CODING
DOCUMENTING MEDICAL NECESSITY
and
AMDA UPDATE

OCTOBER 18, 2013
PAMDA
LEONARD M. GELMAN MD CMD

SNF vs. NF 2009-2011
Frequency of Visits

<table>
<thead>
<tr>
<th>POS</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>22,600,847</td>
<td>23,977,404</td>
<td>24,873,607</td>
</tr>
<tr>
<td>SNF</td>
<td>59.3%</td>
<td>59%</td>
<td>58.5%</td>
</tr>
<tr>
<td>NF</td>
<td>40.7%</td>
<td>41%</td>
<td>41.5%</td>
</tr>
</tbody>
</table>

Total Visits by Specialty 2009-2011

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Int Med</td>
<td>8,042,349</td>
<td>8,154,286</td>
<td>8,187,226</td>
<td>1.8%</td>
</tr>
<tr>
<td>NP</td>
<td>3,842,277</td>
<td>4,383,064</td>
<td>4,936,048</td>
<td>28.5%</td>
</tr>
<tr>
<td>Fam Prac</td>
<td>4,643,898</td>
<td>4,754,913</td>
<td>4,470,273</td>
<td>-3.7%</td>
</tr>
<tr>
<td>PhyMedRehab</td>
<td>905,485</td>
<td>1,044,154</td>
<td>1,102,529</td>
<td>21.8%</td>
</tr>
<tr>
<td>PA</td>
<td>770,255</td>
<td>886,797</td>
<td>1,013,971</td>
<td>31.6%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>946,066</td>
<td>1,028,218</td>
<td>979,822</td>
<td>3.6%</td>
</tr>
<tr>
<td>Geriatric</td>
<td>707,974</td>
<td>769,384</td>
<td>811,320</td>
<td>14.6%</td>
</tr>
<tr>
<td>Psych</td>
<td>610,851</td>
<td>676,442</td>
<td>668,962</td>
<td>14.5%</td>
</tr>
<tr>
<td>Gen Prac</td>
<td>654,954</td>
<td>588,941</td>
<td>516,145</td>
<td>-21.2%</td>
</tr>
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</table>

Increased Visits by Provider Types

<table>
<thead>
<tr>
<th>Group</th>
<th>2009</th>
<th>2011</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional PCP (IM+FP+Gerr+GP)</td>
<td>14,049,175</td>
<td>13,984,964</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Nontraditional (NP+PA+PMR)</td>
<td>4,824,787</td>
<td>7,052,548</td>
<td>46.2%</td>
</tr>
<tr>
<td>Ancillary (Psych+Pod)</td>
<td>1,556,917</td>
<td>1,648,784</td>
<td>5.6%</td>
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</table>

Trends in Initial Visit NH Code Billing Frequency

<table>
<thead>
<tr>
<th>NH Code</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>1,907,059</td>
<td>1,932,687</td>
<td>1,872,892</td>
<td>1,877,113</td>
<td>2,404,529</td>
<td>2,497,985</td>
</tr>
</tbody>
</table>
MEDICARE ADMINISTRATIVE CONTRACTORS

- Local insurance companies that contract with CMS to do Part B billing (some also do Part A, DME)
- Physician billing – Part B

- Pennsylvania – Novitas (Highmark)

MEDICARE CLAIMS PROCESSING MANUAL

CMS Manuals

- cms.hhs.gov
- Look for Regulations and Guidance, Internet Only Manuals

Web Resources

- Manual – Chapter 12

- CMS Transmittal 808 (January 6, 2006)- NH

- Medlearn Matter Articles
  - www.cms.hhs.gov/MLNGenInfo
AMA Documentation Guidelines

AMA Documentation Guidelines
www.cms.hhs.gov/MLNProducts/20_DocGuide.asp#TopOfPage

Medicare Claims Processing Manual, Pub.100-04
• SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

• A. Use of CPT Codes
  – “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”
  – “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.”
  – AMDA White Paper

Medicare Claims Processing Manual, Pub.100-04
• SEC. 30.6.13 - Nursing Facility Services

Medically Necessary Visits

“Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B”

WHAT DO PAYERS WANT AND WHY?

• Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided.

  • They may request information to validate:
    – the site of service;
    – the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
    – that services provided have been accurately reported.

