GIPA DIGEST

Easy-to-digest information for PAs in Gastroenterology and Hepatology — Spring 2011

Board Nominations Extended!

Dear Gastroenterology Physician Assistant:

It is once again time for us to issue a call for nominations for the Gastroenterology Physician Assistants (GIPA) Board of Directors. Board members will serve from July 1, 2011 through June 30, 2012. Each Board member shall be a Fellow GIPA Member and AAPA Member in good standing with GIPA and AAPA (*it isn't too late to join now!*). Directors must maintain this standing for the duration of their term. Individuals nominated will be contacted by GIPA to verify their willingness to serve. Membership will be verified. Please consider your nominations carefully and feel free to nominate yourself or other individuals willing to contribute up to five hours per month for any of the following positions.

- President-Elect
- Secretary
- Treasurer
- Director-at-Large (up to 4)

Please submit your nominations now for as many positions as you would like. All nominations must be received **by noon on FRIDAY, May 6, 2011.** All nominees will be contacted to verify their willingness to serve; and their membership status will be confirmed before assuming the office. You can become a GIPA member now by completing the attached GIPA Membership Application or joining online now at www.gipas.org.

Voting will take place via e-survey May 6-15, 2011. New officers will be announced at the AAPA/GIPA Annual Meeting in Las Vegas on May 31 from 7-9 PM at the Las Vegas Hilton, Conference Room 12; and on the GIPA website at www.gipas.org.

If you have any questions please contact GIPA at GIPA@focus-ed.net or (813) 988-7795. We welcome you to join us to create an association that meets your needs and enhances your professional success!

Sincerely,
David Carpenter, PA-C
David Carpenter, MPAS, PA-C
GIPA President 2010-2012

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Billing For Time—It's All About Time: The Use of Time in Determining the Level of E&M Services
by David Carpenter, PA-C, President

Inpatient and outpatient services are billed under a complex matrix which uses the patient history, exam and medical decision making to determine the appropriate evaluation and management (E&M) codes. What many providers fail to recognize is that in the case of a patient who needs extensive counseling and coordination of care the E&M code can be billed solely based on the time.

Take the example of a patient who has come in for workup of abnormal LFTs. The tests show the patient has HCV genotype 1 with a viral load of 7 million and stage 2 grade 2 fibrosis. The provider meets with them in the office to discuss treatment options. After laying out the options the patient decides to begin Interferon therapy for HCV. The medical decision making is obviously complex. Assuming that either a comprehensive history or a comprehensive exam was done the patient would have 2 of 3 components required for a 99215 (high level follow up encounter).

However, each encounter has a period of time allotted to it. For a 99215 the time allotted is 40 minutes. If the provider used more than 40 minutes and 50% of the time was for counseling and coordination then the encounter could be billed solely based on time.

What Medicare Has to Say About This

Medicare describes time-based billing in the Medicare Claims Processing Manual Chapter 12 as follows.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling
Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

Allotted Time for Outpatient Visits

New Patient Visit Time by CPT code	Established Patient Visit Time by CPT code
99201 10 minutes	99211 5 minutes
99202 20 minutes	99212 10 minutes
99203 30 minutes	99213 15 minutes
99204 45 minutes	99214 25 minutes
99205 60 minutes	99215 40 minutes

How Not to Do Time-Based Billing

One of the key factors in time-based billing is that for an outpatient encounter it occurs in a face to face manner. Time spent coordinating care (for example referring the patient to another provider) does not count in time based billing. For example a provider sees a patient with a recent colonoscopy which showed colon cancer. The provider sees the patient, discusses the diagnosis and discusses treatment options. Total time is 30 minutes. Again this is obviously complex decision making. However, since the time is less than 40 minutes it would have to be supported by a complete history or physical exam to justify a 99215. If the provider subsequently spent another 20 minutes phoning a surgeon and discussing the referral with the surgeon it would not meet the time based billing requirements. Even though the provider has now spent 50 minutes on the patient with presumably 50% of that in counseling and coordination of care, that entire 50 minutes was not spent in face to face time with the patient, a key component to outpatient time-based billing.

