Documentation and Coding for Rural Palliative Care

Tammy Norville, Technical Assistance Director, National Organization of State Offices of Rural Health (NOSORH)

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Objectives

- Summarize components of appropriate documentation and coding
- Describe Palliative Care Services in relation to overall practice services and workflow
- Describe how documentation and coding are the cornerstones of the business
- Describe how service line expansion and transition to value impact long term organizational viability

Stratis Health

- Independent, nonprofit, Minnesota-based organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Working at the intersection of research, policy, and practice
Disclaimer

The Center for Medicare/Medicaid Services (CMS) continues to announce any changes to documentation requirements and/or effective dates periodically. The following materials were created for the current environment.

CMS will continue to issue new guidance throughout the year; Medicare makes changes to its bundling edits each calendar quarter. Changes to Evaluation and Management Services are on the horizon.

The information provided here is general information only, and the user organization should consult with their Medicare Administrative Contractor (MAC) or other payer for specific reimbursement rules prior to implementing any billing processes or decision.

Third-party payer interpretations of coding and billing rules and regulations can differ greatly. The following materials are intended to provide guidance and should not be relied on as a guarantee of payment.

The materials were prepared as a tool to assist healthcare service providers in understanding documentation and coding for palliative care and related services. Although every effort has been made to ensure the accuracy of the information, the ultimate responsibility for the use of this information lies with the user. NOSORH does not accept responsibility or liability regarding errors, omissions, misuse or misinterpretation.
Getting to Know Each Other

• CEOs?
• CFOs?
• Other C-Suite folks?
• Providers?
• Clinical Managers?
• Office Managers?
• Coding/Billing folks?
• Others?

A Little About Me!

• North Carolina native
• Graduate of UNC-Chapel Hill
• Holds CPC-I, CPC, RMM, RMC, RMB certifications
• Worked at NC ORH for almost 15 years providing TA to rural safety-net providers across the state

A Little About You!

• CEOs?
• CFOs?
• Other C-Suite folks?
• Providers?
• Clinical Managers?
• Office Managers?
• Coding/Billing folks?
• Others?

Most Interesting…

Buster

Ryder
Important Reminder

I am not clinical.

National Organization of State Offices of Rural Health

NOSORH promotes the capacity of State Offices of Rural Health and their stakeholders to improve health in rural America through leadership development, advocacy, education and partnerships.

State Offices of Rural Health

Core Activities:
- Information Dissemination
- Coordination – key conveners
- Technical Assistance – at least 20,000 TA clients last year

Noteworthy:
- Unique federal – state partnership
- State, University and non-profits focused on state needs
- Other grantee applicants are required by FORHP to connect with the SORH

Get to know your SORH:
- What are their focus areas?
- What should they know about your work?
- Are their opportunities to disseminate information for you?

Strategic Priorities
National Organization of State Offices of Rural Health

- Rural EMS Conference
- Grant Writing Workshops & on demand Beyond the Basics webinars
- TruServe Web-Based Performance Measures

Power of Rural Campaign

Founded to bring attention to:
- Rural America is a great place to live and work and be a healthcare provider
- Quality and innovation are abundant in rural communities
- Disparities do exist and can be addressed through joint national, state and local efforts
- Growing beyond the day into a movement!

Nominate your stars!

To stay informed take the Power of Rural Pledge
Visit PowerofRural.org

Introduction
What is Palliative Care?
Palliative care is specialized care for people living with serious illness. Care is focused on relief from the symptoms and stress of the illness and treatment—whatever the diagnosis. The goal is to improve and sustain quality of life for the patient, loved ones and other care companions. It is appropriate at any age and at any stage in a serious illness and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care.

Source: https://waportal.org/partners/home/washington-rural-palliative-care-initiative

Why do we provide these services?
Rural populations are disproportionately ill, disabled, poor, and older. Rural adults are more likely than their urban counterparts to have a range of chronic conditions.


Are you currently providing Palliative Care services? If so, how is it funded?

*If you would like, please put answers in chat box!*

Source: https://waportal.org/partners/home/washington-rural-palliative-care-initiative
Operational Perspective

Connection to Value

Value-Based Defined

“Value-based care refers to the departure from a system in which providers were paid for the number of healthcare services provided (e.g., tests, visits, procedures), to a focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care.”

