Palliative Care: Non Traditional Physician Services

December 8, 2021

Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow
President & Sr. Consultant
Acevedo Consulting Incorporated

HOSPICE FUNDAMENTALS

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. Acevedo Consulting Inc. employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.

This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

THIS PRESENTATION CONTAINS ABBREVIATED CODE DEFINITIONS, IS NOT A SUBSTITUTE FOR YOUR CODE BOOKS, AND DOES NOT INCLUDE ALL CHANGES YOU MAY NEED TO KNOW. TO CODE AND BILL ACCURATELY.

Agenda

- Virtual visits and Telehealth
- Principal Care Management
- Cognitive Assessment

Newer Physician Service Codes

- Transitional Care Management
  - 2013
- Chronic Care Management
  - 2015
  - Enhanced in 2017, 2019
- Principal Care Management added in 2020
- Virtual Visits
  - 2019
- Telephone "visits"
  - 2020
- Cognitive Assessment
  - 2021

Virtual Check-In
Telephone E/M Visits
Telehealth.

For now...

"Traditional" telehealth remains as-is, but now we have...

- **Virtual check-ins** – A brief **phone call** to determine whether or not an in-person visit or other appropriate treatment is needed.
- **Telephone services** - A **phone call** to manage a patient's problem(s)/symptom(s).
  - Audio only telehealth
- **Telehealth visits:** A real-time interactive audio and video communication
  - Report with E&M codes

VIRTUAL VISITS

G2012 – Virtual Check-in Service

- G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. [emphasis added]
- G2252 -….11-20 minutes
- Call/other communication must be initiated by the patient.
- New or Established patients during PHE
- Interaction only with the physician/QHP, not other clinical staff.
- Verbal consent by the patient initially and at least annually thereafter must be documented in the medical record.
- Requires permanent documentation of the encounter

Virtual Check-ins – Key Takeaways

- G2012/G2252: A brief phone call to determine next steps; does the patient need a visit?, etc.
- Does not include any actual patient management
- Virtual check-in services can be reported for new or established patients during the COVID-19 public health emergency

Virtual Check-in: New for 2021

- LCSWs, CPs, LPTs, OTRs, SLP can furnish the brief online assessment and management services as well as virtual check ins and remote evaluation services.
  - G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
  - G2251: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

Telephone Services

PHE Approved – through Jan. 16, 2022

- The telephone E/M codes had been considered non-covered. Medicare now considers them covered and payable services and will be paid as 99212, 99213, 99214
- Physicians/NPPs use 99441, 99442, 99443:
  - Telephone evaluation and management service provided by a physician to a patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours…

Telephone Visits*

E&M visit via a telephone call by a Medicare provider who can bill an E&M code (physician, ARNP, CNS, PA, CRNA)

Telephone Evaluation and Management Services codes

- 99441: telephone evaluation and management service; 5-10 minutes
  - ~$46
- 99442: ….11-20 minutes
  - ~$76
- 99443: …21 or more minutes
  - ~$110

* Fees are National Medicare Allowable amounts

Telephone Call Takeaways

- Telephone Services
  - Must be managing a problem
  - For new or established patients during the PHE
  - Requires permanent documentation of the encounter
  - Clinical/office staff time is not calculated as part of the time for these services.
  - Do not report service time less than 5 minutes.
  - Do not bill if E/M provided within the previous 7 days nor leading to an E/M service within the next 24 hours…
  - Medicare deductible and co-insurance apply
  - Considered audio only telehealth during the PHE
    - Modifier 95

Telemedicine/Telehealth Services

Telehealth: What's Changed?

- Under the new waivers, Medicare can pay for office, hospital, home and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020.
  - "Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings."
  - CMS added 100+ new services to the list of covered telehealth services
- A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, are now able to offer telehealth to their patients.
  - Must consider state laws, rules and regs for licensure, scope of practice, etc.
- Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Telehealth Rules and What You Need to Know Now

- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits
  - Based on place of service (11 for example)
  - Append modifier 95
- Medicare coinsurance and deductible would generally apply to these services.
- Providers must continue to comply with state telehealth laws and regulations
  - Treating patients across state lines
  - Professional licensure
  - Scope of practice
  - Standards of care
  - Patient consent
  - Payment requirements for non-Medicare fee-for-service patients.

