Coding and Reimbursement 2023: Optimizing your billables and collectables

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Disclosures

- Speaker Bureau:
  - Sanofi-Pasteur, Merck, Pfizer, Seqirus: Vaccines
  - AbbVie and Biohaven: Migraines
  - Idorsia: Insomnia
- Consultant:
  - Sanofi-Pasteur, Merck, Pfizer, Moderna, and Seqirus: Vaccines
  - GlaxoSmithKline: OA and Pain
  - Bayer: Chronic Kidney Disease
  - Idorsia: Insomnia
  - Shield Therapeutics: Iron Deficiency Anemia

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Learning Objectives

- Identify the most common CPT codes utilized in a primary care/specialty setting.
- Identify ways to effectively code in order to optimize billing and collections.
- Identify common mistakes made with coding.

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January 1, 2021

Significant Changes in Billing and Coding!

Most sweeping changes in 20 years!

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2019 MPFS Final Rule

- Medicare Physician Fee Schedule Rule was published in 2019 with the goal of reducing administrative burden, improving payment accuracy, and updating the code set to reflect current medical practice
- Initially, CMS was going to pay a blended rate for E&M Codes 2 – 4; in other words, pay the same rate for a new patient 99204 as a 99213 established patient
  - Created a lot of comments and significant reactions
  - This was eliminated
  - CMS announced that they would pay a fee for each distinct code

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Where and Why Did These Changes Occur?

- These changes began with the initiative developed by CMS called Patients Over Paperwork
- Goal is to remove barriers which keep providers from spending quality time with patients
- These modifications are designed to relieve documentation burden
- AMA has modified but finally adopted these revisions

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American Medical Association has adopted these modified changes and they are reflected in the CPT 2021 Coding Manual which means, these are not just a Medicare change but are accepted by all payers!

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By the way…

- Recent publications indicate that there has been NO reduction in time spent documenting under the new regulations

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Terminology

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CPT-4 Codes

- Current procedural terminology (CPT) is a national system utilized to identify and bill for specific services or procedures.
- Developed by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA*)
  - *No longer called HCFA, now referred to as Centers for Medicare and Medicaid Services (CMS)

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CPT-4 Codes
(continued)

- Has been adopted by Medicare and third-party payers (i.e., insurance companies)
- Each insurance company, including Medicare, has a corresponding fee attached to each CPT code.

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CPT-4 Codes

- Always a five-digit code
- Code ranges from 99202–99499
- These codes are often referred to as E and M codes (evaluation and management coding).

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Diagnoses

- Claims are now remitted with up to 21 diagnoses
  - Prioritize codes
    - Place HCC codes in first positions to ensure transmission
    - High acuity diagnoses first, even if this is not what they have come in for
    - Leave Z codes for end

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CPT-4 Codes

E and M Codes

- Previously billing was based upon the history, the physical examination, and medical decision making
- Previously, established patients needed to meet 2/3 components and new patients needed to meet 3/3 components to bill that level

What has changed in 2021?

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In 2021:

- 99201 code has been removed due to very low utilization and it has the same requirements as 99202 so redundancy would be confusing
- This code is no longer used for any encounters

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2021

- Billing is now based on either:
1. Documentation of time-based coding, including face-to-face and non-face-to-face activities OR
2. Medical decision making

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Option 1: Billing Based Upon Time

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What Factors Into Time Billed?

- Preparation to see patient (review records, tests)
- Obtaining and reviewing history
- Performing medically appropriate PE
- Counseling and education
- Ordering tests, medications, procedures

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What Factors Into Time Billed (cont.)?