DOCUMENTATION GUIDELINES

• DO NOT UNDERDOCUMENT
  – OVERALL STATUS OF THE PATIENT

• MULTIPLE DIAGNOSES
• CO-MORBIDITIES
• OTHER COMPLICATING ISSUES
• FAMILY ISSUES
• FACILITY ISSUES
Novitas  
Medical Necessity  
“Coverage for subsequent nursing facility care for evaluation of specific medical conditions will be considered reasonable and necessary if they would require the skill of a physician or non-physician practitioner (i.e., nurse practitioner, physician assistant, where permitted by state licensure) to evaluate the patient in a face-to-face contact”

Novitas  
Medical Necessity  
“In the nursing home environment, patients are in a controlled environment in which they are under close supervision and have immediate access to care from trained medical professionals.”

Novitas  
Medical Necessity  
“Under these circumstances, it is customary for physicians to direct nursing home personnel to perform, in the absence of the physician, many of those services that may be necessary but of a relatively minor nature. Frequent visits by the physician under these circumstances would then be unnecessary, particularly if the patient is medically stable.”

Novitas  
Medical Necessity  
• “However, it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness.”

Novitas  
Medical Necessity  
• “The medical record should clearly reflect the particular circumstances requiring the increased frequency of services by documenting the following:”

Novitas  
Medical Necessity  
1. “patient instability or change in condition that the physician documents is significant enough to require a timely medical or mental status evaluation and/or physical examination to establish the appropriate treatment intervention and/or change in care plan;”
Novitas Medical Necessity

2. “therapeutic issues that the physician documents require a timely follow-up evaluation to assess effectiveness of therapy or treatment - for example, recent surgical or invasive diagnostic procedures, pressure ulcer evaluation, psychotropic medication regimens, or (for the terminally ill) comfort measures;”

Novitas Medical Necessity

3. “medical conditions including delirium, dementia, or changes in mental status manifest with behavioral symptoms that require timely evaluation; and
4. nursing staff, rehabilitation staff, patient, or family requests to address a documented medical issue of concern that requires a physical (or mental status) examination.”

Novitas Medical Necessity

“The following clinical situations are examples of conditions where more frequent visits may be considered reasonable and necessary: 1. Stage III or IV pressure sore-healing 2. Management of acute exacerbation of unstable COPD 3. Management of acute exacerbation of unstable angina”

Novitas Medical Necessity

4. "Management of acute exacerbation of unstable diabetes
5. Acute infection
6. Acute behavioral cognitive and/or functional changes”

LEVEL OF E/M SERVICE

7 COMPONENTS

• HISTORY
• EXAMINATION
• MEDICAL DECISION MAKING
• Counseling
• Coordination of care
• Nature of presenting problem
• TIME

LEVEL OF E/M SERVICE

• HISTORY
  – Each type of history includes some or all of the following elements:
  • Chief complaint (CC)
  • History of present illness (HPI)
  • Review of systems (ROS)
  • Past, family and/or social history (PFSH)
LEVEL OF E/M SERVICE MEDICAL NECESSITY

- Chief complaint (CC)
  - “The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.”

- NH Regulatory visit - eg. “Patient seen to evaluate and treat the following acute and chronic medical conditions:”

- NH Acute visit - eg. “Called to see patient for:”

LEVEL OF E/M SERVICE MEDICAL NECESSITY

- MEDICAL DECISION MAKING
  - 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.

MEDCIAL DECISION-MAKING RISK OF COMPLICATIONS, MORBIDITY, MORTALITY

- The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:
  - Presenting problem(s);
  - Diagnostic procedure(s); and
  - Possible management options.

- The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.

MEDCIAL DECISION-MAKING RISK OF COMPLICATIONS, MORBIDITY, MORTALITY

- AMA Documentation Guidelines
  - Table of Risk

Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/ or Counseling

TIME

“When counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient, NF services), time is the key or controlling factor in selecting the level of service.

Document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided.”

30.6.1 C. - Selection of Level of Evaluation and Management Service

Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/ or Counseling

TIME

“The physician need not complete a history and physical examination in order to select the level of service.

Documentation must be in sufficient detail to support the claim.

The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time.”

30.6.1 C. - Selection of Level of Evaluation and Management Service
Selection of Level of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling

TIME

Time spent counseling the patient or coordinating the patient’s care after the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded.

