Cracking the Code: Expert Strategies for Hospital Medicine Billing 2024

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Disclosures and Introduction

I have no relevant relationships with ineligible companies to disclose within the past 24 months

A Little About Me

Jennifer Barnett, DMSc, PA-C, DFAAPA, SFHM, CAQ-HM, CPHQ
Hospitalist/Quality and Safety Team, MedStar Health
Adjunct Associate Professor, University of Maryland, DMSc

- More than 20 years in Hospital Medicine
- IMC/ICU, Obs, Med/Surg – Days and Nights.
- Former Director of Advanced Practice, Hospital Medicine, Two Hospitals in Baltimore
- Certificate of Added Qualification in Hospital Medicine
- Geek about all things policy, advocacy, quality/safety and patient experience

Let’s Learn About Each Other

- Who practices at Academic Medical Center? Community Hospital? Critical Access Hospital? Combo? Am I missing anyone?

- Does your program bill under your NPI?
- Split Share? BOTH depending on the scenario? Don’t Know?

- Do you get bonuses based on RVU?
  Do the physicians in your group get RVU bonuses?
- MDM

Educational Objectives

At the conclusion of this session, participants should be able to:

- Discuss recent changes in hospital medicine billing codes and regulations.
- Explain the concept of split/shared billing and its implications for hospital medicine practitioners
- Differentiate between time-based billing and medical decision-making billing in hospital medicine
- Provide guidance on documentation requirements and coding specifics for critical care billing
- Identify strategies for accurately billing time spent at the bedside, including extended discussions with patients and families

Ground Rules

If it wasn't documented, it wasn't done (in the legal, coding and auditing world)

If it was documented make sure you did it

Good records communicates to peers, is defensible from a risk management perspective, AND can withstand a payment audit

Fraud = knowingly submitting false claims
-punishable by fines up to 3 times the charges and can lead to imprisonment or permanent exclusion from federal healthcare programs. Also applies if you SHOULD HAVE KNOWN it was a false claim

Abuse = practices that may directly or indirectly result in unnecessary costs to the Medicare program

Case #1
45 year old male w/ GIB

Dx: hypotension, Hypovolemic due to GI Bleeding, s/p 4 Units PRBC (last two days ago)
discussed with GI 10/14- if rebleeds stat plan for emergency colonoscopy 10/15 if H/H drops or unstable. If pt stabilizes, then plan for 10/16.
Dispo: IMC, if worsens may need ICU

Have you adequately documented to capture your clinical care?

NEW CMS Guidelines (Centers for Medicare and Medicaid Services)

