12.20.2022 Webinar

2023 Update on Coding and Documentation

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Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or
  - 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives This Evening

- Review the Final Rule findings – high level to help direct your 2023 planning
- Telehealth for 2023 and the Public Health Emergency
- Some insight into new diagnosis codes
- Some insight into new CPT codes/services
  - E&M focus
  - NPP Split/Shared
  - Prolonged Services
  - Critical Care

The Final Rule

- Released early November….2953 pages!
  - "Final" needs to be defined
- Some areas of the Rule are not agreed upon even today – so stay tuned

The Final Rule - Reimbursement

- Released early November….2953 pages!
  - "Final" needs to be defined
- Some areas of the Rule are not agreed upon even today – so stay tuned
- Conversion Factor (CF) was noted to be **decreased** in 2023 by 4.68%
  - For 2022 it was $34.61 → 2023 it is $33.06
  - CF gets multiplied by the aggregate of the work RVU, practice expense RVU, and malpractice expense RVU – each of which is adjusted based on the Geographic Practice Cost Indices
    - CF x {(wRVU x wGPCI) + (peRVU x peGPCI) + (mpRVU x mpGPCI)} = FEE PAID

Telehealth for 2023 and the Public Health Emergency

- Prior to the pandemic, restrictions were placed on telehealth use
  - Underserved, originating site of service to connect, other restrictions
- During PHE, waivers to allow … and with pandemic more services have been added
  - CMS states that geographic waivers, etc. will end after the PHE ends (last 10-13-22) but in Final Rule, we are *allowed 151d post PHE before anything takes effect* – HHS Secretary already announced a 60d heads-up (~7 mo). BUT much going on in Congress
  - Special consideration for behavioral health via audio-only even after PHE ends. In-person visit requirements are waived for 151 days post PHE
  - Office visits via audio/visual communications (99202–99215) and office visits via audio-only communication (99441–99443) covered during the pandemic. Good until 151 days after the PHE ends.

Telehealth for 2023 and the Public Health Emergency

- Continue to use the Place of Service (POS) code that that matches where you would normally have seen the patient as if it were not during the PHE. So, POS 11 for office, if video visit with patient at home, not POS 10. Modifier-95 indicates audio/video visit, modifier-93 audio only encounter
  - POS 02 (other than patient's home – healthcare setting) and POS 10 (in a patient's home) – get paid at the lower facility rate and will come more into play post PHE
- CMS covered services via telehealth, updated throughout the year
  - https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes
- Congress may act to modify/cancel some/all of the above

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- Congress may act to modify/cancel some/all of the above **… or not.**

New Diagnosis Codes

- Effective 10/01/2022, CMS updated the ICD-10-CM code set to include over 1,100 new codes
  - Updates to COVID-19 appear in aggregate
- For disease states, document to the highest degree of specificity (HCC)
  - (1) Diabetic nephropathy vs (1) Diabetes and (2) proteinuria
  - For example, with Dementia codes for 2023 - "think in ink"
    - Categorize as to vascular, other conditions, or unspecified
    - Note any associated behavioral symptoms (psychosis, anxiety, mood disorder, etc.)
    - Comment on if mild, moderate, or severe

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- www.ICD10data.com

CPT Codes/Services: Evaluation and Management[1]

- Several codes have been deleted, to include
  - Hospital observation services (99217-99220, 99224-99226)
  - Consultation codes 99241 (office), 99251 (hospital)
  - Nursing Facility Annual Assessment (99318)
  - Domiciliary, boarding home, or custodial care services (99324-99328, 99334-99337, 99339, 99340)
  - Home/resident services code (new pt initial eval mod/high severity - 99343)
  - Prolonged services codes – provider FTF IP/OP (99354-99357)
- Inpatient and Observation hospital care services are now "initial and subsequent services" (as are nursing facility services)
  - NPPs bill under the specialty and subspecialty taxonomy of their supervising physician in facility-based care either independent or using split/shared services

[1]AMA CPT E/M Companion 2023

CPT Codes/Services: Evaluation and Management[1]

