Billing & Reimbursement for AMS CLINICAL SERVICES

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Background: Billing for and receiving reimbursement for Anticoagulation Management Service (AMS) clinical services is dependent upon several factors including, but not limited to: 1) clinic type & billing structure; 2) clinician type; 3) how the clinical services are rendered; 4) negotiated or regional reimbursement rates. The Centers for Medicare and Medicaid Services (CMS) and private insurance payors reimburse at different financial rates, or not at all, based upon the factors above, as well as via geographical location and patient-specific insurance plans.

BOTTOM LINE

The options presented here are examples of established billing and reimbursement options available to AMS. Clinicians should work closely with their local billing departments and insurance payers to determine what options are available locally. Common barriers to implementation include:

1) Insurers declining to pay for services
2) Translating billing nomenclature to link with clinical terminology
3) Balancing patient-out-of-pocket charges for billed services
4) NPP scope of practice barriers
5) Local institutional billing preferences

Nomenclature[1,2]

Facility vs. Non-Facility Billing Structure

Facility billing structures are for clinics generally linked to a hospital organization.
Non-Facility billing structures are generally utilized by clinics linked to physician offices, stand-alone ambulatory or virtual clinics. The reimbursement rates are generally different between facility and non-facility-based clinics, even within the same billing codes and services rendered.

Point-of-Care (POC) vs. Non-POC

POC generally refers to care provided face-to-face with a patient in the clinic, while non-POC is care provided asynchronously or via non-face-to-face technology, such as telephone-based services.

Tele-health, tele-medicine, and related terms

These generally refer to the exchange of medical information from one site to another, through electronic communication with the goal of improving a patient's health. CMS further defines "telemedicine" as the synchronous provision of medical care face-to-face via use of technology.

Incident-To Billing

Incident-to billing allows non-physicians to bill for clinical services under a collaborating physician's name, and includes the following key elements:
1. Care is provided synchronously, in a non-institutional setting
2. A Medicare-credentialed physician must initiate the patient's care, while
3. The non-physician provider (NPP) continues care (with physician involvement)
4. Both the NPP and Physician must be employed by the same entity
5. The service provided must be normal for condition & usual to be provided in office
6. A physician (or Medicare Part B-approved provider) must be available
7. A service beyond obtaining laboratory value is provided (ie. counseling, drug management, laboratory evaluation, etc.)

Coding

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPS) codes are uniform languages for coding medical services & procedures.

Evaluation & Management (E&M) Codes are used to describe the complexity (or level) of service provided to patients. They are translated to CPT/HCPS codes to facilitate billing. E&M Codes used vary, depending on the SETTING (hospital vs. clinic vs. long-term care facility, etc.) and if billing is based on time spent -OR- medical decision making (complexity).

Chronic Care Management[7]	CPT/HCPCS Code Conversion	Reimbursement Rate[5] Non-facility	Facility
This utility may not applicable to all AMS services. Use requires a primary care/chronic care component and broader scope of disease state management, including: 1) at least 20 minutes of disease state management, 2) for at least two chronic conditions, (i.e. atrial fibrillation plus long-term use of anticoagulation) and 3) a comprehensive assessment & plan for all health issues.	99490	$64.02	$51.56

Examples of AMS Billing Options, Associated Codes and Estimated Revenue Rates*[3, 4, 5]

*Based upon average National Rates provided by CMS. Local negotiated rates expected to vary.

Point-of-Care Visits

E&M	CPT/HCPCS Code Conversion	Reimbursement Rate[5] Non-facility	Facility
Level 5 – Comprehensive	99215	$200	$160.68
Level 4 – Detailed	99214	$141.78	$108.13
Level 3 – Expanded Problem Focused	99213	$100.57	$73.72
Level 2 – Problem-Focused	99212	$62.76	$40.08
Level 1 – Minimal	99211	$25.71	$9.83

Note: Generally utilizing the Incident-To Billing Model. If a POC-INR is also measured in clinic, use CPT code 85610 to bill for the laboratory test. Pharmacists: check your State Scope of Practice for legal requirements as related to practice.

Telephone Visits

Generic CPT Phone Codes per duration of care time provided

Temporary (During COVID)
99441 for 5-10 minutes
99442 for 11-20 minutes
99443 for 21-30 minutes

Established Patients, following CMS Telehealth Code regulations
- 'Employee' phones on behalf of QHP *(inc. PharmDs, RNs)*
- NOT billable if results in visit in 24h or f/u of prior billed visit
- $14.44, $28.15, $41.14* (respectively)

Permanent (Pre-COVID)
98966 for 5-10 minutes
98967 for 11-20 minutes
98968 for 21-30 minutes

Established patients, phone-time *only*
- Non-physician HCP
- $13.32, $26.64 & $39.60* (respectively)
- Documentation matches clinical care & time
- No requirement for physician co-signature

*National Average

Anticoagulation-Specific CPT Phone Codes

93793: New Home, office or lab test
93793: Non-POC review of INR results & management
- ***Flat Rate:*** no time component = $12.24
- INR result of home, office or lab
- Management done by *Physician/NP/PA* with work RVUs
- Pharmacist, Nurse, MA, etc. can phone patient
- Can **not** bill on same day as an E&M code (home or POC INR)

Patient Self-Testing

CPT/HCPS Codes	Reimbursement:[5]
G0248 (CPT 93792): Initial demonstration of use of home INR meter*	G0248: Once = $72.21
G0249: Provision of testing materials (1 per week)	G0249: Q4 tests = $52.93
G0250: "Physician review, interpretation & management per FOUR tests…"	G0250: Q4 tests = $9.07

*COVID-waiver: can be done virtually. Ensure documentation matches the clinical care provided. No Requirement for physician co-signature.

Transitional Care[6]

Includes reimbursement of the non-face-to-face care provided to an established patient during transitions in care from an inpatient hospital setting or skilled nursing/nursing facility to the patient's community setting. Only one visit is allowed that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under their direction. Requirements include: 1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, 2) medical decision making of at least moderate complexity during the service period, and 3) face-to-face (POC) visit, within 14 calendar days of discharge.

E&M	CPT/HCPCS Code Conversion	Reimbursement Rate[5] Non-facility	Facility
Moderate Complexity (8-14 days after discharge)	99495	$228.36	$158.03
Moderate Complexity (within 7 days of discharge)			
High Complexity (8-14 days after discharge)			
High Complexity (within 7 days of discharge)	99496	$307.75	$213.99

References: **1.** CMS ToolKit **2.** Verhovshek, GJ. The Basics of Incident-to billing. Nov 16, 2021. https://www.physicianspractice.com/view/the-basics-of-incident-to-billing?page=5 **3.** Reference: CPT Overview & code approval **4.** Reference: Evaluation & Management Services Guide **5.** *2022 Physician Professional Fee National Payment Amount: Physician Fee Schedule Look-Up Tool | CMS **6.** https://familymedicine.med.uky.edu/sites/default/files/TCM-CPT.pdf **7.** Chronic Care Management (CCM) (aafp.org)

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