





# Optimizing health outcomes using quality metrics while getting paid in the process

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## Quality Payment Program (QPP): Overview

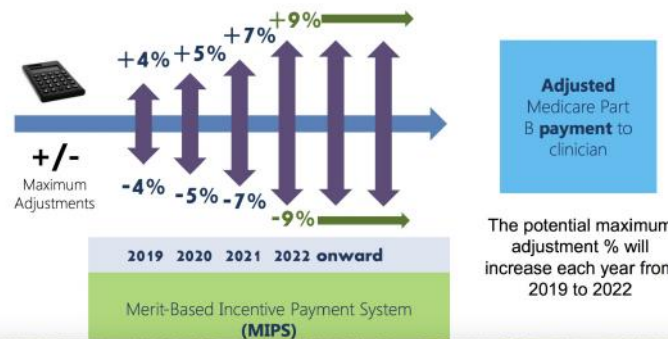
- ▶ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - ▶ Medicare Quality Reporting Program
- ▶ The Quality Payment Program has two tracks you can choose:
  - ▶ Advanced Alternative Payment Models (APMs)
  - ▶ The Merit-based Incentive Payment System (MIPS)
- ▶ For MIPS, you must be a:
  - ▶ Physician
  - ▶ Physician Assistant or Nurse Practitioner
  - ▶ Clinical Nurse Specialist
  - ▶ Certified Registered Nurse Anesthetist

# MIPS: Performance Categories

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
 <b>Quality:</b> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-priority measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
 <b>Advancing Care Information:</b> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
 <b>Clinical Practice Improvement Activities:</b> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in APMs will earn at least half credit.	60 points	15 percent
 <b>Resource Use:</b> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource use measures that can be attributed	10 percent

# MIPS: Performance Scoring

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.



## MIPS: Quality Measures Metrics

- ▶ Quality (60% of total score) - Participants choose six measures
  - ▶ One of which must be an outcome measure
  - ▶ Measured reported must be on at least 50% of eligible Medicare and non-Medicare patient encounters for a period of at least 90 days
    - ▶ Heart Failure: Patient must be taking an ACE or an ARB) for LVDS
    - ▶ Coronary Artery Disease: Patient must be on a Beta-Blocker BEFORE MI or LVSD with an E/F <40%
    - ▶ Heart Failure: Patient must be on a Beta-Blocker for LVSD
    - ▶ Urinary Incontinence: Patient must have a documented care plan for incontinence in Women Aged 65 Years and Older

## Patient Centered Medical Home (PCMH)

- ▶ Patient-Centered Medical Homes (PCMH) automatically receive full credit in the IA category
- ▶ If one practice under the group TIN has PCMH recognition, the entire TIN receives all IA category points
- ▶ If the practice is not a qualified PCMH, participants must attest to two highly-weighted (20 points) or four medium-weighted (10 points) activities
  - ▶ Activities may be combined
- ▶ CMS lists >90 improvement activities
  - ▶ IA must be performed/reported over a period of at least 90 days continuously

## Benefits of a PCMH Family Medicine Practice

- ▶ Benefits to Patients
  - ▶ Better coordinated, more comprehensive and personalized care
  - ▶ Improved access to medical care and services
  - ▶ Improved health outcomes, especially for patients who have chronic conditions
- ▶ Benefits to Providers
  - ▶ A more efficient use of practice resources, resulting in cost savings
  - ▶ A practice equipped to take advantage of PCMH payment incentives for adopting the functions of a patient-centered medical home
  - ▶ A practice that is better prepared for enhanced payment under the Merit-based Incentive Payment System (MIPS) or Alternative Payment Models (APMs)
  - ▶ A practice that is primed to participate in accountable care organizations

<https://www.aafp.org/practice-management/transformation/pcmh/benefits.html>

## Risk Adjustment Factor (RAF) Scoring

- CMS - chose a risk model based on measuring chronic conditions
  - Patients with multiple chronic conditions that may (will) require additional resources, oversight and care
- Each member (patient) is assigned a RAF
  - RAF is a number that indicates the health status of a patient
  - RAF score is made up of several things
    - Demographics of age & gender
    - Risk factors are added together for Medicaid status due to a disability
    - All chronic conditions + some disease interactions

