2021 Office Visit E/M Coding Changes

Case Scenarios for Pediatric Practices

Live Webinar Q&A Session

Categories

Independent Historian

Anyone other than the patient themselves, is considered an independent historian. In the case of an infant, who cannot give any history, the parent/caregiver is still considered the independent historian. For older children, it is best practice to document who provided what information so that it is clear to an auditor. For example, a normal 16 year old can report "sore throat for 2 days, no fever, and other HPI/ROS elements themselves." However, if that 16 year old has chest pain, they are unlikely to be able to accurately report cardiac family history, so commenting "mother denies family hx of

sudden cardiac death or early MI" is appropriate. There is no age limit for using independent historians, it must be relevant for the visit. And if a parent insists on interrupting a teen to give their own history, just document as such "mother emphatically reported and felt it important to note that x."

Reviewing External Reports Not Associated with an E/M Visit

All practices receive reports from the ER or specialist which they process as received. In general, there is no mechanism to bill for this work. If you follow-up with the parent by phone or portal message, the non-direct care billing codes apply. If you are seeing the patient for a follow-up visit, this is appropriate to account in data review for MDM for that visit, even if your partner reviewed it the week before (because that work was not billed/already paid for.)

https://www.aap.org/en-us/Documents/coding_factsheet_nondirectcare.pdf

OTC Meds and Risk

There is not clear guidance on how to rate the "risk" of OTC medications. In general, they would be considered low (level 3) risk. However, if there is a discussion about off-label use, or significant details of dosing that are not evidence to the general public by reading the back of the package, or there are implications for a particular patient based on underlying health conditions and/or interactions with other medications, then you may want to consider that "medication management" in Risk level 4, and articulate why this is out of the ordinary in your note. Just because Medical plans often pay for OTC medications if you write an Rx, does not mean these count for a level 4 risk. If the medication is available for consumers without a prescription, it's considered OTC and level 3 except if articulated why this particular case is different.

Considering Portal Communication

Just as in phone conversations, you may consider the time you spend doing this work in choosing a TIME-based E/M level as long as that message exchange happened on the same day as the encounter. If you choose to bill the portal message or the phone call with its own CPT code, then you cannot count this in your work for choosing an E/M level. No "double dipping".

How much "work" can be done in an hour?

Some people have asked if you can only bill for one 99213 and one 99214 in an hour because an hour is only 60 minutes long. Remember, the visit time is only part of the time that counts, it's also pre-visit and post-visit work (including documenting at lunch). In addition, not every visit will be billed based on TIME as the factor. It will be quite possible to bill multiple 99214s based on MDM for the same hour. Not all patients have the same payer. IF a payer asks for your schedule, please reach out to the AAP Coding

hotline or me directly (skressly@officepracticum.com) as they have no right to see patients who are not their insureds.

Assigning Problem Status

There are multiple questions about how to decide the most appropriate problem status for specific conditions. There is no additional guidance other than what the AMA published (see page 3-4 on link provided below). In addition, this may vary for individual patients. It is also important to remember that when choosing E/M levels you only need to meet 2/3 so in some cases worrying about those nuances will not impact the code you choose.

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Social Determinants of Health

There is a distinction between "environmental factors or physical determinants" and social determinants of health. The link below provides some definitional guidance of what might be considered in the 5 areas. In addition, if a provider chooses to use SDoH as a risk, make it clear in the note why you think it will matter. For example, a child who is in a split household and where parents are not equally engaged in managing their asthma, saying "patient has access to controller medication in both homes, but SDoH of split household in which one parent is not always available to administer medications to child may contribute to the family's ability to effectively manage the medication care plan outlined." Practices have never been audited for this in the past, so we have no clear way of knowing how this will be handled. Second hand-smoke in general is considered an environmental/physical determinant and not an SDoH.

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Documenting "Unusual" Time

If you are coding a visit based on time, and the time is not "typical" of the diagnosis, it is best to document for an auditor why the visit took longer than usual. For example: "Very difficult exam due to patient's underlying developmental disabilities and anxiety, took 22 minutes to get effective exam." However, it is important to remember if you are going to bill that work separately (such as giving an immunization to a toddler you are battling with, or a difficult urinary cath) you cannot count that time which is already accounted for in the CPT you bill for that work.