30.6.1 C. - Selection of Level of Evaluation and Management Service

NH CPT CODES TIMES

- INITIAL
  - 99304 25 minutes
  - 99305 35 minutes
  - 99306 45 minutes
- SUBSEQUENT CARE
  - 99307 10 minutes
  - 99308 15 minutes
  - 99309 25 minutes
  - 99310 35 minutes
- DISCHARGE SERVICES
  - 99315 <30 minutes
  - 99316 >30 minutes
- ANNUAL
  - 99318 30 minutes

Prolonged Care 30.6.15.1

99354-999357

- 99356-99357 - inpatient and NH
- 99354-99355 – office, outpatient setting
- Documentation not required to be sent w/bill, but is required in record as to duration and content of svc

- 99356 – First 30 min of prolonged service
- 99357 – each additional 30 minutes beyond the first hour

Prolonged Care 30.6.15.1

99354-999357

- “Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.”

Prolonged Care 30.6.15.1

99354-999357

- “In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.”
H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based) • “In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.”

Transition of Care Codes

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying non-physician practitioner care management services for a patient following a discharge from a hospital, SNF or CMHC stay, outpatient observation, or partial hospitalization.

99495 Transitional Care Management Services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision making of at least moderate complexity during the service period.
- Face-to-face visit, within 14 calendar days of discharge.

99496 Transitional Care Management Services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision making of high complexity during the service period.
- Face-to-face visit, within 7 calendar days of discharge.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:
- Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and family/caretaker education to support self-management, independent living, and activities of daily living.
- 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.

Non-face-to-face services provided by the physician or other qualified health care provider may include:
- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

AMDA Public Policy Priorities

<table>
<thead>
<tr>
<th>First Tier (AMDA Specific)</th>
<th>Second Tier (Working with Coalitions)</th>
<th>Third Tier (Mootnessing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Dementia Care in Nursing Homes</td>
<td>ScC</td>
<td>Delivery System Reforms</td>
</tr>
<tr>
<td>Timely Access to Pain Medication</td>
<td>Meaningful Use/EHR Issues</td>
<td>Assisted Living</td>
</tr>
<tr>
<td>Regulatory Issues</td>
<td>Medical Liability</td>
<td>QAPI</td>
</tr>
<tr>
<td>Quality Initiatives</td>
<td>ACA Implementation</td>
<td>General Practice Issues</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Physician Payment (BUC)</td>
<td></td>
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<tr>
<td>Geriatric Workforce</td>
<td>ACOs</td>
<td></td>
</tr>
<tr>
<td>Hospital Observation Status</td>
<td></td>
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</tr>
</tbody>
</table>
Reforms will likely include:
- Move from Fee-for-Service to quality-based, flexible payment system.
- Payment based on performance on selected Clinical Quality Measures (CQMs).

Changes to the way you are paid are on the horizon.
- AMDA supports general principles but notes the need to invest in infrastructure to better support PA/LTC practitioners.
- Lack of HIT adoption and appropriate quality measures are a barrier for PA/LTC practitioners.

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“Measures are the New Currency”

3 Goals of Healthcare Reform:
1. Improve Quality
2. Improve Population Health
3. Decrease Cost of Care

6 National Priorities
- Safer Care
- Engage Patients and Families in their Care
- Communication and Coordination of Care
- Promote Best Practices
- Population Health
- Make Quality Care Affordable (spread new delivery models)

CMS Initiative’s and Innovation Programs

- Physician Quality Reporting System (PQRS)
- Value-Based Modifier (VBM)
- Quality Assurance & Performance Improvement (QAPI)
- ACOs
- Bundled Payment for Care Improvement Initiative
- Partnership to Improve Dementia Care

PQRS

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).
- EPs are identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN].
- EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.

PQRS is happening NOW!
- In 2015 you are subject to a 1.5% penalty based on 2013 reporting.
Value-Based Payment Modifier (VBM)

- VBM assess both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule.
- CMS is mandated to begin phase-in of VBM in 2015, complete by 2017.
- CMS is proposing implementation of the VBM to be based on participation in PQRS.
- CY 2015 VBM will apply only to groups of 100+.
- For CY 2016, proposes to apply to groups of 10+ but only groups of 100+ will get payment adjustment up to 2%.

Quality Assurance & Performance Improvement

- The Affordable Care Act requires nursing homes to have an acceptable QAPI plan within a year of the release of the final regulations. (Those have not been released).

