E/M Coding & Documentation Changes | What We've Learned

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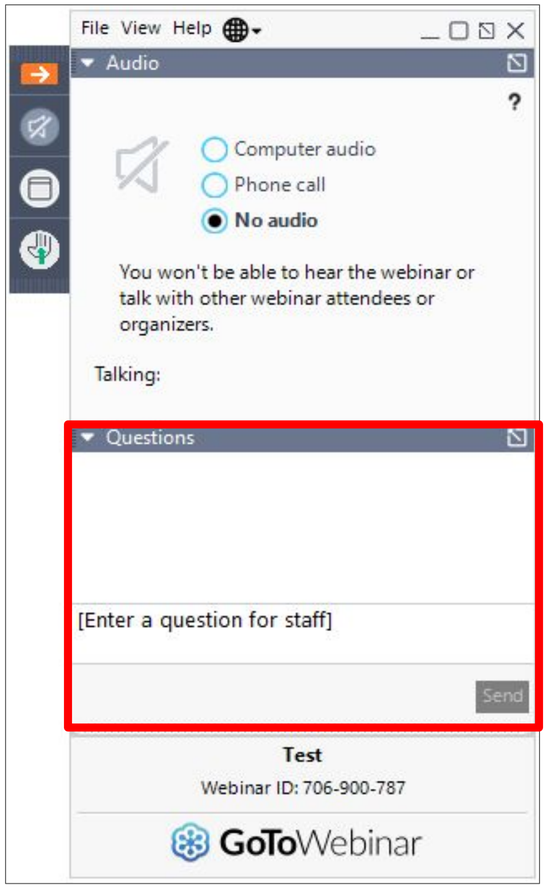
Welcome to E/M Coding & Documentation Changes | What We've Learned

Audience: All

- Attendees will be muted. If you have a question, enter it into the **Questions** box.



Disclaimer

- The information being presented in this webinar is up to date as of 2/22/2021
- This webinar will be recorded and made available after the webinar
- This is an informative webinar to discuss client questions and concerns
- The AMA could have made changes as this webinar is occurring, it is suggested to visit the AMA website frequently

Disclosure

- I am not a certified coder
- I am have no legal credentials
- The information that you are about to see is my personal interpretation of educational materials that are available in the public domain
- There are nuances about coding, documentation and audits that are yet unknown since we are entering uncharted territory
- Expert guidance continues to evolve

It is the legal responsibility of each provider who sees patients to educate themselves to the fullest extent possible, and choose the most appropriate code that represents the work which they performed

Objectives

- Review enhancements to OP coding support
- Discuss common coding struggles
- Apply coding knowledge to common pediatric scenarios
- Answer your questions!

Enhancements

Counting Prescriptions for Risk (Moderate/Level 4)

- In the majority of cases, only counts if you are managing a prescription medication
- Doesn't have to be written on the date of the visit for it to count for coding ***but*** OP only knows to count it if Rx written on the day of the visit
- OP also counts all prescriptions (must adjust if diapers or OTC)
- Current prescription statuses now include all of the following:
  - Sent
  - Printed
  - Faxed
  - Picked Up
  - Called
  - Delivered
  - Mailed

These statuses included in OP as of Version 20.10.4

Counting Prescriptions: Future Consideration

- A checkbox to indicate the provider is managing medications (even if not written today)
- Adding status “pending” (to help with prescriptions that were sent electronically but not yet acknowledged by pharmacy)
- Not counting OTC meds (would necessitate OP storing the category OTC in the database which it currently does not)

NOT CURRENTLY AVAILABLE

Data Review: Documents

Implemented in OP Version 20.11.3

- Each document you review for “counting” should be from a ***unique external*** source
- OP counts everything you review that are in the following (updated) categories:

Valid Document Types	Invalid Document Types
:Chart	Disclosure*
:Chart-Med Hx	Photo ID
:Diagnostic Test	:Insurance
:Referral Letter	:Patient Consent
Miscellaneous	:CHADIS, :Questionnaire**
	:CDA***
	:Forms

- Only Documents that have a valid Document Type are displayed in the Encounter Summary when reviewed on the date of the visit

Time Tracking Improvements

Implemented in OP Version 20.11.3

- Time spent by the provider in the **Coding section** of an Encounter will **not** count towards time-tracking for E/M coding
- The Message window accessible via the New Message button located in the Clinical or Practice Management tab is **now included** in time-tracking for E/M coding

