Important Updates in Coding

Prepared for

Coalition of State Rheumatology Organizations'

National Rheumatology Fellows Conference

March 19, 2022

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Agenda

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

“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.

Payer Documentation Requirements

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

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. “

Evaluation & Managements Changes for Office Visits

Biggest E/M CPT® Changes in >20 Years

- Only office or other outpatient visits are impacted
  - 99202- 99205
    - Not a typo – 99201 is deleted
  - 99212-99215
    - 99211 remains and is not impacted by these changes
  - Consultations, Hospital, SNF/NF, Home, ALF Visits are not included in these code changes
    - 3 Key Components will continue to determine code selection
- Level of service is now chosen based on time or medical decision making
    - How time is computed changes dramatically
    - Determining medical decision making is more definitive
    - Medically appropriate history and/or physical exam
      - No more counting bullets!

2021: What is and isn't changing

- All medical necessity requirements remain in place whether choosing 99202-99215 based on time or medical decision making.
  - The documented Chief Complaint/Reason for Today's Visit and the narrative History of Present Illness (HPI) will set the stage for determining the complexity of MDM.
- Rules for modifiers (e.g., -25) have not changed
- Previously nebulous terms such as "stable chronic illness," or when a "problem" can be counted in determining MDM are now defined.

Let’s look at coding 99202-99215 based only on Time…

Time: Countable Activities

Physician/other qualified health care professional time includes the following activities, **when performed on the date of the OV:** [emphasis added]

- 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
  - But only on the date of the visit
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Time*

E/M Code	Time Ranges
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99212	10-19
99213	20-29
99214	30-39
99215	40-54

*AMA and CMS data files

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

Complexity of Medical Decision Making

3 Elements -2021 Office/Other OP Visits

1. Number and Complexity of Problems Addressed
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Risk of Complications and/or Morbidity and Mortality of Patient Management

2:3 Elements of MDM must meet or exceed to qualify for a given level of service.

MDM Definitions

- ***Problem:*** A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
- ***Problem addressed:*** A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

MDM Definitions

- ***Stable, chronic illness:*** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia. [emphasis added]

Element #1. Number and Complexity of Problems Addressed

- Multiple new or established conditions may be addressed at the same time and may affect medical decision making.
- ➢ Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
- ➢ Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Element #2. Amount and/or Complexity of Data to be Reviewed and Analyzed

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- ***External:*** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
- ***External physician or other qualified healthcare professional:*** An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty.

Element #2. Amount and/or Complexity of Data to be Reviewed and Analyzed

- ***Independent historian(s):*** An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (egg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met. [emphasis added]

Element #3: Risk of Complications and/or Morbidity and Mortality of Patient Management

- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as ‘high’, ‘medium’, ‘low’, or ‘minimal’ risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities).
- For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Element #3. Risk of Complications and/or Morbidity and Mortality of Patient Management

- ***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.

Element #3. Risk of Complications and/or Morbidity and Mortality of Patient Management

- ***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:
  1. straightforward,
  2. low,
  3. moderate, and
  4. high.
- 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

Clinical Example of the 3 Elements: coded 99213

1. #/Complexity of the Problems Addressed
   - Doing well. No joint pain or swelling. Tolerating meds

1 stable chronic illness: Low/99213

2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - Plan Orders: CRP, Sed Rate, CBC w/diff, CMP

3 Unique tests: Moderate/99214

3. Risk of Complications of Patient Management
   - Included in the Plan: Methotrexate 15 mg (6 tabs) weekly, folic acid 1 mg daily,

Rx Mgmt: Moderate/99214

What code level do you think this is and why?

Clinical Example of the 3 Elements: coded 99213

1. #/Complexity of the Problems Addressed
   - OA, right knee still with pain

1 unstable stable chronic illness: Moderate/99214

2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - Consider MRI

1 test: Minimal/99212

3. Risk of Complications of Patient Management
   - Aleve, Voltaren gel, physical therapy

OTC, PT: Low/99213

What code level do you think this is and why?

Example of the 3 Elements: coded 99213

1. #/Complexity of the Problems Addressed
   - Osteoporosis will be treated now that BMD has reduced significantly and FRAX is elevated
2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - (Inhouse) bone density. Sent Vitamin D level and calcium level
3. Risk of Complications of Patient Management
   - continue calcium and vitamin D 2000 IU per day
   - Evista per Dr. Smith
   - restart Prolia

1+ unstable chronic illness: Moderate/99214

2 lab tests ordered: Limited/99213

Rx management: Moderate/99214

What code level do you think this is and why?

Other Coding and Documentation Opportunities & Nuances

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

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
- Insufficient documentation for modifier -25
- 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

Virtual Check-in 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]
- G2252 -…..11 – 20 minutes
- 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.

Public Health Emergency

- On 1/16/22, Secretary Becerra extended the PHE another 90 days.
- So, telehealth flexibilities available during this time have been extended through April 16, 2022
- Three telehealth categories
  - Category 1 – services permanently added to the list of covered telehealth services
  - Category 3 – temporary list of services added during the PHE that will remain on the list through the year in which the PHE ends.
    - CMS intends to have these as covered services through December 31, 2023

Telephone Visits*

E&M visit via a telephone call by a Medicare provider who can bill an E&M code (physician, ARNP, CNS, PA, CRNA)

Telephone Evaluation and Management Services codes

- 99441: telephone evaluation and management service; 5-10 minutes
- 99442: ….11-20 minutes
- 99443: …21 or more minutes

Medicare allowable equates to 99212, 99213, 99214

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