Ask-the-Contractor Teleconference (ACT): Evaluation and Management (E/M) Services Transcript and Follow-Up Information

Transcript

This transcript has changes for clarity and readability.

Event date: April 6, 2022

Operator: Good day and thank you for standing by. Welcome to the ACT: Evaluation and Management (E/M) Services. All participants are in a listen only mode. After the speaker's presentation there will be a question-and-answer session. Today's conference is being recorded. I would now like to hand the conference over to Ellen Berra. Please, go ahead.

Ellen Berra: Good Morning everyone and thank you for joining us this morning. What this ask-the-contractor teleconference addresses are the changes to evaluation and management services. We have already done education on these changes, which includes the changes to 2021 office and other outpatient services. These are the procedure codes 99202 to 99215. The basic change is how you choose your level of service. For those procedure codes, beginning with services January 1, 2021, and after, you will choose your level of service based on the amount of time your physicians or non-physician practitioners spent on that patient on that calendar day. The time does not all have to be face-to-face. There are activities that can be included in that time. Or you will choose your procedure code based on your medical decision-making. The American Medical Association (AMA) Instructions were given for attendees to complete the live course.

Reference

American Medical Association (AMA) Instructions: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Ellen Berra: We've got several pre-submitted questions that we're going to go through first, and then we'll open the lineup for questions. If there are questions that we're not able to get to or something you think about before the course closes, then you can complete the follow-up questions module. Depending on the nature of the question, we may add to our existing question and answer document, that we have listed as an asset within our Learning Center, or we may contact you directly. I want to let you know that we have education available on cognitive assessment and care plan, as well as depression screening. We encourage you to take advantage of education on those two topics. Next, are the pre-submitted questions.

The first question is from Abby. She asks about virtual supervision under the teaching physician guidelines. Does this only pertain to evaluation and management services, or could it be used for other services and procedures?

This is addressed in the Code of Federal Regulation (CFR), and this is in 42 CFR 415.172. This section identifies that teaching physician presence by audio video communications applies to all services under the teaching physician guidelines, not just E/M services.

Reference

42 CFR 415.172: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-415/subpart-D/section-415.172

Learning Center: http://wpsghalearningcenter.com/store-catalog

Ellen Berra: The next question is from Ann. She asked, when the physician is doing a virtual or outpatient visit, if they defer the physical exam or do not do an exam, is it still a billable service?

The answer is, yes. If you are doing the level of service or category of service office or other outpatient, the 99202 to 99215, an exam is not used in determining the level of service. The clinician determines the need for the exam based on the patient's condition. If you are doing another type or another category of service, virtually through telehealth, etc., then it is a clinical decision to perform an exam. Keep in mind, if you're billing for a subsequent evaluation and management service, then you need to meet two out of the three categories, history, exam, or medical decision-making. If you're not doing an exam for some reason, you can still bill the procedure code.

The next question is from a different Ann. Using the new guidelines for E/M services and shared and split service, can the physician provide part of those qualifying activities off the floor or unit?

The rule for E/M inpatient services, skilled nursing facility service, etc., is the time spent and the service provided must either be face-to-face with that patient or on the unit or floor. That has not changed. Time spent off the floor or unit, such as the physician is in his or her office, would not count towards choosing the level of service and determining who provided the substantive portion of the service. It must be face-to-face on the floor with the patient or on the floor or unit.

Brittany sent the next question. She is seeking a clarification on the definition of chronic for problem addressed.

This is part of the office or outpatient procedure codes 99205 to 99215, the AMA document describing and providing education on the changes, has a definition of

chronic. The definition states a chronic illness is one with an expected duration of at least one year or until the death of the patient. So, if your documentation does not show how long the condition has lasted, that it's expected to last one year, or until the death of the patient, then the documentation would not support that this is a chronic illness.

Reference

American Medical Association (AMA) Instructions: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Ellen Berra: The next question came from Celia. She asked about the new shared and split rules for place of service 22. If the physician and the nonphysician practitioner elect to use a time statement to support the substantive portion, is that time used in choosing a level of the E/M service or is it only used in determining the billing provider?

When using place of service 22, the codes are generally going to be 99202 to 99215, or an observation code. If you're using 99202 to 99215, then time can be used both to level the service and determine the billing provider. For example, if the physician provided 15 minutes and the nonphysician practitioner provided 20 minutes, you could bill the level of service using 35 minutes, if you're using time. Then to choose who to bill the service under, use the substantive time. This is the nonphysician practitioner in my example.

If you're not using time with the 99202 to 99215, then currently time is only when providing counseling or coordination of care unless your procedure code description identifies otherwise. If both practitioners are providing the counseling or coordination of care and that's what the time is used for, then yes, you could also use that to level your code.

Cora asked a question concerning auditing for the new shared and split guidelines. She asked what should they look for? How will they determine if it's been billed correctly?

They would do their auditing the same way Medicare medical reviewers from WPS, the Comprehensive Error Rate Testing (CERT) contractor, Recovery Auditor, special medical review contractor looks at this. The documentation must support how this is billed. What Medicare looks for in the documentation is who did what. How much time did the nonphysician practitioner spend with the patient or on the patient on that day? How much time did the physician spend? Did the nonphysician practitioner provide the history, exam, and medical decision-making? If so, then what portion of that did the physician provide?