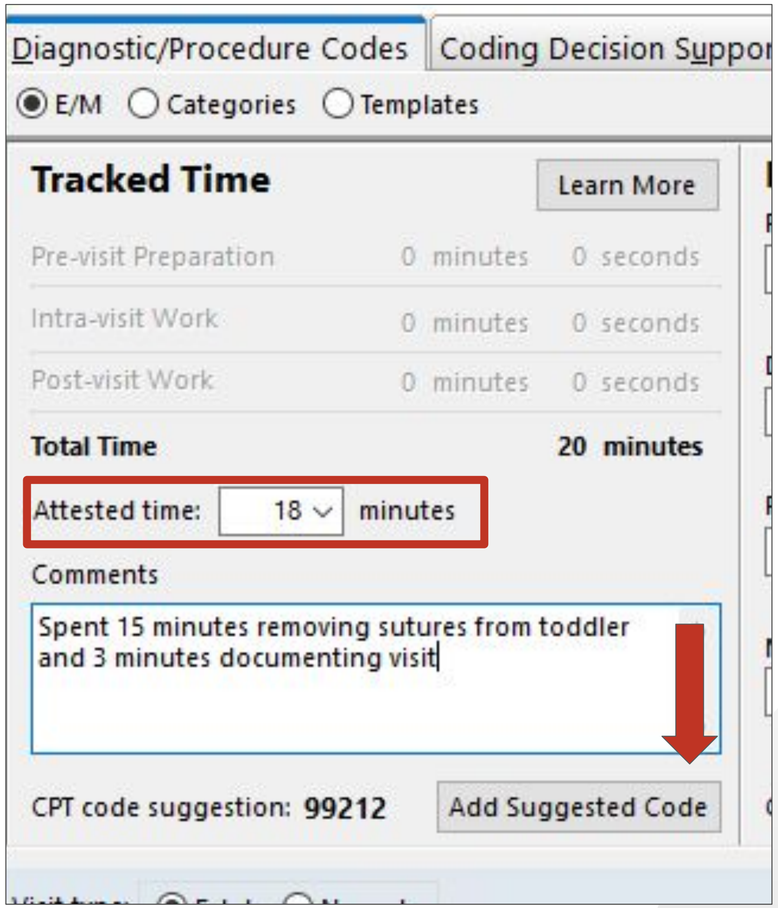
MDM Improvements

Implemented in OP Version 20.11.3

- When an **Independent Historian** is selected in the Visit Info section of an Encounter Note, it is ***displayed in the Encounter Summary***.
- In order to correctly calculate orders for MDM-based E/M coding purposes for practices using a lab interface, a temporary workaround included steps to edit Lab Facilities to be Requisition and Order. ***The workaround is no longer required as of the release of OP 20.11***
- Diagnostic tests ordered will be counted at the **requisition level**, and by each CPT ordered (showed by test names separated by **;**)
- ***In house*** diagnostic tests ordered on the date of visit, will ***not*** be included in the calculation of Data Reviewed/Analyzed