- Same day admit/discharge to a hospital
  - IP or OBS does not matter but need to see TWICE (admit and then discharge)
  - CMS requires 8 or more hours of care and if not then it differs from CPT
- Same calendar date but <8h of care
  - CMS: Initial Hospital Care – 99221-99223
  - CPT: Admit/DC same day – 99234-99326
- Same calendar date but 8+h of care
  - CMS: Admit/DC same day – 99234-99236
  - CPT: Admit/DC same day – 99234-99236

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- DIFFERENT calendar date but <8h of care
  - CMS: Initial Hospital Care – 99221-99223
  - CPT: 2 codes for initial care and DC (99221-223; 99238/39)
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E&M: Leveling of Service

- With 2023, the level of the E&M service is now aligned with the 2021 changes brought forth to the ambulatory space
- Services can be billed based on total time for the encounter or based on Medical Decision Making (MDM) using the 2023 MDM definition
- The time code threshold differs for each place of service (ED, hospital IP, Nursing facility, etc.)
- MDM has been modified from 2021 and is to be clinically applied to the place of service

Billing Basis: Time-based

- Allowed for hospital IP/OBS, home/residence and nursing facility
  - Time can be assigned based on TOTAL TIME rendered by a Provider in a CALENDAR DAY.
    - Review of test(s), review of separately obtained history, performing an exam, ordering medications/tests/procedures, referring/communicating with other providers, documentation in the clinical record, independent interpretation of tests (not separately reported*), and communicating such to family/caregiver, care coordination (not separately reported*)
    - *Not separately reported: if you get paid to do, then it is not MDM related time
    - With split/shared visits (physician and other qualified health care professional(s) both deliver care), only count the times spent together once.
    - DOCUMENT TIME IN THE NOTE to support the billing level IF time is the driver of charge (staff time does NOT count) – no midpoint rule. Must meet threshold to bill.

If not Time, then Medical Decision Making (MDM)

- Similarities to the 2020 version of MDM: 3 components, different verbiage
  - **Diagnoses** managed (number and type) → Number and Complexity of **Problems**
  - **Data** reviewed to manage diagnoses of visit → Amount/Complexity of **Data** Reviewed/Analyzed
  - **Risk** associated with the management plan → **Risk** of Complications and/or Morbidity/Mortality of Patient Management
- Similarities to the 2020 version of MDM: 2 of 3 needed to meet MDM
- MDM will drive the charge for the visit
  - Amount of history, ROS, etc. is of no value if it does not support the MDM
  - The amount of the exam is only present to contribute to the A/P (the MDM)
- So …. No more cut/paste! No copy forward! No "16 system review normal"!

MDM: Diagnoses

- The examples of 2021 MDM clinical diagnoses are gone
- Language for the diagnoses is still generic and needs to be applied to the place of service (here and with Risk MDM)
- Physicians/NPPs need to "think in ink" and let the patient be seen in your documentation – History and Exam are for supporting MDM
  - Self limited means without treatment, it would usually be OK
  - Acute illness with systemic symptoms is in the Moderate MDM category.
    - How severe are the systemic symptoms – can we see that in your note?
  - One chronic illness with exacerbation ….Vs **severe** exacerbation
    - Make note of escalation … of your concerns … of prior patient clinical experience

IP or OBS MDM (cont.) – 2 of 3 Needed

E/M LEVEL and MDM	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (*Each unique test, order, or document reviewed counts in Category 1)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99222 (55 min) Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • Undiagnosed new prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury		
99223 (75 min) High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily f(x)		

Amount and/or Complexity of DATA Reviewed

- Each test that is ordered or reviewed, or each document that is reviewed, counts
  - Order (or review) a CBC – one element of credit
  - Order (or review) a CHEM-7 – ONE (not 7) elements of credit
  - Review ED notes from last weekend – get ONE element of credit if you note such review in the chart
    - Order a CBC, CMET, TSH, and Lipid → get FOUR elements of credit
    - Order a CBC, review the CHEM 7 from the ED and review the ED note → THREE
    - Order a CBC and review it TODAY, then get ONE (not TWO) elements of credit
- If you are already getting paid to interpret the test, (i.e., you own the EKG machine and are billing for the global performance of the test), then you can **NOT** get credit for ORDERING the test, **OR FOR** for the interpretation/review in the MDM (since you are already getting paid to review the EKG). If you own your CBC machine, you CAN get credit for "ordering", but the "interpretation" is inherent in the E&M. (March 2021)
- Independent interpretation does not have to have a "formal" report
- Independent historian must be contributing to the MDM of the history collection (NO: interpreter of a patient with normal cognition, YES: Mother of a 5-year-old)
- There are CATEGORIES that these elements make up and one must perform a minimum number of element reviews to meet the requirements of the CATEGORY