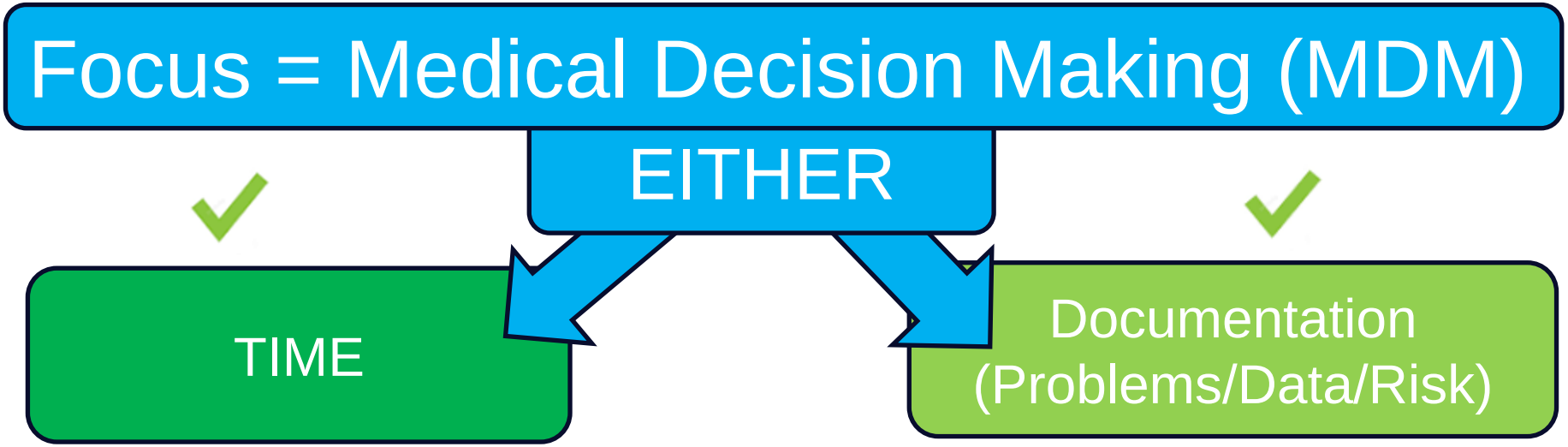
CMS Medicare = Standard

Each insurance plan may vary how they reimburse PA/NPs

2024 Changes- How to Optimize Documentation

No more mandated number of History and Physical Documentation Elements i.e. number of elements in ROS, PE, Hx etc.

CMS still requires a medically appropriate History and Physical



TIME - 2024 Time Based Thresholds

H&P

99221 40 min

99222 55 min

99223 75 min

Prolonged Services 105 min

Subsequent Hospital Visits

99231 25 min

99232 35 min

99233 50 min

Prolonged services 80 Min

Critical care:

99291 30–74 minutes:

99292 75–104 minutes

104 minutes or more

Admit/D/C same day

99234 45 min

99235 70 min

99236 85 min

Prolonged Service 115 min

If you didn't spend those times then consider NOT documenting time, and focus on Medical Decision making to reflect patient complexity

Documentation –Optimizing

1. PROBLEMS –Number and complexity of presenting problems
2. DATA- Amount and Complexity of data
3. RISK - Risk of patient management

Highest level in two or three of the above determines coding

Tips for Presenting Problems

Severity	Number	Ddx	Overnight	Stability
State if severe, potentially disabling, or life/organ threatening	Number of problems, and new complaints and their status	List Differential Diagnosis especially if life or organ threatening R/O ACS, PE, Sepsis, etc	Document overnight events Altered mentation, hypotension, chest pain or IV opiates	Unstable = NOT at goal i.e. B/P goal less than 140, so a B/P of 160 would be “unstable” Holding Norvasc for hypotension

How to Determine DATA?

Two out of three categories
Data points, discussion of management, independent interpretation

3 Data points and interpretation OR

3 Data points and Discussion of management with another appropriate person OR

Discussion of management with another appropriate person AND an Interpretation

i.e. I discussed with Cardiology on July 30 2024 and they advised…

Discussion = phone call, texts, TEAMS messages etc.

Data points, discussion, independent interpretation

Amount and Complexity of Data

State any outside records reviewed	i.e. ED records, Commonwell or similar, Nursing home records
State if you obtained history from anyone other than patient	ED MD/PA/RN count
State you reviewed an image/EKG and your independent interpretation	i.e- state CXR shows Right lung Infiltrate **Don’t just state Reviewed lab/image**

Severity of RISK documentation Hints

- Are you considering change of level of care
  (i.e if worsens may need Bipap/IMC)

- Are you monitoring for possible need for procedure? Cath, surgery, EGD
  - i.e SBO on conservative management, if no improvement might need surgery
    i.e Chest Pain with negative EKG, monitoring for possible need for cath.

