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Coding

7 tips to correctly tap into time to report new, existing prolonged care codes

Your E/M office coding can get tricky when you base your level of service on time spent with the patient, but understanding when to use time thresholds, such as during counseling-based visits, will give your coding a boost — especially when tacking on prolonged services to your encounter codes.

When it comes to time and E/M codes, you'll want to stick to several clear guidelines to avoid any claims disruptions, advised Betsy Nicoletti, president of Medical Practice Consulting in

*(see **Prolonged services**, p. 6)*

Alternative payment models

Comprehensive Primary Care program misses spending mark but practices love it

The Comprehensive Primary Care (CPC) initiative failed to substantially bend the Medicare spending curve, according to a new report. But leaders on the ground remain bullish about the value-based program, which they say has positioned their practices for long-term success.

In a review of the four-year CPC program, which involved about 500 practice sites and ran from October 2012 through 2016, researchers found "no significant differences in spending

*(see **CPC initiative**, p. 7)*

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Coding

Orthopedic practice scores a win in challenge to CCI code pairs

It doesn't cost anything to ask for a correction if you find a possible Medicare coding error. And, as a Syracuse orthopedic practice discovered, you may end up reversing a troublesome code restriction that has been in effect for more than a decade.

Coders and billers at Syracuse (N.Y.) Orthopedic Specialists PC were validating some surgical claims against National Correct Coding Initiative (CCI) code edits when they discovered one code pair that bundled fusion of the great toe (**28750**) as a component of a hammertoe correction (**28285**) on a different toe, which is a lesser paying code, explains Deborah Rossi, surgical billing supervisor at Syracuse Orthopedic.

The orthopedist performed the surgeries on separate toes, and the CCI edit allows you to use a modifier to override it, but Syracuse found the problem went further than simple code unbundling and was affecting their reimbursement for the procedures.

CCI edit affects pay for multiple surgeries

Normally, when you file a claim for multiple surgeries, you list the one with the highest total relative value units (RVUs) first so that the payer applies the 50% multiple procedure reduction to the second and all subsequent codes on the list.

In the case of the two toe surgeries, the high-RVU code is the great toe fusion code 28750, which has 23.34 RVUs in the office setting, compared with the hammertoe correction code 28285, which has 15.49.

But many of Rossi's non-Medicare payers were ignoring that rule and selecting the code listed as a CCI column one code to pay first on the claim. That meant that they are paying the full allowable rate ($557) for 28285 — the lesser valued code — and applying the 50% reduction to the higher-paying code, 28750, which has an allowable fee of $840 (all fees par, not adjusted for locality).

"Our coders were getting frustrated seeing all the work the doctors were doing and not getting reimbursed for it," she explains.

The practice traced the problem to a specific type of CCI edit called a mutually exclusive edit. Mutually exclusive edits are supposed to deny code combinations when "it would be unreasonable to expect these services to be performed at a single patient encounter," according to explanatory language on the Medicare CCI website. To make billing the code pairs even less appealing, mutually exclusive edits put the lesser-paying code in the column 1 position, and the higher-paying codes in column 2, where they are at risk of being bundled.

In addition, practices should be on the lookout for CCI code pairs beyond the mutually exclusives where the column 2 code has the higher value because of Medicare's revaluation of the codes over the years, points out Margie

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Scalley Vaught, CPC, CCS-P, ACS-EM, ACS-OR, coding consultant based in Chehalis, Wash.

Even with a modifier, "private payers just deny the secondary code," Rossi says. "This comes up a lot."

Determine whether a letter is warranted

Rossi remembered hearing a tip from Vaught at a past Advanced Orthopedic Coding Symposium, a DecisionHealth conference, to send a letter to Correct Coding Solutions LLC, the Medicare CCI contractor, when you disagree with a CCI code pair.

Rossi ran it by Vaught to see whether a letter was warranted in this case. Vaught told her it was. "CCI rules state that they only change [code pairs] if there is a request and/or a significant RVU difference," Vaught explained. "Codes 28285 and 28750 do have a significant RVU difference of at least 6 RVUs — but nobody has brought it to their attention to change it."

