Evaluation & Management Coding Office Hours

Webinar Transcript

March 23, 2021

Caitlin Hungate:
Hi everyone and good afternoon. Welcome. My name is Caitlin Hungate and I am a Training and Technical Assistance Provider, with the New York State Family Planning Training Center. And I'd like to welcome you to today's interactive webinar on Evaluation and Management Coding Office Hours. Today, you will hear from Ann Finn of Revenue and Reimbursement Billing Consultants. And my colleague Rachel is also logged in as the New York State Family Planning Training Center. So if you have any issues or questions with technology, Rachel is available to support you. Today's webinar format is slightly different. First, Ann will provide a brief update on the key changes to evaluation and management codes that went into effect on January 1st, 2021. Then we'll address your questions that were submitted in advance of the webinar. And then we'll open up the remaining time for interactive discussion and dialogue with you. Before we begin, I have a few brief announcements:

First, everyone is muted to reduce background noise. While you do have the ability to unmute yourself, please wait to do so until after Ann's brief presentation. We are recording today's webinar and the slides and recording will be posted to our website nysfptraining.org. As this webinar is a different format, the webinar recording will include Ann's brief presentation only. Participants will also receive an email with the webinar materials after the webinar today. As I mentioned, most of today's hour will be spent in dialogue with you. Please feel free to use the chat function to chat in any questions you may have during Ann's presentation, and we'll get to them in the order that we received them and make sure to send your questions or comments to everyone in the chat.

So today's learning objectives are on the slide. And by the end of this hour with you, we hope that you will be able to identify key E/M or Evaluation and Management changes that went into effect on January 1, and apply these to your practice. We also hope that you'll be able to identify and address challenges in your agency to accurately code family planning visits. And last but not least, we hope that you'll be able to describe the changes to medical-decision-making or MDM. As I mentioned, my name is Caitlin Hungate. My pronouns are she/her/hers, and I'm a Training and Technical Assistance Provider with the New York State Family Planning Training Center. At this time, I'd like to turn it over to Ann, to briefly introduce herself and go over the changes to E/M codes. Ann, I'll turn it over to you.

Dr. Ann Finn:
Thank you, Caitlin and hello everyone. It's nice to see, even if virtually some familiar faces. I've worked with many of you over the years, on coding and billing and reimbursement issues within New York State. And for those of you that I haven't worked with before, it's nice to connect with you. So I look forward to this hour and your questions.

So there's been some big changes to Evaluation and Management codes. Those codes are the codes that we use to capture the medical visit portion of a family planning encounter with the client. So we have these changes that took effect on January 1st, 2021 really changed the structure. We used to in the past, we would use the, either the three key components that we're all familiar with which was the history, the exam, and the medical-decision-making. And then when we looked at kind of charts of the combination of the three of those components, and it was pretty tricky to figure out the right code, or

we could use time. But it was very limited when we could use time, in that it was only the face-to-face time when more than half of the visit was spent counseling or with coordination of care.
So this all changed, it really didn't reflect what was happening in the visits. And so there's been some advocacy and work, to align the guidelines better. So we're moving ahead. So we need to remember that those 1995 and 1997 guidelines that outlined E/M coding are no longer active. So we should not be referring to those anymore. And you should be making updates within your practice, and your EHR, and your coding practices.

So how do we do an E/M code now? These are for the problem oriented codes that we're focusing on today. Remember that preventive codes, those are the well visits, the periodic health screenings. Those are the 993 codes. Those did not undergo any changes in 2021. So we're going to focus on the 992 codes only. So now we use either just an updated level of medical-decision-making, so it's much more streamlined and straightforward, or we can use time, but now we can use both face-to-face and non-face-to-face time, that's spent in the client's care on the day of the encounter. So that's a really big change, remember that's all of the time the clinician spends and the entire date of the encounter. So that again, I just want to emphasize that this is a big shift for Clinicians to get familiar with.

So let's first look at the MDM, the medical-decision-making method, and just kind of touch on the key changes to that. So just like in the past, there are still three elements of MDM, but each one of them has been tweaked a little bit. So now we are looking at number and complexity of problems addressed. That's our first element. We look at, "What's going on, visit?" "What is the problem that the patient is here for to be addressed?" The second element is the amount and our complexity of data to be viewed and analyzed. That includes tests different information that we need to get from outside sources, maybe an outside physician that's run some tests or maybe an independent historian that can provide a clearer picture, but we kind of look at, what does it take to make an informed decision? And then we figure out that level.