- If the Rx needs monitoring.
  - i.e. antiemetic in QTC prolongation,
    Vanco monitoring kidney function etc

Examples for RISK

High risk for decompensation given hx copd, OSA, CAD with ongoing wheezing and increased work of breathing requiring oxygen, nebs, steroids

Concern for need for IMC/Bipap

HTN- uncontrolled per coding guidelines but under reasonable control given stress/pain/fever/nausea/resp failure. Resume home meds and treat nausea with IV zofran

Diabetes- POA FS 200s – uncontrolled (per coding guidelines)-insulin sliding scale, titrate Lantus to 30

Tips for Medical Decision Making

PROBLEMS

Document any new complaints

DATA

Any diagnosis you considered

RISK

Any piece of data you reviewed

Any treatment you gave or WITHHELD

- i.e. holding beta-blocker for bradycardia

Any time you interpret data

- i.e. interpreted EKG, CXR, CT scan, Also document official read

Additional considerations- Document NOT done

- Patient wants a test, and you convince pt it is not necessary
- Provider thinks a test or treatment is necessary but pt refuses
- Provider considers a test, but after discussion, it is not done
- Provider considers continued hospitalization but pt leaves AMA
- Family wants patient admitted but provider sends pt back to SNF/Assisted Living
- When emergency surgery is considered but ultimately not done after additional tests/eval/consults

Barriers- SDOH

Anytime a patient has a social factor that affects your ability to either evaluate or manage the patient = more complicated, moderate risk

- Can’t get home/access to safe housing
- Insurance barriers
- Await SNF bed
- Needs Rehab but no beds available
- Lack of transportation
- Lack of Support at Home

45 year old male w/ GIB

Dx: hypotension, Hypovolemic due to GI Bleeding
s/p 4 Units PRBC in ICU last 10/13
discussed with GI 10/14- if rebleeds stat plan for emergency colonoscopy 10/15 if H/H drops or unstable
Dispo: IMC, if worsens may need ICU

What could you add?

Problems- Acute Loss Anemia,
Comorbidities, CAD, Type II MI?

Data- H/H frequency? Transfusion Goal? IV protonix
? D/w CM/SOWK/Pharmacy/IR? Family?
?holding ASA/Plavix?

Risk- High Risk- ? IMC?
Monitoring for Rebleed

?Critical Care?- more than 30 min?

Split Shared Billing

Case #2
65 year old male

65 year old male seen by PA

- To ED for agitation, and positive blood cultures.
- Dx Sepsis with Bacteremia, POA. s/p right arm foreign body removed. WBC 9, afebrile. U/A neg for infection, Urine cult neg. CXR neg on 8/1. MRSA neg repeat blood cult NGTD. BMP cr cl normal, Pro Cal negative.
- Continue IV vancomycin, monitor Cr, D/w Pharmacy to dose 8/3
- Discussed with orthopedics today 8/3. ordered CT scan of Right Arm. Discussed with wound care- new orders placed.
  Reason for hospitalization- Sepsis, repeat blood cultures in AM. IV antibiotics. **55 min spent.**

If the physician also sees this patient, would this be billed under the PA or physician?

CMS guidelines

Medicare Billing

1) Bill under NP or PA National Provider Identification Number (NPI) at 85% of physicians fee schedule

2) Optional: services can be billed Split-Shared Under the physician’s name and NPI number at 100%, if certain criteria are met

Services that Qualify for Split-Shared Billing

- Initial Hospital (99221-99223)
- Subsequent Hospital (99231-99233)
- Hospital Discharge Management (99238, 99239)
- ED Visits (99281-99285)
- Observation Services (99217-99220, 99234-99236)
- Critical Care Services (99291-99292)
- Skilled Nursing Facility/Nursing Facility Visits not required to be performed in their entirety by a physician
- New (99202-99205) and Established (99211-99215) office Visits-
  Only in ON-Campus and Off-Campus Outpatient Hospitals

DOES NOT Apply to procedures

https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

Split-Shared Billing Criteria

1. NP/PA and Physician must work for the **same group/employer** (Tax ID number = **TIN**)
2. NP/PA must provide the service on the **same calendar day**
3. Physician must perform a "**substantive portion**" of the service, sign/date and appropriately document
4. **Either** the NP/PA or physician must have a **face-to-face** encounter with the patient
5. **FS** modifier must be included on the claim to identify the service

https://www.cms.gov/files/document/r11288CP.pdf#page=9

“Substantive Portion” Definition has changed

- **Prior to 1 Jan 2022**
    - All or some portion of the history, exam, or medical decision-making key components of an E/M service
- **2022-2023**
    - One of the key components (history, exam or medical decision-making in its entirety) OR more than half of the total time spent by the NP/PA and Physician
    - More than half of the time is required for critical care and discharge management service

