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 codes for electronic transactions
  • CPT, HCPCS, ICD-9-EM
• CPT and ICD are the code sets used by all US physicians and payers

• 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

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

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
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
    o 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 (e.g., 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 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 (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

• Face-to-Face service by a physician or other qualified health care professional (QHCP) 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 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 99487

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, 99378-9, and 99339-40

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.”

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.

The History of Care Management

- 2013
  * Complex Chronic Care Coordination codes added to CPT (99482, 99483)
  * 2015 MPFS assigned codes 99484 and 99485

- 2014
  * Old Part 4 First Rule released indicating need to pay for chronic care management
  * Revisions were underway for these codes in CPT

- 2015
  * New codes created in CPT
  * Two new subsections created for care management: (Chronic) and (Complex) CPT codes

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 !)

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 reportable 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**

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

* 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 (99485-99496)
  - 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**

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

**MPFS and Care Management Services**

<table>
<thead>
<tr>
<th>CPT/ HCPCS</th>
<th>Value Description</th>
<th>Work RVUs</th>
<th>MPFS Mor</th>
<th>MPFS RVUs</th>
<th>Medicare RVUs</th>
<th>Total RVUs</th>
<th>Total MW RVUs</th>
<th>Global Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99487</td>
<td>Complex care 1/v pt wt</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>99489</td>
<td>Complex care std 30 min</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>ZZZ</td>
<td></td>
</tr>
<tr>
<td>99490</td>
<td>Chronic care mgmt ex.20 min</td>
<td>0.61</td>
<td>0.34</td>
<td>0.04</td>
<td>1.19</td>
<td>NA</td>
<td>XXX</td>
<td>Payment</td>
</tr>
</tbody>
</table>

A – Active Status, B – Bundled, F – Facility, MPFS – Medicare Physician Fee Schedule, NF – Non-Facility, 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

Payment: $1.19 x 35.8228 = $42.63
Clinical Example

- The clinical nursing staff spent 75 minutes during the month of October on 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 1 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
  
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 7 business days of discharge
  - Medical decision making of significant complex issues during the transition period
  - Face-to-face visit within 14 calendar days of discharge

- 99496
  
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 7 business days of discharge
  - Medical decision making of significant complex issues during the transition period
  - Face-to-face visit within 14 calendar days of discharge

TCM Requirements

- Covers services begin the day of discharge and continues next through the next 26 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

<table>
<thead>
<tr>
<th>MFS 2015-</th>
<th>99495- $164.78</th>
<th>99496- $232.49</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(99214- $108)</td>
<td>(99215- $145)</td>
</tr>
</tbody>
</table>

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

| Physical/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 content 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 - ensure 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 who provided service |

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

<table>
<thead>
<tr>
<th>Service</th>
<th>15-30 minutes</th>
<th>&gt;30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home services (not involving home health agency)</td>
<td>99339</td>
<td>99340</td>
</tr>
<tr>
<td>2.03/1.61 RVU (per visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health agency</td>
<td>99437</td>
<td>99438</td>
</tr>
<tr>
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<tr>
<td>2.03/1.61 RVU (per visit) and facility</td>
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</tbody>
</table>

- 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**

Extracorporeal membrane oxygenation (ECMO) or Extracorporeal life support (ECLS)

- **Venoarterial**
- **Veno-venous**

**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.

**New ECMO/ECLS Codes for 2015**

- **Veno-arterial**
- **Veno-venous**

**Daily Management**

- **Veno-arterial**
- **Veno-venous**

---

**ECMO/ECLS Valuation**

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* Modifier-01 is not allowed.
ECMO/ECLS Valuation (cont.)

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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/working-timing-insurance/cpt/about-cpt/category-vaccine-codes.page

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

Vaccine Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptions</th>
<th>Release/Implementation Date</th>
<th>Published</th>
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<td>90630</td>
<td>Influenza virus, quadrivalent (IV)</td>
<td>Released - July 1, 2014</td>
<td>CPT 2015</td>
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<td>90631</td>
<td>Human Papilloma virus, types 6, 11, 16, 18, 31, 45, 52, nonavalent (HPV), 3 dose schedule, for intramuscular use</td>
<td>Released - July 1, 2014 Implementation Jan 1, 2015</td>
<td>CPT 2015</td>
</tr>
<tr>
<td>90638</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use</td>
<td>Released - Nov 1, 2014 Implementation Jan 1, 2015</td>
<td>CPT 2016</td>
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<tr>
<td>90621</td>
<td>Meningococcal recombinant protein vaccine, serogroup B, 3 dose schedule, for IR use</td>
<td>Released - November 1, 2014 Implementation Feb 1, 2015</td>
<td>CPT 2016</td>
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</tbody>
</table>
Developmental Screening

- Code 96110 was revised
- 96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen), with interpretation and output, scoring and documentation, per standardized instrument
- 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

### Instrument Abbreviation CPT Code

- Ages and Stages Questionnaire—Third Edition ASQ 96110
- Ages and Stages 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
- Behavior 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–9 96127
- Parents’ Evaluation of Developmental Status PEDS 96110
- Screen for Child Anxiety Related Disorders SCARED 96127

96110 vs 96127

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<thead>
<tr>
<th>Instrument</th>
<th>Abbreviation</th>
<th>CPT Code</th>
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<td>Ages and Stages Questionnaire—Third Edition</td>
<td>ASQ</td>
<td>96110</td>
</tr>
<tr>
<td>Ages and Stages Questionnaire—Social Emotional</td>
<td>ASQ:SE</td>
<td>96127</td>
</tr>
<tr>
<td>Behavior Assessment Scale for Autistic Syndrome</td>
<td>BASC–2</td>
<td>96127</td>
</tr>
<tr>
<td>Beck Youth Inventories—Second Edition</td>
<td>BRIEF</td>
<td>96127</td>
</tr>
</tbody>
</table>

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

### 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 ameliorated maintained EEG, which the physician interprets, looking for evidence of seizures. Perform neurologic function tests (e.g., Sarnet scores) every 4 hours. Continuously monitor cooling and temperature and make recommendations for adjustments to keep core temperatures within the ordered range.

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 privileges (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.

99184 Valuation

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Work RVUs</th>
<th>MPFS</th>
<th>Total RVUs</th>
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<td>Hypothermia II neonate</td>
<td>4.50</td>
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Payment: $6.60 x $35.8228 = $236.43

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

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

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

- **AAP Coding Resources**
  - Coding At the AAP Site
    - Coding at the AAP
      - Visit http://shop.aap.org/now
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

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” after hours 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 - after hours, 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

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, after hours, preventive care /proactive approach to a population of our members within a practice
- **A New Care Model** – Office based Care Coordination/Management- The Chronic Medical 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)
- **Evidence Based Medicine** Adoption and Adherence to proven diagnosis and treatment guidelines
Newer Models of Accountable Care

Pay for Performances - Evolution

- 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

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 percent 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

Payment Reform in TN

- Initiative by Governor Haslam
- 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/]
Federal Fraud and Abuse Laws

- False Claims Act
  - (31 USC 3729)
- Anti-Kickback Act
  - (42 USC 1320a-7(b))
- Stark Laws
  - (42 USC 1395nn & 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" 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 sophisticated 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