Clinical Scenario #1

- I'm a physician/ARNP. If I treat an established patient who is admitted to inpatient or observation care with audio-only phone, what code(s) can I report?
  - You would report the applicable telephone service based on the amount of time spent: 99441, 99442, 99443

Clinical Scenario #2

- What can I bill if I or another physician in my group perform(s) a follow-up telephone "visit" with the patient the next day?
  - You would report the applicable telephone service based on the amount of time spent: 99441, 99442, 99443

Clinical Scenario #3

- The rule for providing hospital visits via telehealth has always limited subsequent hospital visits provided by telehealth as no more than 1 telehealth visit every 3 days. Is there any way I can bill my daily inpatient visits when they are provided via telehealth?
  - The 3 day limitation has been suspended for the duration of the PHE. During this period, you are allowed to bill all medically necessary telehealth subsequent hospital visits (99231-99233) provided via telehealth.

Clinical Scenario #4

- As a palliative care nurse practitioner, I have a lot of Advanced Care Planning discussions. Now that I am unable to see most patients in person, how do I bill this service if the discussion is on the phone (audio only)? Via telehealth?
  - Advance Care Planning codes (99497-8) are on the list of approved telehealth services. When providing this discussion via telehealth, document as you would if the encounter had taken place in-person, and bill 99497 and, if appropriate, 99498.
  - If this is a telephone conversation with audio only with the patient and/or family, you would still report the ACP codes per CMS's 4/30/20 update.

Clinical Scenario #5

- How do I report my care and treatment of an unresponsive patient?
  - If I speak on the phone with the RN on the floor?
    - Not a billable service
  - If I speak on the phone with the family/caregiver about the care and treatment?
    - Report the applicable telephone visit code (99441-3) based on the amount of time spent on the phone.
  - Ok, but what if I provide a telehealth visit with the patient and/or family the next day after the call?
    - Bill the hospital visit code for the telehealth (9923x), and do NOT bill separately for the telephone service as the telephone visit is not billable if it leads to an E/M service within the next 24 hours.

Clinical Scenario #4

- The Medicare guidance is really clear that patients must not only consent to telephone or telehealth visits, but that these should be initiated by the patient. My schedule still shows some in-person visits. How do I handle this?
  - The rules acknowledge that you will need to reach out and educate patients to the fact that you are providing telephone visits, e-visits, and/or telehealth. So, you are allowed to reach out to these patients to let them know of the alternative(s) being offered. You may document their consent at that time.
  - Perhaps something along the lines of: Called patient to cancel Tuesday's in-person visit and advise of alternatives. Patient consents to and is asking to be scheduled for (telephone visits)(telehealth) during the PHE.

Recap

All require Medical Necessity, Patient Consent & normal POS code

- **Virtual check-ins** – A brief **phone call** to determine whether or not an in-person visit or other appropriate treatment is needed. No actual patient management.
- **Telephone services -** A **phone call** to manage a patient's problem(s)/symptom(s). Time-based codes
  - Require modifier -95
- **Telehealth visits**: An E&M service provided via real-time interactive audio and video communication (some exceptions for audio only).

Resources

- Medicare coverage and payment of virtual services
  - www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Covered Telehealth Services
  - www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Program's benefits help patients access their provider without visiting the office
  - www.cms.gov/newsroom/press-releases/telehealth-benefits-medicare-are-lifeline-patients-during-coronavirus-outbreak
- America's Health Insurance Plans
  - https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/
- OIG Policy Statement
  - https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

Principal Care Management

Care Management Services

- Non face-to-face service
- May be provided by the Physician, NPP or clinical staff*
  - Incident-to direct supervision criteria has been waived for CM when provided by clinical staff
  - 24/7 access for urgent clinical need is required
- Chronic Care Management - Only one physician/NPP can provide in a given month
- Principal Care Management – specialist(s) can provide for their disease-specific care

Development of Care Plan: G0506

- G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service.
- When the provider billing and initiating CCM personally performs extensive assessment and care planning beyond the usual effort described by the E&M, AWV or IPPE code, can also bill G0506.
  - "Add on" code – no modifier required when billed with E/M code
- Can bill this once per patient (Per provider)
- Bill separately from the monthly PCM
  - Cannot count time spent in G0506 towards any other billed service
- Medicare allowable - ~$61 (national)

Principal Care Management 2020

- Principal Care Management (PCM)
  - "We have heard from a number of stakeholders, especially those in specialties that use the office/outpatient E/M code set to report the majority of their services, that there can be significant resources involved in care management for a single high risk disease or complex chronic condition that is not well accounted for in existing coding." CMS in final MPFS rule.
  - "We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting and instead requires management by another, more specialized practitioner." CMS in final MPFS rule.