- Referring and communicating with other professionals
- Documentation of the information in the medical record
- Independently interpreting results of labs and communicating labs/results
- Care coordination

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Documentation in Record

- When time is used, the record must state:
  - 15 minutes spent taking a history, performing PE, reviewing labs, discussing diagnoses with patient, educating patient."
  - This must be on the date of the encounter
  - This person would be billed at 99212 or if new 99202

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Coding/Documentation Pearl

Create a quick text to use

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Billing Based Upon Time

New Patient Code	Total Time (2021)	Established Patient Code	Total Time (2021)
99202	15-29 minutes	99211	N/A
99203	30-44 minutes	99212	10-19 minutes
99204	45-59 minutes	99213	20-29 minutes
99205	60-74 minutes	99214	30-49 minutes
		99215	40-54 minutes

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Additional Code: 99417

Indicates that a prolonged service is supported because the provider has spent 15 minutes more than the " minimum time" for the selected service when time is used to select the office or other outpatient E&M service on the same day as the service.
For Medicare, a different code, G2212, must be used

Can be added to a 99205 or 99215
(60 – 74 minutes)

Begin billing at 75 minutes; 90 minutes for Medicare

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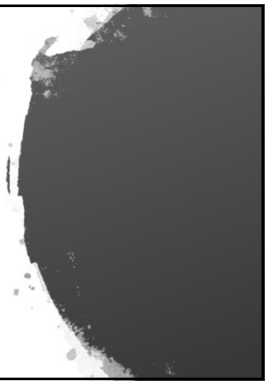

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Billing Medicare Additional Time

Indicates that a prolonged service is supported because the provider has spent 15 minutes more than the "**maximum time**" for the selected service when time is used to select the office or other outpatient E&M service on the same day as the service.

Can be added to a 99205 or 99215
60 – 74 minutes
Begin billing at 89 minutes

You use HCPCS Level II code G2212

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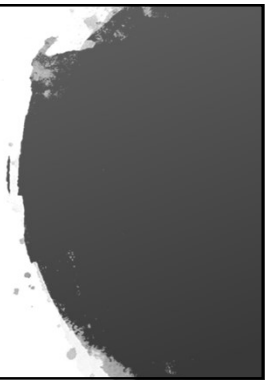

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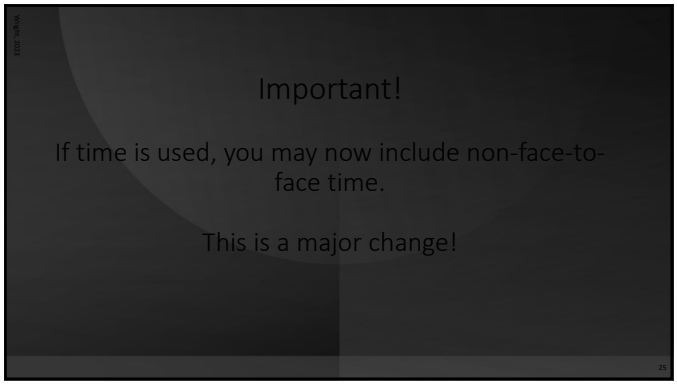

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Counseling/Coordination of Care

- No longer needs to dominate (more than 50%) to bill for visit based upon time
- Also, time does NOT include other staff activities i.e. vital signs

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Option 2: Billing Based Upon Medical Decision Making

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Medical decision making

- Three components
  - Number and complexity of problems addressed
  - Amount and complexity of data reviewed and analyzed
  - Risk of complications and/or morbidity or mortality

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Category 1

- Tests, documents, orders, and review of prior external notes from each unique source or independent historian (each unique test, order, or document is counted to meet threshold number)

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Category 2

- Independent interpretation of tests not reported separately

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Category 3

- Discussion of management or test interpretation with external Qualified Healthcare Provider (QHP) not reported separately

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99211	n/a	n/a	n/a	n/a
99212 or 99202	Straightforward	Minimal: 1 self limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99213 or 99203	Low	Low 2 or more self-limited or minor problems **OR** 2 stable chronic illness OR 1 acute, uncomplicated illness or injury	Limited (must meet the requirements of 1 of the two categories) **1. Category 1: Tests and the documents (any combination of 2 from the following)** a. Review of prior external note from unique source b. Review of of each unique test c. Ordering of each unique test **OR** **2. Category 2: Assessment requiring an independent historian**	Low risk of morbidity from additional diagnostic testing or treatment