Substantive Portion Definition has changed

2024:

1. More than half of the total time spent on the service (more than half the combined time spent by the NP/PA and physician

2. Medical Decision Making (MDM) – according to CPT requires:
   Physician has "performed two of the three elements used in the selection of the code level based on MDM"
   Physician has "made or approved" the management plan and "takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management"

1) Society of Hospital Medicine Compliance. **2024 Policy Update on Medicare Policy on Split (or Shared) Billing for E/M Services.** Accessed August 4, 2024. https://www.hospitalmedicine.org/practice-management/compliance/

What Counts in “total time”?

- Preparing to see patients (Chart review)
- Ordering medications, tests, or procedures
- Care coordination (when not separately reported)
- Obtaining or reviewing separately obtained medical history
- Referring and communicating with other healthcare professionals
- Performing medically appropriate exam and evaluation
- Documenting clinical information
- Counseling and educating the patient/family/caregiver
- Independently interpreting results and communicating to the patient/family/caregiver

1) Society of Hospital Medicine Compliance. **2024 Policy Update on Medicare Policy on Split (or Shared) Billing for E/M Services.** Accessed August 4, 2024. https://www.hospitalmedicine.org/practice-management/compliance/

What does NOT count for “total time”

- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

Note: CMS requires that at least one of the providers see patient face-to-face. Joint care/discussion about the patient- only counts to **ONE provider (can’t count both)**

1) Society of Hospital Medicine Compliance. **2024 Policy Update on Medicare Policy on Split (or Shared) Billing for E/M Services.** Accessed August 4, 2024. https://www.hospitalmedicine.org/practice-management/compliance/

65 year old male seen by PA

- Documented >50 spent, also documented D/w ortho, and 3 labs, and reason for hospitalization.
- Did the physician document
    - High complexity? Physician do not get credit for independent interpretation done by NP/PA or discussions with CM/Pharmacy as not performed by a physician
    - Time Spent- to be billed under physician would have to be clinically indicated more than PA time spent

Example Physician Documentation

- Time Spent more than PA/NP

- Example Documentation

As the Supervising Attending Physician, I have performed a substantive portion of the Medical Decision Making as documented below. This includes consideration of the number and complexity of problems addressed, the data reviewed and interpreted, and the risk of complications and/or morbidity and mortality. Key elements of the Medical Decision Making include:
List Problems and treatment or discussion performed by the physician

Level Up!
Critical Care and Advanced Care Planning

Case #3
75 year old female w/SOB X 1 week

Stock image, free

75 year old female w/shortness of breath X1wk

- SOB/Cough, 83% on RA
  Hx COPD, not on home oxygen, CAD s/p Stents 2007, HTN
- In ED required Bipap, COVID positive
  WBC 15.8, Creatinine 1.2. trop 131, BNP >5000. I personally reviewed EKG and showed sinus Tach 120 without ST-T wave Changes

- Acute on Chronic respiratory Failure due to COVID and COPD exacerbation
- D/w ID, no remdesivir Dexamethasone IV
- Switch to High Flow NC oxygen, recheck VBG

How to maximize documentation for the care you are providing?

Critical Care

- Can be split-shared
- Time Based ONLY
- If you spent >30 min critical Care time you get credit for Critical Care Visit

If pt has a serious illness and you immediately do something- consider critical care!

