



Billing and Coding in Long Term Care:
**Basic Billing and Coding
in Long Term Care – Part 1**
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presented by
Alva S. Baker, MD, CMD

An AMDA Webinar Series
presented by
LEONARD M. GELMAN, MD, CMD
ALVA S. BAKER, MD, CMD
CHARLES CRECELIUS, MD, PHD, CMD

Faculty Disclosures:

Dr. Gelman has disclosed that he has no relevant financial relationship(s).

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

Dr. Crecelius has disclosed that he has no relevant financial relationship(s).

Learning Objectives

- Delineate the CPT codes used in nursing facilities
- Define the CPT requirements for each of these codes
- Discuss associated basic requirements for billing for services in nursing facilities

Session Outline

1. Systems
 1. CMS
 2. Medicare-Medicaid
 3. Carriers
 1. Medicare Claims Processing Manual
2. Codes across the Continuum: Routine Care
 1. Codes
 2. Location of services (POS); home-bound status

Session Outline

3. Special Requirements and Important Concepts: Nursing Homes
 1. POS, SNF vs. NF, time, AI modifier,
 2. Medical Necessity
 1. regulatory visits
 2. E/M visits
 3. Face to face
 4. Initial vs. subsequent

Session Outline

4. Special Situations: Nursing Homes
 1. NPPs
 2. Split Billing, Gang visits, Incident-to services
 3. Telephone calls (telehealth 2011)
 4. Care Plan Oversight
 5. Family conferences
 6. Hospice
 7. Prolonged services
 8. Consultations
 9. Wound Care

SYSTEMS

CMS

- The Center for Medicare and Medicaid Services
- Administratively a part of the Department of Health and Human Services
- Responsible for
 - everything to do with Medicare
 - State requirements for Medicaid (but how the money is spent by the States is up to them, within guidelines)

Medicare - Medicaid

Medicare	Medicaid
Primarily =>65	Any age (need dependent)
Multiple components (A,B,D esp.) A = hospital, SNF costs B = physician, lab, x-ray, therapy D = drugs	Single system
Standardized by CMS	State specific

Carriers

- Business entities that take money from CMS and pay it to providers for services provided to Medicare beneficiaries
 - generally speaking, must follow rules put forth by CMS (Medicare Claims Processing Manual, Transmittals)
 - may make local determinations on some issues

Medicare Claims Processing Manual

- Incredibly huge and complex
- Defines process and procedures for everything related to Medicare claims (billing and payment)
- We are mostly concerned with Chapter 12: Physician/Practitioner Billing
- But also with Chapter 11: Hospice
- Some other chapters have bits and pieces applicable to this topic

Finding the Manual online

- www.cms.hhs.gov/Manuals
 - click on Internet Manuals Only (left panel)
 - click on Publication **100-04**
 - click to read/download any desired Chapters

List of Online Manuals

- 100 Introduction
- 100-01 Medicare General Information, Eligibility and Entitlement Manual
- 100-02 Medicare Benefit Policy Manual
- 100-03 Medicare National Coverage Determinations (NCD) Manual
- 100-04 Medicare Claims Processing Manual**
- 100-05 Medicare Secondary Payer Manual
- 100-06 Medicare Financial Management Manual
- 100-07 State Operations Manual
- 100-08 Medicare Program Integrity Manual
- 100-09 Medicare Contractor Beneficiary and Provider Communications Manual

Medicare Claims Processing Manual Pub.100-04

- Chapter 1 - General Billing Requirements
- Chapter 2 - Admission and Registration Requirements
- Chapter 3 - Inpatient Part A Hospital
- Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSP)
- Chapter 5 - Part B Outpatient Rehabilitation and CORF Services
- Chapter 6 - SNF Inpatient Part A Billing
- Chapter 7 - SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)
- Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims
- Chapter 9 - Rural Health Clinics and Federal Qualified Health Centers
- Chapter 10 - Home Health Agency Billing
- Chapter 11 - Hospice
- Chapter 12 - Physician/Practitioner Billing**
- Chapter 13 - Radiology Services
- Chapter 14 - Ambulatory Surgical Centers
- Chapter 15 - Ambulance
- Chapter 16 - Laboratory Services from Independent Labs, Physicians, and Providers
- Chapter 17 - Drugs and Biologicals