Remember, if you're using a component, the physician must provide one of those three components in its entirety. So, I can't give a good example of that. It would be based on the documentation. Your documentation must show who did what. I have heard from practitioners that they have not currently been providing documentation

in such a format. Remember, if we can't tell from the documentation who provided that substantive portion, then we can't use that documentation to support how you billed the service to Medicare. Also, don't forget that after 2023 the shared or split service would be based on time only.

Francesca submitted a question concerning the discharge management service, procedure codes 99238 and 99239. These are timed based codes for which time is often split between the nonphysician practitioner and the physician. Can you combine the time?

Yes, you can. When choosing the procedure code, count the time spent providing that discharge management service by both your practitioners. 99238 is 30 minutes or less. 99239 is more than 30 minutes. Document the time and what was provided, and then bill under whoever provided the most time. Also, this is true for your observation discharge management, procedure code 99217.

The next question is from Jennifer, and she's combining a couple things. She states the CERT program allows a review of an entire record to support medical necessity as a visit. What she's referencing is that when the CERT contractor or Medicare review contractor looks at documentation for a service to determine medical necessity, we can look at something other than the note from that visit, since we're talking about E/M services. Jennifer continues with for today's encounter there's no documented reason for today's visit. Yesterday documentation showed the patient had arm pain, a broken arm, or whatever, but today there's no documentation of that. Could the coder use the diagnosis code information from yesterday on today's encounter?

The answer is no. Your documentation must support the reason why you're seeing that patient on that day. If it's not documented, it wasn't done. If there's no information for today as to why that practitioner is seeing that patient, then your medical necessity is not going to be shown for today's service.

The next question has to do with surgical clearance or pre-op clearance. The family practice provider, in this case, is seeing the patient to do a pre-op clearance prior to doing a surgery on that patient. A surgeon is doing the surgery, not the family practitioner. They are wondering how exactly to bill this.

First, in your documentation, show what is the medical necessity for providing this pre-operative clearance. If a patient has no other diagnoses, then what makes it medically necessary for the physician to provide this? It's an additional cost to Medicare and the patient. So, medical necessity is the first item to look at.

If there is medical necessity, how do they code that? In the example the patient has hypertension, obesity, and sleep apnea which can cause problems with anesthesia. You code based on the description of the different levels of the service, whether these are chronic conditions, stable chronic conditions, unstable chronic conditions, etc.

Also, in the example, the family practitioner ordered some labs and additional testing. That's going to be part of the amount and complexity of data to be analyzed. And you'll go based on the number of services that you're ordering and then the description of those different categories within that section.

Where it gets a little more confusing is when you get to the risk factor and the medical choice you made. That third column, which is the risk column, goes along with the risk to the patient from the disease process you are evaluating and decisions you are making, and in that AMA document and in the CPT code book there are multiple examples. A decision for surgery is one of those examples. So, look at your documentation to determine is your family care practitioner, for this example, making the decision for surgery or was that decision made by the surgeon? Based on the information, I think the decision for surgery is probably in the moderate level and if you have some additional things going on it could move it into that high level.

Reference

American Medical Association (AMA) Instructions: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Ellen Berra: Those are examples. Even though your practitioner did not decide on surgery, so that example won't apply to you, that doesn't necessarily mean that you would not qualify for a moderate or high level. What your documentation shows is the risk to that patient from the decision you are making and the condition for that patient on that day.

Jessica has the next question. She asks about a nurse practitioner (NP) working under multiple specialties. Today the nurse practitioner may work under a cardiologist, tomorrow they may work under a pulmonologist. They may concentrate their practices under a particular specialty. While a nurse practitioner may have collaboration agreements with physicians of many specialties or only a single specialty, for Medicare a nurse practitioner only has one specialty. That is a nurse practitioner.

This is if you are providing an initial visit. As an example, your nurse practitioner working under cardiology sees the patient the first time, then another nurse practitioner in the same group saw that patient within the three-year time frame. That second nurse practitioner would bill a subsequent E/M service, not an initial. The same thing holds true if you're doing multiple services one the same day. Medicare considers both nurse practitioners as the same specialty.

The next question is from Caitlyn asking about shared or split services within the emergency department. Can the nurse practitioner, who has provided more than 50 percent of the service time or has documented history, exam, and medical decision-making, bill the proper code? So, can the service be billed under the nurse practitioner, or can the physician then document that they saw the patient in connection, and they agree with what the nurse practitioner did?

Documentation must support who's providing the substantive portion of the service. In this example, the nurse practitioner provided this whole service. From this example, bill the service under the nurse practitioner and not under the physician.

Karen's question is concerning nurse practitioners and specialties, and we've already responded to it.

Kelly has several different questions.

First, concerning the shared or split question. CMS has published information concerning having to redocument within the patient's medica l records. The CMS publication Evaluation and Management Services Guide publication shows a practitioner can review and verify information within the medical records without having to redocument it, trying to get rid of the note bloat, make it easier for physicians and practitioners, etc. For the shared or split question, part of the requirement is when using a component, the billing practitioner must provide that component in its entirety. The examples sent to us state the nurse practitioner did history, exam, and medical decision-making. The physician came in, read through the notes, said yes, I agree, and can we bill it under the physician? The answer to that is no. To bill under that physician, he or she must provide either the history, exam, or medical decision-making in its entirety. That's what we would expect to see within the documentation.