	All conditions coded appropriately	Some conditions coded – low level of specificity	No conditions coded
	76 year old female 0.437	76 year old female 0.437	76 year old female 0.437
	Medicaid eligible 65+ 0.151	Medicaid eligible 65+ 0.151	Medicaid eligible 65+ 0.151
	Diabetes w/mention of vascular comps 0.368	Diabetes w/o mention of complications 0.118	No Diabetes coded X
	Vascular disease w/complications 0.410	Vascular disease 0.299	No vascular disease coded X
	CHF 0.368	No CHF coded X	No CHF coded X
	Disease interaction (DM + CHF) 0.182	No disease interaction X	No disease interaction X
	Total RAF 1.916	Total RAF 1.005	Total RAF 0.588

## Determining a RAF Score

- ▶ Risk Adjustment Factors are **additive**
  - ▶ Add all diagnoses for each patient submitted to CMS in claims data over a calendar year
  - ▶ Add all risk factors to determine a patient's total health status
- ▶ Risk Adjustment Factors are also **predictive**
  - ▶ ICD-10 codes reported over the calendar year determine how much resources will be needed in the next year
  - ▶ Health status is assessed at the end of each calendar year

## Medicare Annual Wellness Visit (AWV): Initial Visit

Primary purpose is to establish a care plan...

This is not a preventive physical exam

▶ Data Collection:

- ▶ Demographic data
  - ▶ Where they live
- ▶ Self-Assessment of Health Status
  - ▶ How do they think they are doing?

▶ Psychosocial Risks

- ▶ Depression, hopelessness, stress

▶ Behavioral Risks

- ▶ Weight, smoking status, alcohol use, HBP

▶ Activities of Daily Living

- ▶ Incontinence, eating, bathing

## AWV: History and Risk

- ▶ Past Medical, Family and Social History
  - ▶ Medication reconciliation
  - ▶ Family history of chronic disease
- ▶ Vitals: Height, Weight + BMI, Blood Pressure
- ▶ Care Team
  - ▶ List of ALL providers involved in the patient's care
- ▶ Measurement of cognitive impairment (observable)
  - ▶ Fall risk
  - ▶ Mental health – depression
  - ▶ Personal safety – safe at home

## AWV: Care Plan

- ▶ Establish a **written** plan of care
  - ▶ Includes screening schedule
    - ▶ Do you know what preventive services Medicare covers?
- ▶ Establish a list of risk factors and conditions
  - ▶ With planned interventions
  - ▶ And treatment options
- ▶ Give personalized health advice
  - ▶ Referrals for health education and mental health counseling
  - ▶ Tips on self-improvement
  - ▶ Personal health and wellness

## AWV: Subsequent Visit

- ▶ No more than 20 minutes
- ▶ Risk Assessment
  - ▶ Identical to the "first" visit
- ▶ Medical/Family History
- ▶ Anything that happened over the past year
  - ▶ Change in medications
- ▶ Constitutional Assessment
- ▶ Change/Update in Risk Factors
- ▶ Referrals to Other Programs/Professionals

## AWV: Billing Requirements

- ▶ This is a Medicare ONLY service
  - ▶ Billed after the first year of T18 enrollment
- ▶ It is not a preventive physical exam
- ▶ It is a preventive care plan
- ▶ Use diagnosis code Z00.00
  - ▶ Routine General Medical Exam
- ▶ First Visit is only billable once in a lifetime
- ▶ Subsequent Visit is billable every 365 days

## AWV: Codes + Reimbursement

- ▶ G0438 – Annual Wellness Visit  
{ \$165.09 Work RVUs 2.43 }
  - ▶ First Visit to establish history & care plan
  - ▶ Includes a personalized prevention plan of services
- ▶ G0439 – Annual Wellness Visit  
{ \$110.61 Work RVUs 1.50 }
  - ▶ Subsequent Visit to update history & care plan
  - ▶ Includes a personalized prevention plan of services



## Chronic Care Management (CCM)

- ▶ Documentation of the following using a certified EHR: demographics, problem list, current medications, allergies to medications, plus a clinical summary
- ▶ 24/7 access to care management services
  - ▶ Patient-centered approach to care
  - ▶ Continuity of care for the patient within the care team
- ▶ Assessment of health needs through preventive care services
- ▶ Electronic plan of care
- ▶ Management of transitions of care
- ▶ Care coordination with both home and community-based providers
  - ▶ Improvement in patient-care provider communication
- ▶ **Informed consent** must be documented
  - ▶ This service is voluntary and can be refused

## CCM: Patient Eligibility

- ▶ Patients with two or more chronic conditions that are expected to last at least 12 months, placing the patient at significant risk of death, acute exacerbation, decompensation, or functional decline are eligible for CCM services. At risk for re-admission...
- ▶ Identified chronic conditions:
 

