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CMS Alignment

Survey of Medicare-Medicaid Billing Issue Topics

Jennifer Valentine,
Health Systems Division
Oregon Health Authority

Survey of Medicare-Medicaid Billing Issue Topics

Topic 1: CMS Chronic Care Management Services

What: Beginning Jan. 1, 2015 Medicare pays separately under the Medicare Physician Fee Schedule **CPT Code 99490** for **non-face-to-face care coordination services** furnished to Medicare beneficiaries with multiple chronic conditions

MLN DEFINES THIS NEW SERVICE:

Chronic care management services: at least 20- minutes of clinical staff time directed by a physician or other qualified health professional per calendar month with following required elements:

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised and monitored

Practitioner Eligibility:

Physicians, Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants and Certified Nurse Midwives

Supervision: CMS provided an exception under Medicare's "incident to" billing that permits clinical staff to provide the CCM service incident to the services of they billing provider under the general supervisions (rather than direct supervision).

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Modern Healthcare -10/17/15

Why most docs skip Medicare's chronic-care management fee (and how some are making it work)

By Andis Robeznieks | October 17, 2015

- 35 million Medicare beneficiaries are eligible for this service, but Medicare has only received 100,000 billing requests to date

MODERN HEALTHCARE NOTES:

Complaints about the chronic-care management reimbursement program vary from lengthy documentation to having to have a difficult conversation with patients who now are responsible for a 20% copayment for previously free services. (patient may not understand value of service if there is a copay for them).

Primary-care advocates hoped the care-management fee would transform some practices, encouraging them to invest in infrastructure and adopt a team-based model of care.

Practices that approach care with a team effort have an easier time fulfilling the requirements needed to obtain reimbursement for chronic-care management. Staffing and team roles help define who completes the follow-up and ensures documentation in the record.

Practices that don't have EHR already established have difficulty meeting the requirements from CMS.

http://www.modernhealthcare.com/article/20151017/MAGAZINE/310179987

- 2/3 OF MEDICARE BENEFICIARIES HAD 2 OR MORE CHRONIC CONDITIONS

- ABOUT 1/3 OF MEDICARE BENEFICIARIES HAD 4 OR MORE CHRONIC CONDITIONS

Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

ADVANTAGES FOR PRACTICES

An Annals of Internal Medicine practice-modeling study published online in September showed a “typical” practice with about 2,000 Medicare patients could generate more than $75,000 net revenue per full-time physician if half of their eligible patients enrolled in chronic-care management. October 20, 2015

- Medicare Chronic Care Management Payments and Financial Returns to Primary Care Practices: A Modeling Study, Sanjay Basu, MD, PhD; Russell S. Phillips, MD; Asaf Bitton, MD, MPH; Zirui Song, MD, PhD; Bruce E. Landon, MD, MBA, MSc, Ann Intern Med. 2015; 163(8):580-588. doi: 10.7326/M14-2677
- Editorials, October 20, 2015, Medicare's Chronic Care Management Program: Will It Help Primary Care Survive?, Fitzhugh C. Pannill, III, MD, Ann Intern Med. 2015; 163(8):640-641. doi: 10.7326/M15-1992

Is it as viable for small practices? Is it potentially even better for practices in rural areas that typically have higher numbers of elderly Medicare patients?

CMS REQUIREMENTS

- Billing practitioner must furnish a Comprehensive Evaluation and Management (E/M), Annual Wellness Visit, or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service and to initiate the CCM service as part of this visit/exam.
- Use of a certified Electronic Health Record (EHR) technology for some of the patient agreement provisions (Structured Data Recording)
- Patient Agreement Requirements:

- Inform the patient of the availability of the CCM service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers
- Explain and offer the CCM service to the patient. In the patient's medical record, document this discussion and note the patient's decision to accept or decline the service.
- Explain how to revoke the service.
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
- The CCM Care Plan has an extensive scope, including the electronic care plan addressing all issues, access to care management services, managing care transitions, and coordinating sharing of patient information with practitioners and providers outside the practice

SCOPE OF SERVICE: EIGHT ELEMENTS DEFINE THE CURRENT SCOPE OF CCM SERVICES

1.Access to care management services 24 hours a day, 7 days a week.

