Important Issues in Coding

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- This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and coding information, but is not a legal document. The official CPT® codes and Medicare Program provisions are contained in the relevant documents.

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Agenda

- Payer Documentation Requirements
- Medical Necessity
  - a/k/a being able to keep the money!
- Evaluation and Management Services
- Common Documentation errors
- Changes to come…

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"10 Iron Rules of Medicare"*

* Quote from Attorney Larry Oday; Modern Healthcare, June 19, 2000

1. Just because it has a code, that doesn't mean it's covered.
2. Just because it's covered, that doesn't mean you can bill for it.
3. Just because you can bill for it, that doesn't mean you'll get paid for it.
4. Just because you've been paid for it, that doesn't mean you can keep the money.
5. Just because you've been paid once, that doesn't mean you'll get paid again.
6. Just because you got paid in one state doesn't mean you'll get paid in another state
7. You'll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There's always some schlemiel who doesn't get the message.
10. There's always some schmendrik (jerk) who gets the message and ignores it.

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Payer Documentation Requirements

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Medical Record Documentation

Validates

- The site of service
  - Is it appropriate for the service and patient's condition?
- The appropriateness of the services provided
  - Not experimental
  - Meets but doesn't exceed patient's medical need
  - Ordered and performed by qualified personnel
- The accuracy of the billing
  - CPT®/HCPCS codes accurately represent what is documented
  - ICD-10-CM codes are supported by clinical documentation
- Identity of the care giver (provider)
  - Who personally performed the service?
  - Legible signature

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Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor. "

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So, in plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is "reasonable and necessary" or be one of the preventive benefits
- Much of this is defined in NCDs and LCDs for non-E&M services provided by Rheumatologists

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Evaluation & Managements Basics

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E&M Coding…what the ??

- Where am I?
  - Inpatient, home, SNF/NF, office codes
- Is this a new or established patient visit (inpatient/outpatient)?
- Or is this the initial or subsequent visit for this admission (hospital/inpatient)?
- Once you answer those questions…
  - 3, 4 or 4 levels of service to choose from

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CPT®: E&M Services Guidelines

New and Established Patient

- "solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report [E&M] services…
- "an established patient is one who has received professional services from the physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.
- "…where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician."

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7 Components Define E&M Services

- Key components in selection of level
  - History
  - Examination
  - Medical decision making
- Ancillary elements in selection of care
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity
  - Time

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Use of Time

If a visit consists **predominantly** of counseling and/or coordination of care, time is the key element to assign the appropriate level of E&M service.

- Office/outpatient setting
  - Face-to-face time refers to patient time with the physician only
  - Counseling by other staff does not count
  - Duration of counseling and/or coordination of care may be estimated but must be recorded
  - Total duration of the visit also documented
  - Do not round up!
    - 99214 = 25 minutes
    - 99215 = 40 minutes
    - 35 minute visit is a 99214

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"Results" Visit

At least 45 minutes with patient >50% discussing lab results, lifestyle changes and medications to help manage symptoms; new diagnosis of Lupus. All patient questions answered. Long discussion regarding her desire to get pregnant.

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Coding using the 3 Key Components

1. **History**
2. **Physical Exam**
3. **Medical Decision Making**

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Level 3 E&M

New patient visit/consults

- 99203/99243/99253
  - Detailed history
    - HPI – 4+
    - ROS – 2-9
    - PFSH – 2:3
  - Detailed exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

Established Patient Office Visit

- 99213
  - Expanded Problem Focused history
    - HPI 1-3
    - ROS – 1
    - Expanded Problem Focused exam
      - 2-7 BA/OS
    - Medical decision making of low complexity

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99204
Documentation Required (all of the below*)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from each of these
2. Comprehensive Exam (8 or more organ systems)
3. Medical decision making of Moderate complexity (at least 2 of the following variables)
   - Moderate number of diagnoses or management options
     - New problem with or without a work-up
   - Moderate amount of complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

* *If even one element is not documented (9 systems in the review of systems, "Family Hx: Noncontributory,", etc., the payer could down code you*

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99205
Documentation Required (all of the below*)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from each of these
2. Comprehensive Exam (8 or more organ systems)
3. Medical decision making of **High** complexity (at least 2 of the following variables)
   - Extensive number of diagnoses or management options
     - New problem with a work-up
   - Extensive amount of complexity of data (to be) reviewed
     - Reviewed or ordered lab, caregiver/spouse contributed to history, reviewed/ordered x-ray
   - High degree of risk

* *If even one element is not documented (9 systems in the review of systems, "Family Hx: Noncontributory,", etc., the payer could down code you*

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99214
Documentation Required (2:3 Key Components)

1. Detailed History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from 1 of each of these
     - Listing medications = medical history
2. Detailed* (extended exam of 2-7 body areas/organ systems)
3. Medical decision making of **High** complexity (at least 2 of the following variables)
   - Extensive number of diagnoses or management options
     - New problem with a work-up
   - Extensive amount of complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

