nursing facilities or assisted living facilities?

If all the CCM billing requirements are met and the facility is not receiving payment for care management services (for example, the beneficiary is not in a Medicare Part A covered stay), practitioners may bill CPT 99490 for CCM services furnished to beneficiaries in skilled nursing facilities, nursing facilities or assisted living facilities. The place of service (POS) on the claim should be the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient) as per 53 above.
CCM – 2017 Updates

- Increased payment and additional codes
- Reduced requirements associated with initiating care, and increased payment when extensive initiation work is necessary
- Significantly reduced administrative burden (reduced payment rules for billing the services)
- General supervision in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Instead of G0506, may bill prolonged services if requirements are met.

CCM – 2017 Updates

- Initiating Visit: now only needed for new or patients not seen >1 year; extra payment for extensive initiating services
- Certified EHR: no longer required for ALL CCM documentation (but still for SOME); now can fax care plan; coverage no longer needs access to EHR; removed standards for formatting and exchanging continuity of care documents; continue to encourage advanced technology, but acknowledgement that practitioners will increase technology better based on incentives

CCM – 2017 Updates

- Continuous Relationship with Designated Care Team Member: align better with CPT language
- Comprehensive Care Management and Care Planning: align better with CPT language; no longer specify the format of the care plan copy that must be given to the patient; technology use standards relaxed
- Transitional Care Management: align better with CPT language; clinical summaries for managing transitions renamed "continuity of care document(s)"; technology use standards relaxed
CCM – 2017 Updates

- 24/7 Access to Address Urgent Needs: align better with CPT language; clarify the required access is for urgent needs
- Advance Consent: verbal instead of written consent allowed

CCM – already above??

CMS Recognition of CPT Codes for Primary Care Previously not Paid for Complex Chronic Care Management Codes 99487 / 89

CMS noted that in order to more accurately pay for services based on the relative resources required, that the original somewhat more stringent CCM codes would now be paid for. These codes require the patient be at significant risk of death, acute exacerbation/decompensation or functional decline, and requires the establishment or substantial revision of a comprehensive care plan or moderate or high complexity medical decision making, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. 99487 is for the first 60 minutes per month, 99489 is for each additional 30 minutes.

Chronic Care Management (CCM)

- Resources
  - Medicare MLN
    - Medicare MLN Connects: National Provider Call

Chronic Care Management (CCM)

- Resources
  - ACP – toolkit
  - AAFP

ACP

- Beginning January 1, 2016, Medicare pays healthcare providers for advance care planning (ACP) discussions with Medicare beneficiaries.
- ACP: the face-to-face service between a physician or other qualified healthcare professional (QHCP) and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

Advance Care Planning
99497 and 99498: diagnosis

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare AWV.

Advance Care Planning

- Two codes
  - 99497: first 30 minutes
  - 99498: each additional 30 minutes
- Place of Service
  - Any billable POS
- May be provided by
  - Hospitals
  - Physicians/NPPs; Not specialty dependent
- Billed as
  - Part B (deductible and co-insurance applies)
  - AWV (same day and provider, modifier -33; deductible and co-insurance waived)

ACP: Code descriptors

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Billing Code Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional: first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate</td>
</tr>
<tr>
<td>99498</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional: each additional 30 minutes (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

99497 and 99498: billable with

- new and established patient office visits (99201-99215),
- observation initial, subsequent and discharge care codes (99217-99220, 99224-99226),
- initial, subsequent and discharge hospital service codes (99221-99233, 99238-99239),
- observation or inpatient admit and discharge on the same date (99234-99236),
- outpatient and inpatient consultations (99241-99255),
- emergency department visit codes (99281-99285),
- initial, subsequent and discharge nursing facility care codes (99304-99316),
- new, established and discharge domiciliary or rest home visit codes (99324-99337),
- new and established patient home visit codes (99341-99350),
- initial and periodic preventive medicine codes (99381-99397)
- Transition Care Management Service codes (99495-99496)

Prolonged Services

Policy: CMS has revised the Medicare Claims Processing Manual (Pub. 100-04, Chapter 12, Section 30.6.15.2) to indicate that beginning in CY 2017, CPT codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare Physician Fee Schedule, reflecting policies finalized in the CY 2017 Medicare Physician Fee Schedule Final Rule.
Prolonged Services *without* direct f2f

- 99358 – first 60 minutes
- 99359 – each subsequent 30 minutes

2018 Update:
CMS has clarified that, despite its usual adherence to CPT guidelines of “half plus one” of the designated code time being enough time to bill the code (e.g., if the CPT code time is 60 minutes, 31 minutes spent in the task allows for billing of the 60 minute code), for 99358 and 99359, CMS expects that the practitioner will actually spend the full time designated for the code in order to bill.

Example: extensive review of subsequently received record and communication thereafter with daughter.

Prolonged Services *without* direct f2f

- Rules
  - Cannot be billed during time period of CCCM or TCM
  - Cannot be billed for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set
  - CMS expects that only time spent in excess of CPT code times would be reported under CPT codes 99358 and 99359
  - CPT codes 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff)
  - Prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for CCM services (use G0506)

Behavioral Health Integration

- Centered on Collaborative Care Model (CoCM)
- 4 new codes (HCPCS – 2017 CPTs - 2018)
  - 99492 (G0502), 99493 (G0503), 99494 (G0504) – applicable to CoCM only
  - 99484 (G0507) – other models of Integrated Behavioral Health Services
- Requires initiating visit
  - establishing a relationship with the patient,
  - assessing the patient prior to referral
  - obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record.

