Business of Pediatrics Conference

A 2015 Coding Update and More about Value Driven Care Models

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Faculty Disclosure Information: Joel Bradley, MD, FAAP

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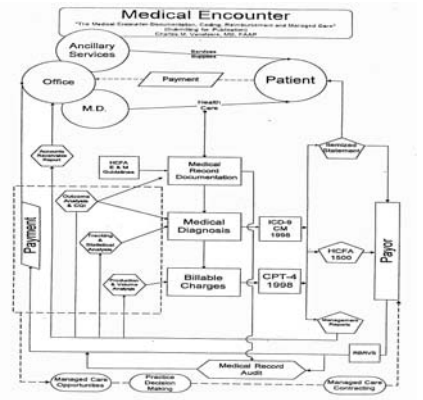
- This presentation will not include discussion of pharmaceuticals or devices that have not been approved by the FDA or if you will be discussing unapproved or "off-label" uses of pharmaceuticals or devices.

Our Agenda for today

1. Coding and Reimbursement Updates on -
   - 1. The Medicare Physician Fee Schedule- RBRVS
   - 2. ICD 9 CM Coding
   - 3. CPT coding
2. Creating Value in Your Medical Home



Driving Health Care

- The Triple Aim
- Population Health
- Accountable Care
- A "new" quality
- Value based payment- pay for outcomes vs volume
- Consumer demand for value- access! (urgent walk in care, telemedicine)

The Coding System

- Physicians report to payers services provided to patients using alphanumeric codes
- HIPAA requires certain code sets for electronic transactions
  - CPT, HCPCS, ICD-9-CM
- CPT and ICD are the code sets used by all US physicians and payers

Current Procedural Terminology (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990's
- Tell payers what service was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
  - Nature and amount of work
  - Place and type of service
  - Patient's health and age (in some cases)

ICD-9-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification in the US is controlled by the 'cooperating parties'
  - CMS
  - National Center for Health Statistics/CDC
  - American Hospital Association
  - American Health Information Management Association
- Tells Payers about the **Medical Necessity** of services

The Revenue Cycle

- Provide the service
- Find the correct codes
- Assign your fee
- Report (Bill) the claim
- Receive your EOB (explanation of benefit)
- Deposit your payment or a denial with a reason

The Medicare Physician Fee Schedule Resource Based Relative Value System

- Is updated each year by CMS- in November Federal Register – "Final Rule"
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit - "RVU"
- Each year an updated conversion factor is published- 2015 Payment- rvu x cf

The Medicare Physician Fee Schedule Resource Based Relative Value System

- 2015 -conversion factor = $35.83
- Payment Example-

- 99213- office visit
- RVU = 2.05
- CF= $35.83
- So Fee= 2.05 x $35,83 = $73.45

Where do documentation guidelines come from?

- EM Documentation Guidelines
  - Centers for Medicare and Medicaid Services (CMS)
    - formerly Health Care Finance Administration (HCFA)
  - Have become the de facto industry standard
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

CPT Code Categories

Category I:

- Most commonly used codes for billing for patients services- numeric

Category II:

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

Category III:

- New procedures and technology
- Can be used for payment, alphanumeric

Terminology for "Getting Paid"

Reporting:

- the "billing" of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

Licensure:

- a state entity allowing the provider to perform a service under a "scope of practice" law, act, or regulation

Credentialing:

- certification by a public or private payer defining the services for which the provider will be paid

Who can get paid for the service? Behavioral Health

- AMA News- March 2011
  - Evaluation and management codes 99201-99205 for new patients and 99212-99215 for established patients are usually reimbursed when accompanied by the ICD-9 diagnosis codes for the condition.
  - The codes 90801-90899 for psychiatric or psychotherapy services generally were not paid if reported by primary care physicians.

How to Improve

Measure your coding profiles

Participate in a practice-based coding education program with regular self auditing of medical records (compliance program)

Always focus on correctly coding

- dollars will follow and you will minimize risk of audits or recoveries

New CPT codes for 2015

- Released September 2014 by the AMA
- Implemented 1 Jan 2015
- Relative Values will be found in the CMS Medicare Physician Fee Schedule in a November Final Rule (Federal Register)
- AAP publishes and updates the RBRVS Brochure- 2015 on www.aap.org

RBRVS Changes for 2015

Medicare Conversion Factor *

- There is a 0% (NO) reduction for the 2015 conversion factor (CF) through March 31, 2015
- The CF will be $35.8228

ICD Changes for 2015

- There are no changes to ICD-9-CM
- ICD-10-CM Implementation date is still planned for 1 October 2015

CPT Changes for 2015

- Changes are reviewed in the following sections of CPT
  - Evaluation and Management (E/M) Services Section
  - Surgery Section
  - Medicine Section
  - Modifiers (HCPCS)

E/M Section

Changes to the E/M Section

- Several changes occurred to the Evaluation and Management (E/M) section that impact pediatrics
  - ❖ Addition of "Military History"
  - ❖ Revisions to the Inpatient Neonatal and Pediatric Critical Care codes
  - ❖ Deletion of codes 99481 and **99482**
    - o Total body hypothermia
    - o Selective head hypothermia
      - ➢ New code added – Located in the Medicine Section
  - ❖ Addition of new codes for Advanced Care Planning

Social History

- Revisions were made to the "Social History" section in the E/M guidelines to add in "military history"
- It was added due to the growing emphasis on identifying those who serve in the military, have served or have a close relative (eg, parent) who serves because of the health implications that may have

Social History

An age appropriate review of past and current activities that includes significant information about:

- ➢ Marital status and/or living arrangements
- ➢ Current employment
- ➢ Occupational history
- ➢ **Military history**
- Use of drugs, alcohol, and tobacco
- ➢ Level of education
- ➢ Sexual history
- ➢ Other relevant social factors

-Medical Decision Making-MDM - A CPT change in "philosophy"