And then our third element is the risk of complications and our morbidity or mortality of client management, which really means that risk of the patient care. So obviously if they're there for a counseling visit and there's really no treatment prescribed, that's a very low level of risk. There's not really risk in that treatment. A little bit, step up more when there's over the counter drugs involved. And it gets a little bit higher where they were prescription level drug management, et cetera. So it makes sense. So we kind of score these three elements, like in the past, and put them together into one element. So let's just talk a little bit about a couple of things that we've kind of figured out by going through, we've been working on the e-modules and doing some great updates to the training modules that I'm excited for you all to be able to access.

But when we started to kind of code some new scenarios and we were working with Dr. Policar as well, he's always part of the team. And at first we were kind of over counting some tests and then it was, we kind of dug in and we were like, wait a minute. Let's think about how this sits. So it's really important that you know, one, that the clinical team and the coding team, and that has training to make sure that they're applying these new guidelines correctly. But if we look at data, here's a couple of key takeaways we got. And there's actually been some updates to the guidelines. The AMA guidelines that's referenced below, which is kind of the Bible of these changes. They did put out some updates to the clarifications in March, at that link below. Okay. So the first thing is, when you're talking about lab tests and tests that you are using to determine the level of data, you can't count the point of care tests that go on during the visit, such as a urine pregnancy test and HIV rapid test or microscopy, right?

Those are separately reported and billed for, with a separate CPT code. So we don't count them as data. So we only count the send-out labs such as chlamydia, gonorrhea, syphilis testing, et cetera. So you can easily over count. You can see if you just added up all the tests. So that was a key takeaway that we figured out. The second one is that if you order a test and review it that's one point total for the test. Our first read was one point for ordering, one point for reviewing, and we were over counting. But when you order a test, they assume that the review is part of it. So when you do a committee on tests, that's one point when you do a gonorrhea test, when you order it that's one point. So each test is one, each unique test counts as one each unique send-out test.

Right? Okay. If you do interpret a test from another provider that you did not order, then you can account the interpretation. So for example, if the patient's primary care physician had ordered some other tests, and then you review those test results to make an informed decision, you can account that interpretation of the test for a point. And if you do talk to an outside physician, if you confer with someone, then that would also count. Whereas you might have a discussion on the findings from some tests in order to make an informed decision for yourself. And the last thing is that we've been asked about is, what about a panel? How do you count a panel of tests? So a panel such as a CDC that counts as one unique test, unlikely, chlamydia, and gonorrhea. Some people have said, well, what about that?

Because sometimes that's ordered together. That is testing for two different diseases. So we count that as two different unique tests, but a panel test is one. Okay. So if we have a healthy patient who schedules an appointment, wanting contraception to avoid getting pregnant. She's screened for chlamydia and gonorrhea. So samples are sent to the lab. She's also administered a pregnancy test, which is negative. She starts on oral contraception and is given a prescription for a six month supply. So let's just first think about the first element is the number and complexity of problems being addressed. And in this case, the condition would be in addressing the need for contraception to avoid pregnancy, which correlates to one acute uncomplicated problem or a low level of problems. Right? So we're going to assign that a low level. If the patient presents with multiple issues to be addressed, or an issue that is more complex with co-morbidities impacting the situation, of course, that level would be higher and would reflect that.

Okay, so now let's move on to the second element for this example, the second element is the amount and complexity of data, right? So remember that we said we had urine pregnancy test and HIV rapid test. So we're not going to count those. We're only going to count the chlamydia and gonorrhea that was ordered for this patient. And we would come up again with a low level of data based on the two tests. Finally, then we look at that third element that risk of complications. This patient was given prescription level contraception or drug, right? So we know that prescription level drug counts as a moderate level of risk. So we can assign that moderate level. So we have a low level of problem, a limited level of data, and risk is moderate right? So we've determined that the overall MDM level, we take the highest two levels that are met or exceeded.

So we have low, low, moderate. So we have met or exceeded the low level for two of those elements. And that low level, when we look at the charts, then refers to a level three, visit, whether it's a new patient. So then it would be 99203. Or an established patient, which is 99213. And an established patient is someone that's been to your practice within the last three years. So you can see that it's really important that the clinicians are trained on this. You do some review, there's some job aids available that will help guide them. And that you do some QA to follow up, to make sure that everyone is achieving the optimal codes for the visit. So that's kind of a high level snapshot of the MDM changes. Let's look at the time level next.