Medicare Claims Processing Manual

To download the Manual – Chapter 12

–<http://www.cms.gov/manuals/downloads/clm104c12.pdf> (Rev 09-03-10, retrieved 11/17/10)

*See Manual references to selected topics as
we proceed through this presentation.*

Codes Across the Continuum: Routine Care

Nursing Homes

Code	Patient	Visit Type	Time	E/M Components
99304	New or Established	Initial *	25	3
99305	New or Established	Initial	35	3
99306	New or Established	Initial	45	3
99307	New or Established	<i>Subsequent**</i>	10	2
99308	New or Established	<i>Subsequent</i>	15	2
99309	New or Established	<i>Subsequent</i>	25	2
99310	New or Established	<i>Subsequent</i>	35	2
99315	New or Established	<i>Discharge</i>	=<30	2
99316	New or Established	<i>Discharge</i>	>30	2
99318	New or Established	<i>Annual</i>	30	2

* Initial: "Initial Nursing Facility Care, per day"

** Subsequent: "Subsequent Nursing Facility Care, per day"

Other (non-office) Venues

Assisted Living, Group Homes, etc.		Level of service	Home	
New Patient	Time		New Patient	Time
99324	20	low	99341	20
99325	30	moderate	99342	30
99326	45	moderate to high	99343	45
99327	60	high	99344	60
99328	75	unstable	99345	75
Established Patient			Established Patient	
99334	15	minor	99347	15
99335	25	low to moderate	99348	25
99336	40	moderate to high	99349	40
99337	60	unstable	99350	60

New Patient: Assisted Living, etc.

99324 Domiciliary or rest home visit for the evaluation and management of a new patient; problem focused history and exam; straightforward medical decision making (phys time approximately 20 minutes)

99325 Domiciliary or rest home visit for the evaluation and management of a new patient; expanded problem focused history and exam; medical decision making of low complexity (physician time approx 30 minutes)

99326 Domiciliary or rest home visit for the evaluation and management of a new patient; detailed history and exam; medical decision making of moderate complexity (physician time approx 45 minutes)

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New Patient: Assisted Living, etc.

99327 Domiciliary or rest home visit for the evaluation and management of a new patient; comprehensive history and examination; medical decision making of moderate complexity (physician time approx 60 minutes)

99328 Domiciliary or rest home visit for the evaluation and management of a new patient; comprehensive history and examination; medical decision making of high complexity (physician time approx 75 minutes)

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Established Patient: Assisted Living, etc.

99334 Domiciliary or rest home visit for the evaluation and management of an established patient; problem focused history and exam; straightforward medical decision making (physician time approximately 15 minutes)

99335 Domiciliary or rest home visit for the evaluation and management of an established patient; expanded problem focused history and exam; medical decision making of low complexity (physician time approx 25 minutes)

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Established Patient: Assisted Living, etc.

99336 Domiciliary or rest home visit for the evaluation and management of an established patient; detailed history and exam; medical decision making of moderate complexity (physician time approx 40 minutes)

99337 Domiciliary or rest home visit for the evaluation and management of an established patient; comprehensive history and examination; medical decision making of moderate to high complexity (physician time approx 60 minutes)

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Special Considerations

- Assisted Living resident services are billed using the AL codes. (Even though the AL is technically their “home”, it is not considered as such by CMS)

Requirements: Home

30.6.14

- Requirement for Physician Presence
 - Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary’s home.

30.6.14

Requirements: Home

- Homebound Status
 - Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

30.6.14

Requirements: Home

The CPT **codes 99341 through 99350**, Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes. **The Home Services codes apply only to the specific 2-digit POS 12 (Home).**

Home Services codes may not be used for billing E/M services provided in settings other than in the private residence of an individual as described above.