- QAPI adds process improvement to existing Quality Assurance activities.
AMDA’s Work in QAPI

AMDA’s HoD passed a White paper on the *Role of the Medical Director in Quality Assurance and Performance Improvement in Long Term Care.*

- States that the medical directors should assist in developing formal patient care policies on quality of care that:
  - Help the facility establish systems and methods for reviewing the quality and appropriateness of clinical care and other health-related services and provide appropriate feedback;
  - Participate in the facility’s quality improvement process; and
  - Help the facility provide a safe and caring environment

Tools & Resources

- CMS’ QAPI website:
  - Learning Modules with videos, case study examples.
  - Downloadable QAPI process tools.
  - News on QAPI implementation.
- WWW.CMS.GOV/NHQAPI

CMS Initiative to Improve Dementia Care

- Centers for Medicare & Medicaid Services (CMS): Initiative to improve behavioral health & reduce unnecessary antipsychotic use
  - Kick-off national video stream March 2012 with two panels
    - Clinical panel
    - CMS officials panel
  - Goal: reduce antipsychotic use by end of 2012
  - Began April 1, 2012

OIG Antipsychotic Report Summary

  - Senator Charles Grassley initiated
  - 14% of elderly NH residents had claims for atypical antipsychotics
  - 83% of Medicare claims for AAP for elderly NH residents were off-label use
  - 22% of AAP were not administered according to CMS standards regarding unnecessary drug use in NHs

CMS Dementia Initiative

- National Action Plan
  - Raising awareness
  - Non-pharmacological interventions first
  - Regulatory oversight
  - Training
  - Research
  - Targeting patient-centered care, particularly those with dementia

- PUBLIC REPORTING (but not linked to 5-star)

CMS Measurement Specs for Antipsychotics

- Two measures: long-stay and short stay now included on CMS NH Compare Website
- Exclusions currently include schizophrenia, Huntington’s Dx, Tourette’s syndrome (not bipolar or MDD - also FDA approved indications)
- Short stay = no. of residents started on an antipsychotic within first 100 days from admission / no. of residents in the facility 100 days or less during the reporting period (those admitted on drug not included)
- Long stay measure = no. of residents in the facility for more than 100 days with antipsychotic drug use / total number of resident in the facility for more than 100 days
CMS Dementia Initiative

• How to Access Your Nursing Home Data
  – Visit Nursing Home Compare
  – Each NH is given advanced access to their ratings.
  – Quality measures updated quarterly.

www.nhqualitycampaign.org

• Advancing Excellence has added a new goal of improving appropriate use of medications – using reduction of inappropriate antipsychotics as the first area of focus.
• The Campaign website has CMS link to model practices and other NH tools for use – these tools are free and you don’t need to join AE to download

Practical Approaches for your Nursing Home to Reduce Antipsychotics

1. Develop a process to review each new start of an antipsychotic drug with the IDT. Within 7 days?
2. Work with the consulting pharmacist to review residents who have been on antipsychotics for longer than 3 months
3. Track incidence (number of new orders over a given time period) and prevalence (number residents who are on antipsychotics over a given time period)?
4. Share this data with your IDT. Attending physicians?

5. Create a process for addressing individuals who are admitted to the nursing home on an antipsychotic?
   – Why was the medication started and when?
   – Has it been effective?
   – Can the family or others identify what tends to get the resident upset or frightened?
   – Can the family or others share what activities tend to give the individual pleasure or calm them down?
   – Have you incorporated this into the care plan?
   – Is it time to reduce or discontinue the antipsychotic?

AMDA Action to Improve Dementia Care

• Issued “Dear Medical Director” letter from AMDA President, Matthew S. Wayne, CMD, MD, to all AMDA Medical Directors urging them to join with AMDA and CMS, in the nationwide effort to reduce the unnecessary use of antipsychotic agents by refocusing the interdisciplinary team on a better understanding of the root cause of dementia related behaviors.
• AMDA supports thorough evaluation and treatment of patients with behavioral issues.
• In non-emergent situations, non-pharmacologic interventions should be considered first.
• Supports CMS Partnership to Improve Dementia Care.
• AMDA’s developed a website on Improving Dementia Care in Nursing Homes:
  http://www.amda.com/advocacy/dementiacare.cfm
Medical Director Impact in Public Policy

- What is happening in CMS and on Capitol Hill impacts your residents, their families and your practice – STAY Informed!

- AMDA provides regular alerts and updates – read them and inform your NH leadership team. Often NH staff are unaware.

- CMS provides opportunity for public comment before all rule changes – many are directly related to clinical care and oversight. YOUR VOICE MATTERS AND CAN SHAPE POLICY!