IP or OBS MDM (cont.) – 2 of 3 Needed

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99223 **(75 min)** High MDM		**Must Meet 2 of 3 Categories Above**	

RISK of Complications or Morbidity of Patient Mgmt

- Minimal risk
  - Non-invasive testing such as EKGs, EEGs, Spirometry, etc.
- Low risk
  - Non-contrast imaging, PT/OT, skin biopsy/minor surgery intervention
- Moderate Risk
  - Rx drug mgmt, mgmt significantly affected/limited by SDoH, decision for minor surgery with patient/procedure having risk factors
- High Risk
  - Drug therapy with intensive monitoring for toxicity, elective major surgery decisions with patient/procedure risk factors, emergency surgery decisions, decision to escalate/de-escalate hospital care

IP or OBS MDM (cont.) – 2 of 3 Needed

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Case Discussion

- 66 yo with COPD exacerbation x 4d. Increased cough, discolored sputum.
- O_2 sat 93% (baseline 98%), T99, 139/88, p82/regular. Moderate wheeze, slight accessory muscle use. Alert. Does not appear toxic in office and not an uncommon occurrence during the winter. Last COPD hospitalization was 3 years ago. Compliant with maintenance inhalers and using rescue daily for the past 2d. Saw pulmonology 9 months ago (note reviewed, unremarkable). CBC w 5,500 WBC. Lives alone and family support is questionable.
- Plan is to treat with antibiotics, prednisone taper, increase pulmonary toilet, symptom management, admit as observation.

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2023 Time take-aways

- Total time for THAT DAY…finish notes "after midnight"…not included
- Staff time does NOT count, only provider time related to ONE patient
- ALL time counts – including dictation of notes (be reasonable), review of labs, talking to family or other providers. Add it up and make a note in record.
- Waiting on the phone for a consultant or auth # is NOT countable
- The time it takes for you to read an EKG or CXR IS countable if you are billing based on TIME….unless you are getting paid to read the EKG or CXR, etc.
- I see time trumping MDM when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

2023 MDM take-aways

- When manageing chronic conditions that are unstable, if clinically merited, make note of care escalation. May be hospital…ED….different unit in house … etc.
- If you own your machine, don't take credit for MDM for that test (EKG, CXR)* interpretation, and you can **NOT** get credit for ORDERING that test because you have been paid already
- Talk to a parent of a 5-year-old = Low MDM for DATA
- Social Determinants of Health = Moderate MDM for RISK
- I see MDM trumping time most often EXCEPT when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

NPP Split/Shared Services

- Who are NPPs?

"NPPs": Defining These Key Team Members

- Providers: "providers" of medical services that can be billed for and paid by CMS – global term for hospitals, physicians, etc. Programs launched in 1965.
- Initial CMS billing was done with physician (MDs, DOs) providers
- Nurse Practitioners and Physician Assistants were added to this group of providers. Since they were not physicians, they were called "non-physician" providers, or NPPs (formerly called "physician extenders")
- Nomenclature has morphed as the NPP role changes
  - Qualified Healthcare Professionals
  - Advance Practice Nurses… Doctor of Nursing Practice … Physician Assistants/Associates … Advanced Practice Providers
- Some states allow independent practice for these QHPs, most only allow practice to be done in conjunction with a physician provider

NPPs Can Bill and Get Paid …

- One of three ways (as credentialled):
  - Using own license. Must be credentialled with the insurer and allowed by the state
    - CMS (and many insurance companies) pay 85% of physician rate
  - Billing under the supervising physician
    - As "incident to"
    - As "split/shared"

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Split/Shared Services in 2023

"Incident to" services are NOT allowed in settings outside office (POS 11).

Outside of office, the NPP/provider relationship is called "split/shared" billing.