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Acute Uncomplicated Illness

- **Acute, uncomplicated illness or injury**
  - The problem is recent and short-term
  - There is little to no risk of mortality with treatment
  - Full recovery is expected
  - Examples: UTI, Allergic rhinitis, Simple sprain

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99214 or 99204	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 uncomplicated injury	Moderate (must meet the requirements of 1 of the 3 categories) **1. Category 1: Tests, documents, or any independent historian (any combination of 3 from the following)** a. Review of prior external note from unique source b. Review of of each unique test c. Ordering of each unique test d. Assessment requiring an independent historian **OR**	Moderate risk of morbidity from additional diagnostic testing or treatment Examples: 1. RX drug management 2. Decision re: minor surgery 3. Diagnosis of treatment impacted by SDOH

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Acute Illness with Systemic Symptoms

- Acute Illness with Systemic Symptoms
  - The illness causes systemic symptoms, which may be general or single system
  - There is a high risk of morbidity without treatment
  - For a minor illness with systemic symptoms like fever or fatigue, consider acute, uncomplicated or self-limited/minor instead
  - Examples: Pyelonephritis, Pneumonia, Colitis

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Acute, Complicated Injury

- **Acute, complicated injury**
  - Treatment requires evaluation of body systems that are not part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment
  - Example: Head injury with brief loss of consciousness

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99214 or 99204	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 uncomplicated injury	2. **Category 2**: Independent interpretation of test performed by another provider **OR** 3. **Category 3**: discussion of management or test interpretation with QHP or external source	Moderate risk of morbidity from additional diagnostic testing or treatment Examples: 1. RX drug management 2. Decision re: minor surgery 3. Diagnosis of treatment impacted by SDOH

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99215 or 99205	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	High (must meet the requirements of 2 of the 3 categories) **1. Category 1: Tests, documents, or any independent historian (any combination of 3 from the following)** a. Review of prior external note from unique source b. Review of each unique test c. Ordering of each unique test d. Assessment requiring an independent historian **OR**	High risk of morbidity from additional diagnostic testing or treatment Examples: 1. Drug therapy requiring intensive monitoring for toxicity 2. Decision re: major elective surgery 3. Decision re: hospitalization or emergency surgery

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Billing by Medical Decision Making

Code	Level of MDM (2/3)	Number and Complexity of Problems Addressed	Amount+/or complexity of data to be reviewed and analyzed	Risk of complication +/or morbidity or mortality of patient management
99215 or 99205	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	High (must meet the requirements of 2 of the 3 categories) 2. **Category 2**: Independent interpretation of test performed by another provider **OR** 3. **Category 3**: discussion of management or test interpretation with QHP or external source	High risk of morbidity from additional diagnostic testing or treatment Examples (cont.): 4. Decision not to resuscitate or to de-escalate care b/c of poor prognosis

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- **Beginning in January 2023, similar new billing changes will take effect for most inpatient work and for consultations (outpatient and inpatient).**
- For both inpatient work and consultations, E&M codes will be selected based only on medical decision making or total time on the date of service.

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99211

- New verbiage:
  - Office or outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or qualified healthcare provider/professional
    - Removed the wording: typically 5 minutes are spent performing this service

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Be Familiar with Verbiage

- External physician or other qualified healthcare professional:
  - Not in the same group practice or
  - Is in a different specialty or subspecialty
- Independent historian
  - Family member, witness or other individual who provides history

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Coding Pearls

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Specificity of ICD-10 is imperative

- As we move from quantity to quality, it is imperative that you document as specifically as possible
  - i.e. Type 2 diabetes, uncontrolled, with renal complications rather than Type 2 diabetes
  - More money per member per month for the higher risk codes
  - Also….given more bundled money to care for these patients as they will require more intensive care