This means providing patients with a means to make timely contact with health care providers in the practice to address urgent chronic care needs regardless of the time of day or day of the week.

2. Continuity of care.

The patient must be able to get successive routine appointments with a designated provider or care team member.

3. Care management for chronic conditions.

This includes the following:

•Systematic assessment of a 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,

•Oversight of patient self-management of medications.

4. Creation of a patient-centered care plan document to ensure that care is provided in a way that is congruent with patient choices and values.

http://www.aafp.org/fpm/2015/0100/p7.html

SCOPE OF SERVICE: EIGHT ELEMENTS DEFINE THE CURRENT SCOPE OF CCM SERVICES

5. Management of care transitions between and among health care providers and settings. This includes the following:

•Referrals to other clinicians, •Follow-up after a patient visit to an emergency department,

•Follow-up after a patient discharge from a hospital, skilled nursing facility, or other health care facility.

Communicating relevant patient information through electronic exchange of a summary care record is required upon these transitions. CMS is not requiring providers to use a specific tool or service to communicate clinical summaries electronically, but faxing is not allowed. Providers must format their clinical summaries according to, at a minimum, the standard that is acceptable for the Medicare & Medicaid Electronic Health Record (EHR) Incentive Program as of Dec. 31 of the calendar year preceding each payment year.

6. Coordination with home- and community-based clinical service providers. This is to ensure appropriate support of a patient's psychosocial needs and functional deficits.

7. Enhanced opportunities for a patient and any relevant caregiver to communicate with the provider regarding the beneficiary's care. This includes communicating through not only telephone access but also the use of secure messaging, Internet, or other asynchronous, non-face-to-face consultation methods.

8. Electronic capture and sharing of care plan information. This information must be available on a 24/7 basis to all providers within the practice who are furnishing CCM services and whose time counts toward the time requirement for billing the CCM code. It must also be shared electronically (other than by facsimile) as appropriate with other providers who are furnishing care to the beneficiary.

http://www.aafp.org/fpm/2015/0100/p7.html

ADDITIONAL HIGHLIGHTS FOR CCM

Getting patient agreement

Before billing CCM services, CMS requires you to do the following:

Inform the patient of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers as part of care coordination,

Document in the patient's medical record that all of the CCM services were explained and offered to the patient, and note the patient's decision to accept or decline these services,

Inform the patient of the right to stop CCM services at any time (effective at the end of the calendar month) and what effect a revocation of the agreement would have on CCM services,

Inform the patient that only one provider can furnish and be paid for these services during a calendar month.

CCM and "incident to" rules

As stated in the Medicare code descriptor, CMS presumes that CCM services will be primarily provided by clinical staff under the direction of a physician or other qualified health care professional. This presumption implicates Medicare's "incident to" policies and how those policies relate to CCM services.

WHY IT WORKS FOR DUALS IN OREGON

- Unlike for other Medicare beneficiaries, full Medicaid-Medicare dual eligible do not have the same cost share that has prevented many Medicare recipients from wanting to participate.
- Fits with Primary Care Home model and allows for Medicare payment to support out of office care follow-up monthly, and supports the team-based model within a primary care home which Oregon has focused on which may not be as pervasive in other areas of the country
- Engages Medicare benefit for dual in CCO PMPM, provides practice with additional funding source for chronic care management of complex duals

- **Additional Notes: CPT Code 99490 cannot be billed during the same service period as CPT codes 99495-99496 (transitional care management), HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951-90970 (certain ESRD services)**

410-172-0860 BILLING FOR DUAL ELIGIBLE INDIVIDUALS

(1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other Third Party Liability (TPL).