Undiagnosed New Problem with Uncertain Prognosis

The AMA defines this as “A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.” The key wording to me, is high risk of morbidity without treatment. It is likely that if you document what you might be worried about that “connects the dots" for any auditor, it can be made clearer. For example, in the case of headache: “Uncertain of etiology of headache. Increased intracranial pressure could be a potential reason, in this patient have low suspicion at this time. However, if develops AM HA, vomiting, change in vision, gait, level of alertness then will consider MRI to r/o. Similarly petechia could be ITP or leukemia or another bleeding problem.”

What does a problem qualify with "systemic symptoms?"

The definition provided by the AMA reads: “An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for ‘self-limited or minor’ or ‘acute, uncomplicated.’ Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis." While there are not pediatric examples provided, we must consider that fever/fatigue can be part of mild illnesses such as a cold, but could also be part of an illness that indicates the patient may be worsening in their clinical status. A reasonable example is a UTI that when is accompanied by a high fever indicates upper tract involvement and pyelonephritis. Contrast that to a healthy 4 year with a fever with a mild respiratory illness. Again, comes down to a high risk of morbidity without treatment. Another example may be strep pharyngitis that progresses to scarlet fever with involvement beyond strep pharyngitis. Since pediatric notes have never been audited according to these criteria, it is best to explain in your note why the systemic symptoms indicate a higher level of risk of morbidity in your note.

Referrals

Unfortunately deciding that the patient needs referral to a specialist does not increase MDM. The problem is the same whether or not you refer to a specialist, the referral in itself does not get counted in data (but if you discuss it with the specialist it does (under management in data), and just referring to the specialist and not managing the problem itself does not increase the risk of your work-up or management.) The time you spend discussing with the patient/family and getting information prepared regarding the referral can be counted based on time.

Well Plus Sick

Since we no longer consider history reviewed and exam in the sick visit, MDM alone can often result in higher CPT coding levels for sick visits that are performed with a well visit on the same day. If you choose to use time, it is best to document in your note "spent 15 minutes with standard time for well visit and in addition, spent x minutes addressing the problem of x presented today." However, remember you need an additional 10-19 minutes (in addition to the normal time for a well visit) to bill a 99212.

Reviewing In-House Labs from Prior Visits

While it makes intuitive sense that if we review prior history of in-house labs in order to formulate a care plan (for example: reviewing frequency of positive strep tests to decide when it is appropriate to refer a patient to ENT for possible tonsillectomy), the AMA recently was clear in guidance that no in-house labs can count for data review when choosing a CPT code by MDM. All in-house labs are considered paid for in their inherent CPT codes. The AAP and professional societies will continue to advocate for a change in this position, but as of 12/14/20, no in-house labs can be counted.

Transitioning Between Hospital and Ambulatory Visits

If your practice cares for inpatients and reviews labs as part of billing for your hospital work, if that patient is then seen in follow-up by a different provider in the practice, can they review the data as part of the hospital follow-up and count it for data review? According to the coding experts, doing labs and reviewing data is part of the in-patient daily CPT codes and your practice was already paid for that work and reviewing it again upon transitioning to the out-patient setting would be considered "double dipping" and is not permitted as part of MDM.

Time Spent by Different Providers

It is absolutely reasonable for 2 providers within the same practice who spend separate time on the problem addressed at the visit, to "cumulatively" bill on the basis of time. For example, if Provider 1 sees the patient in the office and spends 25 minutes doing pre-visit, intra-visit and post-visit work, and then the on-call physician spends 6 minutes discussing additional issues regarding the problem addressed at the visit (before midnight) those 2 times can be added to bill for a total of 31 minutes (increases from a 99213 to a 99214.) It is best practice to document an addendum in the visit note itself referring to the message itself. It is likely best to bill under the rendering provider for the visit. If the phone call has nothing to do with the problems addressed at the visit that is best coded as a non-direct care message exchange (such as 99441).

https://downloads.aap.org/AAP/PDF/COVID%202020.pdf

How granular do we need to document time?

