2022 Update: Rheumatology Coding & Audit Issues

Michigan Rheumatism Society

Annual CME Meeting

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Presented by :

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About the Speaker

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President & Senior Consultant

Jean has 30 years of health care experience including a particular expertise in chart audits, compliance and education relative to physician documentation and coding. Related to these issues, Jean has been an expert witness in civil litigation as well as Federal fraud cases. She is a workshop presenter for the AAPC, an instructor at Florida Atlantic University, a member of several Coding Institute Editorial Advisory Boards and an AAPC subject matter expert on CMS' Quality Payment Program. She is actively engaged with CMS through her involvement with CMS' Medicare Provider Feedback Group, CMS Division of Provider Information and Planning Development since 2007 and Jurisdiction 9 MAC's Provider Outreach and Education Advisory Group.

She is a frequently sought after speaker as she possess the unique perspective of avoiding risk and liability while optimizing reimbursement in the highly-regulated health care industry.

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policy changes frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and coding information, but is not a legal document. The official CPT® codes and Medicare Program provisions are contained in the relevant documents.

Agenda

- Payer Documentation Requirements
  - Medical necessity
    - a/k/a being able to keep the money!
- Evaluation and Management
  - Determining the level of service based on complexity
- Incident-to versus Split/Shared Visits
  - 2022 brought very distinct differences

"10 Iron Rules of Medicare"*

* Quote from Attorney Larry Oday; Modern Healthcare, June 19, 2000

1. Just because it has a code, that doesn't mean it's covered.
2. Just because it's covered, that doesn't mean you can bill for it.
3. Just because you can bill for it, that doesn't mean you'll get paid for it.
4. Just because you've been paid for it, that doesn't mean you can keep the money.
5. Just because you've been paid once, that doesn't mean you'll get paid again.
6. Just because you got paid in one state doesn't mean you'll get paid in another state
7. You'll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There's always some schlemiel who doesn't get the message.
10. There's always some schmendrik (jerk) who gets the message and ignores it.

What the payer wants, and why…

Medical Record Documentation

Validates:

- The site of service
  - Is it appropriate for the service and patient's condition?
- The appropriateness of the services provided
  - Not experimental
  - ✓ Meets, but doesn't exceed, patient's medical record
  - ✓ Ordered and performed by qualified personnel
- The accuracy of the billing
  - CPT®/HCPCS code accurately represent what is documented
  - ICD-10-CM codes are supported by clinical documentation
- Identity of the care giver (provider)
  - ✓ Who personally performed the service?
  - ✓ Legible signature

Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor. “

Documenting Medical Necessity

WPS **L34588** – Trigger Points, Local Injections

Documentation Requirements

1. Documentation of proper evaluation leading to diagnosis of the trigger point.
2. Identification of the affected muscle(s).
3. Documentation of reasons for selecting this therapeutic option.
4. Precise diagnosis code must be used: generalized diagnoses like low back pain, lumbago, etc. will not be covered.
5. Documentation which includes the frequency of injections.
6. Documentation must reflect the medical necessity of providing the service. In a post payment review, the process of making the diagnosis of the trigger point in an individual muscle as detailed in the description section must be documented.
7. If a patient requires more than 4 sets/series of injections during one year, (trigger points in different anatomical locations), a report stating the unusual circumstances and medical necessity for giving the additional injections must accompany the claim for review and individual consideration

Documenting Medical Necessity

WPS **L34588** – Trigger Points, Local Injections

Utilization Guidelines

Repeat trigger point injections may be necessary when there is evidence of persistent pain. Generally, more than three injections of the same trigger point are not indicated. Evidence of partial improvement to the range of motion in any muscle area after an injection, but with persistent significant pain, would justify a repeat injection. The medical record must clearly reflect the medical necessity of the repeat injections.

Only one Trigger Point Injection CPT code can be billed per date of service.

Because the diagnosis code manual does not list "trigger point" or "myofascial pain syndrome," this LCD lists related diagnoses that can reasonably include trigger points and uses "myofascial pain syndrome" to refer to trigger points.