- CPT carefully examined the role that the key element of medical decision making plays in the correct selection of Evaluation and Management codes. EMR-related "upcoding" based on the easy capture of history and exam items is one of the causes for the review
- Consideration was given to requiring MDM as one of the ***"required"*** key elements in the selection of all EM codes
- A decision was made to NOT include this requirement in CPT 2015
- Although not requirement (yet), consider MDM to **the** element that reflects the complexity of a given problem , and the drives the EM code selection. Learn the documentation requirement for this key element

Inpatient Neonatal and Pediatric Critical Care

- Guidelines were revised to
  - Clarify that the initial neonatal code (99468) and initial pediatric critical care codes (99471, 99475) may only be reported once per admission per patient
  - If a patient recovers and no longer requires critical care services, but then their condition deteriorates and have to be re-admitted to critical care services during the same admission, report a subsequent critical care code (99469, 99472, 99476)
  - Allow the reporting of "initiation of selective head or total body hypothermia" in addition to these critical care codes

Inpatient Neonatal and Pediatric Critical Care

- A 2-week old is admitted to the NICU for an acute illness. The baby stays in the NICU for 3 days while they require critical care services. On the fourth day the baby is sent to the step-down nursery and requires "sick" care only. After 2 days, the baby deteriorated again and is re-admitted to the NICU. Based on the guidelines, what codes are reported:
  - Day 1 **99468** (initial critical care)
  - Days 2-3 **99469** (subsequent critical care)
  - Days 4-5 **99231-99233** (Subsequent hospital care - based on complexity)
  - Day 6 **99469** (subsequent critical care)
- This is the coding scenario even if the providers differ.

Inpatient Neonatal and Pediatric Critical Care

- Note that we have requested that CPT publish an errata to address a concern within the new guidelines.
- It states "Codes 99468, 99469 are used to report the services of directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. They represent care starting with the date of admission (99468) to a critical care unit and subsequent day(s) (99469) that the neonate remains critical. **These codes may be reported only by a single individual and only once per day, per patient, per hospital stay in a given facility."**
- The "per hospital stay" should only be limited to the initial critical care code (99468) and not the subsequent critical care code (99469)

Advanced Care Planning

What is An Advanced Directive

- A document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity.
- Examples include: Health Care Proxy, Living Will, Medical Orders for Life Sustaining Treatment or Durable Power of Attorney

Advanced Care Planning

99497 - 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

+ 99498 - each additional 30 minutes
Report **99498** with **99497**

*No Published RVUs for these services

Advanced Care Planning

- Face-to-Face service by a physician or other qualified health care professional (OQHCP) with a patient, family member or surrogate:
  - To discuss advance directives w/ or w/o completing relevant legal forms
  - Reported based on time spent in advanced care planning
  - Can be reported when the mid-point time has passed
    - Meaning you need 15 minutes of time or more to report the 30 minute code (ie,

Advanced Care Planning (cont)

- No active management of the problem(s) is performed during this encounter
- May be reported in addition to many E/M services, including but not limited to 99201-99215, 99381-99397, 99221-99223, 99231-99233
- May not be reported in addition to (global EM Services) 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480

Advanced Care Planning Clinical Example

A pediatric hospice physician spends 45 minutes discussing further medical care and end of life wishes with an adolescent and her parents. The patient has non-responsive relapsing glioblastoma. This time spent also included the signing of advanced directives.

- Note the patient is not receiving critical care services, but did receive a separate subsequent hospital care service that same day by the same physician.

- Report:
  99231-99233 and
  99497 25

Advanced Care Planning Clinical Example

- A 17 year old patient on dialysis with ESRD presents to her nephrologists office with her mom to discuss further directives for care. She is on a waiting list for a transplant, but due to a rare blood type a match has been difficult to find. She meets with a social worker and the physician to discuss this and they develop a plan of care should she continue to decline and transplant is not an option. A total of 50 minutes is spent.

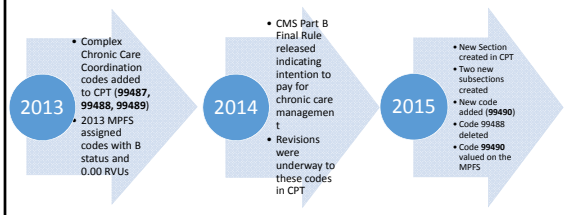
- Report **99487** (first 30 mins) and **99488** (additional 30 mins)
  (Remember that once the mid-point is passed, these codes can be reported).

Care Management Services

Care Management Services

- For 2015 a new CPT code was added and two existing CPT codes revised
- These codes allow for the reporting of face to face and non face to face services provided ***by clinical staff*** who are directly supervised by a physician or other qualified health care professional
- Supplements other CPT existing codes that recognize the key role of primary care and the medical home in providing care coordination
  - Transitional Care Management 99495 and 99496
  - Care Plan Oversight- 99374-5, 99377-8,99378-80, and 99339-40

The History of Care Management



New "Care Management Services" Section

- Provides overarching guidelines over the two new subsections
  1. Chronic Care Management
  2. Complex Chronic Care Management

Care management services are defined as

"management and support services **provided by clinical staff, under the direction of a physician** or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility."

New "Care Management Services" Section

Care Management Services may include

- establishing, implementing, revising, or monitoring the **care plan**
- coordinating the care of other professionals and agencies
- educating the patient or caregiver about the patient's condition, care plan, and prognosis

- The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living **(Comprehensive !)**

A Care Plan Is Required

- Must be documented and shared with the patient and/or caregiver.
- Is based on a physical, mental, cognitive, social, functional, and environmental assessment
- It is a comprehensive plan of care for all health problems.
- **Includes, but is not limited to, the following elements**:
  - problem list
  - expected outcome and prognosis
  - measurable treatment goals
  - symptom management
  - planned interventions
  - medication management
  - community/social services ordered
  - how the services of agencies and specialists unconnected to the practice will be directed/coordinated
  - identification of the individuals responsible for each intervention,
  - requirements for periodic review, and, when applicable, revision of the care plan.

