Core Curriculum Training Workshop
University of Colorado School of Medicine
Department of Internal Medicine
October 23, 2012

Intro to The Colorado M.E.S.A Initiative

- The Colorado M.E.S.A. Initiative
  - Medicare Experts / Senior Access
  - Be adept at Medicare coding & documentation so you are paid fairly for work
  - Be comfortable serving patients with dementia & other geriatric syndromes
- A collaboration:
  - Funded by The Colorado Health Foundation, The Kaiser Permanente Foundation, and Caring for Colorado
  - Alzheimer’s Association, Colorado Chapter
  - Senior Care of Colorado/IPC

Our Underlying Assumptions

- Most providers enjoy taking care of seniors
- Medicare patients are viewed as labor intensive
- Reimbursement levels are viewed as a burden
- We have to live within the current system
Practices Closing to Medicare

- Many physicians restrict the number of Medicare patients in their practice because they feel Medicare pays too little
  - 17% of all physicians
  - 31% of primary care physicians

AMA Online Survey of Physicians
The Impact of Medicare Physician Payment on Seniors’ Access to Care, May 2010
Key findings from a survey of 9,000+ physicians who care for Medicare patients

The Right Attitude

- Seniors deserve access to quality primary care
- Medicare reimbursement is fair (although not adequate to fix the growing crisis)
- We must play by the rules
- We must be responsible stewards of medical resources
- It can be challenging to break old habits

Introduction to Medicare Coding and Documentation
Medicare Does Pay Fairly

Assumes 100% billing for 8 hours per day, 46 weeks per year at average of levels 2, 3, and 4 based on "time."
For illustration purposes only, not suggestive of actual or appropriate annual revenue.
Revenue shown represents gross charges.

Inappropriate Coding

- Cost of over-coding
  - Lost time and money from audits
  - Potential loss of revenue, fines, or even license

- Cost of under-coding
  - By one level in an office setting: 30 - 50%
  - By one level in a nursing home: 25 - 35%

Medicare Allowable ‘12

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Critical Billing Success Factors

- Bill accurately
  - All providers should know how to use ICD & CPT codes
- Bill appropriately
  - Medical necessity
  - Adequate documentation
- Bill courageously
  - Bill fairly for services rendered per the rules
  - Be prepared for audits, not intimidated by them

Expert Medicare Billing

1. Expert at relevant E&M criteria
2. Expert at time-based billing
3. Learn how/when to go either way
4. Don’t leave significant work on the table
   a. Meet threshold then move on
   b. May need to set limits with patients and family

Expert Medicare Billing

5. Be flexible in managing visits
   a. Address key issues and finish on time
   b. If time opens up (e.g. cancellation) may go deeper
   c. Best care and earnings come from flexibility (e.g. E&M vs. time)
   d. Schedule another visit when appropriate
Two Broad Paths

1. The First Path: Bill Based on Evaluation & Management (E&M)

2. The Second Path: Bill Based on Time *

* If >=50% of time is spent on Counseling and/or Coordination of Care (“C&C”)

E & M Coding

The First Path: Bill on E&M
- Evaluation & Management (“E&M”)
- Key components
  1. History
  2. Physical exam
  3. Medical decision making (a.k.a., Assessment & Plan)
- New patient = all 3 components required
- Established patient = 2 of 3 components required (may not need exam, or only a limited one)
E&M 1: History

- Chief complaint
  - A concise statement, usually in the patient’s own words
  - The reason for the encounter

- History of present illness
  - Description of the patient’s illness from the first symptom (if focusing on one problem)
  - Often a summary of chronic conditions
  - May be a combination of chronic and acute conditions

E&M 1: History (continued)

- Review of systems
  - Usually an inventory to identify symptoms, but may include signs or problems past or present

- Past, Family, Social History (PFSH)
  - Past medical history (medication review is key!)
  - Family history includes diseases that may place the patient at risk
  - Social history is review of current or past activities

E&M History Tips

- History elements previously recorded
  - Provider can get credit as long as the element is relevant and referenced