Value-Based Defined

“Value-based care focuses on:
• Provider payment incentives that reward value rather than volume
• Models of care delivery that coordinate and integrate clinical services for both patients and communities, with a focus on prevention and wellness
• Information sharing that creates transparency on the cost and quality of care to support better decision-making by providers and consumers”
Team??

It Takes A Village

Who Is On The Team?

The Reason We Do What We Do
Eye on the Prize
Medical Necessity

Need to answer:
- What service is needed?
- Why are we performing the service?
- How will the service be performed?
- Who will perform the service?
- Where will the service be performed?

Medical Necessity

Important
LOCATION... Does it matter?
Connecting Medical Necessity & Value

In our value definition it says “…focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care.”

Switching Gears...

Documentation, Coding & (a little) Billing

Qualifier!

I am not clinical.
What is Coding?

“Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumerical codes.”


Why Do We Code?

- “Accurate” reimbursement
- Exchange health data with other organizations and government agencies
- Provide evidence for healthcare policy advocacy work
- Evaluate utilization of resources
- Track potential public health threats (such as Lyme Disease, Flu, Ebola, etc.)
- Measure quality of care (aka, VALUE!)

Documentation

The **cornerstone** of the business.

*(aka, If it’s not documented, it didn’t happen and therefore cannot be coded nor billed for reimbursement.)*

Some Palliative Care Considerations...

- Think like payers and “classify” the program/services - a physician practice where provider specialty happens to be palliative medicine
- Remember that (generally) for a service to be payable it must
  1. be medically necessary (complexity/intensity)
  2. was provided by a qualified individual for the benefit category
There are seven components in CPT and the CMS's documentation guidelines for E/M Services:
1. History
2. Physical examination
3. Medical decision making (complexity/intensity)
4. Nature of the presenting problem
5. Counseling
6. Coordination of care
7. Time (complexity/intensity)

The first three of these—history, physical examination and medical decision making—are considered the “Three Key Components.”

CMS’s 1995 or 1997 documentation guidelines are used to determine whether documentation supports the “level of service” billed—but there are some nuances in how the Medicare program and most other payers look at E/M services on medical/documentation review.

Remember...

The Medicare Claims Processing Manual, Chapter 12, §30.6 addresses Medical Necessity as follows:

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management (E/M) service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. (30.6.1A)
Documentation Components

Chief Complaint – describes the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

History

• History of Present Illness
• Review of Systems
• Past, Family, Social History

HPI (History of Present Illness), ROS (Review of Systems), and PFSH (Past, Family, Social History) combine to make the history component of the E/M level determination

4 Types of History

• Problem focused – chief complaint, brief history of present illness or problem (1)

• Expanded problem focused – chief complaint, brief history of present illness, problem pertinent system review (2-7)

4 Types of History (Continued)

• Detailed – chief complaint, extended history of present illness, problem pertinent system review extended to include a limited number of systems, pertinent past, family and/or social history directly related to the patient's problems (5-7)

• Comprehensive – chief complaint, extended history of present illness, review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems, complete past, family, and social history (8 or more)
Nature of Presenting Problem

A disease, condition, illness, injury, symptom, sign, finding, compliant, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.

5 Types of Presenting Problems

- **Minimal** – may not require the presence of the physician, but service is provided under they physician’s supervision
- **Self-limited or minor** – runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance
- **Low severity** – the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected

5 Types of Presenting Problems (continued)

- **Moderate severity** – the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
- **High severity** – risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment

Examination

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four (4) types of examinations.
4 Exam Types

- **Problem focused** – limited exam of the affected body area or organ system (1 body area or organ system)
- **Expanded problem focused** – limited exam of the affected body area or organ system and other symptomatic or related organ system(s) (2 – 7)
- **Detailed** – extended exam of the affected body area(s) and other symptomatic or related organ system(s) (2-7 w/ 1 detailed/expanded upon)
- **Comprehensive** – general multi-system exam or a complete exam of a single organ system (8 or more)

CPT Recognized Body Areas

- Head, including face
- Neck
- Chest, including breasts & axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

CPT Recognized Organ Systems

- Eyes
- Ears, Nose, Mouth, & Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

LIKE IT’S 1995!!
1995 CMS Recognized Exam Elements

**Body Areas**
- Abdomen
- Back, including spine
- Chest, including spine & axillae
- Each extremity
- Genitalia, groin, and buttocks
- Head, including face
- Neck

**Organ Systems**
- Cardiovascular
- Constitutional symptoms (e.g., vital signs, general appearance)
- Ears, nose, throat, mouth
- Eyes
- Gastrointestinal
- Genitourinary
- Hematologic/lymphatic
- Immunologic
- Musculoskeletal
- Neurologic
- Psychiatric
- Respiratory
- Skin

How do you code an encounter?