Requirements: POS

The American Medical Association's Current Procedural Terminology (CPT) 2006 **new patient codes 99324 – 99328 and established patient codes 99334 – 99337** (new codes beginning January 2006), for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services, are used to report evaluation and management (E/M) services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. **These CPT codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). Assisted living facilities may also be known as adult living facilities.**

New Patient - Home

99341 home visit for the evaluation and management of a new patient; problem focused history and exam; straightforward medical decision making (physician time approximately 20 minutes)

99342 Home visit for the evaluation and management of a new patient; expanded problem focused history and exam; medical decision making of low complexity (physician time approx 30 minutes)

99343 Home visit for the evaluation and management of a new patient; detailed history and exam; medical decision making of moderate complexity (physician time approximately 45 minutes)

New Patient - Home

99344 Home visit for the evaluation and management of a new patient; comprehensive history and examination; medical decision making of moderate complexity (physician time approx 60 minutes)

99345 Home visit for the evaluation and management of a new patient; comprehensive history and examination; medical decision making of high complexity (physician time approx 75 minutes)

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Established Patient - Home

99347 Home visit for the evaluation and management of an established patient; problem focused history and exam; straightforward medical decision making (physician time approximately 15 minutes)

99348 Home visit for the evaluation and management of an established patient; expanded problem focused history and exam; medical decision making of low complexity (physician time approximately 25 minutes)

Established Patient - Home

99349 Home visit for the evaluation and management of an established patient; detailed history and exam; medical decision making of moderate complexity (physician time approximately 40 minutes)

99350 Home visit for the evaluation and management of an established patient; comprehensive history and examination; medical decision making of moderate to high complexity (physician time approximately 60 minutes)

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Special Requirements and Important Concepts: Nursing Homes

Session Outline

3. Special Requirements and Important Concepts: Nursing Homes
 1. POS, SNF vs. NF, time, AI modifier,
 2. Medical Necessity
 1. regulatory visits
 2. E/M visits
 3. Initial vs. subsequent

POS, SNF vs. NF

- Place of Service Code
 - 31 = SNF, 32 = NF
- SNF vs. NF: in a nursing facility, the resident is in a
 - SNF bed: when the resident is receiving Medicare Part A benefits (“skilled care”)
 - NF bed: when the resident is not receiving Medicare Part A benefits

Time

- All nursing home CPT codes, as required by Medicare, require a face-to-face visit by the provider. Additional “floor” time (chart review, discussion with staff, writing of notes and orders) are included in the time guidelines for each code.
 - Telephone calls, family conferences without the patient present, off-site work of any kind is not reimbursable

AI Modifier

- Starting in 2010, the AI modifier (A-eye, not A-one) is to be added by the attending physician when billing for the initial comprehensive visit (99304, 99305, 99306)
 - Procedure for when the initial comprehensive visit is performed by a covering practitioner is not clear and is being clarified with CMS by AMDA

Medical Necessity

- Medical Necessity is the overarching criterion required to bill for services provided.

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

<http://www.amda.com/tools/library/whitepapers/mednecwhitepaper.cfm>

Medicare Claims Processing Manual,
Pub.100-04,

- **30.6.13 - Nursing Facility Services**

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”

Federally Mandated Visits

- Patient must be seen initially (within 30 days) and then at least every 30 days for the first 90 days, then at least once every 60 days thereafter

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 visit by the physician, 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.”

“Beginning January 1, 2006, the new CPT codes, 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)

“Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.”

ie. one payment for mandatory visit combined w/ medically necessary visit

“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.”

Medicare Claims Processing Manual,
Pub.100-04,

- **30.6.13 - Nursing Facility Services**

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

“E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.”