Care Management Services: PCM 2020

"We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions will continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. It is also possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously."

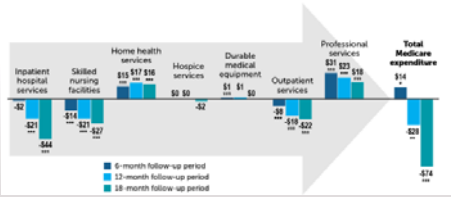
Principal Care Management 2020

- Principal Care Management (PCM) codes
  - **G2064** – PCM by physician or qualified health care professional; at least 30 minutes per calendar month.
  - **G2065** – PCM by clinical staff; at least 30 minutes per calendar month
  - Full descriptors are much like CCM

NOTE: effective 1/1/22 these HCPCS codes are replaced with CPT® codes 99424-99427

CCM Impact on Medicare Spending

Figure ES.2. Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods



"Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report" Mathematic Policy Research report to CMS, Nov. 2, 2017

Resources

- Connected Care: The Chronic Care Management Resource
  - https://go.cms.gov/ccm
- *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*" Mathematic Policy Research report to CMS, Nov. 2, 2017
- CMS's Chronic Conditions Data Warehouse
  - https://www2.ccwdata.org/web/guest/home/k.pdf

Cognitive Assessment and Care Plan Services

CPT® 99483

HOSPICE FUNDAMENTALS

CPT® 99483

- Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, 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); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

CMS on CPT® 99483

- If your patient shows signs of cognitive impairment during a routine visit, Medicare covers a separate visit to more thoroughly assess your patient's cognitive function and develop a care plan – use CPT code 99483 to bill for this service.
- Effective January 1, 2021, Medicare increased payment for these services to $282 (may be geographically adjusted) when provided in an office setting, added these services to the definition of primary care services in the Medicare Shared Savings Program, and permanently covered these services via telehealth. Use CPT code 99483 to bill for both in-person and telehealth services

CMS on CPT® 99483

How do I get started?

- Detecting cognitive impairment is a required element of Medicare's Annual Wellness Visit (AWV). You can also detect cognitive impairment as part of a routine visit through direct observation or by considering information from the patient, family, friends, caregivers, and others. You may also use a brief cognitive test and evaluate health disparities, chronic conditions, and other factors that contribute to increased risk of cognitive impairment.
- If you detect cognitive impairment at an AWV or other routine visit, you may perform a more detailed cognitive assessment and develop a care plan during a separate visit. This additional evaluation may be helpful to diagnose a person with dementia, such as Alzheimer's disease, and to identify treatable causes or co-occurring conditions such as depression or anxiety.

CMS on CPT® 99483

Who can perform this service?

Any provider who can perform an E/M service

- Physicians (MD and DO)
- Nurse practitioners
- Clinical nurse specialists
- Physician assistants

Where can I provider this service?

At any of these locations:

- Office or outpatient setting
- Private residence
- Care facility
- Rest home
- Via telehealth

CMS on CPT® 99483

What's included in this service?

- The cognitive assessment includes a detailed history and patient exam. There must be an independent historian for assessments and corresponding care plans provided under CPT code 99483.
  - An independent historian can be a parent, spouse, guardian, or other individual who provides patient history when a patient isn't able to provide complete or reliable medical history.
- Typically, you would spend 50 minutes face-to-face with the patient and independent historian to perform the following elements during the cognitive assessment: (next slide)

CMS on CPT® 99483

Included services…

- Examine the patient with a focus on observing cognition
- Record and review the patient's history, reports, and records
- Conduct a functional assessment of Basic and Instrumental Activities of Daily Living, including decision-making capacity
- Use standardized instruments for staging of dementia like the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR)
- Reconcile and review for high-risk medications, if applicable

Included services…

- Use standardized screening instruments to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety
- Conduct a safety evaluation for home and motor vehicle operation
- Identify social supports including how much caregivers know and are willing to provide care
- Address Advance Care Planning and any palliative care needs

Questions?

Note:

Coverage, payment and other aspects of this and other services related to the telehealth continue to evolve, so stay tuned!

Acevedo Consulting Incorporated
2605 West Atlantic Avenue, Suite D-102
Delray Beach, FL 33445
561.278.9328
Email: info@acevedoconsulting.com
www.AcevedoConsultingInc.com