Reference

Evaluation and Management Services Guide: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Ellen Berra: The next question has to do with how Medicare defines a group. This applies to shared and split services only. As part of the shared and split services changes, Medicare decided not to define a group. Medicare lets the entities involved, nurse practitioners, physicians, etc., determine if they are a group. The example is hospital employed nurse practitioners working to support an outside group of cardiologists.

Previous to 2022, those two would not be considered a group as they were not the same tax ID number. For 2022 and determining the shared or split service, they could be considered a group. How you determine whether you are a group? That's up to the entity. CMS and Medicare have not published anything about what qualifies as a group. The only thing that Medicare published is that you need to keep within your records how you have determined a group and who you consider to be part of your group, so you can show it to Medicare if needed. That's a question you want to take back to your legal department.

Kelly's last question is if based on the time they end up billing a high percentage of the highest level of office or other outpatient procedure code, 99215, would this cause them a problem?

Data analysis would show an unexpected finding for Medicare if you're billing most of your services at that level. We would probably request medical documentation from you. If your documentation supports your medical necessity and the procedure code billed, then you don't have a problem. It's when your documentation does not support the procedure code billed, then Medicare could take money back. Again, it all goes back to documentation.

Kim's question concerns E/M services and hemodialysis at the same time. Does the provider have the option to bill the 90925, which is the hemodialysis procedure, with a single evaluation or can they bill an inpatient service?

A patient's evaluation is part of the hemodialysis service. So, unless you have something extraordinary going on, the hemodialysis procedure is what you would normally choose. However, we cannot provide coding advice. You choose the procedure code best reflected by the documentation in the patient's medical record.

Kristi has the next question, and it asks whether a consultation can be performed as a shared or split service?

Medicare no longer pays consultation procedure codes. Medicare rules apply based on the procedure code you are using. If you're using an inpatient procedure code or office or other outpatient procedure code to reflect your service, then you can perform the service as a shared or split service.

Martha's question concerns whether you count a test as part of your amount and complexity of data to be reviewed and analyzed. If one physician ordered the CT scan for the patient. The ordering physician didn't bill the professional component as it was provided at an outside facility. They counted the order for the medical decision-making for that office visit. Several months later, another physician in the same office as the ordering physician saw the same patient and did an independent interpretation of the CT scan that was ordered by that first physician. Her question is how do we count this? Can we count that independent interpretation towards the data? Can we count it if that first physician billed the CT scan's professional component?

This question has multiple things going on. First, look at if the two physicians involved are the same specialty. If they're the same specialty, then the second doctor would not count that independent interpretation because someone else already counted the test's order as part of their E/M service.

Also, look at if the first doctor did a review and then the second doctor is doing an independent interpretation. If that first doctor did not bill for the review or the professional component of that CT scan, then the second doctor could count that independent interpretation. If the first doctor billed for an interpretation, then doctor the second doctor could not count it.

This question is confusing because there are many variables. When you have situations like this, you want to go back to the rules. The basic rule for testing, is

that if the practitioner or a member of that same group with the same specialty is billing for the professional component of that test, then you would not count the order of that test as part of your medical decision-making. If your practitioner is not billing for the professional component because another entity is doing that and your physician is ordering that test and reviewing the results of that test, then that's part of your medical decision-making. For the second provider, who is evaluating this information? Again, keep in mind you're not going to count the order or review twice. If the first doctor counted that as part of his medical decision-making six months ago, the second physician is not going to count that order or review again. If that second physician is doing an independent interpretation, they can bill that as long as that first doctor did not bill for the professional component. The independent interpretation is a report. It's not to the level of a radiologist, but it would be a separate report.

Melisa's question is seeking clarification for the 24-hour rule for inpatient services. As far as E/M services, we're not sure where she is going with this question. In the provider community there is terminology about a 24-hour rule in determining whether a patient is admitted to the hospital or considered an outpatient. That's not a subject we're going to discuss today. If there is further information you want to provide on that question, you can do that within the follow-up questions module.

Nancy asked if we have examples of shared and split documentation. We don't have examples. What we want in that documentation is who provided the substantive portion, either based on time or that component. We suggest that your colleagues review redacted documentation. Hand it off to someone else, another professional coder, auditor, or someone along those lines. Ask what they see in the documentation. Medicare is looking for specific documentation as to who provided the most amount of time or who provided a component in its entirety.

Nicole questioned if Medicare uses modifier 93. The answer is no.

Pamela questioned how we classify something as an acute injury or acute complicated injury. The example given is a fracture requiring casting. Our medical review staff would probably not identify that you had to cast it as a complicated injury. It's still an acute injury because of the fracture. The cast, by itself, would not show the complications. Check your documentation for what complications apply to that injury. Are there additional systems involved because of the injury? There's an AMA document defining for acute complicated injury, so I encourage you to look at that.

Reference

American Medical Association (AMA) Instructions: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Ellen Berra: Pamela's second question is can you count a test where the professional component is being provided by your office? And the answer is no. If you're doing that professional component, then you would not count that.

Ruth's questions concerned observation care services. In the example, one physician ordered observation services last night. Another practitioner, or that same practitioner, saw the patient today. Can they report an initial observation care service?

The answer is no. The initial observation care procedure code is only billed on the day the observation care begins. If yesterday the observation care is ordered and the hospital began providing observation care yesterday, then yesterday is the only day you can use that initial service. Any services on the next day, would be subsequent observation care services. It could be an office or other outpatient procedure code if you're not the person in charge of that day's observation.