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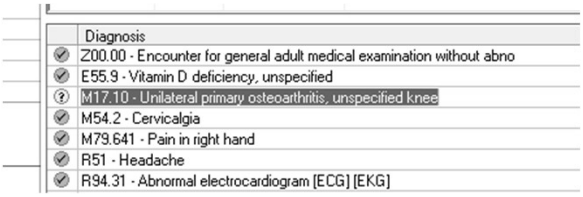
Specificity Example



Diagnosis
Z00.00 - Encounter for general adult medical examination without abno
E55.9 - Vitamin D deficiency, unspecified
M17.10 - Unilateral primary osteoarthritis, unspecified knee
M54.2 - Cervicalgia
M79.641 - Pain in right hand
R51 - Headache
R94.31 - Abnormal electrocardiogram [ECG] [EKG]

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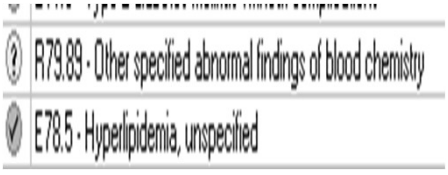
Specificity Example



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HCC (**Hierarchical Condition Category**) Coding

- HCC codes are a subset of **ICD10 codes** that Medicare uses to determine the risk scores of Medicare Advantage patients

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HCC (**Hierarchical Condition Category**) Coding

*Example #1: A 68-year-old patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 37.2

ICD-10	DESCRIPTION	RAF
E11.9	Type 2 Diabetes with no Complications	
I10	Hypertension	
Z68.37	BMI of 38.2	
		Total Risk= 0.000

*Example #2: A 68-year-old patient with type 2 diabetes with diabetic polyneuropathy, hypertension, morbid obesity with a BMI of 37.2, and status post-left below knee amputation (BKA)

ICD-10	DESCRIPTION	RAF
E11.42	Type 2 diabetes with diabetic polyneuropathy	0.0368
I10	Hypertension	
E66.01 & Z68.37	Morbid obesity with a BMI of 37.2	0.365
Z89.512	Status post-left BKA	0.779
		Total Optimized Risk 1.1868

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What does this mean for me?

- If the Medicare advantage plan is aware that the patient has the HCC codes/diagnoses – more money is allotted to provide care for them
- If you save money for the insurer, that money comes back to the clinic/practice/provider
- Also…Medicare forgets that patients have these conditions, they must be billed every year
  - My EHR – in the beginning of the year, all HCC codes are red
  - Once dropped into the plan for billing, they then turn black
  - The codes are "flagged" as HCC

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Important

- Should be done on first visit of every year (patient may not be seen again)
- Drop into note using M.E.A.T criteria for documentation
  - Monitoring
  - Evaluation
  - Assessment
  - Treatment

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This is Important…..

- For Value Based Programs
- with a specialty/focus of Lifestyle Management
- Incentivizes us all to provide high quality care to those with the highest risk and to be rewarded financially for that work!!
- Challenge however….what if your work reverses this code: no longer living with obesity or diabetes…the code should be inactivated

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Coding a Visit

- When coding a visit, it is important to make sure that the ICD-10 code(s) is/are consistent with the E and M code.
  - For instance, do not bill a high-level visit (99214) and then use an ICD-10 for a viral pharyngitis.
    - If this does occur, you should have documentation to support in the event of an audit.

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Words of Warning

- Only include the diagnosis or diagnoses (ICD-10) being addressed at that visit
  - Many believe adding diagnoses can justify the increase in billing/receivables
    - This is NOT true.
  - You must have documentation from that visit to support each of those diagnoses.

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Words of Warning
(continued)

- Only include the diagnosis or diagnoses (ICD-10) being addressed…(cont.)
  - Only include secondary diagnoses if influencing the patient's current problem or if you addressed them and documented it.