So time, like I said, this is a big change, and this is really important. Because when we think about how we've used time in the past, and many of you, when I've looked, you know, there always has not been good documentation of time. I think this is an area of improvement where we really want to take advantage of using time for coding. But in the past we only had that face-to-face time. Now we got to think about everything that's happening right on that date of encounter. So what are some examples of the AMA lays out that you can include? And again, this is all in the AMA publication, they lay out the guidelines, but they include some examples of like preparing to see the patient. So think about reviewing the task, connecting to the teleplatform, right? All the things that happened before you get in to see the patient that now counts.

We have obtaining and reviewing a history, right? Whether it was an established patient, that's coming back and we look at the history, or we've got a new history. We're going to review that. We have the exam or evaluation, that's happening, counseling to the patient, family, caregiver. All of that time, that's spent ordering the contraceptives, medications, referring and communicating with other healthcare professionals, documenting in the EHR. That's a really big change. You can include the time that's documenting the medical visit, as long as you're doing it on the date of the encounter. And as long as things aren't separately reported with another CPT code, then we can include it. So we want to think of all those activities and include it in the time. And so you got to think about how am I going to capture all that time when I go through the chart note, you know?

And we'll talk about that. How to document it in a moment. But what's not included is, don't include, like when you have a separate service, right? So if you are doing a counseling visit with a LARC insertion, that LARC insertion is reported with a separate CPT code. So we wouldn't include the time that's spent on the IUD or implant insertion, right? Same thing with a colposcopy, with our point of care tests that are separately reported, even HIV counseling. When we bill New York state Medicaid for HIV counseling, it's over eight minutes. We don't want to count it both in the ENM and for HIV counseling, or that's kind of double-dipping right? So we want to avoid that situation. We also don't want to include time that's by front desk staff, it's not when the patient checks in, right? It's kind of still the clinicians time or with the nursing staff.

And then finally, like I mentioned, you can include a document, documenting in the EHR, but it's only has to be on the date of the encounter. Remember? So if it's the next day or the day after that time is not included, but really think about, how do we capture this time? And it's important that you either have it in your template, where there's some areas for time, or you can freehand it. You can say total clinician time. So, there's a couple of different ways to document that time. So in this case, in our scenario here, our clinician spends 30 minutes total with our patient on the date of the encounter. So we would code 99203, if it was a new patient or, a 99214 if it was an established patient. So you can see the level goes up using time when it's an established patient.

So remember when we had MDM, it was a level three. And then with the time we had a level three, but if I was an established patient, I could go up to a level four. Sometimes they vary in the level depending on the method, and sometimes you come out with the same code. But we want to make sure that we get familiar with both levels. Okay. Next slide.

So just, I kind of mentioned this, but just to really touch on this in focus, it's important that everybody gets familiar with this. That's not one method for every visit. You don't always use MDM and you don't always use time. You use both methods. Providers should really be using both methods and getting

familiar with them, and then you figure out which level gets you to the optimal code. Right? So like we used to fall on that last example, if that was an established patient and we use time, we could have billed a level four. And remember, while New York state Medicaid typically pays under APGs on a primary diagnosis, that's kind of the exception. Most payers pay on the level of the code. And so we typically get paid more for a level four, obviously than a level three and the same thing under, even under APGs.

And remember if you're a hospital spons... Or if you're a hospital and you're an MD physician, then you can also bill professional claim. And again, you're paid off the level. So it's really important for reimbursement, that you capture that highest level. And one of the things that we were talking about together with Caitlin and Dr. Policar was a best practice, was to really encourage your providers to document both methods in the medical record. And I really liked that takeaway because, so often it's just getting used to it. And so, just having them write down MDM, it can just be no problem, like low, low, moderate, but what did they use for the criteria? And then also time, the more that they do that and kind of do both methods, I think the more efficient and a better there'll be at coding, kind of going forward with these changes. Okay. So, Caitlin, I think I'll hand it back over to you now for some questions.

Caitlin Hungate:
Thanks so much, Ann. So now we want to first take the questions that you all submitted as part of the registration before we open it up for interactive dialogue with you. So, Ann our first question is generally, can you speak a little bit more about coding for difficult Nexplanon removals? And how these updates with ENM have impacted that kind of scenario?

Dr. Ann Finn:
Sure. So a couple of thoughts come to mind with that was one, there is a modifier 22 that is applicable to procedures. Like increased time for procedures. So if you're really having a difficult insertion or removal, you can add that modifier 22. I think it requires a explanation on the claim. Not all payers will pay an increased amount, so it may not, I don't believe that New York state Medicaid recognizes modifier 22, but other payers may. So it's definitely worth capturing, and it's, we always say to code. You're not really coding... Sometimes there's specifics for a payer, but we don't want to be coding just to a payer. We want to capture all the services and apply, and whether or not the reimbursement comes, if you do a good job of capturing everything, you'll get optimally paid. So level 22 comes when on the procedure end.