- Determine the extent of history completed
  - Problem Focused, Expanded Problem Focused, Detailed, Comprehensive

- Determine the extent of exam performed
  - Problem focused, Expanded Problem Focused, Detailed, Comprehensive

How do you code an encounter?

- Determine the complexity *(aka, intensity!)* of medical decision making

- Select appropriate level of E/M services based on key component requirements as stipulated in the CPT manual – some stipulate all key components, some stipulate two of three

Documentation

The **cornerstone** of the business.

*(aka, If it's not documented, it didn't happen and therefore cannot be coded nor billed for reimbursement.)*
How do you determine medical decision making???

AMA Proposal

Code set revisions take effective January 1, 2021.

The proposal scope is completely focused on revisions to the E/M office or other outpatient visits (CPT codes 99201-99215).

Primary Objectives

- To decrease administrative burden of documentation and coding
- To decrease the need for audits, through the addition and expansion of key definitions and guidelines
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

Find it HERE!!
Medical Decision Making

Refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

4 Types of Medical Decision Making

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

To qualify for a given type of decision making, two of the three elements in the Table of Risk must be met or exceeded.

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4 Types of Medical Decision Making

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

To qualify for a given type of decision making, two of the three elements in the Table of Risk must be met or exceeded.
This text can help determine whether the level of risk of significant complications, mortality, and/or morbidity is minimal, low, moderate, or high. It also determines the level of risk of complications, morbidity and/or mortality related to diagnostic procedures and/or management options. The table below contains clinical examples to illustrate the level of risk associated with various diagnostic procedures and/or management options.

Table of Risk

<table>
<thead>
<tr>
<th>Table of Risk (continued)</th>
<th>DIAGNOSTIC PROCEDURES/OPTIONS SELECTED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>- Pathological diagnosis, biopsy, or other types of diagnosis, including imaging or laboratory tests.</td>
<td>- Medical record review or consultation</td>
<td>- Moderate</td>
</tr>
<tr>
<td></td>
<td>- Diagnostic procedures, such as imaging studies, laboratory tests, or endoscopy.</td>
<td>- Consultation or referral to a specialist.</td>
<td>- Low</td>
</tr>
<tr>
<td></td>
<td>- Management options, such as medication, physical therapy, or dietary changes.</td>
<td>- Management plans.</td>
<td>- Minimal</td>
</tr>
</tbody>
</table>

For each level of risk, the table lists diagnostic procedures or management options that are appropriate for the specified level of risk. The table also provides examples of how these procedures or options might be used in clinical practice.
What’s The Big Deal?

Improper coding results in the practice
• Loss of revenue
• Refunds
• Fines
• Accusations of Fraud
• Medicare – OIG – “Men in Black”

Who Cares, Anyway?

Other than the insurance companies that are paying claims – including Medicare and Medicaid

Baltimore Statistical Office

EVERY claim goes through this office without common knowledge. All ICD-10 codes are tracked – including trended to physician – and extracted. This information is disseminated to appropriate agencies (ex, CDC).

CMS Guidelines for Use of ICD-10 Codes

“The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

Like Dominoes

Incomplete documentation, leads to incomplete coding, leads to incomplete billing, leads to incomplete reimbursement.

Services Related to Palliative Care

Transitional Care Management
Chronic Care Management
Advanced Care Planning
Prolonged Services

Coding

- Palliative Care Codes (PCC)
- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Advanced Care Planning (ACP)
- Prolonged Services Codes
- Evaluation & Management (E/M)
**TCM SERVICES**

The requirements for TCM services include:

- Services, during the beneficiary’s transition to the community setting involving multiple levels of interventions.
- Health care professionals accepting use of the beneficiary post-discharge from the facility setting, within a year.
- Health care professionals being responsible for the beneficiary’s care.
- A face-to-face contact with the beneficiary, who have medical and/or psychological conditions, the 30-day TCM period begins on the beneficiary’s expected discharge date and continues for the next 30 days.