Time-Based Billing on the Inpatient

When billing for inpatient care there are some differences. The key difference is that time for counseling or coordination of care does not have to be face to face time. Time spent coordinating care counts if the time is spent either in face to face contact or while on the patient's floor (unit). Time spent after leaving the unit or after starting to care for another patient does not count.

For example, the provider sees a patient in inpatient follow up and determines that while the patient's GI bleed has resolved, the patient will need further rehabilitation prior to returning home. This requires moderately complex medical decision making. If supported by an expanded problem focused interval history or expanded problem focused exam a 99232 (moderate level inpatient) would be justified. However, if the provider spent more than 35 minutes (the amount of time allotted to a 99233 the next level E&M code) or spent more than 35 minutes evaluating the patient counseling the patient and arranging transfer to a rehab facility then the provider could bill for a 99233 (assuming that 50% of the time was spent counseling and coordinating) if the provider spent the time on the unit and before beginning to care for another patient.

In this case unlike the outpatient realm, time spent coordinating care with other providers does count even if it is not face to face time. Take the example given above. The patient comes in with GI bleeding, has a colonoscopy and a biopsy is taken. The next day the biopsy comes back with colon cancer. The provider discusses this with the patient and discusses the treatment options. Total time is 20 minutes. While this is high complexity, it would require either a detailed interval history or detailed exam to bill for a 99233 (high level follow up inpatient encounter). However, if the provider while on the floor and before starting care on another patient, consulted a surgeon and spent 20 minutes coordinating care with the surgeon then it would reach the level of 99233 based on time (a 99233 is allotted 35 minutes of time).

Allotted Time for Inpatient Visits

Initial Hospital Care Time by CPT code	Subsequent Hospital Care Time by CPT code
99221 30 minutes	99231 15 minutes
99222 50 minutes	99232 25 minutes
99223 70 minutes	99233 35 minutes

Documentation of Time-Based Billing

Medicare Claims Processing Manual Chapter 12 States:
The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.
Generally the statement must include the time spent and that 50% or more was spent on counseling and coordination of care.

For example, I spent 60 minutes with the patient discussing treatment options for HCV, side effects and lifestyle changes. More than 50% of this time was spent counseling the patient. Or, I spent 30 minutes with the patient discussing treatment options for his colon cancer. I spent another 20 minutes consulting the oncology and surgery services and coordinating his care. Time spent coordinating care was on the unit and before beginning care of another patient. Careful documentation here is the key to avoiding a Medicare audit.

Billing for time is a highly complex issue. However, for specialties that routinely provide counseling and coordination for the patient above and beyond the time allotted in the CPT codes it can provide valuable revenue to help justify the time spent with the patient. Care must be taken to make sure the documentation justifies the level of service selected and the amount of counseling and coordination provided.

References

University of Michigan Physicians – Coding and Billing Guideline http://www.med.umn.edu/gim/prod/groups/med/@pub/@med/documents/asset/med_96209.pdf Accessed 1-16-11

Medicare Claims Processing Manual Chapter 12 http://www.cms.gov/manuals/downloads/clm104c12.pdf Accessed 1-12-11

Medicare Claims Transmittal 1490 12 April 2008 https://www.cms.gov/transmittals/downloads/R1490CP.pdf Accessed 1-15-11

Periodical Review of Hepatocellular Carcinoma

by *Douglas L. Senecal, PA-C, GIPA Past President*
Medical Research Committee, Chair
Blue Faery: The Adrienne Wilson Liver Cancer Association

Abstract

This review is written to introduce the current landscape of Hepatocellular Carcinoma (HCC) in the United States of America (USA) while allowing the reader to mainly appreciate epidemiologic pressures that are leading to increasing incidence and the importance of adequate surveillance of at risk populations to proactively combat the validated increase the USA will see.