The other thing is that on the ENM side, if we're doing a procedure, we only bill an ENM service when it's separate and distinct from the procedure. And that's really important that we're not overcoding medical visits and overbilling for a cognitive medical visit. That is really just part of the procedure that's happening. But in a lot of these situations, when we have a difficult insertion or a fouled insertion, or a difficult removal or something. There can often be a lot of counseling on other methods, and other criterias on issues, other things that are going on. And so if that is happening. What's really important is to just have a clear note and diagnosis for the problems and then capture. And I would probably, you'd probably use any time that is spent on that for the method to get to that ENM. But again, and then you would put a modifier 25 on the ENM to say this was separate and distinct from the procedure. And just make sure that it's clear, but if it's all part of the procedure, it's not appropriate to bill a separate ENM code.

Caitlin Hungate:

Thanks so much, Ann. So our next question is, when is billing a level two ENM for a nurse appropriate? For a nurse visit?

Dr. Ann Finn:
So, my off the top answer is never. That mid-levels and, which is a nurse practitioner, a physician's assistant, a midwife, and then a physician that those are the people that are licensed to be coding a level 99202 through 99215 codes. The ENM criteria is for mid-levels and above. So, that's why it's important that we think about our flow within the visits, and that they're seeing a practitioner, and what's happening. Everybody's working to the top of their license, right? And that a nurse visit it's really only, the only appropriate code is like a 99211, when there's physician supervision going on and you need to criteria for that code. Or like an injection for depo. There's the 96372 injection code. And then like the Depo.

And again, you kind of got to meet the supervision criteria for the 99211. But those would really be the codes. And again, following each kind of payers guidance, Medicaid has a little bit more restrictions on nurse visits. When outlining under the APG handbook, of saying, when is it appropriate to use a nurse? So we just want to make sure that we're doing that. But really, I think the important thing that when I've had with discussions with people is thinking about, are we utilizing nursing staff and the mid-levels and physicians to the top of their licenses and really making it a flow where we see as many patients as possible?

Caitlin Hungate:
Thanks, Ann. So our next question, back to the Nexplanon topic, is really wondering a little bit about IUD and Nexplanon billing and payment, particularly with Medicaid. So could you speak a little bit more about the process of billing Medicaid for IUD and Nexplanon?

Dr. Ann Finn:
I can, this is a little bit of a, like a little bit of an odd one where people get a little confused. So just very high level, right? We have the, if we have the Nexplanon, let's talk about that. We have three CPT codes, one for an insertion, one for removal and one for reinsertion. So really important that we capture that CPT code based on what's going on. And then we get reimbursed. And the levels are a little bit higher right now than they are for IUD insertions. Okay. So you do get a higher, but here's the caveat just under, for Medicaid, since you asked about Medicaid, New York state Medicaid. Under the APG ambulatory patients group payment system that you would bill as an article 28 facility to Medicaid. When you're billing Nexplanon, if you have an ENM service, a counseling visit the same day that bundles with the procedure code.

And so it doesn't separately pay, right? So one good thing is that you do get out a little bit higher, increased reimbursement, but you will see that your medical visit will come back on that Medicaid claim at a zero payment. Even if you put a modifier 25 on it, which is appropriate, that's just part of their payment right now. And they are aware that this is how it is with the IUD, with the IUD insertions, there's only two codes. Remember Nexplanon. I said there was three, but IUDs there is a code for the insertion and there was a code for the removal. So when you have a reinsertion, you need to capture both codes, right? And put those on, and often you need to use a modifier 51 or 59. And know for Medicaid it'll pay even without a modifier, but it's really important.

Sometimes I hear clinicians say, oh, I forgot about the insertion. I was focused on the removal, or I was focused on the reinsertion. I forgot about the removal, that one, that's why using the accurate ICD code

that goes with it that says this is a reinsertion. Then the coder can ensure that there's both codes there, but it's just really important. I mentioned that because that's an area of lost revenue that I see. And then when you have a same day counseling visit or a separate ENM visit, it does pay in addition. This started off as it's just a nuance within the logic that came. You know, I know that we've talked with the state about it, and it's one of the things that, they're aware of, but they also have said that the reimbursement levels for next one's a little higher, so we'll leave it at that. But that's kind of how it works.