MLN MATTERS NUMBER: SE1010

- The long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

<http://www.cms.gov/MLNMattersArticles/downloads/SE1010.pdf>

Initial vs. Subsequent Care

- Every time a patient is admitted to a nursing facility, an Initial Visit must be done
- Initial visit codes are used even if the patient is an established patient of the provider performing the visit

Initial vs. Subsequent Care

- Initial Visit: the comprehensive history and examination, writing of orders and development of the care plan
 - performed upon admission to the nursing facility
 - 99304, 99305, 99306
 - attending physician appends “AI” modifier
 - must be done by physician in SNF
 - must be performed within 30 days of admission

Initial vs. Subsequent Care

- Subsequent Visit:
 - all other E/M visits (even if performed prior to the Initial Visit being done)
 - includes federally mandated visits
 - 99307, 99308, 99309, 99310
 - may be shared with Non-Physician Providers (NPPs) as allowed by Federal and State regulations and scope of practice
 - includes 99315, 99316, 99318

Special Situations: Nursing Homes

Non-Physician Practitioners (NPPs)

- Nurse Practitioners
- Physician Assistants
- Nurse Clinical Specialists

30.6.13 C 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.”

30.6.13 C Visits by Qualified Nonphysician Practitioners

- **Federally Mandated Visits**
 - **SNF (31)**
 - “Following the initial 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.”

MLN MATTERS NUMBER: SE1010

- The long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

30.6.13 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 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.

30.6.13 Visits by Qualified Nonphysician Practitioners

- “Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.”

	Order to Admit	Admission Treatment Orders	Initial Comprehensive Visit	Other Required Visits
SNF				
NP & CNS employed by facility	N	N	N	Y
NP & CNS not a facility employee	N	N	N	Y
PA regardless of employer	N	N	N	Y
NF				
NP, CNS & PA employed by facility	N	N	N	N
NP, CNS & PA not a facility employee	Y	Y	Y	Y

	Other Medically Necessary Visits	Other Medically Necessary Orders	Certification/Recertification
SNF			
NP & CNS employed by facility	Y	Y	N
NP & CNS not a facility employee	Y	Y	Y
PA regardless of employer	Y	Y	N
NF			
NP, CNS & PA employed by facility	Y	Y	Y
NP, CNS & PA not a facility employee	Y	Y	Y

Split Visits, Incident-to Services, Gang Visits

30.6.13 Incident To Services in the Nursing Home

- Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office.
- “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B.

30.6.13 Gang Visits

- “Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits.”
- Not quantified

30.6.13 Split/Shared Visits

- **Definition**
 - a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.
 - The physician and the qualified NPP must be in the same group practice or be employed by the same employer
 - **Can** be used for hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes
- **Nursing Facility**
 - A split/shared E/M visit **can not** be reported in the SNF/NF setting.

Telephone calls, Care Plan Oversight, Family Conferences

- Medicare does not pay for these services provided in the nursing facility
 - exception: family conference wherein the patient is present
- New in 2011: payment for telehealth services

Telehealth services: 2011

- Effective January 1, 2011, the Centers for Medicare & Medicaid Services approved the addition of subsequent nursing facility care services (99307–99310) to the list of Medicare telehealth services with the limitation of one telehealth subsequent nursing facility care service every 30 days. The initial visit and Federally-mandated periodic visits [as defined by 42 CFR §483.40(c)] should be conducted in-person may not be furnished through telehealth. *Medicare beneficiaries are eligible for telehealth services only if they are in an originating site (skilled nursing facilities are an authorized originating site) located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.*
- As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between a physician or practitioner at the distant site and the beneficiary at the originating site.

Hospice

Medicare Claims Processing Manual Pub.100-04 Chapter 11 – HOSPICE

- 40 - Billing and Payment for Hospice Services Provided by a Physician
 - 40.1 - Types of Physician Services
 - 40.1.1 - Administrative Activities
 - 40.1.2 - Patient Care Services
 - 40.1.3 - Attending Physician Services

- 50 - Billing and Payment for Services Unrelated to Terminal Illness

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Chapter 11 – HOSPICE

– 40.1 - Types of Physician Services

• 40.1.1 - Administrative Activities

- Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates.
- These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.
- These activities are generally performed by the physician serving as the medical director (of the Hospice) and the physician member of the interdisciplinary group (IDG).
- Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.

