Important Issues in Coding & Billing

PREPARED FOR:
CSRO RHEUMATOLOGY FELLOWS CONFERENCE

FEBRUARY 22, 2025

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About the Speaker

LAURA, P/USE THE RHEUMATOLOGY BIO.

Jean Acevedo, LHRM, CPC, CHC, CENTC has over 30 years of health care experience and founded Acevedo Consulting in 2000. She has a particular expertise in chart audits, compliance & education relative to physician and other health care professionals' documentation and coding. Jean has also been an expert witness in civil litigation and an investigative consultant for the DOJ and FBI in Federal fraud cases.

Recognizing physician reimbursement is moving from a pure "fee for service" model to one reimbursing for quality and value, her firm has helped ACOs, and physician organizations understand the rules and nuances of diagnosis coding and the impact on Medicare Risk Adjustment (MRA) coding. She continues to provide chart reviews, physician education and compliance support to the firm's clients.

Jean is a member of several Coding Institute Editorial Advisory Boards. She has been a Participant in CMS' Medicare Provider Feedback Group, CMS Division of Provider Information Planning and Development since 2007 and is a member of the Jurisdiction 9 MAC's Provider Outreach and Education Advisory Group. She is a frequently sought after speaker for local and national meetings as she possesses the unique perspective of avoiding risk and liability while optimizing reimbursement in our highly regulated health care industry.

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policy changes frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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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.

Agenda

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

“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.

New Physicians Need to Understand

- You tell the payer what you did (and what you want to be paid for) with CPT® or HCPCS codes
  - 5-digit medical codes that represent the item or service and allow all physicians to speak the same language
- You tell the payer why you provided that service or item(the medical necessity) by linking ICD-10-CM diagnosis codes to each CPT® and/or HCPCS code.
  - Reporting an unspecified ICD-10 code (Pain in unspecified knee, vs. Pain in right knee) can lead to
    - Denials
    - Down coding
    - Audits

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 caregiver (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 & Management Services (“visits”)

Biggest E/M CPT® Changes in >20 Years

- Since 2021, the level of service of an Office Visit (or any other E/M code) is based solely on
  - How much time you spent in pre-, intra- and post- visit patient activities on the date of the actual visit
  - The complexity of Medical Decision Making (MDM)
- Only a clinically appropriate history and/or exam is required
  - And the extent of that is not used in code selection.

What did and didn’t change

- All medical necessity requirements remain in place whether choosing an E/M code based on time or medical decision making.
  - The documented Chief Complaint/Reason for Today’s Visit and the narrative History of Present Illness (HPI) set the stage for determining the complexity of MDM.
- Rules for modifiers (e.g., -25) have not changed
  - The patient presents with recurrent knee pain. States the injection 2 months ago helped and would like another injection today, which you provide
    - Is there a separate, billable OV?
- Previously nebulous terms such as “stable chronic illness,” or when a “problem” can be counted in determining MDM are well defined.
  - Doctors should review the definitions in a current CPT® book.

Let’s look at coding E/M 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* for Office Visits

*Must meet or exceed these times

O/O E/M Code	Minutes
99202	15
99203	30
99204	45
99205	60
99212	10
99213	20
99214	30
99215	40

E&M Documentation and Coding: Using MDM

Complexity of Medical Decision Making

3 Elements

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, example

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]

MDM Table

Level	Problem Complexity	Amt/Complexity of Data Reviewed/Analyzed	Risk of Patient Management
Straightforward **99202** **99212**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low
 	
99203
99213
	Low
	• 2 or more self-limited or minor problems;
	or
	• 1 stable, chronic illness;
	or
	• 1 acute, uncomplicated illness or injury
	or
	• 1 stable, acute illness
	or
	• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(must meet the requirements of at least 1 out of 2 categories)
		Category 1: Tests and documents
		• **Any combination of the 2 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test(s)*
		  • Ordering of each unique test(s)*
		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

MDM Table – Moderate Complexity

Level	Problem Complexity	Amt/Complexity of Data Reviewed/Analyzed	Risk of Patient Management

Moderate
 	
99204
99214
	Moderate
	• 1 or more chronic illnesses with exacerbation, progress, 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 three of the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) 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…
			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 determinates of health

MDM Table – Moderate Complexity (continued)

Level	Problem Complexity	Amt/Complexity of Data Reviewed/Analyzed	Risk of Patient Management
Moderate	**Moderate (Continued)**	**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)	

MDM Table Continued – High Complexity

Level	Problem Complexity	Amt/Complexity of Data Reviewed/Analyzed	Risk of Patient Management