Care Management Services

- Report only **once per calendar month**
- Report only by the **single physician** or other qualified health care professional who assumes the care management role with a particular patient for the calendar month
- Time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month
- Only the time of the clinical staff of the reporting professional is counted
- Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient
- Do not count any clinical staff time on a day when the physician or qualified health care professional reports an E/M service

Care Management Services

- *Typically* include:
  - communication with home health agencies and other community services utilized by the patient
  - assessment and support for treatment regimen adherence and medication management
  - identification of available community and health resources
  - facilitating access to care and services needed by the patient and/or family
  - management of care transitions not reported as part of transitional care management (99495, 99496);
  - ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service
  - development, communication, and maintenance of a comprehensive care plan.

Care Management Services

- The care management office/practice must have the following capabilities:
  - provide 24/7 access to physicians or other qualified health care professionals or clinical staff
  - provide continuity of care with a designated member of the care team
  - provide timely access and management for follow-up after an emergency department visit or facility discharge
  - utilize an HER system so that care providers have timely access to clinical information
  - use a standardized methodology to identify patients who require these services and ensure that those patients identified begin receiving them in a timely manner
  - use a form and format in the medical record that is standardized within the practice
  - be able to engage and educate patients and caregivers as well as coordinate care

Chronic Care Management Services

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two 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, or monitored.

(Chronic care management services of less than 20 minutes duration, in a calendar month, **are not reported separately**)

Complex Chronic Care Management Services

99487 Complex chronic care management services, with the following required elements:

- same as 99490 plus
- establishment or substantial revision of a comprehensive care plan
- 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

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

(Report **99489** with **99487**)

Complex Chronic Care

- Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately
- To report one or more face-to-face visits by the physician or other qualified health care professional that are performed in the same month as 99487, use the appropriate E/M code[s]
- Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy

Chronic Care Management Time

- Time of care management with the emergency department

is reportable using **99487, 99489, 99490**, but time while the patient is inpatient or admitted as observation is not.

- If the physician personally performs the clinical staff activities, his

or her time may be counted toward the required clinical staff

time to meet the elements of the code.

Complex Chronic Care Time

Total Duration of Staff Care Management Services	Complex Chronic Care Management
Less than 60 minutes	Not reported separately*
60 to 89 minutes (1 hour - 1 hr. 29 min.)	**99487**
90 - 119 minutes (1 hr. 30 min. - 1 hr. 59 min.)	**99487** and **99489** X 1
120 minutes or more (2 hours or more)	**99487** and **99489** X 2 and **99489** for each additional 30 minutes

* The mid-point rule does not apply here

Chronic Care Management

- Do not report chronic care management codes (99487, 99489, 99490) in the same calendar month as:
  - Non-Direct Prolonged Services (99358-99359)
  - Medical Team Conference (99366-99368)
  - Transition Care Management (99495-99496)
  - Care Plan Oversight (99339-99340, 99374-99380)
  - Telephone Care (99441-99443 and 98966-98968)
  - On-line Medical Evaluation (99444 and 98969)
  - Anticoagulant Management (99363-99364)
  - ESRD Related Management (90951-90970)
  - Education and Training (98960-98962, 99071, 99078)
  - Preparation of special reports (99080)
  - Analysis of data (99090, 99091)
  - Medication therapy management services (99605-99607)

Chronic Care vs Complex Chronic Care

	Chronic Care 99490	Complex Chronic Care 99487, 99489
Two or more chronic conditions	√	√
Comprehensive care plan established, implemented, revised or monitored	√	√
Chronic conditions place patient at significant risk of death, acute exacerbation or decompensation or functional decline	√	√
Establishment or substantial revision of a comprehensive care plan		√
Moderate or high complexity of MDM		√
Clinical staff time	20 minutes	60 minutes

MPFS and Care Management Services

CPT/ HCPCS		Status	Description	Work RVUs	NF PE RVUs	Malpractice RVUs	Total NF RVUs	Total F RVUs	Global
99487		B	Cmplx chron care w/o pt vsit	0.00	0.00	0.00	0.00	0.00	XXX
99489		B	Cmplx chron care addl 30 min	0.00	0.00	0.00	0.00	0.00	ZZZ
99490		**A**	**Chron care mgmt srvc 20 min**	**0.61**	**0.54**	**0.04**	**1.19**	**NA**	**XXX**
							Payment	1.19 x $35.8228=	**$42.63**

A – Active Status; B - Bundled; F – Facility; MPFS – Medicare Physician Fee Schedule; NF – Non-Facility; PE – practice expense; RVUs – relative value units

Clinical Example

- The clinical nursing staff spend 45 minutes of non face to face time in July both on and off the telephone providing care coordination and management services to a 8 year old with Type I Diabetes and severe persistent asthma that is not well controlled. The care plan was monitored and slightly revised to ensure the patient managed their condition and stayed out of the emergency department.
- What to code?
  - Time spent was 45 minutes
  - Care plan was monitored and slightly revised
  - Patient has 2 or more chronic conditions

Clinical Example

- Report **99490**
  - While many of the criteria were met for complex chronic care, there was no documentation of a substantial revision to the care plan

Clinical Example

- The clinical nursing staff spend 75 minutes during the month of October of non face to face time developing a care plan with the help of the physician as well as spent time both on and off the telephone providing care coordination and management services to an **18 year old with Type I Diabetes and severe persistent asthma , and severe bipolar disorder**. The member has had two medical admissions and two separate psychiatric admission during the last 6 months. This patient is new to town and therefore a new comprehensive care plan had to be developed. The level of medical decision making was moderate.
- What to code?
  - Time spent was 75 minutes
  - Comprehensive care plan was established
  - Patient has two or more chronic conditions
  - Documented MDM was moderate

Clinical Example

- Report **99487**
  - Even though the time spent was over 60 minutes, the time threshold was not reached for also reporting 99489