Medicare Claims Processing Manual

Pub.100-04

Chapter 11 – HOSPICE

– 40.1 - Types of Physician Services

• 40.1.2 - Patient Care Services

- Payment (to Hospices) for physicians or nurse practitioner serving as the attending physician, who provide direct patient care services and who are hospice employees or under arrangement with the hospice, is made in the following manner:
- Hospices establish a charge and bills the FI (MAC) for these services.

Medicare Claims Processing Manual

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Chapter 11 – HOSPICE

– 40.1 - Types of Physician Services

• 40.1.3 - Attending Physician Services

- an “attending physician” means an individual who:
 - Is a doctor of medicine or osteopathy or
 - A nurse practitioner ; and
 - Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

Medicare Claims Processing Manual

Pub.100-04

Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
 - **40.1.3 - Attending Physician Services**
- In order to bill Medicare as an “attending physician:”
 1. Not employed nor receives compensation by Hospice
 2. Professional services only (not technical)
 3. Can be in addition to the services of hospice-employed physicians
 4. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient’s terminal illness are not considered “hospice services.”

Medicare Claims Processing Manual

Pub.100-04

Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
 - **40.1.3 - Attending Physician Services**
- In order to bill Medicare as an “attending physician:”
 5. Services are reasonable and necessary for the treatment and management of a hospice patient’s terminal illness
 6. Services not furnished under a payment arrangement with the hospice
 7. Must be coordinated with any direct care services provided by hospice physicians.
 8. These services are coded with the **GV modifier:** “Attending physician not employed or paid under agreement by the patient’s hospice provider”

Medicare Claims Processing Manual

Pub.100-04

Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
 - **40.1.3 - Attending Physician Services**
- **Can NOT bill Medicare as an “attending physician:”**
 - When services related to a hospice patient’s terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, the physician must look to the hospice for payment.
 - In this situation the physicians’ services are hospice services and are billed by the hospice to its FI (MAC).

Medicare Claims Processing

Manual

Pub.100-04

Chapter 11 – HOSPICE

- 40 - Billing and Payment for Hospice Services Provided by a Physician
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Medicare Claims Processing Manual

Pub.100-04

Chapter 11 – HOSPICE

- 50 - Billing and Payment for Services Unrelated to Terminal Illness
 - Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the carrier for non-hospice Medicare payment.
 - These services are coded with the **GW modifier:** “service not related to the hospice patient’s terminal condition”

Hospice -Summary

- **Care not related to terminal illness**
 - Bill Medicare – modifier GW
- **Care related to terminal illness**
 - MD not associated with hospice
 - Bill Medicare – modifier GV
 - MD associated/employed with hospice
 - Bill Hospice / Contract

Prolonged Services

Prolonged Care 30.6.15 99354-99357

- Time

“In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.”

Prolonged Care 30.6.15 99354-99357

- Time face to face, continuous or not, **beyond the typical time plus 30 minutes**, of the visit code
- Documentation not required to be sent w/ bill, but is required in record as to duration and content of svc
- 99354-99355 – office, outpatient setting
- **99356-99357 – inpatient and NH**
 - 99356 – First 30 min of prolonged service
 - 99357 – each additional 30 minutes beyond the first hour

Threshold times for prolonged visit codes (99356, 99357)

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

MM6740 www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

**Prolonged Services
Without Face-to-Face Service
30.6.15.2
99358-99359**

- **Medicare does not pay for these codes**
- **Payment included in face to face services**
- **Can not bill patient**