**HEALTH CARE PROFESSIONALS WHO MAY FURNISH TCM SERVICES**

- Physician: (any specialty)
- Non-physician practitioners (NPPs) legally authorized and qualified to provide face-to-face services to the beneficiary.
- Qualified nurse practitioners (QNs) with specialty credentials/ certification in primary care.
- Registered nurses (RNs), nurse practitioners, physician assistants, and community/public health nurses.
- A face-to-face encounter with the beneficiary, who have medical and/or psychological conditions.
- The face-to-face visit is conducted in the beneficiary’s home, or in a health care setting, provided the beneficiary agrees, and with the beneficiary’s consent.
- Physician assistants (PAs) may furnish CPT code 99496 – Family Face Visit.

**Non-Face-to-Face Services**

You must document the beneficiary’s consent in writing, unless you determine that it is not medically advisable to do so. Physician assistants and nurse practitioners may provide certain services to beneficiaries.

**Services Furnished by Physicians or NPPs**

Physicians or NPPs may furnish these services to beneficiaries:

- Health care services, including diagnostic procedures (e.g., diagnostic tests and treatments).
- Health care services that require face-to-face contact with the beneficiary, who have medical and/or psychological conditions.
- Physician assistants (PAs) may furnish CPT code 99496 – Family Face Visit.

**Services Provided by Clinical Staff Under the Direction of a Physician or NPP**

Clinical staff under your direction may provide these services, subject to the State’s supervision law, and the State’s rules and regulations.

- Physician: (any specialty)
- Non-physician practitioners (NPPs) legally authorized and qualified to provide face-to-face services to the beneficiary.
- Qualified nurse practitioners (QNs) with specialty credentials/certification in primary care.
- Registered nurses (RNs), nurse practitioners, physician assistants, and community/public health nurses.
- A face-to-face encounter with the beneficiary, who have medical and/or psychological conditions.
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**Transitional Care Management Services**

Learn about Transitional Care Management (TCM) services:

- TCM services
- Health care professionals who may furnish TCM services
- TCM services settings
- TCM components
- Billing TCM Services

**TCM COMPONENTS**

You may furnish TCM services, beginning the day of the beneficiary’s discharge from one of these eligible hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital (Nursing Facility)

**TCM SERVICES SETTINGS**

The following are TCM settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital (Nursing Facility)

**SUPERVISION**

You must furnish the required face-to-face visits within the minimum observation periods. Inpatient and/or Outpatient, OPIM (other patient being observed in the hospital) visits are subject to certain observation periods.

**Face-to-Face Visit**

The following are TCM services, beginning the day of the beneficiary’s discharge from one of these eligible hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital (Nursing Facility)

**Medicare Beneficiaries**

Benefits will be available to Medicare beneficiaries who do not have Medicare supplemental insurance (Medigap). Medicare beneficiaries may contact an Independent Review Organization (IRO) in the event of a Medicare denial.

**Billing Considerations**

You must furnish TCM services, beginning the day of the beneficiary’s discharge from one of these eligible hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital (Nursing Facility)

**Services during the Beneficiary’s Stay**

The following are TCM services, beginning the day of the beneficiary’s discharge from one of these eligible hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital (Nursing Facility)

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Medication Reconciliation and Management

You must furnish medication reconciliation and management services at the date of your beneficiary’s face-to-face visit to manage the beneficiary’s medical record. For More Information Hyperlink to Medicare Learning Network® Catalog of Disparities

BILLING TCM SERVICES

You are responsible for billing TCM services...

DISCLAIMER

Find it HERE!!
TABLE OF CONTENTS

CM......................................................................................................................
Complex Care Services.......................................................................................1
Providers and their following non-practitioner positions may bill CCM services:
Certified Nurse Midwives
Clinical Nurse Specialists
Rural Practitioners
Physician Assistants

NOTE: CCM may be billed by non-practitioner positions, although in certain circumstances specialty
practice may need to bill for CCM. The CCM service is not to be billed for services performed by
practitioners in an acute care setting where the patient is admitted to the hospital for a limited
period of time (less than or equal to 180 days), and the practice is primarily for the acute care
setting. The practice must also be in the same geographic area as the hospital. The CCM service
may only be billed for the first 180 days of care unless the patient is discharged and later readmitted
to the hospital. If the patient is discharged and later readmitted to the hospital for a limited
period of time, the CCM service may only be billed once per 180-day period. The practice must
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CM: Multiple (two or more) combined codes for CCM services are not permitted. In the event of
complex staff time not described by a physician or other qualified health care professional, per
calendar month.