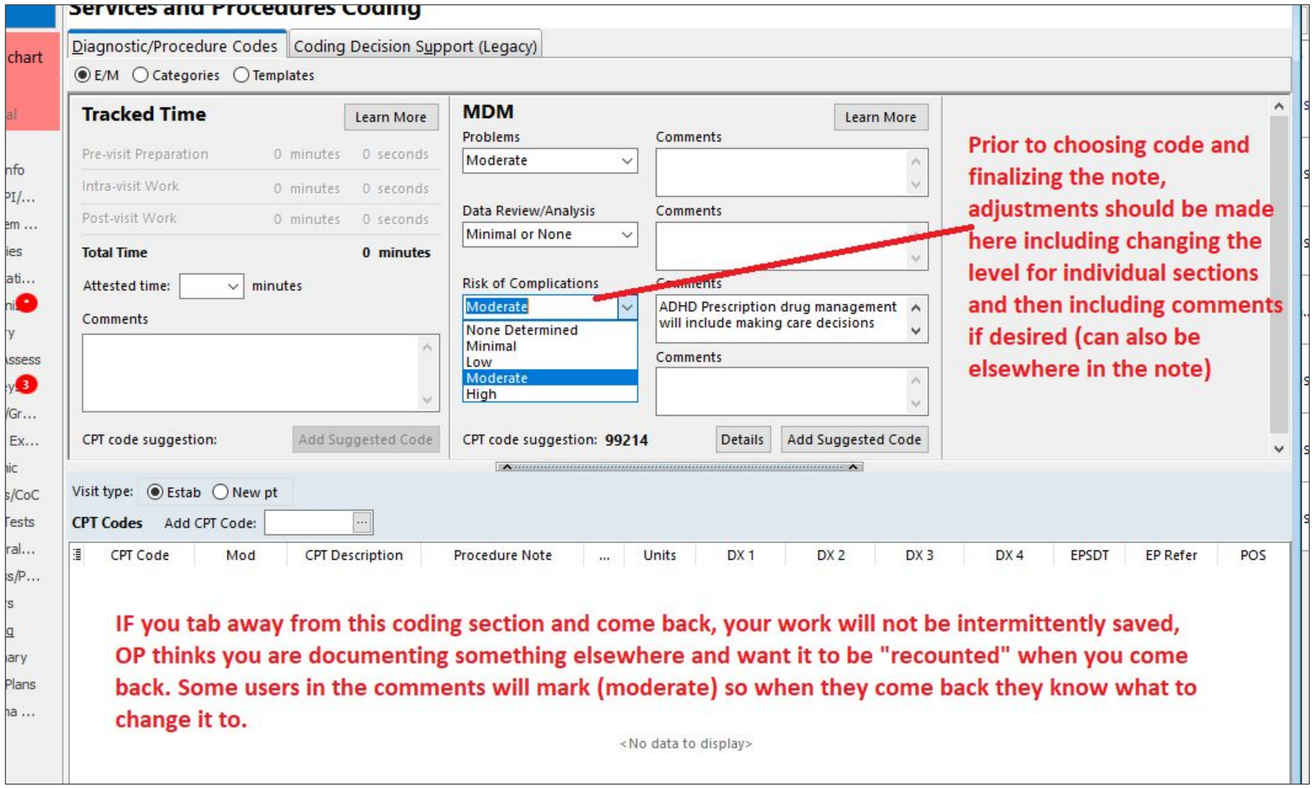
What if I think OP time is wrong?

- Write in your total to “attest” the accurate time
- If you do not put any number in attested time, OP assumes you agree with the math for Total Tracked Time
- Write comments if indicated
- “Use Suggested Code” button to add the comments/language to audit note



What if I think OP MDM is wrong?

- Immediately prior to applying suggested code and finalizing, adjust MDM levels and add comments
- ***Do not navigate away and come back*** or OP will think you want the computer to ‘recalculate’ (comments will stay, but the levels will recalculate)



Additional Improvements: Future Consideration

- Time tracking details (coming soon! in **OP 20.12.0**)
- Making the main E/M coding tab work the same for Time and MDM
- Move editable MDM to a different tab to “do your math/overrides” similar to the legacy coding support tab
- Add functionality in MDM override for “hospitalization” checkbox
- Add coding cheat sheet to a tab in OP so do not have to navigate out to “learn more”
- Eliminate the OP to AMA problem status crosswalk and strictly use AMA language plus a N/A category (for things like BMI)

ALL UNDER CONSIDERATION & NOT CURRENTLY AVAILABLE

Other Comments

- **I am not getting paid more!** While RVUs went up, payment totally depends on your individual payer contracts.
- **My coding curve has shifted substantially!** This completely depends on your patient visit mix but make sure you are getting credit for everything you are doing.
  - Make sure each appropriate diagnosis has a problem status
  - Are you sure there is only one stable chronic problem?
  - Give yourself credit for medications managed but not written today
  - Give yourself credit for additional risk, but ***document it clearly!***

No “Double Dipping”

- Can’t count ordering the test and then separately reviewing the test on a different visit
- Inherent in the test order is “closing the diagnostic test loop”
- Which includes: making sure that it gets done, reviewing the results when they come back and discussing them with the patient/caregiver
- Can’t add time to an E/M for a CPT that’s already being paid separately
- Includes procedures like a bladder cath, wart treatment, tongue clipping, etc
- Includes time spent reviewing Vanderbilt’s, ASQs, etc. that have their own CPT code which you must report
- Can’t add “prolonged services codes” to an E/M visit that you code by MDM

MDM: Problems Addressed

Are not additive except in 2 specific cases:

