ANO REVENUE CYCLE MANAGEMENT MONTHLY NEWSLETTER

October 2024

CODING HIGHLIGHT

New ICD-10 Codes

E66.8 has been expanded

- E66.81 – Obesity Class
- E66.811 – Obesity Class 1
- E66.812 – Obesity Class 2
- E66.813 – Obesity Class 3
- E66.89 – Other Obesity not elsewhere classified

Please make sure you are using the highest specificity for your diagnosis codes.

**** PLEASE DO NOT CONTINUE TO USE E66.8**

Monthly humor

Q&A

Q: Can I bill G2211 with an Annual Wellness Visit and an evaluation and management code?
A: No, you can not bill G2211 with an E/M code that is billed with modifier 25. Which you would have to do to bill both the AWV and E/M.

Q: If a patient is seen for an Annual Wellness Visit (AWV) on September 24, 2024, when would they be eligible for their next AWV?
A: Medicare starts counting on the first of the month following their AWV and counts out 11 months. The patient would be eligible on the first day of the next month, in this case it would be September 1, 2025

Do you have a question you would like answered? Send us your questions at info@ano-rcm.com

"Success is liking yourself, liking what you do, and liking how you do it." ~ Maya Angelou

VERIFYIING SPEECH THERAPY BENEFITS:

Many insurance companies may state they cover speech therapy services however, they don't always state that only certain types of services are covered. It is very important to ascertain the right information before billing services. Reviewing the following five (5) topics with the insurer's customer service representative can help avoid potential claim denials, unexpected bills for patients and balance write-offs.

1) Does the patient's plan cover both rehabilitative and habilitative services?

- **Rehabilitative services** – These services help a patient get back, improve or keep skills that may have been lost due to injury or illness.
- **Habilitative services** – These services help a patient achieve skills they may not have developed to begin with and may impact their daily living.

Habilitative services are frequently considered non-covered services or only covered for patients of a certain age.

2) Is a referral from the PCP required?

A referral is submitted to make sure the patient receives care and treatment from the appropriate specialist. Not all clinics require a referral, however, some insurance companies do require an ordering or referring physician to be listed on the claim. You can decide if your office will require a PCP referral for each patient.

3) Is authorization required for an evaluation and/or treatment?

Many insurance companies require prior authorization before the patient can been seen. Typically, a request for prior authorization includes an evaluation report, chart notes and care plan. Requesting prior authorization can create a delay in receiving care as this process can take days or even weeks to complete.

4) Is there a visit maximum? Does this apply to certain conditions?

- **Hard maximum** - obtaining additional visits is difficult unless there is a policy clause for certain rehabilitation services.

- **Soft maximum** – will frequently approve additional visits based on medical necessity.

Speech therapy services are regularly subject to a visit limit. However, understanding the visit limits as either a hard maximum or soft maximum is very important. Some plans may indicate they have no visit limits for certain diagnosis codes.

5) Are there other exclusions?

Excluded services will differ between plans, even within the same insurance company. Services that are 'educational' are considered maintenance and would be excluded. Cosmetic services, such as an accent reduction, would also be excluded.

Always request a reference number for the call and add that to your note. Make sure to notate the patient's account with your findings.

**AAPC The Magazine; September 2023 issue; *5 Questions to Ask when Verifying Speech Therapy Benefits;* Author Alyssa Carr, CPPM

CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) programs have increased positive outcomes for patients and profitability for medical providers. Medicare, Medicaid and many commercial insurance companies recognize Chronic Care Management (CCM) as a significant component of primary care and influences better health and care for patients. Chronic conditions are frequently complex and pose a significant burden to a patient's health. CCM can help reduce hospital and emergency department visits by approximately 5%. CCM is a separately paid service under Medicare's physician fee schedule.

To establish a foundation for your CCM program, you need to understand the requirements. You will need to know which patients qualify, what services are required, and what role the practice staff will play. The first step is determining who will provide and bill the services related to the CCM program. Codes are based on who the services are rendered by; a physician, other qualified healthcare provider, or nonphysician staff.

Services for Chronic Care Management:

- 99490 – Non-complex, first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional; coordinate care with associated providers and support patient accountability; per calendar month.
    - +99439 – Add-on code for 99490, each additional 20 minutes.

- 99487 – Complex, first 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional; substantially revise or establish a comprehensive care plan for moderate to high complexity; per calendar month.
    - +99489 – Add-on code for 99487, each additional 30 minutes.

- 99491 – CCM services performed by a physician or other qualified healthcare professional; first 30 minutes; per calendar month.
    - +99437 – Add-on code for 99491, each additional 30 minutes.

Principal Care Management (PCM) is a program that helps patients manage a single chronic condition. PCM is similar to CCM, however PCM is primarily focused on a single high-risk condition. This is a preventive program that helps with one specific chronic condition and is covered by Medicare.