- ROS and/or PFSH record
  - Can be recorded by ancillary staff or patient as long as provider documents confirmation of information

- Unable to obtain a history/ROS
  - Document the patient’s condition that precludes getting the history/ROS
E&M 2: Examination

- Should be justified by the history
- May not be medically necessary
- Consider the patient’s expectations
  - You may want to use the stethoscope, even if you don’t have to

E&M 3: Medical Decision-Making

- Common codes in a geriatric practice
  - Address at least 3 acute or chronic problems
    - 214 (office, level 4)
    - 309 (nursing home, level 3)
    - 336 (assisted living, level 3)
    - 349 (home, level 3)
- Highest level codes
  - Difficult to meet criteria unless patient is quite ill and/or very frail and medical decision-making is very complex
    - 215 (office, level 5)
    - 310 (nursing home, level 4)
    - 337 (assisted living, level 4)
    - 350 (home, level 4)

Common E&M Codes With Seniors

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E&M Documentation Tips

- Update problem status - do not just use “stable”
- Be specific - do not just state “continue present treatment”
- Summarize discussions with interested parties (patient, family, staff)

Know a 214

A typical geriatric patient with multiple problems

1. History
   a. Brief chief complaint
   b. History of present illness
      1) Summary of 3 chronic problems
      2) OR elaborate on one acute problem
      3) OR a combination of chronic & acute
   c. Past medical history
      1) Often a medication list update
   d. Review of systems (ROS)
      1) Brief, minimum of 2

2. Examination: targeted, if necessary at all

3. Medical decision-making
   a. Summary of 3 chronic problems
   b. OR elaborate on one acute problem
   c. OR a combination of chronic & acute
An E&M 215 is Challenging

- A high hurdle compared to a 214
  - 10 ROS instead of 2-9
  - A social history instead of none
  - Comprehensive vs. targeted exam
  - Criteria for medical decision-making is more complex

- Exceptions
  - Patient is quite ill and/or very frail and medical decision-making is very complex
  - History justifies an extensive ROS & comprehensive physical exam (e.g. progressive weight loss, worsening fatigue)

Time-Based Coding

The Second Path: Bill Based on Time

- >=50% of the encounter spent on counseling and/or care coordination (C&C)
- Great patient care
- Fair compensation
- E&M detail not necessary
Counseling & Coordination Visit

- Time is the key factor in selecting the level of service when counseling and/or coordination of care dominates (≥50% of) the encounter
  - Estimate an actual percentage
  - Follow the “typical time” standards set by the AMA and published in the CPT book
  - Time approximation must meet or exceed the specific CPT code billed
  - Time should not be “rounded” to the next higher level

Definitions by Location: Inpatient

- Inpatient, SNF, NH
  - Includes activities such as:
    - Patient/family teaching
    - Patient/family discussion
    - Reviewing old records
    - Discussing case with other providers
    - Coordinating discharge planning, etc.

*Time can be spent in the patient’s room or at the nursing station, but must be on the premises of the patient’s unit (i.e., “Floor Time”)*

Definitions by Location: Outpatient

- Outpatient, home, ALF
  - Includes activities such as:
    - Teaching and/or planning
    - Coordinating care
  - Requires that time be spent directly with the patient, face-to-face
### C&C Documentation Requirements

- Continuous visit: document total time spent (actual number of minutes)
  - Example: “8:00 – 8:40, >=50% C&C”

- Discontinuous visit: document that the duration of the visit was scattered over a longer period of time
  - Example: “Time of visit was 40 minutes, scattered over a two-hour period, >=50% C&C.”
  - Each note should have a start time.

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### C&C Documentation Requirements

- If in an outpatient setting, confirm through documentation that time was spent face-to-face

- Outline what was done and/or discussed during time spent
  - Treatment and/or alternatives
  - Importance of compliance with treatment
  - Risks and morbidities
  - Prognosis and recommendations
  - Summarize discussions
  - Patient and/or family education
  - Instructions for management and follow-up care

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### Typical Time - Established Patient

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Which Path?

E&M or Time-Based Billing?