(2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:

(a) For behavioral health services that are never covered by Medicare or another insurer;

(b) For behavioral health services that are not covered when rendered by the following provider types:

(A) Qualified Mental Health Professional (non-licensed) as defined in OAR 309-019-0105;

(B) Qualified Mental Health Associate as defined in OAR 309-019-0105;

(C) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(D) Certified Peer Support Specialist as defined in OAR 410-180-0305;

(E) Recovery Assistant;

(F) Certified Alcohol and Drug Counselor.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

Hist.: DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

MEDICARE BILLABLE PROVIDERS FOR BHS

- Psychiatrist or other Physician
- Clinical Psychologist
- Clinical Social Worker
- Clinical Nurse Specialist
- Nurse Practitioner
- Physician Assistant

LONG-EXISTING OARS

410-141-3420 Billing and Payment

6(e) CCOs **may not require** Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare,

(7) CCOs shall pay for Medicare co-insurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO for authorized referral care and urgent care services or emergency room services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

410-120-1280 Billing (f)

The provider may bill the Division directly for Services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first.

" INCIDENT TO " BILLING

"Incident to" billing:

- Are paid at 100% of the Medicare physician fee schedule, PAs and NPs receive 85% of the
- Must relate to a service initially performed by a physician
- Part of patient's normal course of treatment, physician performed initial service and **remains actively involved** in the course of treatment
- Documented in patient record
- Must be performed under direct supervision (meaning the physician is directly in the office suite and available to provide assistance or consultation when the service is performed).
- Location regulations: in office, in patient's home exceptions to physician presence for qualifying under Pub 100-02, Chapter 15, Section 60.4 where general supervision allowed (typically related to homebound patients in medically underserved areas without home health services)
- May not include diagnostic testing
- Shared visits: Physician performs evaluation and Management services to hospital inpatients, outpatients or in the ED that includes face-to-face time, but the patient also shares the visit with an NPP who works in the physician's group. Physician then call bill 100% of the MPFS rate as if performed entire service.
- Outside of new chronic care management service, "counseling and care coordination are not available for incident-to billing" and require physician "face-time".
- Non-physician practitioners (NPP): PAs, NPs, Clinical Nurse Specialists (CNSs), Physical Therapists, Occupational Therapists, Speech language pathologists, audiologists, certified registered nurse anesthetists, nurse midwives, psychiatrists, clinical psychologists, clinical social worker

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

ADDITIONAL STARK CONSIDERATIONS

Physician must be enrolled in Medicare to bill for services in his/her own name

Keep enrollments information current, most changes have to be current within 90 days for NPPs within practice

General Supervision –Physician need not be on –site

Direct Supervision –The physician must be in the office suite, but not necessarily in the same room

Personal Supervision – They physician must be in the same room

Physicians can take advantage of their ability to supervise NPPs to meet the “in office ancillary services” exception

Not all NPPs have to enroll in Medicare, some services can be billed as incident to when performed by office staff not enrollable in Medicare, such as medical assistants

WHAT MEDICARE DOES NOT COVER

Transportation to or from behavioral/mental health care services

Meals

Support Groups, though Group Psychotherapy is covered

Services provided by non-billable providers

Medicare billable professionals who do not accept assignment BEFORE you schedule a visit

WHAT IS COVERED:

One annual depression screening completed in primary care

Individual and group psychotherapy

Outpatient services for mental health and alcohol and drug use

Family Counseling for purposes related to treatment only

Psychiatric Evaluation, Diagnostic Tests

Medication Management

Welcome to Medicare preventive visit, yearly wellness visit (every 12 months) where physicians accept assignment

Partial Hospitalization

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

PREVENTIVE SERVICES

Medicare Learning Network
Official Information Health Care Professionals Can Trust

SELECT A SERVICE FOR CODES AND BILLING INFORMATION

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

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

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

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

ICN 006559 October 2015

ORAL HEALTH & MEDICARE

Fluoride application

There is a new code for application of topical fluoride varnish: 99188, “Application of topical fluoride varnish by a physician or other qualified health care professional.” Family physicians and other primary care physicians sometimes find themselves in the position of providing primary, preventive dental services to their patients, especially children. This new code will allow physicians to report one such service. (Effective Jan. 2015)

When performed by the clinical staff, this service cannot be reported.