The practice's billing and coding staff drafted a letter and the Syracuse Orthopedic CEO signed it.

In addition to the CCI pair for the two toe codes, Syracuse Orthopedic asked the CCI contractor to take a look at a second mutually exclusive edit that had been causing them problems — this one bundled **29882** (Arthroscopy, knee, surgical; with meniscus repair [medial OR lateral]) as a component of lesser-paying code **29881** (Arthroscopy, knee, surgical; with meniscectomy [medial OR lateral, including any meniscal shaving] including debridement/shaving of articular cartilage [chondroplasty], same or separate compartment[s], when performed).

"When 29881 and 29880 were revalued a few years back, no one checked to see how the column 1/column 2 issue would fall out," Vaught says. "It really is up to offices, coders and staff to bring these to the attention of CCI."

Codes address separate problems

In the CCI letter, "we told them we were a large orthopedic practice and that our foot surgeons do a lot of these code combinations," Rossi says. They explained that while the procedures were done during the same operative session, they addressed two separate problems with their own diagnosis codes and were done on different digits.

The practice also described the problems the practice was having getting reimbursed for the higher-RVU code "and to please review and reverse the order," she adds.

In the same letter, Syracuse also made the case for flipping the codes in the knee code pair.

Syracuse sent the letter by fax Feb. 21.

CCI version 24.2 scorecard

Changes effective July 1.
(*For more on CCI version 24.2 edits, see related story, p. 2.*)

Code range	CCI code pairs added	CCI code pairs deleted	MUEs added	MUEs deleted	MUEs revised
0001T – 0999T	0	0	3	0	4
00000 – 09999	0	0	0	0	0
10000 – 19999	6	1	1	0	3
20000 – 29999	3	2	1	0	8
30000 – 39999	18	0	4	0	2
40000 – 49999	4	0	2	0	2
50000 – 59999	14	0	1	0	1
60000 – 69999	0	0	9	0	1
70000 – 79999	2	2	8	0	0
80000 – 89999	236	0	18	0	5
90000 – 99999	31	58	114	0	13
A0000 – V9999	636	0	123	3	17
Totals	**950**	**63**	**281**	**3**	**56**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI version 24.2 changes.*

The response from Correct Coding Solutions was quick. On March 9, the CCI contractor responded that it would examine the issue and, on March 27, the company sent a letter back to Rossi's practice to say it would keep the code pairs in place but would reverse the column 1/column 2 order as Syracuse had requested, Rossi says. The changes will take effect July 1.

The changes mean that starting July 1, code 28750 will be the column 1 code in the CCI code pair with 28285. Also, code 29882 will be the column 1 code in the code pair with 29881. The edits will continue to allow a modifier to override them when appropriate.

In its response, Correct Coding Solutions commented that the mutually exclusive edit on the toe codes had been in place since 1996 and no one had ever complained about it – until now.

Syracuse Orthopedic will continue to keep a list of mutually exclusive CCI code pairs as they find them, Rossi says. And Correct Coding Solutions can expect to get more faxes. — *Laura Evans, CPC* (*levans@decisionhealth.com*)

Resource:

- Instructions to comment on specific CCI edits: *www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*

Editor's note: *Get more expert coding guidance that can make a real difference in your reimbursement and coding compliance at this year's* ***Advanced Specialty Coding Symposium****, Oct. 15 through 17 in Florida. The conference includes tracks in hierarchical condition categories (HCCs), anesthesia, orthopedics and pain management. Visit* www.decisionhealth.com/specialtycoding/ *and get $200 off if you register by Aug. 31.*

Practice management

Use higher pay, openness to outside experience to recruit non-clinical employees

Recent evidence suggests good non-clinical practice employees — from receptionists, billers and coders to managers and department heads — have gotten harder to hire and keep and that you'll have to spend money and look in new directions to do so.

A May 1 STAT poll with 1,299 respondents by the Medical Group Management Association (MGMA) found "more than 60% of respondents reported that it's been challenging to find qualified candidates in today's health care market." Causes include "lack of turnover, increased wages and utilization of temp agencies and job fairs to fill vacancies."

