Coding and Billing Moving Into 2021

Shawn Maria Bromley

NEPHO

Wednesday, December 30, 2020

Agenda

- Introduction
- 2020 Coding & Billing Highlights
- 2021 E/M Updates
  - Overview of Changes
  - Time Leveling
  - Medical Decision Making (MDM) Leveling
  - Prolong Service Code Update
- Telehealth Review
  - Telehealth Diagnosis Capture
- Review of Top 10 Diagnosis Missed for Chronic Conditions
- Risk Adjustment Coding Review
  - Diagnosis Codes Reset January 1, 2021

2020 Coding & Billing Highlights

- COVID Coding and Billing
- Telehealth Services
  - Driven by COVID 19
  - Additional Access to Patient Care
  - Building a Telehealth Practice Program
  - Staying Compliant in COVID 19 Timeframe
  - Restrictions Being Put Back in Place
- ICD-10 Updates Effective October 1, 2020
- Preparation for 2021 E/M Updates
- Risk Adjustment Coding Reset January 1, 2021

Reason Behind E/M Updates

PRINCIPLE	ACTIONS
Decrease administrative burden	Remove scoring by History and Examination Code the way physicians/other qualified health care professional (QHP) think
Decrease needs for audits	More detail in CPT® codes to promote payer consistency if audits are performed and to promote coding consistency
To decrease unnecessary documentation that is not needed for patient care in the medical record	Eliminate History and Examination scoring Promote higher-level activities of MDM
To ensure that payment for E/M is resource based and has no direct goal for payment redistribution between specialties	Use current MDM criteria (CMS and educational/audit tools to reduce likelihood of change in patterns)

Overview of Changes

- Remove history and exam as key components – code descriptor “which requires a medically appropriate history and/or examination”
- Code selection based on MDM or time
- 99201– will be deleted
- 99211 – same requirements – no components need to be met and physician presence is not required (nurse visits)
- 99202 & 99212– Straightforward
- 99203 & 99213 – Low
- 99204 & 99214 – Moderate
- 99205 & 99215 – High

Visit Time Range Updates

- New Patient Codes
  - 99202: 15-29 minutes
  - 99203: 30-44 minutes
  - 99204: 45-59 minutes
  - 99205: 60-74 minutes
- Established Patient Codes
  - 99211: Outlier
  - 99212: 10-19 minutes
  - 99213: 20-29 minutes
  - 99214: 30-39 minutes
  - 99215: 40-54 minutes

Time Redefined

- Face-to-face time to total time spent on the day of the encounter
- Will help to clarify when more than one provider is involved
- Total time will include:
  - Preparing to see the patient (review of tests, prior medical visits)
  - Obtaining and/or reviewing separately obtained history (established patient)
  - Performing the medically appropriate exam and/or evaluation
  - Interpreting results and/or communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

MDM Updates

- Revision of MDM definitions
- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management
- There will be a new table for calculating medical decision-making
  - “Number of diagnosis or management options” will become “Number and complexity of problems addressed”
  - “Amount and/or complexity of data to be reviewed” will become “Amount and/or complexity of data to be reviewed and analyzed”
  - “Risk of complications and/or morbidity or mortality” will become “Risk of complications and/or morbidity or mortality of patient manangement”

MDM Table Example Level 3

Elements of Medical Decision Making | *2 of 3 Elements Required*

Problems Addressed (Low)	Data Reviewed (Limited)	Risk of Complications/ Patient Management (Low)
• 2 or more self-limited or minor problems **OR** • 1 stable chronic illness **OR** • 1 acute, uncomplicated illness or injury	**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* ***Each unique test, order, or document contributes to the combination of two.*** **OR** **Category 2:** Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

New Patient 30-44 minutes **Est. Patient 20-29 minutes**

MDM Table Example Level 4

Elements of Medical Decision Making | *2 of 3 Elements Required*

Problems Addressed (Moderate)	Data Reviewed (Moderate)	Risk of Complications/ Patient Management (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	***(Must meet 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) † **Each unique test, order, or document contributes to the combination of three.** **OR** **Category 2**: Independent interpretation of a test performed by another physician or QHP **OR** **Category 3**: Discussion of management or test interpretation with other QHP	Moderate risk of morbidity from additional diagnostic testing or treatment **Sample Conditions** • Prescription drug management • Minor surgery with risk factors • Elective major surgery without risk factors • Diagnosis or treatment significantly limited by social determinants of health

New Patient 45-59 minutes **Est. Patient 30-39 minutes**

Prolong Service Code

- A major component of the 2021 E/M changes is the introduction of CPT prolong service code 99417(an official CPT code number will be assigned at a later date) effective January 1, 2021.
- The code reflects a **“prolonged office or other E/M service that requires at least 15 minutes or more of total time either with OR without direct patient contact on the date of the primary E/M service (either CPT codes 99205 or 99215)”.**
- CPT 99417 Code may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. A service of less than 15 minutes should not be reported.
- For example: Existing prolonged E/M code + 99354 will change to specify that you should not report the code in conjunction with 99202-99215