Chronic Care Management – CMS Rule

- In order to bill Medicare for code **99490** (Chronic care management) they require:
  - That the patient is notified (and signs) a notice that they may receive a bill for this service (important as there may be no face-to-face service)
  - That the patient or primary caregiver receives a copy of the actual care plan
- Something to consider if you implement in your practice as some other payers may have similar requirements

Transitional Care Management (TCM)- 2013

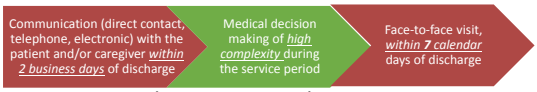
- Manage transition from hospital care setting
  - acute inpatient
  - rehabilitation
  - long-term acute care
  - observation status
- To the patient's community setting
  - home
  - domiciliary
  - assisted living facility
- New or Established patient (2014)

Transitional Care Management Elements

- 99495

  - 4.82/3.96 RVUs non-facility/facility

- 99496



  - **6.79/5.81 RVUs non-facility/facility**

TCM Requirements

- Covers services begin of the day of discharge and continues next through the next 29 days
- Interactive contact with the patient or caregiver must occur within 2 business days of discharge
  - contact can be face-to-face, by phone or electronic means
  - business days = Monday through Friday
- Must be a face-to-face visit within 14 (moderate MDM) or 7 calendar days (high MDM)
  - additional visits may be separately reported
- Medication reconciliation and management must occur no later than date of first face-to-face visit

Providers of TCM

- Physician or QHCP
  - NP, PA, CNM
- Licensed clinical staff provide services under physician supervision
  - RN, LPN

Physician or QHCP Non-Face-to-Face Services

- Obtain and review discharge information (eg, discharge summary, as available, or continuity of care documents)
- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with others who will assume or resume care of the patient's system specific problems
- Educate patient, family, guardian, and/or caregiver
- Establish or reestablish referrals and arrange for needed community resources
- Assist in scheduling any required follow-up with community providers and services

Licensed Clinical Staff Non-Face-to-Face Services

- Communicate aspects of care with patient, family members, guardian, caretaker, surrogate decision makers, and/or other professionals
- Communicate with home health agencies and community services utilized by the patient
- Educate patient, family, caretaker supporting self-management, independent living, and activities of daily living
- Assessment/support treatment regimen adherence and medication management
- Identify of available community and health resources
- Facilitate access to care and services needed by the patient and/or family

TCM: Initiation

- Mary's PCP receives notification of her discharge by the nurse on the observation unit
- Mary's PCP receives and reviews the observation records
- LPN phones Mary's mother the next morning explaining TCM services, verifies understanding of discharge instructions and current medications and schedules appointment within 7 calendar days at time most convenient to Mary's needs

TCM: Physician Visit

- Mary's pediatrician and RN develop visit agenda
- The pediatrician reviews test results not available on day of discharge
- The face-to-face visit is within 7 calendar days of the date of discharge
- The pediatrician and Mary's mother set health goals including any OT, PT, psychosocial or subspecialty services that may be needed
- The pediatrician makes appropriate referrals

TCM: Clinical Staff – 28 Days

- RN meets with Mary and her mother and assesses psychosocial needs
  - Mother is overwhelmed with caring for Mary
    - Provides information on local community services that may be helpful
- RN collaborates with health services to support Mary's goals and follow progress
- Mary's mother prefers communication by email so RN emails weekly to encourage review progress, answer questions, and address mother's concerns

All 3 criteria of the codes must be met

- Report **99495** if-
  1. contact within 2 business days
  2. **moderate** complexity MDM
  3. visit within **14** calendar days
- **99496** must include:
  1. contact within 2 business days
  2. **high** complexity MDM
  3. visit within **7** calendar days

MFS 2015- 99495- $164.78 (99214- $108) **99496- $232.49 (99215- $145)**

TCM Points to Remember

- Medication reconciliation and management must occur no later than the date of the face-to-face visit
- Same physician can report discharge services and TCM if physician did not provide a service for which global period applies
- One individual reports once per patient within 30 days of discharge, cannot report again within 30 days (even if new discharge)
- First physician to report TCM is paid, all others denied

TCM: Documentation

- Physician/QHP review of the discharge records including test results and follow-up on any pending results or scheduled tests
- Date of initial post-discharge contact (and attempts) and context of communication
- Document patient's conditions, psychosocial needs, support necessary for activities of daily living, other factors affecting care management (nature of presenting problems)
- Document and date medication reconciliation
- Document TCM non-face-to-face services listed in CPT (for Medicare - reason services were not necessary)
- Document face-to-face encounter within specified time period for code (30 days)
- Include legible signatures and credentials of physicians, QHP's and licensed clinical staff

Care Plan Oversight- Reporting Physician Non face to face time

- Oversight of services for children with special health care needs and chronic medical conditions by primary care physicians
- Coordinate medical care management with other medical and non-medical service providers and family
- May encompass oversight of work or school programs the patient may be attending where therapy is provided
- Includes
  - review of patient records, reports and labs
  - communications for assessment and care decisions
    - To other health care professional
    - To family, caregiver or guardian

Care plan oversight

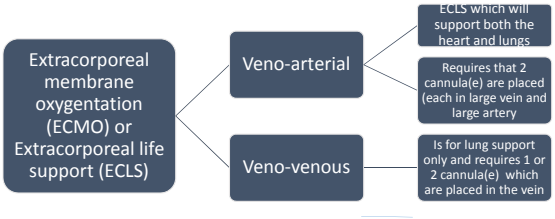
Service	15- 30 minutes	>30 minutes
Home services not involving home health agency	99339 2.25 RVU	99340 3.15 RVU
Home health agency	99374 2.03/1.61 RVU non-facility/facility	99375 3.04/2.54 RVU non-facility/facility
Hospice	99377 2.03/1.61 RVU non-facility/facility	99378 3.04/2.54 RVU non-facility/facility

- Patient is not present
- Count the time spent by the MD or "OQHCP"
- Services are "per calendar month"