▶ High Blood Pressure	Dementia/Alzheimer's	Hyperlipidemia
▶ Arthritis	Ischemic Heart Disease	Osteoporosis
▶ Asthma	Depression	CKD
▶ Diabetes	TIA/Stroke	Heart Failure
▶ COPD	A-Fib	Cancer

## CCM: Patient Access

- **CMS Requires that the patient receive a face-to-face visit such as an AWV, or comprehensive E/M service before CCM can begin**
- 24/7 Provider Access = Continuity of Care within a calendar month
- A Care Team Member must be accessible to the patient 24 hours a day, 7 days a week
- They must also be accessible to other healthcare professionals involved in the patient's care
- Patient must be attended to with timely response to address the patient's urgent chronic care needs
- Patient must have remote access to an EHR, messaging through a secure EHR portal, secure email, or via telephone

## CCM: Providers

- ▶ Physician
- ▶ APPs - NP, PA
- ▶ CNS or CNM subject to state licensure and scope of practice
- ▶ Clinical staff incident to
  - ▶ Qualifying clinical staff defined as licensed personnel (RN)
  - ▶ General supervision of clinical staff in incident to capacity
- ▶ Non-clinical staff time is excluded from the minimum 20 minute time required to bill
  - ▶ Clerical staff involved in phone calls and scheduling

## CCM: 99490 Non-Complex 20 minutes

- ▶ Payment on the non face-to-face portion of CCM services for CPT code 99490 is based on similar care management services {\$40 Work RVUs .61}
- ▶ Chronic care management includes at  $\geq 20$  minutes of clinical staff time under the direction of a physician or other qualified health care professional, within a calendar month, that requires:
  - ▶ It assumes 15 minutes of work time
  - ▶ Two or more chronic conditions expected to last at least 12 months, or, until the patient passes away
  - ▶ Why? Chronic diseases place the patient at significant risk for death, with periods of acute exacerbation/decompensation, or, lead to a functional decline
  - ▶ A comprehensive care plan must be established, implemented, revised, with demonstration that it must be monitored

## CCCM: 99487 60 mins + 99489 additional 30 mins

- ▶ Payment for CPT code 99487 Complex Chronic Care Management {\$94 Work RVUs 1.30}
  - ▶ Two or more chronic conditions expected to last at least 12 months, or the patient passes away
  - ▶ Chronic conditions that put the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - ▶ Establishment or substantial revision of a comprehensive care plan
  - ▶ Moderate or high complexity medical decision making (MDM)
  - ▶ 60 minutes per calendar month
    - ▶ Assumes 26 minutes of work time
- ▶ Payment for CPT code 99489 Complex Chronic Care Management {\$47 Work RVUs 1.00}
  - ▶ Each additional 30 minutes per month
    - ▶ Assumes 13 minutes of work time
  - ▶ Billed in addition to the primary CCCM code

## Transitional Care Management Services

- ▶ **Transitional Care Management** services “are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity Medical Decision Making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living).”

Making the Jump into Transitional Care Management Billing  
By Elizabeth Wright CPC, CEMC

## Transitional Care Management (TCM)

- ▶ Services are required during the beneficiary's transition to the community setting following inpatient discharge
- ▶ Healthcare Provider accepts care of the patient following discharge without a gap in treatment
- ▶ Healthcare Provider assumes total responsibility for the patient's care
- ▶ Patient has medical and/or psychosocial problems requiring moderate or high complexity medical decision making
- ▶ The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days
  - ▶ Note: This is a 30-day period, not a calendar month

## TCM: Rules

- ▶ The date the beneficiary is discharged from an inpatient hospital inpatient stay starts the 30 day period of TCM
- ▶ Providers must furnish the following three TCM components:
  - ▶ An interactive contact (does not include Day #1, day of discharge)
    - ▶ An interactive contact with the beneficiary and/or caregiver, as appropriate, must be made within 2 business days following the beneficiary's discharge to the community setting
    - ▶ Contact may occur via telephone, email, or face-to-face
  - ▶ Non-face-to-face services
  - ▶ A (one) face-to-face visit

## TCM: Non Face-to-Face

- ▶ Non-Face-to-Face services include:
  - ▶ Obtain and review hospital discharge documents
  - ▶ Review and determine patient's needs for follow-up (pending) testing and/or treatments
  - ▶ Connect with all health care professionals involved in the care of the patient's medical conditions
    - ▶ Schedule follow-up with extended care team providers and services
  - ▶ Provide education to the patient and his or her family/guardian/caregiver
  - ▶ Establish new referrals or re-establish existing referrals

