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How physicians can get paid for care coordination

New Current Procedural Terminology codes mean that just about any practice can bill for coordinating the care of those discharged from a hospital or with multiple chronic conditions, even without having formally to transform into a patient-centered medical home or become part of an accountable care organization.

What the codes cover

The first step for practices, coding experts say, is to contact the various insurers to find out how they are responding to these new codes.

Medicare will pay for transitional care management and expects to pay out about $600 million for practices to handle a patient's move from a hospital to other settings in 2013. No additional money is on the table from Medicare for complex chronic care coordination, although that is expected to change.

The second step is to determine how to use the codes to make proper payment more likely.

For instance, the transitional care management codes should be used when a practice takes care of the issues of a patient returning home or going to another care setting from a hospital or skilled nursing facility. Both codes, 99496 and 99495, require a physician to have and document some kind of medical discussion, although not necessarily in person, with the patient or their caregiver within two business days of discharge.

The higher-level code, 99496, calls for a face-to-face visit within a week. For the lower-level code, 99495, the face-to-face visit may be within two weeks.

The other set of new codes can be used for patients a physician or insurer considers in need of significant care coordination services outside of usual face-to-face visits. These services can be provided by a physician, but coding designers say they are a better fit for nurses or others staffers within their scope of practice.

The code 99487 should be used if the patient is not actually seen by the physician, but instead if other practice staff spend an hour over a 30-day period on care coordination involving that patient. Code 99488 includes this hour of care coordination time and a face-to-face visit. Code 99489 should be used for 30-minute increments over the initial hour of care coordination.

The key to the care coordination codes, consultants say, is to develop systems that track actual time spent. A physician and medical practice staffers may spend 10 minutes coordinating a patient's care one week and 15 minutes the next, but these codes are to be used only once per patient per month and are dependent on the total number of minutes spent on these activities over 30 days. Other evaluation and management services would be billed separately.

The third step, coding experts say, is to have contacts with other parts of the health system to identify opportunities to provide these services. For example, strengthen links with local hospitals to make it more likely that a practice is notified when a patient is discharged.

Consultants say most hospitals should be amenable, since improving transitions can reduce readmissions and Medicare penalties for having too many of them. Patients who are good candidates for complex chronic care coordination may be identified by the practice or an insurer.

Excerpted from an article by Victoria Stagg Elliot You can find the full article in AMED News, *January 21, 2013.*

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Editorial

Time to eliminate the sustainable growth rate

by Harvey B. Lefton, MD

The Medicare sustainable growth rate [SGR] is the method that Medicare uses to calculate payments for physician services. It was devised in 1997 to prevent the yearly increase in the cost for each Medicare beneficiary from exceeding the growth of our gross domestic product. The Payment Advisory Commission receives a yearly calculation from CMS about the yearly expenses and projections on the coming year expense targets. If payment for one year exceeds projections, the payment for the next year is reduced to keep expenses in range. Conversely, if one year's expenses were lower then physician reimbursement would be increased.

Since expenses have gone up every year since 1997, there has been no increase in physician fees but yearly threats of decrease in doctor reimbursement occur. Most recently, there was a threat that payment for the coming year would be reduced by 27.2%.

Each year we live with the specter of pay cuts only to have Congress enact stopgap legislation to freeze the cut at the last minute. The net effect of this process has been to keep payments near 2001 reimbursement levels. On January 1, 2013, Congress enacted legislation to again freeze reimbursement and avoid a pay cut until January 1, 2014, in the hope of a solution to this "kick the can down the road" process. This one-year patch will cost $7 billion.

Mixed in with this dilemma is the implementation of Obamacare, which may have no true funding as the bill was written. Since no solution to funding was provided in the past, it appears now that all forms of healthcare might not be funded. Pennsylvania recently chose not to expand Medicaid funding, leaving 700,000 citizens without healthcare. If it is not dealt with, we will all be forced to pay for the healthcare for the needy with physicians providing billions in unpaid care.

This looming dilemma means that government must consider alternative healthcare solutions to control the cost of care. Most parties agree that a transitional framework needs to be developed to pay for our healthcare services. A number of specialty and state societies, including the Pennsylvania Medical Society, have endorsed new payment models that reward physicians for controlling costs while improving healthcare quality. These societies promote rewards for meeting quality standards while eliminating penalties. Also, new models must not punish doctors for factors beyond their control. Government must support shared saving models and accountable care organizations that reward physicians for controlling costs.

Organized medicine must join the fight to reform our health system. If we are not vocal players in this debate, we and our patients will be the victims of ill-conceived policies that will benefit none of us.

Representative Allyson Schwartz and Joe Heck introduced legislation entitled "The Medicare Physicians Payment Innovation Act" which could eliminate the 27% Medicare pay cut of January 1, 2014, and keep 2013 rates through the end of 2014. Thereafter, a shift towards rewarding quality from the present fee-for-service methodology would be instituted. A 2.5% rate increase for primary and preventive care would occur yearly through 2018. Under this act all other services would rise by 0.5% yearly. By 2019, CMS would have transitioned to alternative health delivery systems such as accountable care organizations or bundled care. There would be emphasis on home healthcare. After 2019, rates would decrease for those still in the fee-for-service model. While the AMA has yet to endorse this proposal, they have supported it in an effort to get rid of the SGR model.