Consultations

- **Revised regulations as of January, 2010**

L

Consultations 99241-99255

- **30.6.10 - Consultation Services**

Consultations – Gone With the Wind

- Consultation codes no longer recognized by CMS effective 1/1/10 (except telehealth codes)
- Fiscal Effect
 - Increase the work relative value units (RVUs) for new and established office visits
 - Increase the work RVUs for initial hospital and initial nursing facility visits
 - Incorporate the increased use of these visits into the practice expense (PE) and malpractice calculations
 - Increase the incremental work RVUs for the codes that are built into the 10-day and 90-day global surgical codes

Revised Consultation Policy

- Inpatient hospital setting and nursing facility setting
- “All physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).”
- AMDA clarified language re: initial evaluation in SNF and NPP: MLN MATTERS SE 1010
- **30.6.10 - Consultation Services**

R1875CP-Revisions to Consultation Services Payment Policy – instructions to carriers

<http://www.cms.gov/MLNMattersArticles/downloads/SE1010.pdf>

Use of initial nursing facility (NF) care codes for E/M services that could be described by CPT consultation codes

- “Physicians may bill an initial NF care CPT code for their first visit during a patient’s admission to a NF in lieu of the CPT consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care CPT code are satisfied.
- The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).
- The initial NF care CPT codes 99304 through 99306 are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c)”

MLN MATTERS NUMBER: SE1010

Initial E/M service that could be described by a CPT consultation code not meeting the requirements for reporting an initial NF care CPT code

- May bill a subsequent NF care CPT code in lieu of the CPT consultation codes they may have previously reported.
- Otherwise, the subsequent NF care CPT codes 99307 through 99310 are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.

MLN MATTERS NUMBER: SE1010

Revised Consultation Policy

- Principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care.
- Only the principal physician of record shall append modifier “-**AI**”, Principal Physician of Record, in addition to the E/M code.
- Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

DOCUMENTATION

- "Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient.
- In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician.
- This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes."

MLN MATTERS NUMBER: MM6740

Wound Care

Types of Debridement Codes

- Two types ulcer procedure codes
 - Active wound care
 - Removal of devitalized tissue, any method, with minimal or local/topical anesthesia
 - Any stage ulcer
 - Physician, NP/PA, podiatry, PT can bill
 - Can bill at any site of service
 - Debridement codes
 - More extensive not billable in LTC
 - More extensive requires pre / post operative care

Active Wound Care Codes

- Two levels of care depending only on total surface area (not depth or stage)
 - 97597 Removal devitalized tissue / selected debridement wound(s) no anesthesia total surface area ≤ 20 cm²
 - 97598 Removal devitalized tissue / selected debridement wound(s) no anesthesia total surface area > 20 cm²
- Involves ongoing care, may involve use of whirlpool
- Typically billed in outpatient settings
- Specialties billing: PT 16%, Gen Surg 14%, Pod 12% IM 12% FP 9% ER 8% NP 8%

Debridement Codes

- Lower level debridement codes generally used by general or plastic surgery, podiatry, primary care and NP/PA
- Billed as outpatient or inpatient
- Considered a surgical procedure
 - 11040 Debridement; skin, partial thickness
 - 11041 Debridement; skin, full thickness
 - 11042 Debridement; skin, & subcutaneous tissue

More on Debridement Codes

- Deeper / extensive debridement codes
 - Considered surgical procedures
 - 11043 Debridement; skin, subcutaneous tissue, & muscle (45 min intraservice, 175 min total)
 - 11044 Debridement; skin, subcutaneous tissue, muscle, & bone (90 min intraservice, 268 total time)
- Now paid for only in inpatient hospital, outpatient hospital, ambulatory care centers (ACS)
- Can file an appeal for other sites of service

Problems with Debridement / Active Wound Care Codes

- When do you cross the line between removing devitalized tissue and doing a debridement?
- Depth is not a factor in active wound care
- Extensive debridement does occur in LTC
- Should podiatric debridement be different?
- Medicare / CPT / RUC aware of problems:
CPT codes revised, new wRVU values – 2011

WHEW ! ! !

Next month: the basics of E/M documentation and the relationship of E/M documentation to the selection of billing codes for services provided in the nursing home!