CPT 99489
Each additional 10 minutes of clinical staff time described by a physician or other qualified health care
professional, per calendar month. CCM services are not permitted. In the event of
complex staff time not described by a physician or other qualified health care professional, per
calendar month.

COMPLEX CCM

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

Hospitals and the following non-practitioner positions may bill CCM services:
Certified Nurse Midwives
Clinical Nurse Specialists
Rural Practitioners
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CPT 99489
Each additional 10 minutes of clinical staff time described by a physician or other qualified health care
professional, per calendar month.
### Patient Eligibility

Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, include:

- Alzheimer's disease
- Arthritis (osteoarthritis and rheumatoid arthritis)
- Asthma
- Chronic Care Management Plan (CCM) patients
- Chronic kidney disease
- Diabetes (Diabetes Mellitus Type I and II)
- Depression
- Heart failure
- Heart attack
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Liver disease
- Lung disease
- Major depression
- Mental illness
- Neurological disease
- Opioid use disorder
- Parkinson's disease
- Renal disease
- Stroke
- Tobacco use
- Tuberculosis
- Vascular disease
- Vision impairment
- Weight management
- Cancer
- Chronic (not acute) conditions
- Congenital defects (including genetic disorders)
- Emergency department visits
- Hospitalizations
- Inpatient and outpatient health care events
- Mental, behavioral, and addictive disorders
- Pregnancy
- Post-operative care
- Respiratory disease
- Sleep disorders
- Stroke
- Traumatic brain injury
- Cardiovascular disease
- Cystic fibrosis
- Diabetic retinopathy
- Epilepsy
- Gastroesophageal reflux disease (GERD)
- Glaucoma
- Gout
- Huntington's disease
- Idiopathic pulmonary fibrosis
- Immunodeficiency disorders
- Inflammatory bowel disease
- Iron deficiency anemia
- Kidney stones
- Liver cirrhosis
- Malnutrition
- Musculoskeletal disease
- Neuroendocrine tumors
- Neurofibromatosis
- Obsessive-compulsive disorder
- Polycystic kidney disease
- Psychosis
- Renal disease
- Renal failure
- Rheumatoid arthritis
- Sleep apnea
- Thyroid disease
- Urologic disease
- Sickle cell disease
- Spinal cord injury
- Spondylosis
- Substance use disorder
- Systemic lupus erythematosus
- Traumatic brain injury
- Ulcerative colitis
- Ulcerative proctitis
- Ventricular tachycardia
- Wound care
- Work-related injuries
- Wound healing

**Access to Care and Care Continuity**

- Telehealth services
- Provider email
- Provider website
- Provider social media
- Medicare Advantage
- Medicare Part D
- Medicaid
- Health care credit
- Health care charity
- Medicare

**Transitional Care Management**

- Hospital discharge plan
- Home health care
- Skilled nursing facility
- Continuing care
- Outpatient clinic
- Pharmacy
- Specialized care
- Health care provider

**Concurrent Billing**

- Concurrent billing is not allowed for services provided to Medicare beneficiaries.
Chronic Care Management Services

Table 1. CCB Service Summary

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with Care Provider</td>
<td>This service is to be reported in the following codes: 99381, 99382, 99383, 99384, 99385.</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>This service is to be reported in the following codes: 99386, 99387, 99388, 99389.</td>
</tr>
<tr>
<td>Assistance with Transportation</td>
<td>This service is to be reported in the following codes: 99390, 99391, 99392, 99393.</td>
</tr>
</tbody>
</table>

Table 2. CCB Resources (Optional)

<table>
<thead>
<tr>
<th>Resource</th>
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<tbody>
<tr>
<td>CCB Forms</td>
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Advance Care Planning

Table 1: Eligible Services

<table>
<thead>
<tr>
<th>Eligible Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning</td>
<td>Counseling and planning for future care decisions.</td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>Support services for patients who are considering advance care planning.</td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>Services for patients who are planning for future health care needs.</td>
</tr>
</tbody>
</table>

ICD-10-CM codes include:

- CPT codes for specific services
- ICD-10 codes for diagnosis
- HCPCS Level II codes for services