- Payment MFS- 99339- $78.45 **99340- $109.62**

Surgical Section

ECMO/ECLS

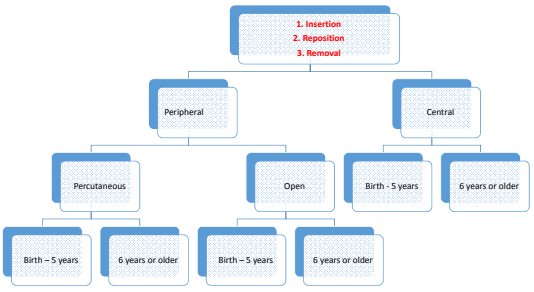


New ECMO/ECLS Codes for 2015

Initiation
- Veno-arterial
- Veno-venous

Daily Management
- Veno-arterial
- Veno-venous

ECMO/ECLS



ECMO/ECLS Guidelines

- Daily management and repositioning services may not be reported on the same day as initiation services **by the same or different individuals**
- Repositioning of the cannula(e) at the same session as insertion is not separately reportable.
- Replacement of cannula(e) in the same vessel should only be reported using the insertion code
- If cannula(e) are removed from one vessel and new cannula(e) are placed in a different vessel, report the appropriate cannula(e) removal and insertion codes
- Extensive repair or replacement of an artery may be additionally reported
- Fluoroscopic guidance used for cannula(e) repositioning is included in the procedure if performed and should not be separately reported
- Daily management codes should not be reported on the same day as initiation
- Initiation codes should not be reported on the same day as repositioning codes

ECMO/ECLS

ECMO/ECLS Service	CPT Code
Initiation	33946*, 33947*
Daily Management	33948*, 33949*
Insertion Peripheral Cannula	33951, 33952, 33953, 33954
Insertion Central Cannula	33955, 33956
Reposition Peripheral Cannula	33957, 33958, 33959, 33962
Reposition Central Cannula	33963, 33964
Removal Peripheral Cannula	33965, 33966, 33969, 33984
Removal Central Cannula	33985, 33986

*Modifier 63 is not allowed

ECMO/ECLS Valuation

CPT/ HCPCS	Status	Description	Work RVUs	NF PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total NF RVUs	Total F RVUs	Global	Total F Fee	Total NF Fee
33946	A	Ecmo/ecls initiation venous	6.00	NA	1.86	1.21	NA	9.07	XXX	$324.9128	NA
33947	A	Ecmo/ecls initiation artery	6.63	NA	2.05	1.21	NA	9.89	XXX	$354.2875	NA
33948	A	Ecmo/ecls daily mgmt-venous	4.73	NA	1.53	0.68	NA	6.94	XXX	$248.6102	NA
33949	A	Ecmo/ecls daily mgmt artery	4.60	NA	1.49	0.68	NA	6.77	XXX	$242.5204	NA
33951	A	Ecmo/ecls insj prph cannula	8.15	2.78	2.71	0.35	11.28	11.21	000	$401.5736	$404.0812
33952	A	Ecmo/ecls insj prph cannula	8.15	2.49	2.40	0.35	10.99	10.90	000	$390.4685	$393.6926
33953	A	Ecmo/ecls insj prph cannula	9.11	3.10	3.03	0.35	12.56	12.49	000	$447.4268	$449.9344
33954	A	Ecmo/ecls insj prph cannula	9.11	2.78	2.68	0.35	12.24	12.14	000	434.8888	$$438.4711

F – Facility
NF – Non-facility
PE – Practice expense
RVUs – Relative Value Units

ECMO/ECLS Valuation (cont.)

CPT/ HCPCS	Status	Description	Work RVUs	NF PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total NF RVUs	Total Facility RVUs	Global	Total Facility Fee	Total NF Fee
33955	A	Ecmo/ecls insj ctr cannula	16.00	6.21	6.12	3.81	26.02	25.93	000	$928.89	$932.11
33956	A	Ecmo/ecls insj ctr cannula	16.00	4.80	4.70	3.45	24.25	24.15	000	$865.12	$868.70
33957	A	Ecmo/ecls repos perph cnula	3.51	1.43	1.34	0.95	5.89	5.80	000	$207.77	$210.99
33958	A	Ecmo/ecls repos perph cnula	3.51	1.24	1.17	3.45	8.20	8.13	000	$291.23	$293.75
33959	A	Ecmo/ecls repos perph cnula	4.47	1.80	1.71	1.12	7.39	7.30	000	$261.50	$264.73
33962	A	Ecmo/ecls repos perph cnula	4.47	1.35	1.25	3.45	9.27	9.17	000	$328.50	$332.08
33963	A	Ecmo/ecls repos perph cnula	9.00	3.53	3.44	2.07	14.60	14.51	000	$519.79	$523.01
33964	A	Ecmo/ecls repos perph cnula	9.50	3.23	3.16	3.45	16.18	16.11	000	$577.11	$579.61
33965	A	Ecmo/ecls rmvl perph cannula	3.51	1.34	1.43	0.80	5.65	5.74	000	$205.62	$202.40
33966	A	Ecmo/ecls rmvl prph cannula	4.50	1.26	1.36	3.45	9.21	9.31	000	$333.51	$329.93

Medicine Section

Vaccines

- Changes you will see to many vaccine product descriptors (90476-90748) reflect the most recent US vaccine abbreviations references used in the Advisory Committee on Immunization Practices (ACIP) recommendations at the time of CPT code set publication
- Interim updates to vaccine code descriptors will be made following abbreviation approval by the ACIP on a timely basis via the AMA CPT website abbreviation designations in the CPT code set does not affect the validity of the vaccine code and its reporting function
- Reminder – Vaccines are updated twice annually and as needed