Ruth's next question is whether you can use modifier 57 as an order for surgery, if you're not doing the surgery? The example given is the practitioner admitted the patient to the hospital today and orders surgery. Another member of his practice does the surgery the following day. What happens with that E/M code?

If they're the same group with the same specialty and the order if for a major surgery, then that first physician appends modifier 57 to the E/M service. If they are in the same group but not the same specialty, then append no modifier.

If it is a minor surgery, then you determine if that E/M meets the qualification for modifier 25. Modifier 25 is a significant, separately identifiable E/M service.

Sandra's question is concerning physicians and nonphysician practitioners. How is the new or established status determined when they're working together?

If a nurse practitioner is working with a physician and they're billing incident to, that nurse practitioner is going to use a subsequent E/M service. If the nurse practitioner is taking over treatment and they're responsible for the patient's care starting from this point, then they could use an initial E/M service if no other E/M service has been billed during the previous three years by themselves or another nurse practitioner.

Another part of that question is does Medicare classify a nurse practitioner or physician assistant (PA) under who they working under that day? And the answer no.

Next, Sandy had a question on consultations which we've already answered.

The next question is an unusual situation. It is if the physician discusses the need for a patient to have a particular test, but documents that he needs to discuss this with the radiologist because of the patient's condition. Can this count towards the data section as a test ordered?

The answer is that if he orders the test, then yes, he can count that. If there needs to be a conversation with the radiologist, then until that conversation happens the test has not been ordered.

The next question goes back to chronic care. There's no documentation of how long it has lasted or how long it is expected to last. This is not considered chronic.

Next question is a patient is having trouble with nutrition and the physician wants to refer to a registered dietician, how would you count that in the level of risk?

Referral to a registered dietician is not one of the examples given. You want to go back to what is the risk to the patient? What's happening with that patient? And the medical decision that you're making. That's a clinical determination. If the patient is suffering malnutrition, how bad is it? What is the risk to the patient when referred to the medical nutritional therapy person? It all goes back the documentation.

That ends the pre-submitted questions we received.

Operator: Your first question comes from the line of Cheryl. Your line is now open.

Cheryl: Will there be a transcript of the 1/6/22 E/M education and was this event ever published?

Ellen: We published the 1/6/22 teleconference as an encore. We don't have plans to publish a transcript. We do have a Q&A document in our Learning Center Content Library assets.

Cheryl: I have two questions regarding that Q&A, In the miscellaneous section, question four states do we have to hold submission of the claims for the practitioner's signature? The answer states the practitioner must complete documentation of the service prior to submission to Medicare. The practitioner should sign the medical record at the time of service or shortly after. It continues that you don't have to hold the claim for the signature. Seems contradictory. What's the thought?

Ellen: You can't bill your service until your physician or practitioner documents it. If it's not documented, it wasn't done. There are provisions which allow signature exception. This is on the Internet-Only Manual (IOM) Publication 100-08, Chapter 3, Section 3.3.2.4. This allows for physician attestation statements. CMS is giving provider education that physicians and practitioners need to sign when doing the documentation, but this provision allows for unsigned documentation to use an attestation statement later.

Reference

IOM Publication 100-08 Medicare Program Integrity Manual (PIM), Chapter 3 Verifying Potential Errors and Taking Corrective Actions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

Cheryl: Thanks for that answer. Next, on question 6 and 7 regarding prolonged care services and whether they need to have the start and stop time documented. Question 6 answers that the start and stop time should be documented for prolonged services. Question 7 asks about G2212 and if time should start and stop time be documented. The answer is there is no requirement for G2212, but that is the Medicare prolonged care code. It seems contradictory.

Ellen: The IOM Publication 100-04, Chapter 12, Section 30.6.15.1 D indicates that for the prolonged care codes 99354 to 99360 documentation must contain the start and stop times. The IOM does not list G2212 as the code is new code. The fact sheet for the G code does not include mandatory use of start and stop times. It's a situation where the two CMS publications for prolonged care codes are different.

Reference

IOM Publication 100-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Fact Sheet - Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits: https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

Cheryl: Thank you.

Operator: Your next question comes from the line of Kristi. Your line is open.

Kristi: Hi Ellen. Can you clarify the data counting information? I thought you stated if a provider orders the test but a provider of another subspeciality within your group reviews, you could not count that as data.

Ellen: Wording in the AMA document is that in your group a provider with the same specialty cannot bill the professional component when a provider previously billed it. For this definition, the same group is the same tax ID. Yes, you could count the data if it's the same group, but different specialty. Here's an example. Your family practitioner orders a test. Your groups radiology person bills the professional component of that test. Your family practitioner can count the order of that test as part of their medical decision-making.

Reference

American Medical Association (AMA) Instructions: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Kristi: Okay. When one provider orders an x-ray, i.e., orthopedics, the x-ray is done at the hospital. Orthopedics get those results back and performs their own independent interpretation at the patient's next visit. This is for orthopedics MDM, is that still valid?

Ellen: If they're doing an independent interpretation of the test provided by someone else, yes, they can count that. I would caution you to make sure there is a separate report. If it's not very clearly documented, we're going to assume it's the review. This does not count.

Kristi: Thank you.

Ellen: Okay

Operator: Your next question is from the line of Karen. Your line is now open.

Karen: Thank you. Hi Ellen, I have a couple of questions.

In an earlier question about shared visits, you stated time is used to determine both the substantial portion and to choose the level of service. To clarify, we can use time to determine who provided the substantial portion but still use key components to determine the level of visit?