High
 	
99205
99215
	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) (Continued)
		• 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 (Continued):
			
			• Decision regarding emergency major surgery
			• Decision regarding hospital or escalation of hospital-level care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patent or procedure risk factors

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:

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

   1 unstable 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:

1. #/Complexity of the Problems Addressed

   Osteoporosis will be treated now that BMD has reduced significantly and FRAX is elevated

   1+ unstable chronic illness: Moderate/99214

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

   (Inhouse) bone density. Sent Vitamin D level and calcium level

   2 lab tests ordered: Limited/99213

3. Risk of Complications of Patient Management

   continue calcium and vitamin D 2000 IU per day

   Evista per Dr. Smith

   restart Prolia

   Rx management: Moderate/99214

What code level do you think this is and why?

Telemedicine
Evaluation & Management Services

E/M Telemedicine Code Structure

Telemedicine Services

Not Payable by Medicare

Synchronous Audio-Video Evaluation and Management Services

New Patient

#•98000-#•98003

Established Patient

 # • 98004-# • 98007

Synchronous Audio-Only Evaluation and Management Services New Patient

 # • 98008- # • 98011

Established Patient

 # • 98012- # • 98015

Allowable ~$15

Brief Synchronous Communication Technology Service (eg, Virtual Check-In)

 # • 98016

HCPCS code G2012 is Deleted

Brief Synchronous Communication Technology Service (eg, Virtual Check-In) (98016)

- 98016

Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

►(Do not report 98016 in conjunction with 98000-98015)◄

►(Do not report services of less than 5 minutes of medical discussion)◄

Telemedicine CPT Codes and CMS

- CMS considers the AMA's Audio Video and Audio Only codes invalid for Medicare
  - Except 98016
- Per CMS, use O/O E/M with modifiers and POS codes
  - 93 or 95
  - 02 or 11, for example
- CMS states the payment must be the same as the in-person service by statute:
  - "Additionally, as stated above, section 1834(m)(2)(A) of the Act requires us to pay an equal amount for a service furnished using a "telecommunications system" as for a service furnished in person (without the use of a telecommunications system). Were we to accept the AMA's recommendations and add the telemedicine E/M codes to the Medicare telehealth services list, we would need to establish RVUs for the telemedicine E/M codes to equal the corresponding non-telehealth services to satisfy the requirements for payment under section 1834(m)(2)(A) of the Act."

E/M Complexity Add-on Code: G2211

G2211 Defined

G2211*:

“Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious condition or a complex condition.”

*Report only with 99202-99205 and 99211-99215

O/O E/M - G2211
Visit Inherent Complexity Add-On Code

This add-on code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care.

Generally, it will be applicable for Office and Other Outpatient visits as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for al needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition.

For example, a primary care clinician, as the continuing focal point for all needed health care services for a patient, often bears the cognitive load, responsibility, and an accountability for building the most effective, trusting relationship possible amongst evaluating and managing other health care problems during a visit.

Building an effective longitudinal relationship, in and of itself, is a key aspect of providing reasonable and necessary medical care and will make the patient more likely to comply with treatment recommendations after the visit and during future visits.

It's the work building this important relationship between the practitioner and patient for primary and longitudinal care that has been previously unrecognized and unaccounted for during E/M visits.

CMS CR 13451
(Effective 1/1/24)

This code [sic G2211] is not restricted to medical professionals based on specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits of any level (other than those reported with the -25 modifier) for the care that serves as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

When G2211 Should Not be Reported

- When the O/O E/M code has modifier -25 appended, and
- “Furthermore, in contrast to situations where the patient's overall, ongoing care is being managed, monitored, and/or observed by a specialist for a particular disease condition, we continue to believe that there are many visits with new or established patients where the O/O E/M visit complexity add-on code would not be appropriately reported, such as when the care furnished during the O/O E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature; such as, but not limited to,
  - a mole removal or referral to a physician for removal of a mole;
  - for treatment of a simple virus;
  - for counseling related to seasonal allergies,
  - initial onset gastroesophageal reflux disease;
  - treatment for a fracture;
  - and where comorbidities are either not present or not addressed, and/or when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent ongoing medical care for that particular patient with consistency and continuity over time.”