**CPT Codes:**

- 99480 - Advance care planning service, initial (first 15 minutes)
- 99481 - Advance care planning service, subsequent (after first 15 minutes)

**ICD-10-CM Codes:**

- Z71.39 - Advance care planning

**HCPCS Level II Codes:**

- 99201 - Advance care planning service, initial (first 15 minutes)
- 99202 - Advance care planning service, subsequent (after first 15 minutes)

**Billing Codes:**

- 19108 - Advance care planning service, initial (first 15 minutes)
- 19109 - Advance care planning service, subsequent (after first 15 minutes)

Provider and Location Eligibility

Eligibility includes:

- Physicians, nurse practitioners, and clinical nurse specialists
- Certificates for advance care planning services

**Diagnostics:**

- Age
- Primary care setting
- Health status

Coding:

- ICD-10-CM codes for primary care services
- HCPCS Level II codes for advanced care planning services

**Billing Codes:**

- 19108 - Advance care planning service, initial (first 15 minutes)
- 19109 - Advance care planning service, subsequent (after first 15 minutes)
ACP EXAMPLE

ACP services may be intended to be voluntary or non-face to face. In the example below, the physician is discussing end of life treatment options with a patient and his family. He is also discussing ACP options with the patient. The physician and patient can discuss a possible plan to develop treatment if congestive heart failure worsens. They also discuss ACP, including the patient’s desire for care and what it means to others. ACP services may be provided in the patient’s home, in the hospital, or in any setting where it is most convenient.

In the case, the physician reports a standard E/M code for the E509 service and one of the ACP codes depending upon the situation of the ACP service. The ACP service in this example does not occur on the same day as the E509 service.
This page contains tables and diagrams, likely related to medical or healthcare coding. The tables and diagrams are not fully visible due to the page orientation. The text references codes such as 99354, 99355, and 99356, which are part of the CPT (Current Procedural Terminology) codes used in healthcare billing. The diagrams and tables may be illustrating time thresholds or service code details, but the specific content is not readable in this orientation.
The time the patient that the definition of an office or an office visit (99354 and 99356) includes the total time the patient was in the office or the patient’s time in the office or the patient’s time in the office. The physician's office includes all the patient's time in the office or the patient’s time in the office. The physician’s office is defined as the time that the patient was in the office or the patient’s time in the office. The physician’s office includes all the patient's time in the office or the patient’s time in the office. The physician’s office is defined as the time that the patient was in the office or the patient’s time in the office. The physician’s office includes all the patient's time in the office or the patient’s time in the office. The physician’s office is defined as the time that the patient was in the office or the patient’s time in the office. The physician’s office includes all the patient's time in the office or the patient’s time in the office.
**FUNDING:**

For the 99357 column, Contractors shall instruct physicians and nonphysician practitioners (NPPs) to report any additional time spent to meet the definition for prolonged services.

**ATTACHMENTS:**

Business Requirements

**Manual Instructions**

*Qualified services specified the effective date is in this column.

### Table: ATTACHMENT - Business Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Responsible person on 99357 column</th>
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</thead>
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**Implementation Date:** April 04, 2008

**Release date:** Correct date is 10/20/2020

**Provider denial:** Per Medicaid program requirements, no preadmission or postadmission services will be billed unless an inpatient encounter is documented by the physician or nonphysician practitioner (NPP) or unless the encounter is not an inpatient encounter but is reported as an inpatient service.

**10/20/2020**
Service or product associated with the consultation and management service as described in section VI. Post-R/Medicare Administrative Contractor Implementation: A-Medicare Administrative Contractor.

Threshold (99304–99327) to service associated with consultation and management service as described in section VI. Post-R/Medicare Administrative Contractor Implementation: A-Medicare Administrative Contractor.

A: Definition of Prolonged Physician Services

30.6.15.1 Prolonged service of less than 30 minutes total duration on a given date is not separately billable. Prolonged services may be reported by codes. Each additional 30 minutes of direct face contact can be billed.

Prolonged service refers to the service provided when the face patient contact time of a furnished service exceeds the threshold of 20 minutes. The threshold for each service is based on the service code. The threshold for each code is determined by the Medicare Administrative Contractor(s) (MAC) for whom the service is furnished. The threshold for each code is determined by the Medicare Administrative Contractor(s) (MAC) for whom the service is furnished.