Practice managers should address that shortfall by "assessing how they are approaching retention of their best employees and mitigating turnover before it becomes an issue," writes Nick Fabrizio, principal with the MGMA Health Care Consulting Group in Baldwinsville, N.Y.

That makes sense in light of recent job numbers, which show low unemployment generally and a particularly robust market for health care workers in America. The sector gained nearly 29,000 employees from April to May and 318,000 between May 2017 and May 2018, according to the most recent Bureau of Labor Statistics report. A February SUNY Albany School of Public Health report finds jobs in the sector are projected to grow 18.1% between 2016 and 2026.

Baby boom to bust

On the management front, "it's a candidate's market," says Seth Lee, president of Summit Talent Group, an executive health care search firm in Columbia, Md. "People who have some level of tenure are not actively looking for a job and are becoming impossible to recruit; they get counter-offered and don't leave."

Demographic and economic factors are part of the reason for this scarcity. "We've known for a while the baby boomer generation is retiring," says Eric Dickerson, managing director and senior practice leader with Kaye/Bassman International Corp in Plano, Texas. "On the flip slide, the generation that would succeed them and backfill those roles — the 'baby busters' — are just not there" in sufficient numbers to replace them, says Dickerson. Together with a low unemployment trend in recent years, "this creates a war for talent."

3 ways to get good help

- **Pay more.** In the short term, to keep the best talent in this environment, you'll probably have to open your wallet. "The competition for talent starts with compensation," says Lee. "Wages have been flat in this country for many years, and now, with the labor crunch, employers must quickly pivot."

- **Offer better benefits packages**, "including time off and reimbursement for additional college, graduate and vocational training," says Lee. With candidates in the driver's seat, they also can afford to consider lifestyle features ranging from maternity leave and sabbaticals to

(continued on p. 6)

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Benchmark of the week

AWV, IPPE denials stay high; initial AWV use, after a burst, falls

Providers have seen no big break in the long tradition of high denials for both initial (**G0438**) and subsequent (**G0439**) annual wellness visits (AWVs), nor for the Welcome to Medicare visit (**G0402**; also known at the Initial Preventive Physical Examination or IPPE).

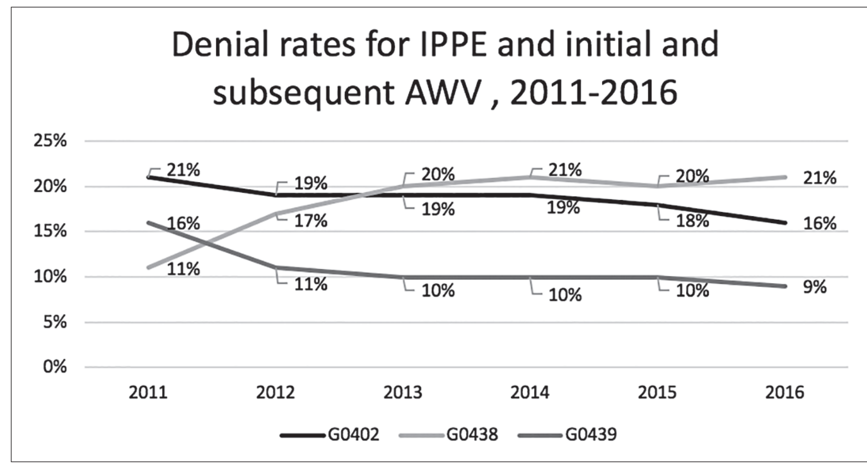
The services began in 2011 and had double-digit denial rates from the start. G0439 caused considerable confusion and was billed more than 380,000 times in 2011 even though not enough time had elapsed for Medicare patients to be eligible for a subsequent AWV; that it was only denied 11% of the time may have something to do with the fact that the initial AWV charge to which those providers were entitled was much higher than what the subsequent AWV paid, and contractors decided to let it slide (*PBN 9/17/12*).