Ellen: You can, yes. The office or other outpatient is time or medical decision-making. Other categories of service are time spent in counseling and or coordination of care when more than 50%, or history, exam, or medical decision-making.

Karen: Along those same lines, you were talking about time, for example an inpatient visit as a split or shared visit. I know that's true for using time to determine a level when 50% is counseling, but is that also true when using time to determine the substantive portion?

Ellen: Yes.

Karen: In your example about a nurse practitioner seeing a patient in a cardiology office, if the patient has seen a nurse practitioner in another office but the same group in the previous three years, I understand that for this nurse practitioner must be an established patient visit. If a cardiology doctor sees that patient six weeks later, can the doctor bill as a new patient?

Ellen: If no other cardiologist has seen them within the previous three years, that is correct.

Karen: One final question. You mentioned that for initial observation, if the order is written and the patient is place in observation one day, but the physician doesn't see the patient until the next day, that would have to be billed as subsequent observation. Is that also true of inpatient or is that just for observation?

Ellen: It's just for observation. An initial inpatient service is the first time a practitioner or a member of the same group with the same specialty sees the patient during an inpatient an inpatient stay. Observation works different.

Karen: Thank you so much.

Ellen: Okay, thank you.

Operator: Next question comes from Stephany. Your line is open.

Stephany: We have NPs and PAs throughout our clinic, in urgent care, family medicine, dermatology. If a patient sees NP in urgent care or acute care and then sees our doctor in internal medicine, would that be a new patient to the doctor?

Ellen: For initial services, Medicare uses the physician specialty the practitioner is enrolled under. A nurse practitioner enrolls as a nurse practitioner. They're not the same specialty as any doctor; therefore, yes, that doctor has an initial visit. Medicare does not use taxonomy codes. These codes allow the nurse practitioners to identify practice specialties.

Stephany: What if there are multiple NPs in different arears of the clinic, either in family medicine or internal medicine, would it be an established visit all the way through?

Ellen: That is correct.

Stephany: One last question. We have a NP working with our dermatologist. The patient sees the doctor first, then follow-up visits are with the NP, would that be established or new for the NP?

Ellen: That's a clinical decision you'll have to make. If your nurse practitioner is following what the physician is doing, then it's not a new patient. If that nurse practitioner is taking over the care, then they can bill an initial service.

Stephany: Thanks for your help.

Operator: Next question comes from Hope. You line is open.

Hope: Hi. When a shared service is done using the outpatient codes 99202 through 99215 because the substantive portion must support the level of service billed, does that mean the provider must have performed medical decision-making (MDM) or majority of the time to be the billing provider?

Ellen: Yes.

Hope: Okay. To add to that initial observation scenario. The observation provider didn't see the patient the night it was ordered, they see them the next day. That next day when they see them for the first time, the patient was discharged. Do they have the option of billing a subsequent day or discharge depending on what their documentation reflects?

Ellen: Yes. You're either going to bill that subsequent service or discharge management based on your documentation.

Hope: Perfect. It seems like all the observation information was removed from the website, is there a reason why? I don't know if you can answer that, but maybe just in follow-up it can be addressed.

Ellen: I don't know that we removed any information from our website. Include a follow-up question that you would like this information available our website. We can see what see can do.

Hope: Perfect, thank you so much.

Ellen: Thank you.

Operator: Next question from is form Sandra. Your line is open.

Sandra: I'm going back the reference made to the PIM chapter covering amendments, corrections, and delayed entries in the medical record. I know it was mentioned there's an attestation but when I look at section 3.3.2.5, it clearly indicates all services are

expected to be documented at the time they are rendered, and occasionally certain entries related to services provided are not properly documented. In which case, they'll need to be amended, corrected, or entered after rendering the service. How would an attestation account for that? What would you consider a reasonable timeframe for an addendum to the record? Do you have anything published on the timeframe for making that amendment?

Reference

IOM Publication 100-08 Medicare PIM, Chapter 3 Verifying Potential Errors and Taking Corrective Actions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

Ellen: First, you're talking about a different section than what was identified earlier.

When you're talking about an addendum, you're talking about the practitioner identifying there's a problem, need for additional information, a mistake, or something. We expect the addendum would be done as soon as that error or additional information is identified. We have instances where we're performing an audit, so we request medical documentation, and we find all these addendums. We did not count them because we could tell that the provider was trying to beef up the documentation to support the procedure code billed. That is not considered a correction. This is not related to timeframe.

The information within the IOM does not give a timeframe. Add then when you identify you need additional information in the note. Also, include how you identify the error and what you're correcting, etc.

Sandra: Okay, so you don't you don't have a timeframe like 24 to 48 hours or 10 days max?

Ellen: No.

Sandra: Okay, alright. Thank you.

Ellen: Thank you.

Operator: Next question is from Pamela. Your line is open.

Pamela: Thank you. I wanted clarification on the shared split rule. We're seeing situations where our nurse practitioner documents the patient's history, exam, and medical decision. The doctor will come on in and will just review and agree with the history and exam. The doctor adds his own full medical decision-making. Are we able to consider the physician doing the full medical decision-making also as a substantive portion because it was his own? It wasn't copied or anything. Can we count that to bill under the physician?

Ellen: For 2022, yes you can. Shared and split means either you're dividing and billing under who provided the substantive portion of time, or if your physician provided one of the components in its entirety, then you can use that component as the substantive portion.