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Questions to Ponder

• Do any of these related services incorporate/include services provided in the current palliative care program of your organization?

• Is this how you’re paying for/covering the cost of providing these services now?

• If no, could you within allowable guidelines?
Switching Gears...

Components & the Revenue Cycle
A Crash Course

Operational Perspective

Reimbursement 101

- Step 1. Document the details necessary for payment.
- Step 2. Assign medical codes.
- Step 3. Submit the claim electronically.
- Step 4. Interpret the payer’s response.
- Step 5. Prepare for post-payment actions (audits, document requests, etc.).

Source: https://www.carecloud.com/continuum/how-healthcare-reimbursement-works/

10/20/2020
Telling the Story

- Use reports (aka, data) to tell the story of the services provided.
- Every service has a purpose – or don’t do it, right? (aka, medical necessity)
- Why, How & What of the service
- Connect to value

Don’t Forget About Related Services When Telling Your Story!

- Transitional Care
- Chronic Care Management
- Advanced Care Planning
Like Dominoes

Incomplete documentation, leads to incomplete coding, leads to incomplete billing, leads to incomplete reimbursement.

Documentation

The **cornerstone** of the business.

(aka, *If it’s not documented, it didn’t happen and therefore cannot be coded nor billed for reimbursement.)*

Value-Based Defined

“Value-based care refers to the departure from a system in which providers were paid for the number of healthcare services provided (e.g., tests, visits, procedures), to a focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care.”

Value-Based Defined

“Value-based care focuses on:
- Provider payment incentives that reward value rather than volume
- Models of care delivery that coordinate and integrate clinical services for both patients and communities, with a focus on prevention and wellness
- Information sharing that creates transparency on the cost and quality of care to support better decision-making by providers and consumers”
A Quick Commercial Break

Operational Perspective

Documentation

The **cornerstone** of the business.

*(aka, If it’s not documented, it didn’t happen and therefore cannot be coded nor billed for reimbursement.)*

No Time For...

MODIFIERS!!

*A mention in passing...*

25
51
59
Conclusion
Making the Pieces Fit

Putting the Pieces Together

Where Did We Start?

Making it Fit & Making a Difference

Together!!
What is Palliative Care?
Palliative care is specialized care for people living with serious illness. Care is focused on relief from the symptoms and stress of the illness and treatment—whatever the diagnosis. The goal is to improve and sustain quality of life for the patient, loved ones and other care companions. It is appropriate at any age and at any stage in a serious illness and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care.

Source: https://waportal.org/partners/home/washington-rural-palliative-care-initiative

Why do we provide these services?
Rural populations are disproportionately ill, disabled, poor, and older. Rural adults are more likely than their urban counterparts to have a range of chronic conditions.


Operational Perspective

How do we bring all this together—wrap it up with a pretty bow?
Power of Rural Tenets

- Communicate
- Educate
- Collaborate
- Innovate

It's time for rural providers to prepare for quality-driven programs that will directly impact value and, therefore, reimbursement.

Questions??

Resources & Contact Information
Resources

National Organization of State Offices of Rural Health (NOSORH)
https://nosorh.org/

The Power of Rural (#powerofrural)
http://www.powerofrural.org/

Stratis Health
http://www.stratishealth.org/expertise/longterm/palliative.html

Resources

CMS Rural Health Clinic Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

CMS Critical Access Hospital Center
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs.html

Resources

CMS ICD-10 Guidelines for Coding & Reporting 2019

Medicare Learning Network (MLN)

Resources

Rural Providers and Suppliers Billing

Rural Health Value (RUPRI)
https://ruralhealthvalue.public-health.uiowa.edu/

Rural Health Information Hub
https://www.ruralhealthinfo.org/
Resources

Acevedo Consulting Inc. (Private Consultants)
https://www.acevedoconsultinginc.com/hospice-palliative-care

Get Palliative Care
https://getpalliativecare.org

Questions or Comments?
Thanks so much!
Your participation is appreciated!

Tammy Norville
NOSORH Technical Assistance Director
Phone: 919.689.5110
Mobile: 919.215.0220 (including text)
Email: tammyn@nosorh.org

Stay Well & Be Safe!

Ryder & Buster
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety and serves as a trusted expert in facilitating improvement for people and communities.

Questions?
Kathie Nichols BSN, RN, CRRN
knichols@stratishealth.org
www.stratishealth.org