- **1 self-limited or minor problem is straightforward** (Level 2 visit) but **2+ self-limited or minor problems get you to low** (Level 3) for problems addressed (still need to get there with data reviewed or risk also)
- **1 chronic stable problem is low** (Level 3) but **2+ chronic stable problems gets you to moderate** (Level 4) for problems addressed (still need to get there with data reviewed or risk also)
- Don’t stress yourself finding the most appropriate category if it isn’t going to matter
- Undiagnosed new problem with uncertain prognosis or 1 acute illness with systemic symptoms? Doesn’t matter, both moderate (Level 4)
- Didn’t order any tests, review external notes, manage any medications… not going to get to a level 4 anyway

MDM: Data Reviewed

- As of 2/22/21 **in house tests *cannot* be counted** (neither to order or review results)
- Be on the lookout for a CPT assistant article and AAP communication with update
- As of 2/22/21 other CPTs that are billed separately such as surveys (even if they have no physician work in their RVUs) ***cannot*** be counted
- External sources: outside entities (different Tax ID) or different specialty within your Tax ID

STAY TUNED FOR AN UPDATE FROM THE AAP IN NEAR FUTURE!

Acute Illness with Systemic Symptoms

- An illness that causes systemic symptoms and has a high risk of morbidity without treatment (AMA definition)
- 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.’
- Examples:
  - OM with fever??? Are you treating with antibiotics and concerned if not treated?
  - Strep pharyngitis w/nausea/vomiting: higher risk of not being able to tolerate antibiotics and progress to complications
  - Viral illness with dizziness: higher risk of falling and subsequent harm
  - Conjunctivitis with fever and eye swelling: higher risk could be pre-septal cellulitis and worsen if not followed closely/treated

When in doubt: *spell it out* for the auditor to connect the dots

New Problems: No Tests, No Rx

Examples: chest pain, abdominal pain, headaches: shouldn't this be a level 4?

- Likely appropriate to use problem "undiagnosed new problem with uncertain prognosis" if you "spell out your differential" diagnosis (Moderate/Level 4 for Problem Status)
- No tests: if you document tests you consider but do not order it will ***likely*** pass an audit.
- Medications: if you document medications you are considering, but do not write on the date of the visit, it will ***likely*** pass an audit.
- Increases your ***risk***

"*Mother reports no family hx of early heart disease/MI or dysrhythmia. If chest pain continues, would consider EKG and/or stress test (if worse with exertion.) At this time differential dx is broad including GER, musculoskeletal. Feel cardiac cause unlikely but possible and discussed with parent.*"

"Chest pain differential dx broad but based on exam and history feel most likely mild GER. With shared decision making elected to not start medications at this point but will try to control with lifestyle modifications including diet. If not improving in 2 weeks, parent to call and would start a PPI and manage prescription medications appropriately."

Same Day Well and Sick

- Likely MDM more favorable than time for many items
- Must document that it is a separately identifiable problem being addressed
- IF use time, should use language like “in addition to the usual 20 minutes of the well visit, spent an additional x minutes addressing the following problems….”
- IF use MDM (likely more helpful), same rules apply as if were doing a sick alone
- More likely with MDM to get more level 99213s/99214s since no longer have to “eliminate” exam and history elements that apply to both well and sick
- -25 modifier still applies (although OP no longer automatically adds in current versions)

Common Pediatric Scenarios

COVID Exposure No Sxs/Symptoms

- Time: need **10** minutes for a **99212**, **20** minutes for a **99213**, **30** minutes for a **99214**, **40** for a **99215**
- **MDM No symptoms**: (testing because of exposure or need for note to return)
  - Problem addressed: straightforward (limited/minor) or low (?? Acute uncomplicated illness?? They aren't ill?)
  - Data: independent historian alone will get you to a low (level 3)
  - Risk: straightforward? (minimal risk of morbidity from additional diagnostic testing or treatment) or Low?
- **MDM Symptoms:**
  - Problem addressed: (depending on how sick): acute, uncomplicated illness (Low) or Acute illness with systemic symptoms (moderate)
  - Data: Independent historian plus a COVID test (if external) only gets you to a low. Need 2 tests and independent historian to get you to a moderate.
  - Risk: Without prescription medications, likely a moderate (OTC meds)