Vaccine Product Changes

- Most recent updates are found at:

http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page

Vaccine Codes

CPT Code Descriptors	Release/Implementation	Published
↗● **90630** Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	Released - July 1, 2014 Implementation Jan 1, 2015	**CPT 2015**
↗● **90651** Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use	Released - July 1, 2014 Implementation January 1, 2015	**CPT 2015**
↗● **90697** Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP- IPV-Hib-HepB), for intramuscular use	Released - July 1, 2014 Implementation January 1, 2015	**CPT 2016**
↗● **90620** Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	Released - Nov 1, 2014 Implementation February 1, 2015	**CPT 2016**
● **90621** Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for IM use	Released November 1, 2014 Implementation Feb 1, 2015	**CPT 2016**

New Vaccine Codes

- Remember that coverage will depend not only on the CPT publication date, but the recommendations of ACIP or the AAP
- Always check with your payers regarding coverage
- **NOTE:** The new meningococcal vaccine Trumenba (reported with CPT code 90621) has received FDA approval, however ACIP recommendations are not out and the code is not being implemented by CPT until February 1, 2015

Developmental Screening

- Code **96110** was revised
- **96110** Developmental screening (eg, developmental milestone survey, speech and language delay screen), with ~~interpretation and report~~ scoring and documentation, per standardized instrument ~~form~~
- For emotional/behavioral assessment, use **96127**

Behavioral/Emotional Assessment

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

- New code was added to differentiate those instruments that look solely or mainly at behavioral and/or emotional issues
- These may include ADHD/ADD, inattentiveness, depression or anxiety
- For developmental screening, use **96110**

96110 vs 96127

Instrument	Abbreviation	CPT Code
Ages and Stages Questionnaire-Third Edition	ASQ	96110
Ages and States Questionnaire: Social-Emotional	ASQ:SE	96127
Australian Scale for Asperger's Syndrome	ASAS	96127
Beck Youth Inventories - Second Edition	BYI-II	96127
Behavior Assessment Scale for Children-Second Edition	BASC-2	96127
Behavioral Rating Inventory of Executive Function	BRIEF	96127
Connor's Rating Scale		96127
Modified Checklist for Autism in Toddlers	M-CHAT	96110
Patient Health Questionnaire	PHQ-2 or PHQ-9	96127
Parents' Evaluation of Developmental Status	PEDS	96110
Pediatric Symptom Checklist	PSC	96127
Screen for Child Anxiety Related Disorders	SCARED	96127
Vanderbilt Rating Scales		96127

96127 Vignette

- A mother brings in her 13 year old daughter who is having difficulty adjusting to a new school. The patient is showing early signs of depression. In order to determine if indeed the patient is suffering from depression the physician has the patient fill out a Beck Youth Inventory. A level 4 E/M service is also performed.

Report a **99214** (with modifier **25**) and a **96127**

96127 Valuation

CPT/ HCPCS		Status	Description	Work RVUs	NF PE RVUs	Malpractice RVUs	Total NF RVUs	Total F RVUs	Global
96127		**A**	**Brief emotional/ behavioral assmt**	**0.00**	**0.14**	**0.01**	**0.15**	**NA**	**xxx**
							Payment	0.15 x $35.8228 =	$5.37

Hypothermia

- **Codes 99185, 99186** have been deleted
- **Combined into one new code**

99184 Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling

- Do not report **99184** more than once per hospital stay
- May be reported in addition to the critical care codes

99184 Vignette

- A 2-hour old critically ill neonate born with severe in utero hypoxemia and admitted to the NICU receives total body or head cooling after meeting the required criteria.
- After evaluating the radiograph, confirm the position of the esophageal temperature probe. Initiate total body or selective head cooling. Under the physician's direction, the patient is cooled to a core temperature of 91.8° to 95°F and maintained at that temperature. The patient may be continued on the amplitude maintained EEG, which the physician interprets, looking for evidence of seizures. Perform neurologic function tests (eg, Sarnet scores) every 4 hours. Continuously monitor cooling and temperature and make recommendations for adjustments to keep core temperatures within the ordered range.

99184 Valuation

CPT/ HCPCS		Status	Description	Work RVUs	F PE RVUs	Malpractice RVUs	Total NF RVUs	Total F RVUs	Global
99184		A	Hypothermia ill neonate	4.50	1.72	0.38	N/A	6.60	XXX

Payment 6.60 x $35.8228 = $236.43

Application of Fluoride Varnish

99188 Application of topical fluoride varnish by a physician or other qualified health care professional

Reminder that a "qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff."

A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.

Application of Fluoride Varnish

- State Medicaid plans may continue to use the CDT codes that have been used previously
- Do not replace those CDT codes with this new CPT code unless otherwise directed by your Medicaid plan
- Code 99188 was not valued on the MPFS and therefore was published with 0.00 RVUs
- Private payers and State Medicaid plans *may* choose to pay

Modifiers

New Modifiers – HCPCS Only X {ESPU}

- In a response to better clarify the circumstances in which modifier **59** is reported to CMS, subsets of modifier **59** were created under the HCPCS modifiers for more granularity. Medicare plans to implement these in starting now, however, it does not appear they are mandatory yet. As for private payers and Medicaid, no word yet on requirements for use.

XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

New Modifiers – X {ESPU}

- HCPCS Only modifier
- While not yet required by Medicare and Medicaid, they can be used starting January 1, 2015
- CPT proposed new modifiers to mirror these, however chose not to implement
- Continue to review information from your Medicaid providers and private payers regarding the use of these modifiers
- Education will be ongoing in AAP resources throughout 2015

Private Payer Advocacy

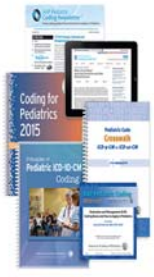
- In response to new codes and their corresponding values, the AAP's Private Payer Advocacy Advisory Committee reaches out to major payers to remind them they must load the codes in a timely manner to remain HIPAA compliant.
- Letter also advocates for appropriate payment for these new codes

2015 Changes - ICD

- Reminder that the current implementation date of ICD-10-CM is October 1, 2015
- This does NOT impact your CPT reporting however
- Be sure to continue or begin your planning early!
- The AAP has many resources to help you out!

AAP Coding Resources

AAP Pediatric Coding Publications



AAP Pediatric Coding Newsletter™

Stay current with all the latest in pediatric coding and compliance.