That's only for 2022. Beginning January 1, 2023, it's going to be time only based on current instructions.

Pamela: Okay. We wouldn't use the medical decision-making from the nurse practitioner's notes.

Ellen: That is correct.

Pamela: Okay, thank you.

Operator: Next question is from Michelle. Your line is open.

Michelle: Hi, thank you. You mentioned these questions would be available after the meeting. Are those available on the website in a Q&A format?

Ellen: Today's Q&A, will be part of this call's transcript. The transcript will be in our Learning Center Content Library as an asset.

Michelle: Okay. My second question has to do with duplicative services related to critical care. Do you have any examples?

Ellen: I don't have any documentation examples. Something we see quite often is when the patient is admitted to the hospital, whether it's in a regular or critical care bed, and the hospital assigns a hospitalist or an intensivist to this patient, but the patient's problems are being treated by somebody else. In this example, the patient goes into the hospital due to a heart problem. A cardiologist is the one treating the heart problem, but the hospitalist is also billing for services. Unless the patient has something else going on that a hospitalist is actively treating, then Medicare would consider those to be duplicative services.

Michelle: Okay, the documentation should clearly support the work they're doing if they are both seeing the patient. Thank you very much.

Ellen: You're welcome.

Operator: Next question is from Julie. Your line is open.

Julie: Hi Ellen. Can you clarify your previous split shared services statement regarding time? CMS did not identify the split shared had to be 50% of counseling or coordination of care, only time. Are you saying it must be 50% of counseling or coordination of care time?

Ellen: No. You have two different things. How you choose your level and how you determine the substantive portion.

To choose your level, CMS breaks the E/M codes into two sets. For 99202 to 99215, leveling by time does not mention counseling or coordination of care. You level by time or medical decision-making. For other categories of service, your choice of the level of service if you're using time is more than 50% in counseling and coordination of care. That's your level.

If you're using to time to determine the substantive portion, it is whoever is providing the most amount to time.

You could choose who provide the substantive portion based on time. You can choose your procedure code, level of service, based on time for counseling and coordination of care or the component.

Julie: Can you give an example using the inpatient setting if they wanted to bill based on time?

Ellen: Sure. Your nonphysician practitioner, in an inpatient setting, completes the history, exam, and medical decision-making. You choose your procedure code level based on the nonphysician practitioner's history, exam, and MDM.

Next, you're going to determine whether to bill under the physician or the nonphysician practitioner. This is based on the total of time each spent on that patient day. So, the nonphysician practitioner spent 20 minutes completing the history, exam, and MDM. As part of the shared split service there are many activities that can happen. The physician spent 30 minutes on these qualifying activities that day, though did not see the patient face-to-face. In that case, you bill under the physician based on the 30 minutes.

You choose your level based on the history, exam, and medical decision-making and then you would choose who to bill under on who spent the substantive portion of the time. It's two different things.

Julie: Okay, thank you.

Operator: Next question is from Karen. Your line is open.

Karen: Hi. If we have a physician that is teaching a physician assistant during the student clinical rotation, can we bill for services rendered by the student if the physician is in the exam room while the student's performing the evaluation and procedures and documents as such? This is during the graduate medical program, but the hospital is not receiving reimbursement through the program for the physician assistant.

Ellen: The teaching physician guidelines would not apply.

Karen: Thank you.

Operator: Next question is from Heidi. Your line is open.

Heidi: Hi. Based on the Q&A January, our education team is concerned about there not being documentation specific to an ambulatory setting for shared split visits. In the outpatient setting, both the physician and NPP document the same level of MDM with the equal time and documentation for the components for the shared service. If the NPP and the physician document equal amounts of time, or as the same level of service for MDM, they complete the same components, who can we bill as the substantive provider? We are using the outpatient codes.

Ellen: If you're using the 99202 to 99215 and have the exact same amount of time or medical decision-making, your chosen component, then you would choose. When documentation supports it was exactly the same, then Medicare could support your choice

Let me make a point here, shared or split is only for outpatient services, that means outpatient hospital services or skilled nursing facility. Place of service code 19 or 22. You cannot use shared or split in an office setting.

Heidi: Thank you. For the prolonged care, as it applies to shared visits, is the FS modifier required?

Ellen: Yes.

Heidi: Okay. For the physician's MDM documentation when it is copied and pasted from the NPP, would we have to bill under the NPP, or can we use that copied and paste documentation to support billing under the physician?

Ellen: Using documentation copied and pasted from your nurse practitioner does not show the physician performed that component in its entirety.

Heidi: Perfect, thank you.

Ellen: Okay. We have time for one more question.

Operator: Next question comes from Abi. Your line is open.

Abi: Hi, thank you. In our medical documentation program, we can hover over information to see which providers contribute which information within a note. All though we can see this information if we were to submit those records Medicare for review for any reason, will the documentation need to have a signature on which portion each provider contributed or can we send that information from our system?

Ellen: We would not need a signature from each practitioner. The signature requirement is for the practitioner submitting the charge.

In the note, we must be able to tell who did what. I'm not saying you have to identify that the nurse practitioner asked the patient how long they had the issue, and the physician asks the patient whether their pain is on a scale of one to ten. Medicare is not requiring that level of detail, but we do have to be able to determine who provided that substantive portion.

If you have a signature from one of your providers, that is acceptable. If your documentation can identify nurse practitioner here and physician here, then that's acceptable also.

Abi: Okay, thank you.

Ellen: That was our last question.