## TCM: Timing of Contact

- ▶ Interactive contact must be made with the patient within two (2) business days following discharge
  - ▶ Contact may be via telephone, email, or face-to-face
- ▶ Medicare requires that a provider continue to contact the patient following the first two attempts until they are successful
  - ▶ Reminder: the required attempts must be made within two (2) business days
- ▶ Documentation should demonstrate two or more separate attempts were made in a timely manner, even if they were unsuccessful
  - ▶ As long as all other TCM criteria are met, a provider may report the service
- ▶ Expectation that communication attempts will continue until they are successful
- ▶ TCM services cannot be billed if the face-to-face visit is not performed within the required timeframe

## TCM: Start Time

- ▶ Patient must be seen during the transition period back to home or another setting (nursing home, rest home, assisted living, domiciliary) following discharge
- ▶ Patient must be seen by the healthcare provider following discharge from the inpatient arena without a gap
- ▶ Clinic provider assumes responsibility for all of the patient's care
- ▶ Patient must have a medical and/or psychosocial problems that requires moderate or high complexity medical decision making
- ▶ **The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital arena and it continues for the next 29 days**

## TCM: Face-to-Face Visit

- ▶ Providers must perform one face-to-face visit following discharge according to the timeframes of each billing code:
  - ▶ CPT Code 99495: TCM services with moderate medical decision complexity require patient contact within two business days following discharge;
    - ▶ Face-to-face visit within 14 days of discharge { \$158.98 Work RVUs 2.11 }
  - ▶ CPT Code 99496: TCM services with high medical decision complexity require patient contact within two business days following discharge;
    - ▶ Face-to-face visit within 7 days of discharge { \$224.33 Work RVUs 3.05 }

## TCM: Notable 'Other'

- ▶ Only one provider may report TCM services
- ▶ Report services once per patient during the TCM period
- ▶ The same provider can discharge the patient from the hospital, provide TCM services throughout the 30 days, and bill for the TCM services
- ▶ The face-to-face visit (required) may not take occur on the same day the patient is discharged
- ▶ Additional E/M services to manage the patient's other conditions may be billed in the same session provided these problems are not related to the conditions managed through TCM services
- ▶ Providers cannot bill TCM services that fall within a global post-operative period

## TCM: Table of MDM

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

## TCM: Moderate Medical Decision Making

Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
<ul style="list-style-type: none"> <li>-One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</li> <li>-Two or more stable chronic illnesses</li> <li>-Undiagnosed new problem with uncertain prognosis</li> <li>-Acute illness with systemic symptoms</li> <li>-Acute uncomplicated injury</li> </ul>	<ul style="list-style-type: none"> <li>-Physiologic tests under stress</li> <li>-Diagnostic endoscopies with no identified risk factors</li> <li>-Deep needle or incisional biopsies</li> <li>-Cardiovascular imaging studies</li> <li>-Obtain fluid from body cavity</li> </ul>	<ul style="list-style-type: none"> <li>-Minor surgery with identified risk factors</li> <li>-Elective major surgery with no identified risk factors</li> <li>-Prescription drug management</li> <li>-Therapeutic nuclear medicine</li> <li>-IV Fluids with additives</li> <li>-Closed treatment of fracture /dislocation without manipulation</li> </ul>



## TCM: High Medical Decision Making

Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
<ul style="list-style-type: none"> <li>-One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</li> <li>-Acute or chronic illness or injury that poses a threat to life</li> <li>-Psychiatric illness with potential threat to self or others</li> <li>-Abrupt change in neurologic status</li> </ul>	<ul style="list-style-type: none"> <li>-Cardiovascular imaging studies with contrast and identified risk factors</li> <li>-Cardiac electrophysiological tests</li> <li>-Diagnostic endoscopies with identified risk factors</li> <li>-Discography</li> </ul>	<ul style="list-style-type: none"> <li>-Elective major surgery with identified risk factors</li> <li>-Emergency major surgery</li> <li>-Parenteral controlled substances</li> <li>-Drug therapy requiring intensive monitoring for toxicity</li> <li>-DNR decision</li> </ul>

## TCM: Documentation Minimums

- ▶ At a minimum, a provider must document the following information in the beneficiary's medical record:
  - ▶ Date of discharge
  - ▶ Date of contact with the patient and/or family member
  - ▶ Date of service of the face-to-face visit
  - ▶ Medication reconciliation
  - ▶ Level of complexity of medical decision making
    - ▶ Moderate
    - ▶ High