- When billing E&M services, the provider must make a decision about whether or not time spent counseling and coordinating (C&C) care dominated the encounter.
- Document the chief complaint and a detailed problem list & plan in either case. This establishes medical necessity for the visit and sets the stage for billing E&M should this be the end result.

Practice Tips

- New patient visit
  - Focus on E&M criteria
- Regulatory nursing home visits
  - Focus on E&M criteria
- Meet with family and patient
  - Will likely be focused on C&C
Be Prepared to Take Either Path

• Construct your note to go either way

• Start Down 1st Path: E&M
  – Relatively brief and focused
    • 213, 307, 308, 334, 335, 347, 348
  – Review of several stable conditions
    • 214, 309, 336, 349

Be Prepared to Take Either Path

• Jump to 2nd Path if Appropriate: Time
  – Visit will be long - family meeting, multiple issues, counseling and/or care coordination
  – An expected “E&M 214” of 40 minutes
  – Switch to time, don’t worry about the details of E&M criteria

Prolonged Care Services

• Prolonged care service codes are an option for visits that require more time
• Watch the MESA webinar on “Nuances of Time Based Billing” for more information
**Miscellaneous Coding**

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**Incident-to Qualifications**

- Under “incident-to” billing, NPs/PAs are paid at 100% if:
  - Established patient
  - Physician has seen patient
  - Physician initiated plan of care
  - Physician is in clinic during visit
- Otherwise, NPs/PAs earn 85% of Medicare allowable

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**Incident-to Conditions**

- Physician must:
  - Remain actively involved in patient care
  - “Periodically” see the patient
- No “incident-to” with a new illness or problem
- Billing is under the billing number of the physician actually “on-site”
Audits

- Be prepared for an audit, not afraid
  - Know the rules and guidelines
  - Have confidence
  - Show proper intent
- Audit yourself
- Use the MESA Progress Note Audit program

MESA Pearls & Protocols

- 20 geriatric experts contributed
  - An average of 20+ years' experience working with seniors
  - Board-certified geriatricians, NPs, and PAs
  - Unique styles, philosophies and approaches to practicing medicine
- Melded information from
  - Day-to-day experience
  - Clinical journals
  - Professional organizations
  - Research literature

MESA Pearls & Protocols

- Pearls of Geriatric Wisdom
  - Provider-focused
- Clinical Geriatric Protocols
  - Intended for use by office staff (medical assistants, triage nurses, office managers)
- Entire document included on handout CD and available for download on www.ColoradoMESA.org
  - Must be signed in as a registered user to access downloads
Alzheimer’s Association CO Chapter

- Founded in 1980
- Statewide access for Colorado families through offices in Denver, Colorado Springs, Pueblo, Durango, Grand Junction, Fort Collins, and Greeley

Rapid Referrals

- Immediately connect your patients to us through the Rapid Referral Form
- Simply fill out and fax it back
- Forms are inside folders and on www.ColoradoMESA.org website, by region
Alzheimer’s Association Colorado Chapter

alzheimer’s association

24/7 Helpline
800-272-3900

www.alz.org/co

MESA Educational Resources

MESA Resources

• Face-to-face workshops
  – Please help us by completing your surveys
    • Clinician or practice survey
      – Some questions may not apply to you
    • Workshop satisfaction survey
    • Follow-up survey: we will email you in the future
  – Handout materials
    • Today’s slides in spiral booklet
    • Clinical Pearls & Protocols
    • CD with documents and presentations
Website: www.ColoradoMESA.org

- Registered User status
- No charge to participate or use
- At your fingertips
  - Training videos
  - Webinar archives
  - Downloads & links
  - Discussion forum
  - Clinical guidelines/Pearls & Protocols
  - List of upcoming workshops and online registration
  - Links to Alzheimer’s Association resources and Rapid Referral Forms

MESA Resources

- Webinars
  - Unique topic each month
  - First Friday at lunchtime (12:15), 30 minutes
  - Watch live or watch archives on website
- eNewsletters
- Progress note audit program
- MD conference call
  - Active MESA participants who have implemented principles
  - Participated in progress note audit
  - One-on-one phone consultation

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