ADD/ADHD Recheck

- Doing well/stable (patient is at their treatment goals)
  - 1 stable chronic illness
  - Find a second one that is stable (school issues, behavior concerns, appetite suppression, sleep issues, most have a comorbid something)
  - Problems Addressed: 2 stable chronic illnesses = Moderate (level 4)
  - Data Reviewed: can't count those separately billed for Vanderbilts; If you are managing likely don't have external reports to review, Independent historian only gets you to a Low (likely level 3)
  - Risk: writing or managing medications = Moderate (level 4)
  - No meds? Time? (for a 99214 need 30 minutes all provider work that day, can't double dip those Vanderbilts)
- Not doing well or side effects of treatment
  - 1 chronic illness w/exacerbation, progression or SE of treatment = Moderate (level 4)
  - Data Reviewed (again, going to be hard to get to a level 4 in this category)
  - Risk: manage meds….Moderate (level 4)

Anxiety or Depression Initial Visit

- Problem Addressed: Undiagnosed new problem with uncertain prognosis = Moderate (level 4)
- Data Reviewed:
  - Likely get a family hx from parent for accuracy (independent historian) that alone = Low (level 3)
  - What does it take to get to a level 4? Add 2 more Category 1 points (order a test, review outside records??) AND Discuss with therapist/psychologist you are referring to
- Risk:
  - Write a prescription = Moderate (level 4)
  - Consider a prescription but decide to try other things first and you document it likely OK to consider a Moderate (level 4)

“Discussed use of medication and alternative treatments with patient/caregiver. Both choices have associated risks. Elected with shared decision making to first try counseling (referred to psychologist), lifestyle improvements (good sleep habits, adequate exercise), mindfulness (recommended apps to be used). Emphasized need to reach out urgently for thoughts of self-harm or inability to function with activities of daily living.”

Bronchiolitis

- Problem Addressed: Undiagnosed new problem with uncertain prognosis or Acute illness with Systemic Symptoms (document tachypnea/poor feeding or concerns about progression to) = Moderate (level 4)
- Data Reviewed:
  - Independent historian = Low (level 3)
  - What does it take to get to a level 4? Add 2 more Category 1 points (order a test, review outside records??) AND Discuss with external source? Not likely
- Risk:
  - ~~Write a prescription~~
  - Consideration for worsening, when to admit, medications, etc. Can likely justify at least a Moderate (level 4) if you document your thought process…. *"Discussed with parent AAP guidelines say best practice is to not perform any diagnostic studies such as CXR and not to treat with bronchodilators or antibiotics. Explained to parents that best guidance is supportive care and frequent contact/close monitoring. Some infants with bronchiolitis can worsen quickly are require hospitalization. Not indicated at this time but discussed with parents what to watch for increased work of breathing (grunting/flaring/retracting), poor feeding/choking with feeding, signs of dehydration (discussed) and when to reach out for further instructions which may indicate worsening and require referral to higher level of care or hospitalization."*

Have a Question?

- Type it into the **Questions** box
- Any unanswered question(s) will be communicated to the Webinar attendees via email

OP Resources

- Where and How MDM is Indicated and What OP Can and Cannot Do
- Definitions and Examples of the Elements of MDM
- Medical Decision Making Calculation Support in OP

External Resources

- AAP Guidance including
- Summary of Time Changes
- New Prolonged Service Code*
- FAQs (updated frequently)
- Summary of Prolonged Services
- Coding for Care Management and Non-Direct Services *
- Coding Newsletter (subscription required but well worth it!)
- Coding for Pediatrics 2021 Edition (purchase but a must have!)
- Pediatric Evaluation and Management: Coding Quick Reference Card 2021 ($21.95 for non members, $16.95 for AAP Members)
- Section on Administration and Practice Management AAP FAQs: http://bit.ly/faq2021cpt (and while you are there, join SOAPM!)

Need AAP Assistance?

- For specific coding questions not covered in the FAQs: contact the Coding Hotline: https://form.jotform.com/Subspecialty/aapcodinghotline

- For assistance with Payer Advocacy use the Hassle Factor form: https://form.jotform.com/Subspecialty/aapcodinghotline

BONUS SLIDES

What About Referrals?

Do ***not*** get credit in any way for sending a patient to a specialist in and of itself

- No way to distinguish between:
  - You have acne? Here's the dermatologist list we often use from
  - OK, we have tried PPIs at max dosing and we have tried lifestyle changes for your GERD and we have ruled out a bunch of other causes with lab work, and you still are having uncontrolled symptoms, it's time to see GI and you might need endoscopy.
- What about ER referrals vs hospitalization?
  - Many pediatricians don't direct admit anymore
  - Many pediatricians work in an area where referring to the ER is a requirement before hospitalization
  - Sending a patient to the ER with notation in the chart: "referred to ER for further evaluation and possible hospitalization due to worrisome condition…" is likely good enough for Level 5 for risk.
  - Automatic Level 5 for ER referral? Nope. What about the kid with sutures?