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Words of Warning
(continued)

- Some insurances may not reimburse for diagnoses such as…
  - Obesity
  - Pes planus
    - Ortho/podiatry code
  - Presbyopia
    - "Ophthalmology" code

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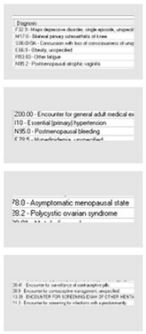
Do NOT….



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- **Include 3 codes for the same condition**
  - **Urinary urgency**
  - **Urinary frequency**
  - **UTI**

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Additional Codes

In addition to the E and M codes utilized for office visits, you will also use other CPT-4 codes to bill for various procedures.

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Modifiers

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Modifiers
(continued)

- Used to indicate that a particular service or procedure has been modified by some special circumstance but not changed in its definition
  - Service or procedure was performed by more than one provider
  - Only part of a service was performed
  - Unusual events occurred

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Modifiers
(continued)

- Indicate that a service or procedure has both a professional and technical component.
- Service or procedure has been increased or decreased.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.

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Modifier 25

- Utilized for the following conditions…
  - Condition #1
    - If the nurse practitioner is performing some type of preventive service, (i.e., a physical examination) and encounters a problem or abnormality that is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate code can also be used.

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Patient #2
Example from my Practice

- 52-year-old man presents for a complete physical examination. Needs to renew his antihypertensive medications.
  - On ROS – Increase urination, polyphagia and a 45 lb (20.4 kg) weight loss within the last 3 months
  - Last physical examination
    - Approximately 10 years ago despite encouragement from previous providers

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Patient #2
Mr. H's Physical Examination Findings

- BP – 124/80 mm Hg
- Weight
  - 208 pounds (94.3 kg)
- Pulse
  - 108 bpm and regular
- Heart
  - S1S2; RRR; +S4; no murmurs or S3
- Lungs – Clear
- Eyes
  - PERRLA
  - Fund: Optic disc
    - Round, regular; no cupping
    - Retina – Pink; no exudates or hemorrhages

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Mr. H's Physical Examination Findings
(continued)

- PV
  - DPPT – 2+ bilaterally
- Neuro
  - Sensation intact to light touch and vibration
- Urine dip
  - 4+ glucose; no ketones
- Finger stick – 448 mg/dL (24.9 mmol/L)

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Mr. H
(continued)

- Codes utilized
  - Complete physical examination
    - ***and***
  - Modifier 25 plus 99214 code because of his new onset type 2 diabetes
    - Plus urine dip
    - Plus capillary stick
    - Plus glucose
    - Plus A1C

Interpretation of each of these

1 undiagnosed new problem with uncertain diagnosis, Plus 3 tests, Plus prescription drug management, Moderate risk

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Coding pearls

- If patient has HTN and impaired fasting glucose,
  - When you do microalbumin put HTN as diagnosis, you will get it covered
- This should NOT have a mod 25 when each of those diagnosis has no plan other than PCWAS

ervice Date	Procedure	Modifier	Diagnosis Codes
3/10/2020	99395	25	Z00.00, M54.2, M54.5, G89.29, M25.561, M

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Patient #3

- The nurse practitioner sees the patient for a follow-up of his hypertension and diabetes. During the visit, the patient mentions an abnormal nevus that seems to be enlarging.
  - During the visit you examine it and feel very strongly that it is a melanoma.
  - You decide to biopsy that day.

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You can…

- Code the visit as a 99213: Diabetes and hypertension
- Add a modifier 25 and bill for the surgical procedure during the same visit

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It is essential to remember…

- …An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive evaluation and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

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Modifier 95

- Modifier for telehealth services
- COVID-19 has resulted in numerous modifications to telehealth reimbursement and requirements.