* *Interpretation of "extended" varies by payer. From 2 elements for at least 2 body areas or 2 organ systems (PalmettoGBA), to at least 4 elements of at least 4 body areas or 4 elements of at least 4 organ systems (Novitas).*

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Changes to E&M Documentation and Coding:
Impacts only Office Visits – Using Time

Biggest E/M CPT® Changes in 2021

- Office or other outpatient visits are impacted
  - 99202- 99205
    - Not a typo – 99201 will be deleted
  - 99211-99215
  - Level of service will be chosen based on time or medical decision making
    - How is time computed changes dramatically
    - Determining medical decision making is more definitive
    - Neither time nor medical decision making applies to 99211

Biggest Changes in 2021: Time

- Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service.
  - May not use time for 99211
- Time may only be used for selecting the level of the other E/M services (hospital visits, home visits, etc.) when counseling and/or coordination of care dominates the service.

Biggest Changes in 2021: Time

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Changes to E&M Documentation and Coding:
Impacts only Office Visits – Using MDM

Services Reported Separately

"The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making."

Medical Decision Making

- ***Drug therapy requiring intensive monitoring for toxicity:*** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify.

Medical Decision Making

- ***Drug therapy requiring intensive monitoring for toxicity (cont'd):*** **….**The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.

Medical Decision Making

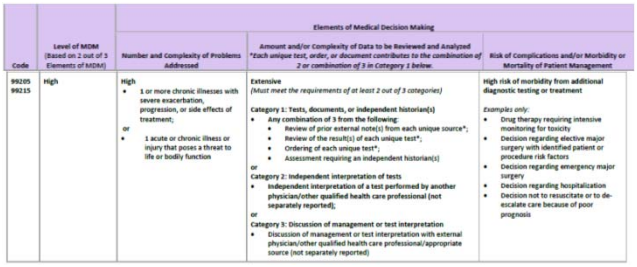
- Four types of medical decision making are recognized: straightforward, low, moderate, and high. The concept of the level of medical decision making does not apply to code 99211.
- Shared medical decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.
- Medical decision making may be impacted by role and management responsibility.
- When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

99203
99213
	Low	Low
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• Any combination of 2 from the following:
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	Moderate
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• Any combination of 3 from the following:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health



Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive *(Must meet the requirements of at least 2 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; ◦ Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

New Patients

99202	**Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.**
99203	…low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	…moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	…high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Established Patients

99211	**Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.**
99212	…which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	…low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	…moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	…high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Common Documentation Errors

Common Documentation Errors

- Services were rendered by one provider and billed by another provider
  - Understand incident-to and shared visit billing
  - You must be in the office suite for ancillary staff's services to be billed under your name and NPI for "incident to" billing
  - If employing an ARNP/CNS or PA
    - They MUST have their own Medicare number
    - Cannot bill their visits under you ("incident-to") if they see a new patient
      - Or they see an established patient with a new problem, or if they change anything
    - Check private/managed care payers' criteria

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Common Documentation Errors

- Conflicting information in the medical record
  - The diagnosis on the claim is not consistent with the diagnosis in the medical record
  - "denies erectile dysfunction" female patient's review of systems
  - Review of systems states "denies knee pain," in a patient presenting with knee pain as the chief complaint
- Date of service in the documentation is different from the date of service billed
- Medical documentation does not support medical necessity for the frequency of the visit
  - 99214 every 3 weeks for a stable patient
  - If ICD-10 is reported correctly, the patient may not be quite so "stable"
- Documentation does not support the payer's requirements for coverage (payment)
  - 3 or more months of more conservative treatment for Viscosupplementation, for example

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Briefly: Medical Necessity and EMRs

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information
- Even when a "complete" note is generated, only medical necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service
- Information not pertinent to patient's condition at time of encounter cannot be counted
  - Patient is seen in 'routine' follow-up of stable OA. History is "comprehensive" including past, family and social history. Was it "medically necessary" to repeat these history elements?

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Other Coding Opportunities & Nuances

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G2010 - Remote pre-recorded services

New Medicare Covered Service

- G2010 - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- In layman's terms: Remote evaluation services when a physician uses pre-recorded video and/or images submitted by a patient in order to evaluate a patient's condition
- ~$13.00

G2012 – Virtual Check-in Service

New Medicare Covered Service

- G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. [emphasis added]
- Call/other communication must be initiated by the patient.
- Established patients only
- Interaction only with the physician/QHP, no other clinical staff.
- Verbal consent by the patient must be documented at least annually.
- ~$15

CPT®: Radiology Guidelines

- S&I and Imaging Guidance:
  - All imaging guidance requires 1) image documentation in the patient record and 2) description of imaging guidance in the procedure report
  - All S&I codes require 1)image documentation in the patient's permanent record and 2) a procedure report or separate imaging report that includes written documentation of interpretive findings of information contained in the images and radiologic supervision of the service.
- Written Report(s)
  - With regard to CPT® descriptors for imaging services, "images" must contain anatomic information unique to the patient for which the imaging service is provided.

Questions??

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