And you then separately want to bill for Medicaid, you bill for that Lark device, which is really important that you have a one-to-one match on, for every insertion. You have a device that you know, is accounted for and paid for. If you're billing Medicaid, you need to bill acquisition cost, right. So really important you capture, if you're 340B, you would use a UD, not modifier in the NDC code, or if it's not 340B you'd report, the higher code costs. And then it's really important for your other payers that you build to the highest contractual amounts so that you don't leave money on the table. So that if you had like Nexplanon 340B costs about $400, right? So if you had somebody that was willing to pay a thousand dollar charge, and you only report a $600 charge on your claim, you're only going to get paid $600. You're going to leave that $400 kind of on the table. So you don't want to lose out. So for your commercial, your private insurance, and you want to make sure your charge is set to that highest amount. And for Medicaid, you want to be reporting acquisition cost.

Caitlin Hungate:
Great, Ann. Thank you so much for that very detailed explanation.

Dr. Ann Finn:
It's tricky.

Caitlin Hungate:
It is tricky for sure it is.

Dr. Ann Finn:
But understanding it really helps to know, one of the things that's a key takeaway for billers is they have to know what should be being paid and what the reimbursement is in order to do QA. You have to know what the payment was. Where I see so much missed money, is that the claim paid, but maybe lines within that claim did not pay. And so having your billers know what should pay, and what is kind of the typical payments is really helpful for QA practices.

Caitlin Hungate:
Absolutely. Which actually is a perfect segue into our last question, that someone on the line asked about. Which is, what is the best way to document time spent in chart review and documentation generally in order to capture that for billing charges?

Dr. Ann Finn:
So that's a great question. And again, this is an area I see when I look at a lot of your charts and I just kind of do friendly looks and reviews, and it's often, I just don't see time captured. Or, and think about any time-based code needs to be supported, right? Whether it's smoking cessation, remember it's over three minutes, right? HIV counseling for Medicaid's over eight minutes. So we really have to make sure or the ENM code, if we're using time, that we are supporting it. So, sometimes people get worried that it's got to be very complicated. It can be as simple as a free, text line. Sometimes people say, I don't

have a place to put time. You can always add pretext. So you can say the total clinician time on this encounter was 22 minutes. Right?

You could also put, maybe you have time and then you go back and you say, I spent 10 minutes documenting the chart or something. It can be the cumulative time too. So there's different activities. If I was doing separately reported counseling services, like let's take smoking cessation. I would want to make sure under that assessment and that, and smoking cessation that I clearly say that it's the three minutes and that it's clear, it's not included in the ENM code.

So again, and the other thing is making sure that your templates work for you and the more that you can kind of fit these templates, especially like even with tele-health and their whole need to capture time. Right? And thinking about what's going on, is make that template work. And so if there's just some areas to have like some time that you can put in, that's easiest, right? You'll get clinicians. If there's a spot to fill in, and then you'll get that information. And I also encourage using like total clinician time. Getting used to it being so it's very clear to somebody else that this isn't front, that this isn't the nurse that did all the history that you're very clear and again, that's just the best practice for quality coding.

Caitlin Hungate:
Excellent. Thanks so much, Anne. And thank you all to submitting these questions in advance, and we want to open it up for some interactive dialogue with you. So please feel free to use the chat function or to unmute yourself right now. And we can dig into some interaction with you. Great to hear from you and what you and your agencies are working with and navigating whether it's your EHR, or training opportunities, or just starting to dig into this. As Ann mentioned, the first resource is the AMA, as we say the Bible. So to speak of our changes to the evaluation management codes, again, as Ann mentioned, this was recently updated and clarified. So the link on the slides reflect those clarification's from the American Medical Association. There's another resource from Aycock around these key changes, which is linked, and then last but not least the reproductive health national training center is revamping and revising an e-learning module and modules around coding.

So that first module is the fundamentals of coding. And that will be really soon in the coming weeks on our HNDC.org. Additionally, we're working on some ICD 10 and CPT hand picked jobs, job aids to support you and your teams and navigating these changes with evaluation management, problem oriented visits. Again, there's a lot of great resources out there, ACOG, AMA there are tremendous resources to support you and your teams in working through these key changes, and practicing both MDM and time and documenting those in your clinical records or documentation in the EHR of your client records. Thank you all so much for your time today. Please complete the brief evaluation, which will be emailed to you following the webinar today. And again, we'll be posting the slides from today's webinar, this interactive coding format with you all on our website and YSFPtraining.org within a few days. And you'll be able to see those slides on our website. And thank you so much for joining with us. Thank you, Ann, for your expertise and answering questions. And that concludes today's interactive office hours, webinar. Thanks so much.