Potential Critical Care Cases

- Stroke like syndromes
- PE with anticoagulation
- Chest Pain/ Elevated Troponin
- Severe Dyspnea with Bipap/High Flow
- Sepsis (SIRS with a source)- *PNA with Lactate over 4, Pyelo with tachycardia*
- Severe Asthma
- Anaphylaxis
- Electrolyte abnormalities with EKG or Neuro changes
- GI bleed w/ interventions (medical or procedures)
- Drips (Precedex, Nicardipine, NTG)
- Anion Gap Acidosis/DKA

Critical Care

Critical Care = Impairment to one or more vital organ systems

- Increased risk of rapid or imminent health deterioration.
- Direct patient/clinician involvement
- Highly complex decision making
- To evaluate, control, and support vital systems functions and/or
- To treat one or more vital organ system failures and/or
- To avoid further decline of the patient's condition.

Additive- Combine- Great Team Based Care

- Critical Care
  - 5pm pt seen for chest pain documents
    20 min critical care time
  - 9pm- re-eval troponins, Starts Heparin gtt
    additional 20 min critical care time
    Total 40 min

- H&P performed at 2am - 55 min (level 2)
- 4PM Day team - 25 min spent
- Total 80 min – (LEVEL 3)

Advanced Care Planning

- List as a separate Problem or clearly in Medical Record
- Minimum 15 minutes
- Separately billable except on the day of Critical Care

Includes

- Goals of Care
- Code Status with patient and/or family
- Even if no decision is made or partial decision made

Advanced Care Planning

- Documentation recommendations:
  Date/ Time spent
- Must have a Face-to-Face Encounter
- Summary of Discussion- goals of care, medical issues, Code status
- Who was present
  Consider documenting capacity if appropriate
- Patients wishes

ACP Minutes	CPT Code & Units
15 or less	Don't bill any ACP services
16–45	CPT code 99497 (1 unit)
46–75	CPT code 99497 (1 unit) **and** CPT code 99498 (1 unit)
76–105	CPT code 99497 (1 unit) **and** CPT code 99498 (2 units)

Optimize documentation

- *Additions if clinically appropriate: Tobacco Cessation Counseling- 3 min or more. State time spent and must have smoking-related issue*

- *Lifestyle Counseling: Obesity, drug alcohol- Min 15 min.*

Be specific on interventions and discussions

Possible for a daily note, then a separate Critical Care note later in the day

75 year old female w/shortness of breath X1wk

How to maximize documentation for the care you are providing?

- High Risk of Life-threatening condition
- You provided immediate care (Bipap/High Flow, IV meds)
- Was greater than 30 min spent?

- *I have personally spent _____ minutes of critical care time, exclusive of time spent on any procedures, other PA/NP/MD time, in the evaluation and management of this critically ill patient's condition of _____. I provided the following critical care treatment _____.*

Take Home Points

- **Problems / Data / Risk**
  Highest TWO of THREE determine the level of billing
  DATA - TWO of Three data, discussion or Individual interp

- If you split shared billing, ensure you are doing it right!
  MDM vs time spent

- Critical Care- 30 min or more (exact time)
- Advanced Care Planning- 15 min or more

References

1. Federal Register Accessed August 4, 2024 https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other
2. CMS guidelines Accessed August 4, 2024. https://www.cms.gov/files/document/r11288CP.pdf#page=9
3. Society of Hospital Medicine Compliance. 2024 Policy Update on Medicare Policy on Split (or Shared) Billing for E/M Services. Accessed August 4, 2024. https://www.hospitalmedicine.org/practice-management/compliance/
4. AAPA Medicare Split-Shared Billing. Accessed August 4, 2024. https://www.aapa.org/download/5023/?tmstv=1722799400.
5. Guidelines for reimbursement- AAPA https://www.aapa.org/shop/essential-guide-pa-reimbursement/ Essential Guide to PA Reimbursement

Thank you and Credit

- SHM- compliance documentation
- AAPA Split Shared Billing References-
  Sondra DePalma, Vice President of Reimbursement and Professional Practice, AAPA and Governmental Affairs Team
  Guidelines for reimbursement- AAPA
  https://www.aapa.org/shop/essential-guide-pa-reimbursement/
  Essential Guide to PA Reimbursement
- Dr. Malaz Alissa from MedStar Health who developed tip sheet for MedStar Providers in 2023.

Questions

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