Just as a reminder, we are interested in your feedback. We are very interested in those things you like about the WPS website and the different departments you work with. If there are ways we can improve, we want to hear about those also. There are two options on our website for feedback. A survey static button called feedback is available on the right-hand side of the screen. There are questions about your opinions of working with WPS and our website. Also, several departmental web pages, training, claims review, provider enrollment, and appeals, have a way to provide feedback. Select the link on the top of the page.

Thank you for your attendance today. This concludes today's call.

Operator: This concludes todays conference call. Thank you for your participation. You may now disconnect.

Follow-up Questions

Question – We have a Physician Assistant (PA) working in our group under both Family Practice and Ortho. The patient sees the Family Practice PA and then sees the PA in Ortho. Can the second visit be an initial service?

- Answer – Medicare views providers as the two-digit specialty under which they enrolled. The PA working in Family Practice is the same specialty as the one working in Ortho. Submit a subsequent service when the patient received care by a PA in your group within the previous three years.

Question – The Non-Physician Practitioner (NPP) and the physician split (share) the service. The physician provided a component to moderate level. The NPP provided services to comprehensive level. Which level do we submit?

- Answer – You would submit moderate. You can use a component to show the substantive portion of the service. The physician must perform that component in its entirety. Use the component in choosing the level of service.

Question – My physician did not enter the room per COVID-19 guidelines but provided an E/M. Can they code to a comprehensive level even though they did not perform an exam?

- Answer – The requirements for the choice of your level of service did not change. Code to what you performed for the patient.

Question – Why must the qualifying activities for split (shared) need the presence of the physician at the hospital?

- Answer – CPT inpatient services are in-person or on the floor or unit.

Question – The electronic health record shows the physician ordered several tests. The note for today's service does not mention the tests or the reasons for the tests. Can we use the nature of the tests as part of the physician's documentation?

- Answer – No.

Question – Patient has morbid obesity, sleep apnea, hypertension, and diabetes. The physician medical note only mentions the morbid obesity. Can we consider this as a high level of number and complexity of problems addressed? Would this be "1 or more chronic conditions with severe exacerbation, progression, or side effects of treatment"?

- Answer – Code to what the physician documents. When documentation is not clear, discuss with your physician.

Question – The physician determines the patient needs bariatric surgery. Medical record shows the morbid obesity. The patient problem list includes sleep apnea, hypertension, and diabetes. Can we consider this a high level of risk using the problem list as the risks to the patient?

- Answer – The documentation must identify the patient or procedure risks. You do not need a separate section showing "surgical risks".

Question – We use time to determine the level of service when spending more than 50% of the total time in counseling/coordination of care. This is for inpatient and SNF services. In a split (shared) service must both practitioners provide counseling/coordination of care?

- Answer – No. Counseling/coordination of care must be more than 50% of the total time between both practitioners.

Question – A pre-submitted question mentioned a physician needing to consult with the radiologist first before ordering a test. The speaker said this would not count as a test. Is that correct?

- Answer – Yes. A decision to order, or a consideration but no order would count as a data element. However, in the example given, the physician has not yet made the determination. The discussion with the radiologist could count as a Category 3 element. If after the discussion, the physician then decides to order or not, then this could count as an order.

Question – Patient is on hypertension medication. Physician documents history of hypertension. What can we use to show the physician to document hypertension?

- Answer – Based on the information given, the patient currently has hypertension controlled by medication. If the patient had hypertension in the past but does not now, this would be history of hypertension.

Question – Will Medicare recognize the place of service (POS) 10?

- Answer – Medicare will process POS 10. CMS has published that after the Public Health Emergency (PHE) providers should continue to use POS 02.

Question – Can you clarify when the teaching physician is not present when the resident performs the service?

- Answer – Medicare reimburses the teaching physician when either:
    - He/she performs the service
    - He/she is present when the resident performs the key and critical portions of the service

  The resident may see the patient late at night. The teaching physician sees the patient the next day. The teaching physician must perform the E/M service. The teaching physician can use the resident's notes. He/she does not have to redocument. The teaching physician would identify changes in the patient condition based on their service.

Question – Can you provide an example of a payable E/M on the same date as a joint injection?

- Answer – The documentation determines whether an E/M would be separately payable. Payment for the knee injection includes E/M. For Medicare to pay separately, documentation must show the E/M is a significant, separately identifiable service. This is over and above what the physician would normally provide when doing the joint injection. If significant, separately identifiable, append modifier 25 on the E/M.

Question – Emergency department visits do not include a time component. How will we determine under whom to submit charges in a split (shared) situation?

- Answer – Providers are confusing choosing the correct level of service with the split (shared) guidelines. Choosing the level of service has not changed. Choose the level of service based on the description of the procedure code. For 2022 use either time spent by each provider or a component of the service. For 2023 it will only be the time spent by each practitioner.

Question – We provide services in the outpatient department of the hospital. We use codes 99202 – 99215. The choice of the level of service is either time or medical decision-making. How do we determine under which practitioner to submit when providing a split (shared) service?

- Answer – Choose your level of service based on the documentation. This has not changed. Choose under whom to submit the charges based on who provided the substantive portion of the service. For 2022, use either the time of each practitioner, or a component of the service. This would be history, exam, or medical decision-making. The practitioner must have completed the component in its entirety. You must use the component to choose the level of service.

Question – Should we ask the physician and NPP document time for a split (shared) service?

