Coding for the Practitioner

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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 Services
- EMR Pitfalls
- A word about Medicare's Quality Payment Program

“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. “

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

Evaluation & Managements Basics

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

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."

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

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

“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.

Coding using the 3 Key Components

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

Level 3 E&M

<u>New patient visit/consults</u>

- 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

<u>Established Patient Office Visit</u>

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

99204/99244
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*

99205/99245
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*

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).*

Common Errors Identified

- 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
  - 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 established patient with a new problem or if they change anything
    - Check private/managed care payers' criteria

Common Errors Identified

- 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
- Documentation does not support the payer’s requirements for coverage (payment)
  - 3 or more months of more conservative treatment for Viscosupplementation, for example

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?

Medicare's Quality Payment Program: 2018

"Modernizing Medicare to provide better care and smarter spending for a healthier America"

Merit-Based Incentive Payment System

QPP's MIPS

- The default track, initially encompassing most physicians: Merit-Based Incentive Payment System (MIPS)
- A combination of 3 existing Medicare incentive programs plus 1 new one:
  - Advancing Care Information (f/k/a Meaningful use of electronic health records)
  - Cost (f/k/a Value-Based Payment Modifier)
  - Quality Reporting (f/k/a Physician Quality Reporting System)
  - Clinical Practice Improvement (new)
- Physicians/NPPs will receive a bonus or penalty based on their composite score across the 4 performance categories

In payment year 2019, MIPS bonuses and penalties will be as high – or low – as 4% of Medicare FFS revenue and will increase to 9% in 2022 and beyond

MIPS'* 4 Categories

You earn a practice adjustment based on evidence- based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories:

1. Quality reporting (50%)
2. Cost (10%)
3. Advancing Care Information (25%)
4. Improvement Activities (15%)

https://qpp.cms.gov
https://www.cms.gov/medicare/quality-payment-program/resource-library/resource-libary.html

MIPS' 4 Categories (2018)

1. Quality
   - Choose six measures from available "specialty sets" and report for an entire year
   - Example: Rheumatoid Arthritis: Functional Status Assessment
     - Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months
2. Advancing Care Information
   - Fulfill the required measures for a minimum of 90 days:
     - Security Risk Analysis
     - e-Prescribing
     - Provide patient access
     - Send summary of care
     - Request/accept summary of care
   - Choose to submit up to 9 measures for additional credit

MIPS' 4 Categories (2018)

3. Cost (2 claims-based measures)
   - The Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measure is a payment-standardized, annualized, risk-adjusted and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique Taxpayer Identification Number/National Provider Number (TIN-NPI)
   - The Medicare Spending Per Beneficiary (MSPB) clinical measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during and following a patient's hospital stay.
4. Improvement Activities
   - **Most participants**: attest that you completed up to 4 improvement activities for a minimum of 90 days
   - **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area**: attest that you completed up to 2 activities for a minimum of 90 days
   - Examples of the 100+ activities:
     - Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due and/or routine medication reconciliation
     - Expand practice access such as Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management
     - Expand hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternative hour office visits and urgent care)

Cost Category and Risk Adjustment

- The process of modifying payments and benchmarks to reflect the degree of illness,
- That allows Medicare/payers to estimate and project future spending, and
- Provides information to providers that helps them understand the health characteristics of the patient population they manage
- Incorporated
  - HCCs
  - Age-Sex
  - Disability status
  - Medicaid eligibility
  - And adjusts for the interaction of certain diseases
    - Example: having both renal and heart failure is predictive of higher costs when considered together than the scores assigned to each of these disease states independently

Documentation Requirements

- Coding guidelines
  - Providers must report all diagnoses (not just primary diagnosis) that impact the patient's evaluation, care and treatment including:
    - Main reason for the visit
    - Co-existing conditions
      - Such as aFib, CHF, CKD, RA, DM, COPD/Asthma
    - Care rendered
    - Conclusion and diagnosis
      - Your Assessment and Plan

Additional Documentation Tips

- Address and document chronic conditions annually
- Document every problem you addressed or that impacted your medical decision making
  - Patient presents with painful, swollen right knee; had an Arthrocentesis for osteoarthritis, but due to their DM, you advised frequent checking of their blood sugars after the steroid injection: code both OA and DM

In Summary…

- Key Components: History, Exam, Medical Decision Making
- Time only matters if more than 50% of your face-to-face time with the patient was for counseling and/or coordination of care
- Must meet or exceed requirements for level of service
- Medical necessity
  - Think in ink
  - ICD-10-CM codes paint a picture to the payer
- Documentation is key
  - For all places of service
  - Reduces liability
  - “Safe” reimbursement
  - Fair reimbursement

Questions??

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