It is clear there will be much debate over funding in the next two years as we search for affordable healthcare and try to solve our funding dilemmas. Organized medicine must join the fight to reform our health system. If we are not vocal players in this debate, we and our patients will be the victims of ill-conceived policies that will benefit none of us.

Dr. Lefton is President of PCMS.

How to validate your specialty for the Medicaid Primary Care payment boost

Certain primary care specialties are eligible for increased fees in 2013-2014. What this means is instead of getting paid $31 for 99213 under the Medicaid fee schedule, they will receive the Medicare fee of $67 for the next two years.

In order to qualify, you must be board certified in either family care, internal medicine or pediatrics, or a subspecialty of one of these as recognized by the American Board of Medical Specialties.

DPW just released revised instructions and an attestation form that all physicians must submit. A deadline to submit the attestation has been extended from March 1 to April 1. Because DPW does not anticipate the fee schedule to be updated to pay the increased amounts until around April 1, they will have to reprocess all claims paid prior to the fee schedule update in order for providers to retroactively receive the increases but only if you file your attestation before April 2.

Anyone who previously submitted any data or attestation prior to the release of this attestation form will have to resubmit the attestation. Access the form at *philamedsoc.org/wp-content/uploads/2013/02/DPW-attestation.pdf.*

PQRS reporting in 2013 is crucial
Reminder to all practices that if they do not report PQRS by 2013, they will automatically have their payments adjusted via the value-based payment modifier in 2017.

The cost of surgical mistakes

A review of medical liability settlements and judgments in the National Practitioner Data Bank between 1990 and 2010 sheds light on the financial consequences of surgical "never events." Payouts ranged up to $7.1 million. *Source: "Surgical never events in the United States," Surgery, Dec. 17, 2012.*

Type of "never event"	Cases	Average payout
Wrong procedure	2,447	$232,035
Wrong site	2,413	$127,159
Wrong patient	27	$109,648
Retained foreign body	4,857	$86,247

Preparing for transitional care management services in 2013

In January, Medicare began reimbursing physicians and other qualified non-physician professionals for time spent transitioning a patient out of institutional care and back into the community setting. In order to get reimbursed, physicians need to develop specific strategies and processes for delivering these critical services, being sure to document the non-face-to-face activities of transitional care management (TCM) to show that the criteria has been met.

Below is a summary of what you need to know, including the new CPT codes, requirements for physicians and patients, and how to bill for TCM services.

TCM services will be reported using newly created codes CPT 99495 or 99496. Some highlights of TCM include:

CPT 99495: TCM services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within two 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.

CPT 99496: TCM services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within two business days of discharge
- Medical decision-making of at least high complexity during the service period
- Face-to-face visit within seven calendar days of discharge.

Requirements for patients and physicians

To be eligible for the service, the patient's condition must be of moderate to high complexity as defined by evaluation and management (E/M) documentation guidelines.

During the time period for TCM services, which includes the 30-day period beginning on the date of discharge, the physician must:

- Contact the patient within two business days of discharge. The physician must have a face-to-face visit with the patient within the time frame listed for each code above. This first E/M service is not separately reportable, meaning that the practice may not bill for this E/M service if it intends to bill TCM codes. Medication reconciliation is required during the visit. Any subsequent medically necessary E/M service may be billed to Medicare.

Non-face-to-face services include: communication with the patient, caregiver, family, home health agency or other community services involved in the patient's care; education to support activities of daily living; assessment and support of the treatment regimen and medication management; identification of community and health resources; and facilitating access to these resources.

- Review the discharge summary to: determine the need for pending or follow-up tests and other services; interact with other healthcare professionals involved in the patient's care; provide education of patient, family or caregiver; establish or reestablish referrals; and assist in scheduling medical care or community care.

Billing for TCM services

Physicians and other qualified non-physician practitioners may bill for TCM services. The Centers for Medicare and Medicaid Services (CMS) is modifying the prefatory instructions for the CPT TCM codes allowing a physician to bill these services for new patients. There is no restriction on physician specialty designation.

Medicare will pay for only one TCM claim for the 30-day period following discharge. Claims can be submitted no sooner than 30 days following discharge. The first claim to be filed will be paid. Medicare will not pay a second TCM claim in connection with a discharge that occurs within 30 days of the original discharge (i.e., the patient is readmitted and discharged within the same 30-day period).

For a complete list of limitations on submitting claims for TCM services, visit *www.philamedsoc.org.*

If you have any questions, call the PAMED Division of Practice Economics and Payer Relations at 800-228-7823.

pcms people

Jerry A. Shields, MD, PCMS 2011 Strittmatter Awardee, has been named the 2013 National Physician of the Year Awardee for Clinical Excellence by Castle Connolly Medical, Ltd.

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