What About Z Codes? It Depends!

- Academic Problems? That's a chronic condition: stable or worsening
- Family disruption? That's a SDoH but need to make sure it ***significantly limits diagnosis or treatment*** (is not usually a problem you personally are managing, so contributes to risk, not the diagnosis itself counting as one of the problems addressed)
- COVID exposure? Unless the patient is ill and it will change your management, is not in and of itself an increased risk

What About Risk?

- For MDM purposes: level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated
- Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization
- Does not have to do with the complexity of the patient overall
- Is related to the risk of the provider initiating a diagnostic work up (or not) and the treatment plan
- It's ***not*** just what we ***do***, it's how we managing the problem in coordination with the patient/caregiver.

BUT...***if it isn't documented, according to an auditor, it didn't happen***

Independent Historian

Category 2: Assessmen requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

- An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
- Patient themselves do ***not*** count
- Only counts **ONCE** no matter how many independent historians
- This alone gets to you a low (Level 3) for data, and this plus 2 other data elements gets you to a moderate (Level 4) for data
- Likely not enough to just check a box for “independent historian used” without indicating whom, and for older children what or why was contributed.
  - “Mother confirms no past hx of recurrent strep throat.”
  - “Grandmother reports has been sulking/hiding in his room for the past week.”
  - “Sitter reports that her appetite has been off for 3 days.”

Data Review and Visit Levels

- For a **level 4 visit** (Moderate) in data must meet requirement of ***ONE of the 3 categories***
- For a **level 5 visit** (High) you must meet requirements of ***TWO of the 3 categories***
  - CATEGORY 1: tests, documents or independent historian (here doesn't count alone as a category)
    - 3 Items from any combination of the following (can all be in the same category or different but only 1 independent historian counts)
    - Prior note from external source (each source can count as one)
    - Lab orders (each CPT counts as one distinct test)
    - Review of each unique test (each CPT counts as one distinct test)
    - Independent historian

  OR
- CATEGORY 2: Independent Interpretation of Tests (must do your own reading and document)

  OR
- CATEGORY 3: Discussion of management or test interpretation (with external source)

Data Reviewed and Visit Levels

- For a **level 3 visit** (Low) in data category need:
  - Independent Historian alone OR
  - 2 Items from any combination of the following (can both be in the same category or different)
    - Prior note from external source (each source can count as one)
    - Lab orders (each CPT counts as one distinct test)
    - Review of each unique test (each CPT counts as one distinct test, but cannot count something your practice already “got credit for” for ordering, so in most cases these are labs ordered by someone other than your practice such as ER or specialist)

Prolonged Services 99417

- Can only be used in addition to 99205 or 99215 when you use time as your E/M basis
- Disagreement between CPT (chart below) and CMS: which will your payers follow?

New Patient Time Range	Reported Code(s)
60-74 mins	99205
75-89 mins	99205 and 99417
90-104 mins	99205 and 99417 X 2
105-119 mins	99205 and 99417 X 3
120 mins or more	99205 and 99417 X 4 or more for each additional 15 minutes
Est Patient Time Range	**Reported Code(s)**
40-54 mins	99215
55-69 mins	99215 and 99417
70-84 mins	99215 and 99417 X 2
85-99 mins	99215 and 99417 X 3
100 mins or more	99215 and 99417 X 4 or more for each additional 15 minutes

Thanks to our MDM Provider Workgroup!

George Rogu, RBK Pediatrics (NY)

Sandra Herron Tanque Verde Pediatrics (Tucson, AZ)

Silvia Operti-Considine Kidz1st Pediatrics (Rochester Hills, MI)

Pat Hynes, Prospect Pediatrics (Prospect, KY)

Charlie Cavallo, Pediatric Associates, PSC (KY)

Amy Guzek, Hip Kids Pediatrics (Chandler, AZ)

Cecile Fraley, Pediatric Partners of the Southwest (Durango, CO)

Parul Bawa, Springdale Mason Pediatrics (Cincinnati, OH)

Michelle Henry, Litchfield County Pediatrics, (Torrington,

Teresa Stevens, Island Coast Pediatrics, (Fort Myers, FL)

Thanks for Attending!