## TCM: Guideline Specifics

- ▶ How often can TCM services be billed?
  - ▶ Not defined by CMS
  - ▶ Note: documentation must state that the patient's health status has changed
- ▶ Where can TCM services be provided?
  - ▶ Clinic, Inpatient, Nursing Home
- ▶ Who can perform these services?
  - ▶ Faculty, Residents, APPs
- ▶ Are there rules for billing these services?
  - ▶ Services are voluntary
  - ▶ **Patient must consent**...patient may refuse services

## Advanced Care Planning (ACP)

- ▶ Advance care planning is making decisions about the care you would want to receive if you become unable to speak for yourself. These are your decisions to make, regardless of what you choose for your care, and the decisions are based on your personal values, preferences, and discussions with your loved ones.

<http://www.nhpco.org/advance-care-planning>

## ACP: Time-Based Billing

- ▶ Time-Based CPT Codes (billing codes)
- ▶ CPT Code 99497- Initial 30 minutes, face-to-face time with the patient and/or family member {\$83.14 Work RVUs 1.50}
  - ▶ Advance care planning should include and explanation with the elements of the discussion surrounding advance directives such as standard forms that must be completed by the provider
- ▶ CPT Code 99498- Each additional 30 minutes face-to-face time with the patient and/or family member {\$72.37 Work RVUs 1.40}
  - ▶ Additional time spent beyond the first 30 minutes
    - ▶ Billed in increments of 30 minutes

## ACP: Documentation

- ▶ Performing providers must document the total amount of time spent face-to-face with the patient and/or family members
- ▶ Examples of appropriate documentation may include, but are not limited to the following:
  - ▶ A summary of the discussion with the beneficiary (or/and family members) explaining that the ACP is a voluntary service
  - ▶ Explanation of advance directives plus the completion of those forms, when performed);
    - ▶ Who was present during the service
    - ▶ How much time was spent in the face-to-face encounter

## ACP: Notable 'Other'

- ▶ Can I bill other services with ACP?
  - ▶ May be performed with another E/M on the same date of service
  - ▶ May be performed during the same period as Chronic Care Management Services
- ▶ What diagnosis code(s) should we use?
  - ▶ Choose the ICD-10 code that best represents the condition for which you are seeing the patient, or, an administrative examination/well exam diagnosis when the ACP is performed as part of a Medicare Annual Wellness Visit (AWV)
- ▶ Do the same co-Insurance/deductible Fees apply?
  - ▶ Both Part B coinsurance/deductible fees apply **EXCEPT when the ACP is performed at the time of an AWV**

## Email Correspondence

- 99444 Typical Commercial Reimbursement is \$35 {Work RVUs 0}
- Patient or guardian (with release on file) must initiate the email
- Physician must respond timely
  - 48 hours is standard practice
- The email must be housed in the Medical Record
- If the email occurs on the same day as an E/M service, it is not separately billable
- May not bill if the email occurs seven (7) days prior to a related E/M visit or during any related post-op period
- Stand alone service

## Phone Calls

- 99441 5-10 minutes {\$14.40 - Work RVUs .25}
  - Patient must be established, parent or guardian
  - Not originating from E/M service during the past seven days
  - Or, a Procedure within the next 24 hours
  - Or, soonest available appointment
- 99442 11-20 minutes {\$27.36 - Work RVUs .50}
- 99443 21-30 minutes {\$40.32 - Work RVUs .75}

A call that occurs on the same day as a clinic visit should be included in the service for that day which could result in a higher level of service.

## Telehealth Billing

- ▶ Place of Service (POS)
  - ▶ 02: Telehealth
- ▶ HCPCS Codes (facility fee)
  - ▶ Q3014 \$24 {\$0.00 - Work RVUs 0}
- ▶ CPT Codes: Multiple
- ▶ Modifiers
  - ▶ GT: "via interactive audio and video telecommunications systems"
  - ▶ GQ: "via an asynchronous telecommunications system"

## Telehealth Sites

- ▶ Distant or Hub site: Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system
- ▶ Originating or Spoke site: Location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs
  - ▶ Online facilitators may be needed to mediate the delivery of this service
- ▶ Asynchronous: Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation
  - ▶ Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services