- Answer – For 2022, you do not need time if using a component. For 2023, the practitioners would need to document time.

Question – The physician spent 30 minutes with the inpatient with more than 50% spent in counseling/coordination of care. The NPP spent 20 minutes with the patient. Can we choose the procedure code based on 50 minutes?

- Answer – The choice of the level of service has not changed. The provider must spend more than 50% of the total time of the visit in counseling/coordination of care.

Documentation must show more than 25 minutes spent in counseling/coordination of care. If so, then you can use the 50 minutes to choose your level of service.

Question – The physician for today's inpatient encounter documented a compound fracture of the arm. They did not show right or left. Yesterday's encounter indicated compound fracture of right arm. Can we use the information from yesterday's service to show the laterality?

- Answer – The best practice is for your physician or practitioner to document what he/she is treating. Medicare reviews documentation based on the date of service. We expect documentation to support the diagnosis codes and procedure codes chosen.

Question – Please clarify the documentation requirement for an independent interpretation.

- Answer – The interpretation of a test for which there is a CPT code. An interpretation or report is customary. This does not apply when the provider is reporting or previously reported the service. A provider must document a form of interpretation. This need not conform to the usual standards of a complete report for the test.

Question – Must the provider document the time the patient has had the disease to count as chronic?

- Answer – Yes. Chronic means a problem with an expected duration of at least one year or until the death of the patient. If documentation does not show, then this is not chronic.

Question – Do we need to have documentation of what we consider members of a group? CMS did not define this for split (shared) services?

- Answer – Yes. You would need some type of documentation to show who you consider to be members of the group.

Question – How do we submit the following in a critical care situation,

Dr. A saw the patient for 20 minutes,

NPP saw the patient for 35 minutes, and

Dr. B saw the patient for 30 minutes.

- Answer – If all are part of the same group, submit the service under the NPP. Submit the 99291-procedure code. The NPP provided the substantive portion of the service.

Question – The NPP provided 15 minutes and the MD/DO provided 20 minutes for an inpatient service. Is it correct we could count 35 minutes for this service?

- Answer – Yes

Question – How do we submit when both the MD/DO and NPP see the patient in the office?

- Answer – Split (shared) guidelines do not apply to services provided in locations other than a hospital or skilled nursing facility (SNF). In an office setting, you can submit under the MD/DO when the documentation meets all the incident to guidelines. If documentation does not meet all the incident to guidelines, submit using documentation from one of the practitioners only.

Question – Can you clarify the use of a component to determine the substantive portion of the service?

- Answer – In a split (shared) service, you can use a component of the service as the substantive portion. The components are history, exam, and medical decision-making. For 2022, submit under the physician when the physician performs the component in its entirety. You must use the component to choose the level of service. For an initial service, you must meet three out of three levels. For a subsequent service, you must meet two of the three components for that level of service.

Question – Can I submit an initial observation care procedure code? I didn't see the patient until the day after the hospital started observation services on my order.

- Answer – No. You can submit initial observation care for the date observation began. This is the attending provider. You can find more information in the CMS Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.8.A.

  Reference

  IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Question – The surgeon or member of the same group with the same specialty provided critical care. Should we use Modifier 24 in addition to Modifier FT?

- Answer – Yes. When critical care is unrelated to the surgery, the surgeon should append Modifier 24 and Modifier FT.

Question – Must we record start and stop times when providing telehealth in the office setting?

- Answer – No. Record the time spent on the patient on that day when using time to choose your level of service.

Question – The telehealth service started at audio/video, but the connection failed. Must we change this to an audio only visit?

- Answer – If the encounter started as audio/video you can submit that way. Documentation should show what happened.

Question – Can you clarify modifier 78? Can you use this when the procedure performed in the office?

- Answer – Modifier 78 is for a return trip to the operating room for the treatment of complications. If the service is not a return trip to the operating room, do not use modifier 78. IOM 100-04, Chapter 12, Section 40.1.B provides the definition of an operating room (OR). An OR for this purpose, is a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR). If the location of the treatment of the complication does not meet these guidelines, do not submit. The service is part of the global surgery package of the original surgery.

  Reference

  IOM Publication 100-04, Medicare Claims Processing Manual Chapter 12 Physicians/Nonphysician Practitioners: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Question – Can you clarify the new patient when services provided by both an MD/DO or NPP?

- Answer – Patient has not had a professional service by the provider or a member of the same group with the same specialty within the previous three years. Submit a new patient service.

  Both MD/DO and NPP see the patient for the initial visit in the office. This is not an incident to service. Submit under either the MD/DO or NPP using only their documentation.

  MD/DO sees the patient and on a different date the patient sees the NPP. You can have incident to when meeting all guidelines. This would be a subsequent service.

  MD/DO sees the patient and on a different date the NPP sees the patient. This can be a new patient for the NPP if the NPP has taken over patient care.

  Patient sees the NPP first and then later sees the MD/DO. The MD/DO can submit a new patient when meeting requirements.

Question – Can we submit under the incident to guidelines in an outpatient hospital setting?

- Answer – No. Incident to does not apply to a hospital or SNF. If only the NPP sees the patient, the NPP will bill the service.

Question – Doctors often exchange wound for ulcer or vice versa. Can we assume ulcer?

- Answer – No. If the documentation is not clear on what the physician performed and why, have a conversation with the physician. Do not make assumptions.

Question – Can we count a review of the state Prescription Monitoring Program as review of external notes?

- Answer – Yes.