PUBLIC HEALTH: HCV SCREENING

Background*

Hepatitis C Virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

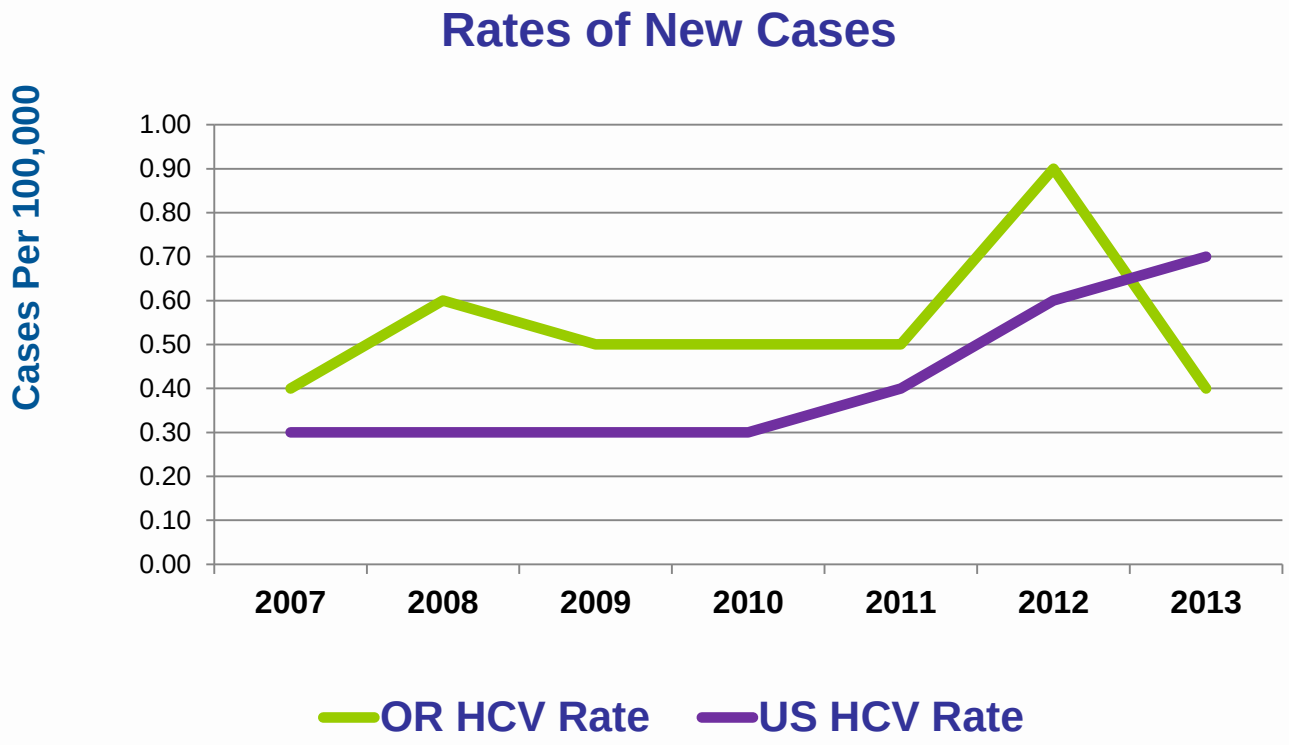
*Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. **Adults at high risk for HCV infection**. "High risk" is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.