Since no practice has ever been audited using these new guidelines we do not know how granular you need to document. The entire initiative by CMS was patients over paperwork, the intent was not to replace one burden of documentation with another. Remember, when you submit CPT codes, the payer does not have any idea whether you reached that code based on time or MDM. Be certain your note makes that clear and if time is "outside the average expected time" it is likely to withstand an audit if you document more granular information. If it's average, simply document total time spent on the day of the visit. It is up to the provider how to best 'keep track' of the time they spend including using independent tools or those available through your EHR.

Teaching and Time

Medical student time cannot be counted. For residents, the primary care exception may apply. This is a good question for the AAP coding hotline.

Complexity and Number of Problems Addressed

The specifics of complexity and problems addressed are not additive and described fully by the AMA. For example addressing 2 separate acute, uncomplicated problems does not rise to a level 4 visit, it still remains at a level 3. The specifics of acute illnesses (not chronic) that rise to a level 4 include: 1 (or more) undiagnosed problem with uncertain prognosis or 1 acute illness with systemic symptoms or 1 acute complicated injury.

Difference between Self-limited and Uncomplicated Illnesses

"The AMA defines a self-limited or minor problem as one that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. In contrast, an acute, uncomplicated illness they define as ‘A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain."

Time Spent on the Day Prior to the Visit

While it may seem "punitive" to prep charts the day prior to the visit, and write notes after the visit, the AMA recognized that total time likely remains the same. They wanted to put boundaries around using time when choosing a CPT code and felt that workflow could be adjusted to accomplish the same total time on the day of the visit. For providers who choose to continue their work on the day before and after the visit, they may benefit from using MDM instead.

Provider Directed Work

If the provider instructs a practice team member to call a patient in follow-up, only the time the provider spends discussing the instructions with the team member counts. The time the non-provider staff spends calling/discussing care with the patient cannot be included in time-based coding that is reflective of direct provider clinical work.

Choosing Time vs MDM

For many providers, they will look at both time and MDM and decide which definition arrives at the higher code prior to choosing what to bill on a claim. Over time, as we all gain proficiency at this, typical visits may become intuitive at which path to choose.

COVID and MDM

Theoretically many illnesses we observe or treat can either be benign or potentially result in death (RSV bronchiolitis, rotavirus gastroenteritis). COVID in itself does not represent innately higher risk. Remember the risk is the risk of your work up (could something bad happen to the patient because you are performing an endoscopy) or the treatment that you are suggesting (high risk of substance use disorder if you use an opioid, for example).

"Counting" History and Exam

While the history and exam elements do not in and of themselves count with this new coding guidelines, the time it takes you to perform that work, ask those questions and document the answers can be included in the CPT code chosen if you are using time.

Reviewing Prior Office Visit Notes

Any time you spend formulating a diagnosis and performing "clinical work" is counted for time (if using time based criteria to choose your CPT code). Reviewing any work performed in your office (labs, prior notes written by other team members) is not considered part of MDM because presumably you already were paid for the work when you submitted the original CPT code at the time of the visit.

Reviewing Lab Results after the Day of the Visit

When you receive lab results and your office team reviews/processes them on a day different then the day of the visit, that work is considered included in the MDM that was used at the time that you ordered the test. If the test is not part of an office visit (instead part of a phone call or portal message) then consider using non-direct care codes to submit a claim for that work separately.

https://www.aap.org/en-us/Documents/coding_factsheet_nondirectcare.pdf

How best to count time?

Some EHRs have embedded assistance. The SOAPM FAQs has links to some other tools that are available.

http://bit.ly/faq2021cpt

Providers Performing Their Own Tests

Remember that any work that has its own inherent CPT code (throat culture, urine cath, etc.) cannot be counted for total time as that work will be inherently covered when reporting the CPT code for the diagnostic in house test or the procedure itself. So swabbing your own throat culture, or doing your own rapid flu test on a weekend, will not count and the time it takes the provider to do that work should be subtracted from total clinical time spent.

Common Acute Problems, Uncomplicated for Pediatrics

While the AMA offered no pediatric specific examples, subject matter experts are starting to come to agreement that problems such as the following would be considered an acute, uncomplicated illness: Pneumonia with fever without hypoxia or increased work of breathing, otitis media, otitis externa, conjunctivitis, pharyngitis.

How do we count ADHD forms such as Vanderbilts?