Periodical Review of Hepatocellular Carcinoma

Hepatocellular Carcinoma (HCC) was reported in approximately 24,000 patients in 2010. The mortality, based on the stage at which the majority of cases are being diagnosed, is such that some 19,000 of those cases were cancer deaths in 2010, translating to an approximate five-year survival rate of 12% [1]. The significance of this poor prognosis is enhanced by the fact that HCC has become the fastest growing cause of cancer death in the United States of America (USA) [2,3]. This epidemiologic pressure is nicely visualized by the increasing incidence of Cirrhosis, driven by the 3.2 million HCV infected patients in the USA that are rapidly expanding the base of patients at risk for developing HCC (see figure below).

Increasing Prevalence of Cirrhosis Due to HCV and Its Impact on HCC Prevalence

Number of cases: 160,000 / 140,000 / 120,000 / 100,000 / 80,000 / 60,000 / 40,000 / 20,000 / 0
Hepatocellular cancer — Decompensated cirrhosis
Year: 1950 1960 1970 1980 1990 2000 2010 2020 2030

Unfortunately, despite our refined knowledge of those patients at risk and the increasing number of patients, the current penetration of or adherence to surveillance guidelines is only about 30% in patients who were diagnosed with HCC between 1994-2002 [3]. This has likely contributed significantly to HCC's poor prognosis as a vast majority of these at risk patients were not being active or appropriately monitored and thus presenting with much later stage disease. In turn, we as providers are charged with doing all we can to ensure that the well defined at risk groups are in active surveillance programs either under the auspices of their Primary Care Providers or at the level of the Gastroenterology practice where they are being managed for their Chronic Hepatitis and/or Cirrhosis.

The currently known risk factors for HCC that necessitate a patient undergo surveillance with Ultrasound every six months are established Cirrhosis, Chronic Hepatitis B Virus (cHBV) infection and, to a yet to be fully defined degree, Non-Alcoholic Steatohepatitis (NASH) [4]. In respect to treatment, the last decade has been definitive in further developing the available data and emerging science into a much broader landscape of treatment options for the HCC patient. Surgical resection or Radio Frequency Ablation (RFA) in the Non-Cirrhotic or Compensated Cirrhotic patient population with HCC confined to the liver now offer a proven five-year survival of around 60% [5].

With the introduction of an appropriate organ allocation measure such as the Milan criteria (three lesions < 3cm or one lesion <5cm), the transplant setting has been able to offer a five-year survival of around 70%, rivaling outcomes in patients transplanted for liver failure [5]. Trans-Arterial Chemo-Embolization (TACE) therapy in the patient who's not a candidate for Resection, RFA or Transplant yet who has HCC confined to the liver without vascular invasion yields a one-year survival between 60 and 80% [5]. In patients with more advanced HCC that is metastatic and/or invading into the vasculature, oral systemic therapy with Sorafenib yields a one-year survival of around 44% [6]. This Evidence-Based Medicine multi-disciplinary approach is best represented by the Barcelona Clinic for Liver Cancer (BCLC) Staging and Treatment guideline noted in the figure below.

Current stage-based EBM approach to treating HCC

Barcelona Clinic Liver Cancer (BCLC) Staging System, 2008
HCC
Stage 0 — PST 0 and Child-Pugh A
Stage A-C — PST 0-2 and Child-Pugh A-B
Stage D — PST >2 or Child-Pugh C
Very early stage (0) — Single< 2cm. Carcinoma in situ
Early stage (A) — Single or 3 nodules < 3cm, PS 0
Intermediate stage (B) — Multinodular, PST 0
Advanced stage (C) — Portal invasion, N1,M1, PST 1-2
End stage (D)
Single — Portal pressure/ bilirubin — Increased / Normal
3 nodules ≤3cm — Associated diseases — No / Yes
Resection | Liver Transplantation (CLT / LDLT) | PEI/RF | TACE | Sorafenib
Curative Treatments (30%) 5-yr survival : 40-70%
Randomized controlled trials (50%) 3yr survival: 10-40%
Symptomatic ttc (20%) Survival<3mo

So, in closing, it's important to note that HCC proposes a current and emerging cancer epidemic in the USA that urgently needs the concerted multi-disciplinary attention of our medical community. Given the fact that this is an emerging epidemic in which we have the privilege of foresight, I believe we can make a more significant difference. Imperative to impacting change in the HCC patient population will be the efforts toward patient advocacy, education and support. To date, The Adrienne Wilson Liver Cancer Association (aka: Blue Faery) has heralded the efforts in this area for the USA and more information regarding their efforts can be found online at www.bluefaery.org.