2. **Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965.** A single, once-in-a-lifetime screening test is covered for these individuals. The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

New cases of HCV, Oregon vs US, 2007-2013



- 45% of new cases occurred in persons < 30

Total reported cases of chronic HCV

By 2013, 47,435 cases were reported to Oregon's HCV registry

Assuming that at least 50% of Oregonians with HCV are unaware of their diagnosis, the actual number is probably closer to 95,000

Oregon Health Authority

Public Health Summary (report provided in today's meeting materials)

- Significant burden of disease resulting in high numbers of hospitalizations, liver cancer and deaths from HCV
- Majority of cases of chronic infection, liver cancer, hospitalizations and deaths from HCV occurred in person 45-64
- In contrast, highest number of new cases in persons under 30
- Rates of new cases and deaths higher than national rates
- Affects all regions of Oregon
- High risk populations in Oregon: American Indians/Alaska Natives, Blacks, persons who inject, incarcerated persons

General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:

1.New HCPCS G0472, short descriptor -Hep C screen high risk/other and long descriptor-Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2015 recurring updates of the Medicare Physician Fee Schedule Data Base (MPFSDB) and the Integrated Outpatient Code Editor (IOCE) with a June 2, 2014 effective date. Contractors shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2014, that contain HCPCS G0472.

2.Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.

3.For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
-HCPCS G0472

4.For those determined to be high-risk initially, claims must be submitted with:
HCPCS G0472; and
-ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)

5.Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
-HCPCS G0472;
-ICD diagnosis code V69.8/Z72.89; and

ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note:
Annual is defined as 11 full months must pass following the month of the last negative HCV screening

ALSO NEW WITH MEDICARE FOR 2016

Medicare Reimbursement and Meaningful Conversations about End-of-Life Care

On October 30, the US Centers for Medicare & Medicaid Services (CMS) announced that, starting January 1, CMS will reimburse physicians and other practitioners for talking with any Medicare recipient about their health care preferences at the end of life — also known as advance care planning. Caught up in a political maelstrom several years ago, CMS has now caught up with a growing desire of patients and loved ones to express, and have health care respect, their wishes. Talking with a trusted provider is an important part of the process.

IHI Webinar available on November 19th

Medicare Reimbursement and Meaningful Conversations about End-of-Life Care

The new codes, 99497 and 99498, cover "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 healthcare professional (QHP); face-to-face with the patient, family member(s), and/or surrogate."

- ❑ first 30 minutes –99497
- ❑ each additional 30 minutes – 99498

<u>This service requires three basic elements:</u>

1.A face -to- face meeting between physician/QHP and patient, family surrogate

2.Counseling and discussing advance directives–the document which appoints an agent and/or recording the wishes of patient's pertaining to their medical treatment at a future time should they lack decisional capability at that time

3.Completion of relevant legal forms. Note that it may be appropriate to complete the forms at the time of this visit. However, if the patient needs additional time and planning, the forms could be completed at a later date

NEW WITH MEDICARE FOR 2016, CONT'D

Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1

Prescribers of Part D drugs must enroll in Medicare by June 1, 2016. Submit your application by January 1, so your application can be approved by the deadline. Be sure your patients' drugs are covered by enrolling now.

Two free ways to enroll in Medicare, so you can prescribe Part D drugs:

Use the PECOS website. Download instructions or watch the video tutorial

Submit a paper application to your Medicare Administrative Contractor (MAC). MACs process Medicare claims, enroll health care providers in the Medicare program, and educate providers on certain Medicare requirements.

Did you already enroll? Check the list of enrolled providers: http://go.cms.gov/ProviderList

For More Information: MLN Matters® Special Edition Article #SE1434

Part D Prescriber Enrollment website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html

Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?

Beginning June 1, 2016, prescribers who write prescriptions for Part D drugs must be enrolled in an approved status or have a valid opt-out affidavit on file with Medicare in order for their prescriptions to be covered under Medicare Part D. Before opting out of Medicare, you should consider the following impacts:

You will not be able to participate in a Medicare Advantage plan, and

Your opt-out status lasts for two years and cannot be terminated unless within 90 days of your opt out designation

To learn more about the options available to you, refer to the decision chart.

MEDICARE ADVANCE BENEFICIARY NOTICE REMINDERS FOR PROVIDERS

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form 10055, is issued for Part A SNF items and services.

MLN Matters provided as resource, covers mandatory uses, including those added in 2011, as well as voluntary uses of the ABN (Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.)

Triggering Events: Notifiers are required to issue the ABN when an item or service is expected to be denied based on one of the provisions in the Mandatory Use section. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as “triggering events.”