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Modifier 59

- Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day
- All other possible modifier choices should be reviewed before using modifier 59
- It is typically the modifier of last choice
  - We use it for flu testing and if you do a procedure on the same day to 2 separate areas.

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Don't Forget…

- Immunization administration fee: 90471
- Injection administration fee: 90772
- Collect capillary blood: 36416
- Collect venous blood: 36415
- Occult blood: 82270
- Wet mount: 87210

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Telemonitoring Additional Billing/Coding Options

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Telemonitoring – Enhanced Payments

- 99453: One time practice fee for set up and patient education
  - Can bill this code every 30 days
  - Must have 16 days of readings in 30 days
  - Standard reimbursement: $18.77

Source: https://validic.com/your-guide-to-reimbursement-for-remote-patient-monitoring/

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Telemonitoring – Enhanced Payments
(continued)

- 99454: Covers supplies and provision of devices for monitoring
  - Billable × 1 in a 30-day period
  - $62.44 for technologies (regardless of supply costs)
  - 16 days of readings in a 30-day period

Source: https://validic.com/your-guide-to-reimbursement-for-remote-patient-monitoring/

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Telemonitoring – Enhanced Payments
(continued)

- 99457:
  - Direct monthly expense for remote monitoring
  - Must provide remote monitoring services for at least 20 minutes per month
  - Billable × 1 per calendar month and is paid at $51.61 (non-facility) and $32.84 (facility).

Source: https://validic.com/your-guide-to-reimbursement-for-remote-patient-monitoring/

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Telemonitoring – Enhanced Payments
(continued)

- 99458:
  - Add on code for each additional 20 minutes of remote monitoring and management services
  - $42.22 (non-facility) and $32.84 (facility)
  - Billable per calendar month

Source: https://validic.com/your-guide-to-reimbursement-for-remote-patient-monitoring/

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Procedures

- Work with your billing team/manager to make sure you understand which insurances allow you to bill procedures with E&M code
  - Don't forget:
    - Taking out sutures if you are not the one who put them in (S0630)
    - Specimen handling and sample collection for paps
    - Injection fees for ketorolac or corticosteroid + medication code (96372)
    - Injection fee plus vaccine code; 2nd vaccine is a different code: 1st – 90471; 90472 is the second
    - IV fluid bag, line, starting intravenous catheter
    - Hearing screening (92552) and Vision screening (99173)
    - Size of lesions matters – choose correct size code

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Chronic Care Management

- Chronic Care Management Services:
  - Separate payment in CY 2015 under PFS for new CPT code 99490 for non face-to-face care management/coordination; about $62.00 per month (office) and standard coinsurance applies
  - Qualified patients: 2 or more chronic conditions
  - Bill: Once per calendar month
  - MUST: furnish a minimum of 20 min of qualifying care
  - Only one practitioner can bill per month (per CPT and Medicare instructions)
  - 99484: Behavioral health: 43.00 per month

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Eligible Patients

- Eligible Patients
  - Beneficiaries with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patients at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Examples: Diabetes, HTN, COPD, Cancer

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Documentation

- Emphasize! Importance of making sure the documentation matches the level of coding
- If audited and the documentation consistently fails to match the coding, Medicare/Medicaid fraud can ensue.

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The most important component of reimbursement is the requirement for accurate documentation

Source: https://journals.lww.com/jwocnonline/Fulltext/2012/03001/Reimbursement_of_Advanced_Practice_Registered.4.aspx accessed 06-27-2020

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How can you simplify the coding process?

- Use reference sheets to scan for physical examination and medical decision making/complexity.
  - Using handwritten notes, very hard to accurately document the criteria necessary to meet the various levels
  - Consider dictation
  - Consider forms

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Remember…
As with the IRS, ignorance is not a good defense.

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Happy Coding!

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References

- American Medical Association, *CPT 2023 Professional Edition*, 2023.

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I would be happy to entertain any comments or questions you may have!

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End of Presentation
Thank you for your time and attention!

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