Telehealth Review

- Follow guidelines for E/M documentation requirements
- Obtain patient verbal consent for audio/video visit
- Make sure HIPAA compliant platform is being used for the video visit
- Document provider performing visit location
- Document location of patient “state/city”
- Document all participants on the call – parent, spouse, care manager
- Exam
  - Vital signs – heart rate, temperature, weight, general appearance
  - Have the patient be an active participant in the exam – respiratory, cardio, musculoskeletal (check movement/pain), skin (view skin on video), neuro (check gait), psych (check mood/anxiety), eyes
- Documenting time will help support level of service being billed “I spent 25 minutes with the patient and 50% of time was spent counseling plan of care”
- Current billing for Telehealth include:
  - Outpatient E/M services 99211-99205 (audio/video)
  - Audio only visits – 99441 - 99443

Telehealth Documentation Examples

- Document plan of care for chronic conditions, condition status
  - **Example:** A Fib I48.91 – heart rate within normal limits, converting back to normal sinus rhythm, apixaban is helping to regulate heart rate
- Chronic conditions need to be captured/recaptured annually
  - **Example:** Depression (F33.8) or depression in remission (F33.4), Opioid dependence (F11.20) or opioid dependence in remission (F11.21) (Depression: when depression has stabilized coding depression in remission would be appropriate)
- Chronic conditions should be discussed and documented during a new patient visit
  - **Example:** New patient visit with the following chronic conditions: Hypertension I10, CKD stage 3 N18.3, Recurrent depressive disorder F33.8, Opioid dependence in remission F11.21
- Document confirmed chronic conditions to their highest specificity
  - **Example:** Diabetes with CKD stage 3: E11.22, N18.3 (1st code diabetes with chronic kidney disease then code chronic kidney disease)

Top 10 Risk Adjustment Coding Capture

The following grid highlights the Top 10 Risk Adjustment condition categories that are being captured during a Face-to-Face visit versus a Telehealth visit. This provides an overview of the chronic condition focus during each visit type.

Top 10	Face-to-Face	Telehealth
1	Diabetes with Chronic Complications	Diabetes with Chronic Complications
2	Vascular Disease	Major Depressive, Bipolar, and Paranoid Disorders
3	Morbid Obesity	Morbid Obesity
4	Chronic Obstructive Pulmonary Disease (COPD)	Diabetes without Complications
5	Specified Heart Arrhythmias	Chronic Obstructive Pulmonary Disease (COPD)
6	Major Depressive, Bipolar, and Paranoid Disorders	Specified Heart Arrhythmias
7	Congestive Heart Failure	Vascular Disease
8	Diabetes without Complications	Congestive Heart Failure
9	Angina Pectoris	Angina Pectoris
10	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease

Risk Adjustment Coding Capture Update

Coding to the Highest Specificity Value

Risk Adjustment Factor (RAF) Documentation Impact

Sam Brown DOB: 1/10/1931 Clinical Picture: Diabetic CKD Stage 5, Chronic Diastolic CHF, A Fib and Rheumatoid Arthritis

Patient Health Status	No Conditions Documented	Missing Conditions	Accurate Coding to the Highest Specificity
84 year old Male	0.537	0.537	0.537
RA		0.423 (M0.09)	0.423 (M0.09)
Diabetes		0.104 (E11.9)	0.318 (E11.22)
CKD stage 5			0.237 (N18.5)
Chronic Diastolic CHF			0.323 (I150.32)
Chronic AFib			0.268 (I48.2)
(CHF and Renal Failure)			0.271
(CHF and Diabetes)			0.154
(CHF and A Fib)			0.105
Total RAF (Demographics and HCC)	0.537	1.064	2.636
PMPM Payment	$430	$851	$2,109
Annual Payment	**$5,155**	**$10,214**	**$25,306**

Diabetes with Complications

- **Patient is seen for diabetes, with CKD stage 3a, the patient has type 2 diabetes and takes insulin on a daily basis – Accurate coding would be:**
  - E11.22: Type 2 diabetes mellitus with diabetic CKD 3a
  - N18.31: Chronic kidney disease, stage 3a
  - Z79.4: Long term (current) use of insulin
- **Patient is seen for type 2 diabetes and has hypothyroidism - Accurate coding would be:**
  - E11.69: Type 2 diabetes with other specified complications
  - E03.9: Hypothyroidism unspecified
- **Patient is seen for type 2 diabetes with peripheral vascular disease of the lower extremity – bilateral legs with intermittent claudication- Accurate coding would be:**
  - E11.51: Type 2 diabetes with PVD
  - I70.213: Artherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs

NEPHO Coding Support

- Shawn Bromley @ shawn.m.bromley@lahey.org or 978-236-1704
- Helpful Resources:
  - https://emuniversity.com/
  - https://www.aapc.com/evaluation-management/em-coding.aspx#DefinitionofTimeforEMServiceLevels
  - https://med.noridianmedicare.com/web/jeb/specialties/em