Behavioral Health Integration: Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Medicare</th>
<th>Non-Facility</th>
<th>Hospital and FQHC</th>
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<tbody>
<tr>
<td>99492</td>
<td>Initial primary care visit, 15 min</td>
<td>$81.48</td>
<td>$81.72</td>
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<tr>
<td>99493</td>
<td>Subsequent primary care visit, 15-30 min, CoCM</td>
<td>$82.88</td>
<td>$82.88</td>
<td>$82.88</td>
</tr>
<tr>
<td>99494</td>
<td>Initial/subsequent primary care visit, additional 15 min CoCM</td>
<td>$69.60</td>
<td>$41.56</td>
<td>$41.56</td>
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<tr>
<td>99484</td>
<td>CoCM, services, max 20 min – General BHI Services</td>
<td>$48.00</td>
<td>$32.76</td>
<td>$32.76</td>
</tr>
</tbody>
</table>

*Please note actual payment rates may vary. Check with your billing/finance department.*
Behavioral Health Integration – 99484

99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Cognitive Assessment Services – 99483

- Required elements:
  - Cognition-focused evaluation including a pertinent history and examination
  - Medical decision making of moderate or high complexity
  - Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity
  - Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR])
  - Medication reconciliation and review for high-risk medications
  - Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)

Additional Resources

- FAQ CMS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Downloads_for_CCM-Services_FAQ.pdf
- CMS fact sheet: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Chronic-Care-Management.html

Billing and Coding in PA/LTC: How to Do it Right!

Objective 2

REVIEW DETAILS OF SOME RECURRENTLY PERPLEXING PA/LTC CODING AND BILLING ISSUES.
Medicare Claims Processing Manual, Pub.100-04

SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

A. Use of CPT Codes

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code."

"The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

AMDA White Paper

Visits by Qualified Nonphysician Practitioners

State Regulations, State Scope of Practice

"All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs."

"General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed."

Medically Necessary Visits

"Qualified NPPs may perform medically necessary E/M visits prior to and after the physician’s initial visit in both the SNF and NF."

"A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit."

Medically Necessary Visits

"Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B."

Prior to/after Initial Federally Mandated Visit:

"other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit."

"Qualified NPP may perform."

"Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B."
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

- READMISSION
  - “A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.”
  - Definition of “readmission” unclear
  - Patient needs to be officially discharged from the facility to be able to use another Initial Visit code, otherwise a Subsequent Visit code should be used

Medicare Claims Processing Manual, Pub.100-04

30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician, or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

“Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.”

Medicare Claims Processing Manual, Pub.100-04

30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.”

30.6.13 I SNF/NF Discharge Day Management

- Requires a face-to-face visit
- Reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.
  - 99315-99316

30.6.13 I SNF/NF Discharge Day Management

Death

- “may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.”

Visits by Qualified Nonphysician Practitioners

Federally Mandated Visits

- SNF (31)
  - “Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.”
Visits by Qualified Nonphysician Practitioners

Federally Mandated Visits

- NF (32)
  - "Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits."

<table>
<thead>
<tr>
<th></th>
<th>Order to Admin</th>
<th>Admission Treatment Orders</th>
<th>Initial Comprehensive</th>
<th>Other Required Visits</th>
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</thead>
<tbody>
<tr>
<td><strong>SNF</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>PA, NP &amp; CNS employed by facility</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y (alternate)</td>
</tr>
<tr>
<td>PA, NP &amp; CNS not a facility employee</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y (alternate)</td>
</tr>
<tr>
<td><strong>NF</strong></td>
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</tbody>
</table>

Other Medically Necessary Visits

<table>
<thead>
<tr>
<th></th>
<th>Other Medically Necessary Orders</th>
<th>Certification/Recertification</th>
</tr>
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<tbody>
<tr>
<td><strong>SNF</strong></td>
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Billing and Coding in PA/LTC: How to Do it Right!

DON’T LOSE REVENUE BECAUSE OF INCORRECT ICD-10 CODING

ICD-10 Considerations

ICD-10

- The Devil is in the Details

[http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm]
ICD-10: What details:

- Laterality
- Severity
- Complexity
- Injuries (cause, how, where happened)
- Pregnancy trimester
- Operative (intra-, post- complications)
- New concepts not in ICD-9 (under dosing, blood type, the Glasgow Coma Scale, and alcohol level.)

http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm

How detailed??

16. V97.33XD: Sucked into jet engine, subsequent encounter.
15. W51.3XXA: Accidental striking against or bumped into by another person, sequela.
14. V00.01XD: Pedestrian on foot injured in collision with roller-skater, subsequent encounter.
13. Y93.0: Activities involved arts and handicrafts.
11. Y92.146: Swimming pool of prison as the place of occurrence of the external cause.
10. S10.87XA: Other superficial bite of other specified part of neck, initial encounter.
9. W55.41XA: Bitten by pig, initial encounter.

Top Coding Challenges (AHIMA, July 2016)

- Incorrectly applying 7th character for trauma and fracture
- Improperly using procedure codes that drive a diagnostic related group
- Misidentifying respiratory failure
- Mistaking the use of guidance tools
- Insufficiently documenting devices, components, and grafting material

ICD-10: Billing implications

- Correct code
- Adequate level of detail
- Initial/subsequent encounters
- Staff training
- Timely response to rejections

Billing and Coding in PA/LTC: How to Do it Right!

summary
Summary

• Differences in billing related to Place of Service
• Constraints on visit services for patients receiving Medicare Part A benefits
• Updates in billing and coding requirements
• Impact of ICD-10 implementation

Summary

• 2018 Updates and Emphases
• Behavioral Health Interventions: conversion of G-codes to CPT codes
• Full “code time” for non-face-to-face prolonged services
• Cognitive assessment
• CCM: prolonged service codes vis-à-vis G0506

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Thank You