Coding for Pediatrics, 2015

In its 20th edition, this signature coding publication complements standard coding manuals with proven pediatric-specific documentation and billing solutions.

Pediatric Code Crosswalk ICD-9-CM to ICD-10-CM

Simplify *ICD-9-CM* coding AND prepare for *ICD-10-CM* transition!

Principles of Pediatric ICD-10-CM Coding

A practical desktop handbook and an efficient training tool, it provides a wealth of pediatric-focused knowledge for accurate diagnosis coding.

Save 15% with exclusive package savings and receive a

FREE coding tool!

Visit http://shop.aap.org/ now.

AAP Coding Resources

- Coding At the AAP Site

  - One stop shop for all coding related resources from the AAP!
- AAP Coding Hotline aapcodinghotline@aap.org

AAP Pediatric Coding Webinars

Visit www.aap.org/webinars/coding for additional information or to register or order an archived event !

FUTURE WEBINAR TOPICS:

Top 10 Procedures to Increase Your Bottom Line
Richard H. Tuck, MD, FAAP | January 13, 2015 | 12:00pm

Coding for Inpatient-Provided Services
Edward Liechty, MD, FAAP | February 24, 2015 | 12:00pm

Proper Modifier Use in Pediatrics
David M. Kanter, MD, FAAP | April 21, 2015 | 12:00pm

ON-DEMAND WEBINAR TOPICS:

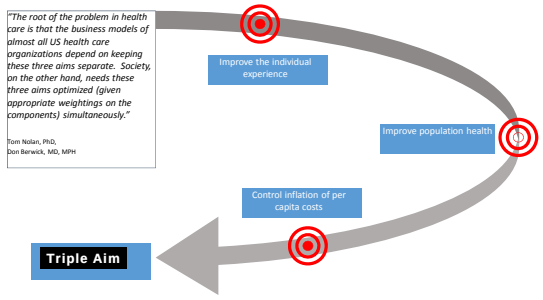
ICD-10-CM Coding: Part 1
ICD-10-CM Coding: Part 2
Evaluation and Management Coding Basics and How to Apply in Pediatrics
Coding for Pediatric Preventive Services

The 'Talk" Coding, Value, and Risk

Why We Do What We Do?
Achieving the "The Triple Aim"!

"The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized (given appropriate weightings on the components) simultaneously."

Tom Nolan, PhD,
Don Berwick, MD, MPH

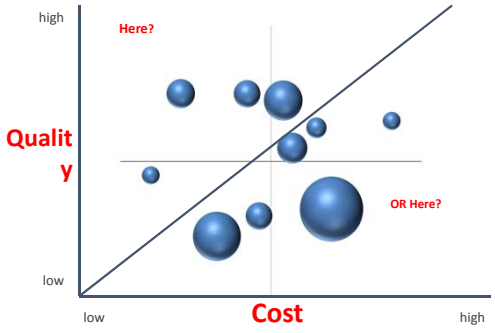


"The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,

Creating Value in Your Practice

- The Triple Aim - Improving –
  - health care (delivery- eg PCMH)
  - quality of care (outcomes- eg NCQA Measures)
  - the cost of care (right care at right time and right place)
- **Creating Value** **Value = Quality / Cost**
- **Payment will follow Value**

A Triple Aim "Valuegram"



So…"Something Centered Care"- Finding the Balance

- **Physician/Provider Centered – What you want and ? Need**
- **Patient/Family Centered Care- the PCMH- what your patients NEED**
- **Consumer Centered Care- What your patients WANT**

A New Quality- Through the Lens of the Triple Aim

- **Ability to reduce variation in outcomes including cost**
- **Ability to provide *access* allowing "right care, right time, and right place"-afterhours and walk-in (patient centric)**
- **Ability and performance in closing "Care Gaps"- claim analytics- look at evidenced based care which has not been delivered**
- **Member Experience- patient activation, shared decision making, and navigation**

Network "Safety"

- **ACCESS-** Great patient access to care- afterhours, walk-in, school, telehealth
- **Quality**- Ability and high performance in closing "Care Gaps" claim analytics- look at evidenced based care which has not been delivered
- **Affordability**- lowering the total cost of care for your patients- high levels of preventive and proactive care- lower ER and Inpatient utilization, value based selection of labs, imaging, and specialists

The New Lexicon – of Health Care

- **The Triple Aim**
- **Accountable Care**
- **The Value Equation for Health Care**
- **Value Based Contracting**
- **Value based insurance product design**
- **The New Quality**
- **Population Health**
- **Care Opportunities**
- **Variation**
- **Transparency**
- **Episodes of Care**
- **Patient Centered Medical Home**
- **Health Home for "Superutilizers"**
- **Narrow Networks**

111

Definition-ACO

An Accountable Care Organization (ACO) is -

- a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that
- accept a shared responsibility to deliver a broad set of medical services to a defined set (population)of patients across the age spectrum, and
- who are accountable for the quality and cost of care provided through alignment of incentives.

Principles of ACO Structure- Strong Tie to Medical Home

The **core purpose** of an Accountable Care Organization is –

- -to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves
- which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.