## Telemedicine Rules in Wisconsin

- ▶ A physician-patient relationship may begin via telemedicine
- ▶ A physician who uses telemedicine in the diagnosis and treatment of a patient located in Wisconsin must hold a valid license to practice medicine in Wisconsin
- ▶ Physicians must follow the same practice and conduct guidelines (patient confidentiality, recordkeeping, etc.) in a telemedicine environment
- ▶ A physician using a website to communicate with a patient located in Wisconsin may not provide treatment recommendations that include writing a prescription

## PHQ-9 Screening

- ▶ G0444 Depression Screen – 15 minutes {\$18.36 - Work RVUs .18}
- ▶ Reimbursement for screening depression in adults is paid once-a-year
  - ▶ There is no coinsurance or deductible charged to the patient
- ▶ Depression screening and depression care support improves clinical outcomes in adults and older adults
  - ▶ It is recommended by the [US Preventive Services Task Force \(USPSTF\)](#)
- ▶ Improvements in clinical outcomes with enhanced morbidity have been noted when treating older adults diagnosed with depression through primary care screening and intervention with a documented (written) plan of care

## Vaccination Counseling

- ▶ Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of the vaccine.
  - ▶ 90460 Vaccination through 18 years of age via any route with counseling by physician or other qualified health care professional; first vaccine {Medicaid \$20.83 - Work RVUs .17}
  - ▶ 90461 Each additional vaccination through 18 years of age via any route, with counseling by physician or other qualified health care professional; each additional vaccine {Medicaid \$0.00 - Work RVUs .15}

## Time-Based Billing

New Patient Clinic Visit	99201	99202	99203	99204	99205
Time - Face to Face if >50% is counseling	10 - 15	16 - 25	26 - 37	38 - 52	53 - 60
Established Pt Clinic Visit	99211	99212	99213	99214	99215
Time - Face to Face if >50% is counseling	5 - 7	8 - 12	13 - 20	21 - 32	33 - 40

## Relative Value Units (RVU) Basics

- ▶ The system used by Medicare and many HMOs is called the Resource Based Relative Value Scale (RBRVS)
- ▶ Every CPT code has an assigned relative value unit, or RVU
- ▶ RVUs are units of measurement that indicate the value of healthcare services and a difference in the resources used when providing different services
  - ▶ Establishes reimbursement
  - ▶ Standardized method of analyzing healthcare services

Physician Work RVU  
Total RVU



## RVUs: Adding up the pieces

1. The work required by the physician: Considers how much time, level of skill, advanced training, and intensity needed to provide a service
  - ▶ CPT codes are reviewed every five years to evaluate the value of the service as described in the code
2. Cost of doing business as a medical practice: Includes rent, equipment, supplies, and staff dollars
3. The malpractice/liability expense of a provider: Malpractice/liability expenses vary based on specialty (Primary Care Providers performing OB services pay higher premiums)
  - ▶ These three RVU factors are then multiplied by a geographical adjustment that creates the compensation level for the service in that exact location
    - ▶ Geographically adjusted RVUs are multiplied by a conversion factor converting the RVU into a dollar figure that determines reimbursement by Medicare

## Online References:

- ▶ <http://www.dummies.com/careers/medical-careers/medical-billing-coding/relative-value-units-in-medical-billing/>
- ▶ <https://qpp.cms.gov>
- ▶ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf>
- ▶ [https://mdinteractive.com/2017 MIPS Family Practice](https://mdinteractive.com/2017_MIPS_Family_Practice)
- ▶ [PFS Final Rules o2014 PFS final rule \(CMS-1600-FC\) pages 74414-74427 and 2015 PFS final rule \(CMS-1612-FC\) pages 67715-67730,](#)
- ▶ [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFFactSheet oMedicare Learning Network@ "Chronic Care Management Services" Fact Sheet](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFFactSheet%20Medicare%20Learning%20Network%20Chronic%20Care%20Management%20Services%20Fact%20Sheet)
- ▶ [eeSched/PFS-Federal-Regulation-Notices.html](#)
- ▶ <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

## Resources continued...

- ▶ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>
- ▶ CMS Medline Matters; Medicare Learning Network - Quick Reference Guide
- ▶ <http://www.nhpco.org/advance-care-planning>
- ▶ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf>
- ▶ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>
- ▶ <https://www.aafp.org/practice-management/payment/coding/admin.html>
- ▶ [https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/FAQGuideMedicaidPaymentRule\\_Dec2012.pdf](https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/FAQGuideMedicaidPaymentRule_Dec2012.pdf)
- ▶ <https://www.aafp.org/practice-management/transformation/pcmh/benefits.html>

## Presenter

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