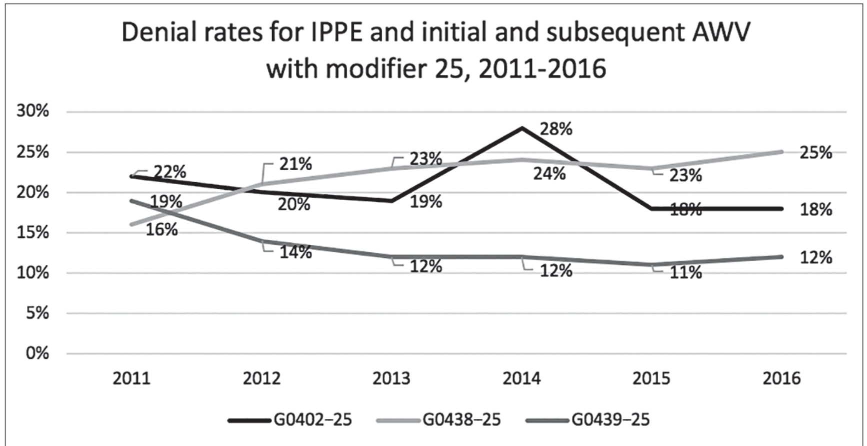
In 2016, the most recent year of Medicare data, the G0439 denial rate sank to 9% — the first time any of these codes has had a denial rate in single digits. Also, utilization of G0439 continued to go up — from 2012, the first legitimate year for it, to 2016, it has risen from about 1.8 million to 6 million, a 233% boost. G0402 is another success story, if on a more modest scale; it has nearly doubled utilization from 274,311 claims in 2011 to 535,826 in 2016.

G0438 use, conversely, has dropped every year except for 2015, when it ticked up by 3.3%. In 2016, it fell a fraction of a point to just over a million and a half claims — a steep decline from the 2.2 million claims with which it debuted.

AWVs and IPPEs are relatively simple to bill with E/M services using the modifier **25** (Significant, separately identifiable E/M service) (*PBN 9/26/16*). But the second chart shows many Medicare providers haven't got the hang of it. There was a 10-point crash in the G0402-25 denial rate in 2015, but that appears to have been a fluke; rates remain poor for providers.

Among specialties billing the service in 2016, for each of these codes, the top five providers were the primary-care stalwarts you'd expect: internal medicine, general practice, family practice, nurse practitioner and physician assistant. Those comprised 96% of G0438 and G0439 and 97% of G0402 claims. — *Roy Edroso* (*redroso@decisionhealth.com*)





Source: Part B News *analysis of Medicare claims data*

(continued from p. 4)

practice location, says Dickerson. Your package should “bring them a story about your organization that can get the candidate to reconsider.”

- **Recruit outside of health care.** Part of the executive scarcity issue in the acute-care hospital and health system world is cultural, says Lee: They’re “very traditional and not usually welcoming to people from general industries” — that is, they want people who are already working in the health care space and tend to discount candidates from outside it. Even when recruiting out of schools, they want candidates with Master of Healthcare Administration (MHA).

Non-acute institutions such as outpatient infusion centers and physical therapy clinics are more broad-minded, in Lee’s experience; they’re willing to recruit from the service, hospitality and manufacturing industries. “Take an organization like DaVita,” says Lee. “They take talent from companies like Frito-Lay that have outstanding early management programs. These candidates are data- and analytics-focused, they’re responsive to clients and their adaption is easy – mainly they just have to learn the lingo.” – *Roy Edroso* (*redroso@decisionhealth.com*)

Resources:

- MGMA: “Demand still high for qualified non-clinical applicants in healthcare industry: *www.mgma.com/news-insights/human-resources/mgma-stat-poll-demand-still-high-for-qualified-no*
- U.S. Bureau of Labor Statistics, Employees on nonfarm payrolls by industry sector and selected industry detail, May 2018: *www.bls.gov/news.release/empsit.t17.htm*
- “Health Care Employment Projections, 2016-2026: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation,” Center for Health Workforce Studies, SUNY Albany, February 2018: *www.chwsny.org/wp-content/uploads/2018/02/BLS-Projections-2_26_18.pdf*

Prolonged services

(continued from p. 1)

Northampton, Mass., during a recent DecisionHealth webinar on prolonged-service codes, including face-to-face codes (**99354-99357**), non-face-to-face codes (**99358, 99359**) and the new category of prolonged preventive service codes (**G0513, G0514**) that debuted Jan. 1 (*PBN 1/8/18*).