Services included with PCM include developing a disease specific care plan, monitoring and revising the care plan, coordinating with community organizations, engaging patients in preventative care and reducing hospital visits. PCM services can last up to a year or until death. Services can be remote visits, prescription refills, or interactions with other providers.

Chronic conditions to qualify for PCM;

- Expected to last at least 3 months
- Have contributed to recent hospitalization
- Patient is at significant risk of death, exacerbation, or functional decline

Services for Principal Care Management:

- 99424 – Single high-risk disease; first 30 minutes personally provided by a physician or other qualified healthcare professional; per calendar month.
    - +99425 – Add-on code for 99424, each additional 30 minutes.

- 99426 – Single high-risk disease; first 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional; per calendar month.
    - +99427 - Add-on code for 99426, each additional 30 minutes.

Identify the patients that are best suited for a CCM program. These patients have chronic conditions expected to last at least 12 months, are at high risk for hospitalization, or have recently been seen in the emergency department. Utilize the EMR system to search for patients who have applicable chronic conditions. This can be done by running diagnosis reports.

In order for patients to benefit from the CCM program they need to understand how the program works and how it can help them. Patients need to be educated on how CCM services extend their care outside of your practice to ensure their best possible health. Inform patients that benefits of a CCM program include:

- Coordination of home health or medical equipment needs
- Guidance of how and when to take medications any time or when changed
- Help with locating community resources
- Assistance with scheduling appointments, lab tests, or other tests
- Access to other support services
- Coordination of follow-up care after leaving the hospital
- Answering questions outside of calls with a coordinator

Enrolling a patient in the CCM programs requires verbal or written consent from the patient, verbal consent must be documented in the patient's note. If written consent is obtained, the patient must be given a copy of the consent. Either consent needs to inform the patient that they can only sign up with one provider and be given instructions on how to opt out at any time.

After consent is obtained, the patient should be given a comprehensive digital care plan that includes:

- Comprehensive assessment
- List of current problems / conditions
- Treatment plan and goals
- Resources associated with care
- Medication management

Benefits of CCM are extensive for patients and providers. These resources ensure patients have better access to care, which in turn leads to fewer hospitalizations and emergency department visits.

**AAPC The Magazine; May 2024 issue; *implementing a successful CCM program;* Author Corella Lumpkins, CPC, CPCO, CDEO, CPB, CMPA, CPPM, CPC-I, CEMC, CHC, CCS, CCS-P and Google AI Overview PCM

BEHAVIORAL HEALTH DOCUMENTATION

A provider can give excellent care and yet an insurance company can still take back payment if medical necessity and other requirements have not been met. Documentation is essential for accurately coding provider services. The provider needs to tell a story in clinical terms using behavioral language in order for coders to assign correct codes.

Identifying factors that may cause a payor or auditor to look closer at behavioral health charts:

- **Coding the same diagnosis too often:** The same diagnosis repeatedly for one patient is questionable, however the same diagnosis for many patients is a problem. Any condition has a spectrum that is informed by the severity of the condition as it changes.
- **Unspecified diagnosis:** Use of an unspecified diagnosis should be the exception, never the rule.
- **Using the same code for each patient:** Utilizing the diagnosis of 'Unspecified' repeatedly is not sufficient, this leads to repetitive use of non-specific codes. There should be clinical documentation to support a more specific diagnosis.
- **Severity of condition never changes:** If the patient's condition is not changing, why hasn't the treatment plan and goals been updated?
- **Seeing the patient too often:** Is the level of care for the patient at the highest level? Why has there been no improvement?
- **Missing or incomplete evaluation:** Evaluations need to be present and complete for correct coding and continuity of care.
- **Always seeing the patient for the same exact amount of time:** A patient being seen for exactly 45 mins for every visit means it is unlikely the provider is using real-time tracking. Some coding software will bill for the scheduled time, not the actual time the patient was seen. An entire note can come into question if real-time documentation is not used.

Auditors, coders, and payers want to see behavioral language within the documentation to show functional impairments. Encounter notes should include why the patient is being seen, how their condition is affecting their daily living, progress made, and how the patient and provider will adjust goals and objectives. Additionally, charts should include the following elements:

- Start and stop times
- Patient progress
- Facts of patient encounter
- Patient ID and date of service on each page
- Legible / understandable writing or typed notes
- Measurable objectives
- Criteria / symptoms to support the diagnosis
- Consent for treatment and related information
- Signature with credentials

Always remember, if it is not in the note, it was not done and can't be coded.

**AAPC The Magazine; February 2024 issue; *Crafting Comprehensive Behavioral Health Records;* Author Lee Fifield, BS

If you have any questions or would like a specific code highlighted in our next newsletter, please send those requests to info@ano-rcm.com.

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