- Hospital Inpatient (POS 21), Hospital Outpatient (POS 19, 22), ED (POS 23), and NH (POS 31, 32)
- On new and established patients

- A split/shared E/M visit is a medically necessary encounter with a patient where the physician and a QHP of the same group each perform portions of the visit on the same patient and same date of service.

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- A split/shared E/M visit is a medically necessary encounter with a patient where the physician and a QHP of the same group each perform portions of the visit on the same patient and same date of service.
- The billing of the encounter goes to the person performing a substantive portion of the visit or >50% of the total time of the encounter

Split/Shared "**Substantive**" Part

- For 2022 ("transition year") the substantive part of the encounter can be either (a) more than half of the total time spent on the encounter **OR** (b) performing/documenting one of the key components (history, or exam, or medical decision making) of the encounter
  - CMS 2022 Physician Fee Schedule Final Rule, https://public-inspection.federalregister.gov/2021-23972.pdf, pp429-430.

2023 Total Time Calculation

- Total time for the day of service that is tied to the patient's care delivery ("qualifying time")
  1) Preparing to see the patient (review labs, notes, etc.)
  2) Obtaining/reviewing separate history
  3) Performing the exam
  4) Counseling and education of the patient, family, caregiver
  5) Order tests, medications, procedures
  6) Referral/communication with a provider
  7) Documentation of the note
  8) Time to do independent interpretation of tests and relay info
  9) Time spent in care coordination

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  6) Referral/communication with a provider
  7) Documentation of the note
  8) Time to do independent interpretation of tests and relay info
  9) Time spent in care coordination

Provider that spends more than 50% of total time in care delivery in calendar day gets to bill for the "total time"

2023 Time-based Billing: Hospital

- If using time to bill for services, the provider must **exceed the 50% threshold** for the time required for the service
  - If the time for the service is 55 minutes, then >50% (28 minutes) must be spent to bill for the service

2023 Time-based Billing: Hospital

- If using time to bill for services, the provider must exceed the 50% threshold for the time required for the service
  - If the time for the service is 55 minutes, then >50% (28 minutes) must be spent to bill for the service
  - Admit of a patient by a PA that works with you takes the PA 35 minutes. You follow, do a review of note and a FTF. Your time is 22 minutes. The total time is 57 minutes. The 57 minutes is more than the TOTAL TIME of the 99222 (55 min time, admit code). You bill 99222 for the admission (if using time).
  - Also, since the PA spent more than half of the total time (35 vs 22) in the encounter, the bill gets dropped under the PA and NOT THE MD.
- If not time, then bill based on the "Substantive Part" of the encounter

2023 Split/Shared **Substantive Part**

- *Key component* performance must be adequate to carry the visit charge, i.e., perform/document the component to its entirety
  - For history or exam: Complete and document the component to meet the level of the charge – either history OR exam
  - For medical decision-making: document all portions required to meet the level of charge billed (diagnoses, data, and/or risk) – based on site of service (office vs hospital)

Split/Shared Substantive Part

- The substantive part of the encounter can be either (a) more than half of the total time spent on the encounter OR (b) performing/documenting one of the key components (history, or exam, or medical decision making) of the encounter
- This does not make sense as History and Exam are no longer required for billing…..so use MDM and document FULLY
  - No more "agree with above"…. "saw pt. with NP and agree with CT of abdomen" …
- For 2023, either (a) or (b) can be used for billing for NPP services (w FS modifier)

Prolonged Services

- May not be used much and when it is, there is a fairly high denial rate (10% in 2020, 30% in 2021 (*Part B News*, 11.21.2022)
- Disagreement exists related to time tracking
- Agreement on the fact that it is to be used only on the highest level of care delivered (level 3 hospital admit, level 3 hospital rounding, etc.)
- Agree that time needs to be used for those "highest level care" codes and that the time for prolonged services needs to be billed once the threshold is exceeded.
- But, the "highest level care" time is under debate as CMS is using the Medicare time file and not the CPT time

Prolonged Services Nuances

- CMS does not agree with the CPT prolonged service codes (99417, 99418)
  - In medical office, 99417 is not recognized and G2212 is to be used
  - In hospital, 99418 is not recognized and G0316 should be used
  - In nursing facility, 99418 is not recognized and G0317 should be used
  - In home/residence settings, CPT does not have a code, CMS says use G0318
- CMS also says with nursing facility prolonged service, the total time includes time spent one day before, the day of the visit, and up to three days after the visit. CPT does not have such "flexibility"
- CMS says with home/residence care prolonged service, the total time includes THREE days before, the day of, and then SEVEN days after the encounter. (CPT does not have a code for this service)