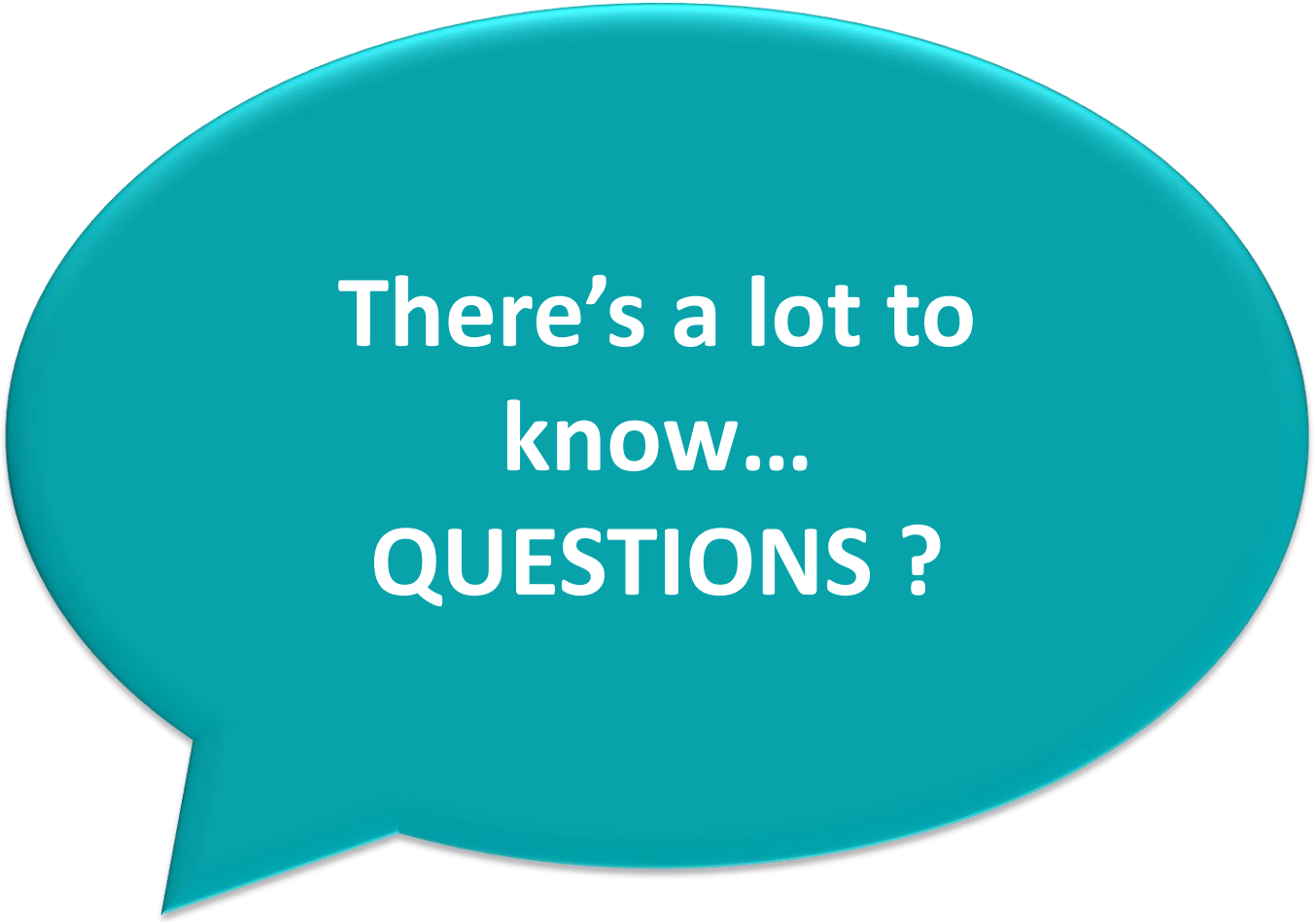
Other Coding and Documentation Nuances

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
    - Shared/Split visits are only allowed in a facility setting
      - Inpatient hospital, outpatient hospital, SNF
  - If employing an ARNP/CNS or PA
    - They MUST have their own Medicare number
    - Must be following your plan of treatment to bill as the physician
    - 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 billing an E/M and a procedure
  - Modifier -25
- Documentation does not support the payer’s requirements for coverage (payment)
  - 3 or more months of more conservative treatment for Viscosupplementation, for example



About Acevedo Consulting Incorporated

Acevedo Consulting Incorporated prides itself on not providing cookie-cutter programs, but a quality work product formulated and designed to meet your desired goals. We treat each client as unique, and we tailor our reviews, recommendations, training and action plans accordingly. **One size does not fit all**!

You can rely on us to guide you and your staff through the labyrinth of coding, reimbursement and regulatory compliance issues of the ever-changing and complex health care industry.
We are a client-focused, service-oriented firm specializing in:

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