- **Remember that E/M office codes already have pre- and post-time baked in.** “Prolonged services are not intended to be used for typical pre- and post-work,” said Nicoletti. For instance, typical time includes reviewing the patient’s record, documenting the visit and performing any follow-up work, as necessary. It’s when your service time goes beyond the standard E/M times, such as when you provide extended consultation or in-office therapy, that you can turn to prolonged services and report them as add-on codes or, in the case of 99358, as a standalone code.

- **Use time to select an E/M code “when counseling dominates the visit,”** advises Nicoletti. When the visit notes show an emphasis on work-ups and exams, your best bet is to use those elements to define your level of service. But when counseling makes up the majority of the visit, you can turn to time to define your code choice, said Nicoletti. Counseling

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is a discussion-based activity during which the provider may talk about diagnostic results, risks and benefits of care management, risk-factor reduction and education.

- **Be sure to document the total face-to-face time and make a clear note that at least 50% of the encounter was spent in a counseling capacity,** suggests Nicoletti. Example: Your note might read, "I spent 40 minutes with the patient and his partner, over half in discussion of the options related to his cancer diagnosis." Or it could say, "I spent 25 minutes face-to-face with the patient, over half in discussion of the importance of fluid and salt restriction and elevating her legs. I explained in detail the complications that could arise without compliance," described Nicoletti.

- **Note that the threshold time for prolonged services varies by E/M code.** "It is a moving target," said Nicoletti. That is, each E/M office code has a typical time, so the threshold you must hit to correctly report face-to-face prolonged care codes 99354 and 99355 will vary. Example: The typical time for 99203 is 30 minutes. To bill 99354, you'll have to hit at least 60 minutes total, and you must meet 105 minutes to also report 99355.

- **Report only direct face-to-face time, not the entire duration of the visit.** Say a patient comes in for nebulizer treatment and the doctor is in and out of the patient's room over the course of the two hours that the treatment lasts. You can't report the time when the doctor isn't seeing the patient directly. But remember that the time "does not need to be continuous," said Nicoletti. You can add up all the separate times the doctor or non-physician practitioner (NPP) saw the patient.

- **Remember that 99358 is not an add-on code — so you can report it on a separate date of service.** Unlike face-to-face codes 99354 and 99354, you can treat 99358 in its own right — provided you link the non-face-to-face care to a companion E/M code. You're eligible to report 99358 "for a patient where direct face-to-face patient care has occurred or will occur and be part of ongoing patient management," said Nicoletti. You could even report 99358 "weeks later" following an E/M encounter, she said. Just be careful about reporting 99358 too far in advance — if the face-to-face visit never materializes, you may have to refund your payer.

- **Count time of clinical staff members when reporting prolonged preventive service codes.** Among the 18 Medicare-covered preventive services to which you can tack on add-on codes G0513 and G0514 are several diagnostic tests, such as bone density screening (**76977**) and mammography screening (**77067**).

That means you can include the time of work performed by a technician when reporting the new series of codes. However, note that the technician's time will only count toward the base code, such as the screening test. Your provider's time will count toward any counseling or education that occurs as part of the G0513 and G0514 services.

Of course, you're more likely to report the add-on codes with a provider-based visit, such as an annual wellness exam (AWV), noted Nicoletti. — *Richard Scott* (*rscott@decisionhealth.com*)

Editor's note: *Find additional guidance on successfully reporting prolonged services with the on-demand webinar* ***Navigating Prolonged Services: Find Success with New Preventive Add-on Codes and Existing Codes****. Learn more: www.codingbooks.com/ympda030818*.

CPC initiative

(continued from p. 1)

growth" between CPC sites and control groups, according to a *Health Affairs* study released June 4 (*see resources, below*). In actuality, the CPC sites curtailed spending by 1% overall, but the researchers did not consider that amount statistically significant.

Yet a deeper look into the results finds more cause for optimism, which may be a warming thought for practices involved in the expanded CPC+ program, which runs through 2020, as well as other value-based models of care. For example, CPC sites achieved steady progress on one of CMS' core goals — keeping patients out of the hospital. Overall, CPC sites reduced outpatient emergency department (ED) use by 2% compared with control sites.