"The Core 4"

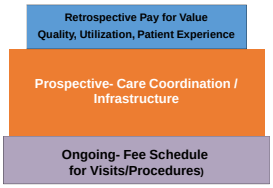
PCMH Attributes Which Create Value

- Access - Improved Access to Care – same day, walk-in, afterhours, preventive care , proactive approach to a population of our members within a practice
- A New Care Model – Office based Care Coordination/Management- The Chronic Disease Model, active patient Care Plans, Personnel and Processes for Patient Care Management and Care Coordination
- Health Information Technology - (HIT)-Use of Data to Improve care- The providers act on patient care registries (data driven opportunities)
- Evidenced Based Medicine- Adoption and Adherence to proven diagnosis and treatment guidelines

Newer Payment Models – Multimodal and Evolving to Risk Model

- **Enhanced Fee for Service**
  - Typically higher rates than "non" PCMH
  - Payment policy (afterhours care, care plan oversight)
  - Evolution to risk – capitation
- **Prospective Payments- funding infrastructure**
  - Care coordination
  - EHR
  - NCQA certification costs
  - Evolution to risk based on outcomes
- **Retrospective Payments- For Performance or Value (new)**
  - Quality Indicators
  - Patient experience
  - Evolution to risk based on a Gain Share

PCMH Reimbursement



Concept of Financial Risk

- Upside Risk- you win- chance of getting a payment if performance targets are met or exceeded
- Downside Risk- you may not get a payment if targets are not met (even if you have resource costs in the effort), or in certain models you may lose payment by not hitting targets
- Programs with downside risk typically have higher potential gains

Pay for Performance or Value- Quality Measures

- Quality Indicators
  - Generally based on national guidelines and evidenced based measures
  - NCQA, NQF ,Joint Commission, CMS develop measures
  - Can be reported on billing forms- CPT Category I and Category II codes , ICD codes, other (pharmacy)
  - Measured from claims (administrative), or chart review , or both (hybrid)
  - Can relate to a process or to an outcome
  - Payer will define the measures, the reporting, the targets, and the payments in the contract

NCQA HEDIS Quality Measures

- Measure the per cent of patients who have had or not had a given health intervention
- Measures have a denominator of the eligible patient population
- Measures have a numerator of the patients who have had the intervention

Pay for Performances- Evolution Newer Models of Accountable Care

- Gain Sharing – (shared savings)a method for physicians and other providers to share in a defined way in savings a program generates for the population

Gain share may be determined by –

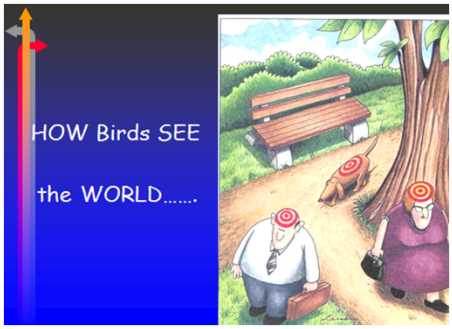
- Improvements compared to a past year(s) in chosen utilization metrics- ER, Inpatient
- Improvements in Medical Loss Ratios (MLR)
- Meeting Quality Targets

Payment Reform in TN

- Initiative by Governor Haslem
- Supported by a CMS Grant
- Administered by TennCare
- Timeline- Begins in 2014
- Goal- Move payment for health services to an outcomes based method
- Goal – across all payers and all lines of business
- Two components
- Population health strategy- the PCMH
- Specific services- Episodes of Care
- For both -Payment will reward both Cost savings (gain share) and Quality (quality thresholds)
- Has downside risk- high cost providers will pay back money
- 2015 episodes include URI, Otitis, ADHD

http://www.tn.gov/tenncare/HCFA/

The Risk



Federal Fraud and Abuse Laws

- False Claims Act
  - (31 USC 3729)
- Anti-Kickback Act
  - (42 USC 1320a-7b(b))
- Stark Laws
  - (42 USC 1395 nn & nn(h)(6))
  - HIPAA creates a new category of offenses which includes Health care fraud
- These laws are upheld through a nationwide network of audits, investigations and inspections

Pediatricians and Risk

- High rates of participation in government Programs- Medicaid, CHIP, TriCare
- Have a high rate of EM billings- more difficult coding rules
- Many pediatricians do not know the CMS documentation rules or have compliance programs
- Now joining larger groups and may "inherit" compliance risk

The RAC- Ouch!!

The "RAC"
Recovery Audit Contractor Program

- In 2006, the Tax Relief and Health Care Act made permanent the Medicare Recovery Audit Contractor (RAC) program for identifying improper Medicare payments in all 50 states
- **The ACA required state Medicaid programs to hire RAC contractors to audit payments, effective Dec. 31, 2010. The RAC program will apply to physician Medicaid payments**
- RAC's are Private auditing firms contracted by the Centers for Medicare & Medicaid Services (CMS) and paid on a contingency fee basis and use sophistic claims data analytics to recognize improper payments, aberrant trends, and utilization variance
- RACs may review the three preceding years of a provider's claims and review medical records (per your contract and state insurance laws)

Coding/Billing Areas of Risk

- EM "Upcoding" - 99214-99215
- Afterhours Care- billing add-ons incorrectly
- Unbundling of comprehensive services- overuse of modifiers which break CCI edits
- Billing services during a global period
- Failure to document time in using time based codes
- Billing for "New" patients who are by definition established in the practice
- Billing 90461 to VFC, or using 90460/1 when the MD does not counsel

The Bad News: How Is it Delivered?

- Request for Records: the payment audit
  - Request by payer for medical records of given patient to review documentation of coding on claims which were flagged in an audit
- Recovery Letter: the request for money
  - Request for money- based on a claims review using sophisticated algorithms you have incorrectly submitted claims for a number of patients amounting to $XX

Compliance Programs

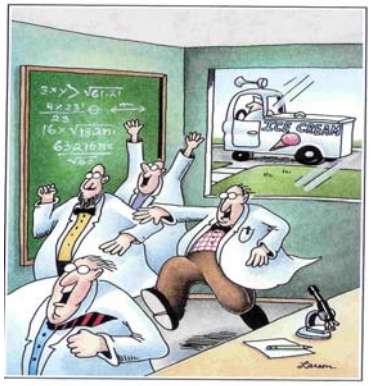
- A comprehensive set of policies and procedures, along with a method of independent verification, to ensure that all applicable laws regulations, and rules of an organization are followed. (i.e. a proactive method to prevent, detect and rectify improper practices)

Change…Is Constant in Health Care

"It is not necessary to change… Survival is not mandatory"

- - Edward Deming
- Speaking to a group of Detroit automaker executives 1970s

(there will likely be no "Pediatric" bailout)



So…Thank You!!

Thank you!
Questions