Since ADHD surveys have their own associated CPT codes, they should not be counted in data review for MDM not counted in the time you spend reviewing them. The AMA considers that "double dipping" since you are already submitting 96127.

Billing Separate CPT Code vs MDM

While you may get paid more for counting work on MDM rather than paid separately for diagnostic tests or other CPT codes, both over-reporting and under-reporting can be considered fraud. Providers are required to submit all the codes that are reflective of work performed. You cannot choose to count reviewing a Vanderbilt, for example and instead count reviewing it in the CPT code for the visit. And ordering surveys that have their own CPT code cannot be considered as ordering external tests.

Counting External Lab Test Orders

According to CPT guidance, no in house labs can count, so a rapid strep, rapid flu, rapid COVID in your office, is reported only by their CPT codes and cannot count as data. Any tests ordered externally (regardless of whether you swab the patient in your office and send for culture or give the patient a lab slip to performed at the external lab), can be counted as data reviewed per CPT code. For example, if the rapid strep is negative and you order a send out throat culture that counts as 1 data point. If you perform the

same throat culture in your office, you bill for that by a separate CPT and cannot count it as data. If you send a patient to the lab for a CBC, chem panel and EBV titers, that counts as 3 data elements as those each have 3 distinct CPT codes for the tests.)

Independent Interpretation

The AMA defines this as "The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified healthcare professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test." This work can only be reported if done in the context of the visit itself. You cannot report this code with the intent that you "plan to look at the EKG itself" next week. Your results need to be documented with the visit note. Again, this cannot be you just reviewing the report itself. You must be reviewing the "raw data" and making your own, independent interpretation (reading an x ray film/not report, reading an EKG with your own calipers, etc.)

Researching Treatment Options

Using web-based resources that increase your general knowledge for a particular problem cannot be included in clinical time spent or data reviewed. Information must be uniquely specific to the patient and the problems you are addressing.

New Patients 2/3 for MDM

It is no longer required that new patients meet 3/3 of the components for MDM. Established and new patients must both meet 2/3.

What is the "24 hour period" for time?

The only 24 hours that count is during the same calendar date as the visit occurs. So from 00:01 AM through 11:59 PM: If a provider does work at 9 PM preparing for their 9AM visit the next day that does not count because it is not the same calendar day.

Co-signing/finalizing Notes

Cosigning or finalizing notes on a date subsequent to the date of the visit, should not have any material impact except any work done at that time cannot be counted if you are choosing a CPT level based on time.

Use of Scribes

Scribe independent work cannot be counted. Only the provider who is billing for the visit can count their work, so if the scribe and the provider are in the room together, that provider time counts. If the provider is having a discussion with the scribe before or after

the visit, that time counts. If the scribe is documenting the note, that time does not count. In addition, if the scribe reviews the data but the provider does not do the work themselves, it cannot count for data analyzed in MDM.

Modifier -25

The new CPT office visit documentation and coding guidelines have no impact on modifiers

Telemedicine and In-person Visits Same Day

Only one E/M code can be submitted per problem for the same day. This is true for patients who you see in the office in the morning and then get sicker and return later in the day for the same issue. You can only bill the insurance company one CPT code for both of those visits, but the CPT you choose can reflect the combination of the work, even if it was performed by two different providers in the same practice. Similarly, if a telehealth visit is performed and it is deemed that an in-person visit is warranted, you can only submit one code for the sum of the work performed that day. (It may vary whether time or MDM is more favorable based on the particular circumstances). Whether you choose to write 2 different notes or one, is up to the practice, but it should be clear to auditors who documented what portions of the notes.

Audits

Any practice is subject to an audit by a payer at any time for any reason. It's part of your contract. In general, payers can audit as part of contractual obligations (many Medicaid MCOs are mandated to audit a portion of their providers every year as part of due diligence/transparency to audit what is essential public funds), or because there is a change in coding patterns for the practice or because coding patterns differ from peers in the same area/same specialty. This should not be a deterrent to code appropriately for all the work you do. Just make sure that your notes reflect the work done and support the CPT codes you choose. It is best practice for all offices to conduct internal note reviews/audits several times per year to identify concerns and improve documentation and coding. If you have in-office expertise, it can be done within your own practice team. If you do not have in-house expertise, there are consultants who would be happy to provide this service.