References

1. ACS Cancer Facts and Figures. 2010. http://www.cancer.org/downloads/STT/Global_Facts_and_Figures_2007_rev2.pdf; 3.
2. Davis, G, Alter, M, et al. Aging of the Hepatitis C Virus (HCV) Infected Persons in the United States: A Multiple Cohort Model of HCV Prevalence and Disease Progression. Gastroenterology 2010; 138:513-521.
3. Davila, J, El-Serag, H, et al. Use of Surveillance For Hepatocellular Carcinoma Among Patients With Cirrhosis In The United States. Hepatology 2010, V52, 1:132-141.
4. Bruix, J, Sherman, M. AASLD Practice Guideline: Hepatocellular Carcinoma. Hepatology 2010, V0:1-35. Best referenced online at www.aasld.org.
5. Said A and Wells J. Minerva Medica. 2009; 100:51-68.
6. Llovet JM, et al. Molecular Therapy in Hepatocellular Carcinoma. Hepatology, V48-4; 1312-1337

Don't Miss GIPA in Las Vegas!
The GIPA Annual Membership Meeting will be held Tuesday, May 31 at 7:00-9:00 pm in the Las Vegas Hilton, Conf. Rm. 12. Don' t miss this networking

2011 GIPA Board of Directors

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June GIPA Presentations
Saturday, June 4th, Las Vegas Hilton
Hepatitis C for Primary Care and **IBS-C**
Presented by Rick Davis, PA-C
See www.aapa.org, *Impact Meeting* for details.

Please send your news and submissions for future newsletter issues to GIPA@Focus-ED.net

To Unsubscribe please email GIPA@Focus-ED.net

Renew or become a GIPA Member Today!
Online payment available at www.gipas.org

By joining or renewing your membership to the Gastroenterology Physician Assistants (GIPA) now, you'll and 14 months membership for the price of 12 months!
May 2011 through June 2012

Membership Categories include Fellow, Sustaining, Physician, Affiliate, & Student Members for only $10-$30

Benefits include up-to-date gastroenterology information, exclusive job opportunities, CME member specials, newsletters and networking.

Professional Resources for your Networking and Career Development
- *GIPA Digest*, a quarterly newsletter designed specifically for GI PAs
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GIPA Fosters Professional Relationships with premier Gastroenterology & Hepatology Organizations

American Gastroenterological Association (AGA)
American College of Gastroenterology (ACG)
American Association for the Study of Liver Diseases (AASLD)

Please take a few minutes to renew your membership or join now. The GIPA membership application is attached for your convenience.

Only your continued support of GIPA makes these resources possible!

For additional information please contact gipa@focus-ed.net.

New Online Membership Registration & Renewal!
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I am interested in serving GIPA as a volunteer ☐
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My sub-specialty/areas of expertise are: ____________
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Please use this address for my membership mailings: ☐ Email (to conserve cost and paper) ☐ Home ☐ Work
May we share your contact information CME, employment, and product information? ☐Yes ☐No
Please check here if you do not want to be listed in the annual GIPA membership directory. ☐

Membership Types and Dues

☐**Fellow Membership - $30**: Physician Assistants who currently practice in the field of gastroenterology
☐**Sustaining Membership - $30**: PAs, certified by the NCCPA, who have chosen not to practice in Gastroenterology and Hepatology, but who still wish to support GIPA.
☐**Physician Membership - $30**: U.S. licensed physicians who wish to associate with and support the organization.
☐**Affiliate Membership - $30**: are ineligible for the above categories and wish to associate with the organization. Their memberships must be approved by the Board of Directors.
☐**Student Membership - $10**: Physician Assistant students who are currently enrolled in an ARC-approved PA program Students are not eligible for membership to the Crohn's & Colitis Foundation

☐I would like to make an additional donation to support the efforts of GIPA. Amount: ____________

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