"I think it's pretty remarkable that primary care practices could reduce emergency department and hospital use, even if these reductions in service use didn't produce enough savings to cover the costs of the care management fees," says Deborah Peikes, senior fellow with Mathematica Policy Research in Princeton, N.J., and co-author of the *Health Affairs* study.

As part of the CPC model, CMS furnished practices with an average of $20 in care management fees per patient per month. The fees were intended to help practices build an infrastructure to better track patients along the continuum of care.

Keeping patients out of acute care settings was significant because the providers, in particular hospitals, "had no

incentives in a fee-for-service setting to reduce spending and utilization," Peikes says.

Find success with patient-centered tools

Practice leaders who were involved in CPC say that the changes they've implemented as part of the program, including an enhanced care management function and risk-stratification tools, have been instrumental in improving care and forming stronger bonds with their patients.

"We strongly feel that this program has helped our practice get to the next level of providing care," says Chris Holland, business manager with University of Arkansas for Medical Sciences (UAMS) West regional campus in Fort Smith, Ark. The UAMS West practice, which has re-upped with the CPC+ program, continues to use enhanced patient-management techniques to keep patients coming to the office, rather than going to another setting.

The UAMS West practice formed an affiliation with a local hospital, Sparks Regional Medical Center in Fort Smith, and the practice leaders receive a daily list of patients who have visited the hospital or emergency room, describes Virginia King, quality improvement coordinator at UAMS West. Equipped with this information, the practice's care management staff contacts the patient or the patient's caregiver to ensure timely follow-up care and streamline the discharge process. The direct communication also serves as an intervention point. "We try to discourage them from using the emergency room if it's not urgent," King says.

Developing a risk-stratification system was critical for UAMS West to identify high-risk patients, and other groups that were involved in the CPC model invested in similar systems to figure out which patients were in need of additional care management services.

Mercy Family Medicine in Durango, Colo., developed a risk-stratification tool based on various factors, including the number of chronic conditions, current medications and the number of prior ED visits, explains Tamra Lavengood, CPC coordinator and clinical performance coordinator for Centura Health, which operates the 22-provider Mercy practice. Lavengood worked with the group's electronic health record (EHR) vendor, Epic, to automate the tool and enable risk scores to appear on along with the rest of the patient's record in the EHR.

But the EHR-based system also gives providers some leeway by building in an "intuitive part of the risk-stratification tool," which operates on a scale of one to six, depending on the patient's severity, Lavengood says. Providers can add a point to the patient's score when certain factors — an uncontrolled case of diabetes, for example — aren't picked up by the system. Patients with a high risk score are put at the top of the list for care management interventions, particularly those who have recently visited a hospital.

"Care managers visit patients in the hospital before discharge and set up an appointment [at the Mercy Family practice]," Lavengood says. "Our goal is to get patients in to see the primary care physician within a week."

At UAMS West, the practice is finding value through risk scoring and allowing its providers to assign a score based on the patient's comorbidities and social conditions, King says. The scoring system allows the practice to "take care of those high-risk patients and establish care plans for them."

Overall, the majority of physicians taking part in the CPC program viewed the initiative favorably, with 80% of physicians reporting that CPC had "improved the quality of care or service they provided for their patients," the study notes. Shifting core responsibilities to staff members, such as care managers, was one of the biggest transformations at Baptist Health Family Clinic in Little Rock, Ark., says William Hawkins, M.D., a family physician at the Baptist practice. That can be a big boost to provider satisfaction.

"Some physicians noted that the work of the care managers on patient education, self-management and coordination with other providers allowed physicians to focus on other aspects of patient care," the study notes.

As far as the spending curve, Hawkins believes it's too soon to make a definitive call. "Return on investment can't be seen in the time period to date," he says. That jibes with other research about value-based models showing they tend to have a slow burn (*PBN 4/12/18*).

"Focusing on prevention may raise this year's expenditure," Hawkins adds. "I'm personally convinced that we're spending more today to save for tomorrow." *— Richard Scott* (*rscott@decisionhealth.com*)

Resources:

- Health Affairs article: *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1678*
- CPC initiative: *https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/*

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