Prolonged Service Threshold Crosswalk*

Primary E&M (time-based)	CMS code	Time Threshold (min)	CPT code	Time Threshold (min)
Est OV (99215)	+G2212	70	+99417	55
New OV (99205)	+G2212	90	+99417	70
Initial Hosp. (99223)	+G3016	105	+99418	90
Subsequent Hosp. (99233)	+G3016	80	+99418	65
Admit/Discharge (99236)	+G3016	125	+99418	100
Init Nursing Facility (99306)	+G3017	95	+99418	60
Subsequent NF (99310)	+G3017	85	+99418	60
New Home/residence (99345)	+G3018	140	N/A	N/A
Est Home/residence (99350)	+G3018	110	N/A	N/A
Cognitive Assessment (99483)	N/A	N/A	+99417	75

*Time is time for primary E/M plus one unit of appropriate 15-min add-on code. Table 24, CMS Final Rule, p 590. 2023 CPT Manual for CPT codes

2023 Critical Care Services – not new

- Agreement with critical care being delivered anywhere (not needed to be in ICU)
- Agreement that this needs to be documented clearly as to "why"
  - "Failure" and note should indicate the clinical state that requires this
- Agreement on bundled services not being billed separately

Bundled Procedures for Critical Care

- No bill allowed as time to perform them is time-captured for CCT…
  - 71045, 71046, 71047—Chest x-rays, professional component
  - 36415—Venipuncture
  - 43752, 43753—Gastric intubation
  - 94760, 94761, 94762—Pulse oximetry
  - 92953—Temporary transcutaneous pacing
  - 94002–94004, 94660, 94662—Ventilator management
  - 36000, 36410, 36415, 36591, 36600—Vascular access procedures

NON-Bundled Procedures for Critical Care

- CAN bill, but do not count time to perform procedure w CCT…
  - 36555, 36556 Central line placement
  - 31500 Intubation
  - 36680 Intraosseous IV
- As in prior years, *procedures cannot be shared* with NPPs

2023 Critical Care Services – not new

- Agreement with critical care being delivered anywhere (not needed to be in ICU)
- Agreement that this needs to be documented clearly as to "why"
  - "Failure" and note should indicate the clinical state that requires this
- Agreement on bundled services not being billed separately
- Agreement of "sharing" of care between NPP and physician and that the time in critical care is ADDED between the two (same group, same specialty). New for 2022. Need to see the minutes in CCT documented for each provider.
  - And the "greater than 50% time spent" gets to bill rule applies here

2023 Critical Care Services – NEW

- Agreement with critical care being delivered anywhere (not needed to be in ICU)
- Agreement that this needs to be documented clearly as to "why"
  - "Failure" and note should indicate the clinical state that requires this
- Agreement on bundled services not being billed separately
- Agreement of "sharing" of care between NPP and physician and that the time in critical care is ADDED between the two (same group, same specialty). New for 2022.
  - And the "greater than 50% time spent" gets to bill rule applies here
- Time tracking discrepancies exist between CMS and AMA/CPT – hoping more direction comes out in early 2023

In Summary

- There are a lot of changes
- We probably are not done yet given the AMA/CMS areas of difference, CF, etc. So, stay tuned.
- The SCAFP, TNAFP, and MAFP all have an education platform available for 2022, and 2023 education will be loaded by mid January (special end of year offer currently)
- For 2023 …
  - Combined track 20 AAFP prescribed/AMA Cat I CME
  - Hospital Track 12.5 AAFP prescribed/AMA Cat I CME
  - Ambulatory Track 15 AAFP prescribed/AMA Cat I CME
  - Individual Module 0.5 AAFP prescribed/AMA Cat I CME
- Go to the specific state Academy site or go to https://courses.protimellc.com/ to learn more
- MANY THANKS for logging in. Contact me for questions @ NUlmer@protimellc.com

12.20.2022 Webinar

2023 Update on Coding and Documentation

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