- see **A56909**

E/M Office Visits and Complexity of E/M

Complexity of Medical Decision Making

3 Elements -2021 Office/Other OP Visits

1. Number and Complexity of problems addressed
2. Amount and/or complexity of data to be reviewed and analyzed
3. Risk of complications and/or morbidity and mortality of patient management

2:3 Elements of MDM must meet or exceed to qualify for a given level of service

Clinical Example of the 3 Elements:
Coded 99213

1. #/Complexity of the Problems Addressed
   - Doing well. No joint pain or swelling. Tolerating meds

1 stable chronic illness: Low/99213

2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - Plan Orders: CRP, Sed Rate, CBC w/diff, CMP

3 Unique tests: Moderate/99214

3. Risk of Complications of Patient Management
   - Included in the Plan: Methotrexate 15 mg (6 tabs) weekly, folic acid 1 mg daily,

Rx Mgmt: Moderate/99214

What code level do you think this is and why?

Clinical Example of the 3 Elements:
Coded 99213

1. #/Complexity of the Problems Addressed
   - OA, right knee still with pain

1 unstable stable chronic illness: Moderate/99214

2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - Consider MRI

1 test: Minimal/99212

3. Risk of Complications of Patient Management
   - Aleve, Voltaren gel, physical therapy

OTC, PT: Low/99213

What code level do you think this is and why?

Clinical Example of the 3 Elements:
Coded 99213

1. #/Complexity of the Problems Addressed
   - Osteoporosis will be treated now that BMD has red

1 unstable stable chronic illness: Moderate/99214

2. Amount/Complexity of the Data to be Reviewed/Analyzed
   - (In-house) bone density. Sent Vitamin D level a

2 lab tests ordered: Limited/99213

3. Risk of Complications of Patient Management
   - continue calcium and vitamin D 2000 IU per da
   - Evista per Dr. Smith
   - restart Prolia

Rx Management: Moderate/99214

What code level do you think this is and why?

Incident-to Versus Split/Shared Visit Billing

Incident-To vs. Split/Shared Visits

- Services were rendered by one provider and billed by another provider
  - Understand incident-to and shared visit billing
  - You must be in the office suite for ancillary staff's services to be billed under your name and NPI for "incident to" billing
  - If employing an ARNP or PA
    - They MUST have their own Medicare number
    - Cannot bill their visits under you ("incident-to") if they see a new patient
      - Or they see an established patient with a new problem, or if they change anything
    - Check private/managed care payers' criteria

First order of confusion:

CPT® on Split/Shared Visits

2021 - Present

New Concept: Time and Split/Shared Visits

- A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.
- When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.
- Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

Nonphysician Practitioner?

Physician?

Who to bill under? CPT® is silent.

What are the chances that some providers, coders and billers interpreted that it's their choice whose name/NPI should be repo

80/85% $$

100% $$

Split (or Shared) Visits Redefined for 2022 and Beyond

- CMS defines split/shared visits as an E/M visit in the facility setting that is performed by both a physician and a NPP who are in the same group, in accordance with applicable law and regulations such that **the service could be billed by either the physician or NPP if furnished independently by only one of them**.
- Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.
- Payment will be made to the practitioner who performs the substantive portion of the visit.

Split (or Shared) Visits Redefined for 2022 and Beyond

- Split (or shared) visits can be reported for new and established patients, initial and subsequent visits, and prolonged services.
- ***Modifier -FS*** should be included on the claim to identify these services "to inform policy and help ensure program integrity."
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

For office/clinic visits, you can only bill for a "shared/split visit" if the POS on your claim is 19 or 22 designating "provider based," i.e. you work for the hospital.

Incident-to Billing (POS 11) – Why all the attention?

- Depending on who actually performed the service, erroneous reporting could result in either a 15% or 100% overpayment.
  - Nonphysician Practitioner (NPP) or Auxiliary personnel person is unlicensed – 100%
  - NPP is licensed (NP/PA), but is not credentialed – 100%
  - NPP is licensed (NP/PA), and is credentialed in the group – 15%

‘Incident-To’ Requirements

- The services/supplies are an integral, although incidental, part of the physician’s/NPP’s professional services.
  - Course of treatment initiated by physician
  - Physician involvement reflected as continuing active participation in the patient’s management/care
- The services/supplies are of a type that are commonly furnished in a physician’s office or clinic.
  - Rules out services performed in the hospital or SNF/NF

‘Incident-To’ Requirements (continued)

- The services/supplies are furnished under the physician’s direct personal supervision.
  - A member of the group who is physically in the office suite
- The ARNP/PA is a Medicare Provider
- The services/supplies are furnished by an individual who qualifies as an employee of the physician.
  - W2, 1099 or leased employee
  - Cannot bill for the hospital’s PA/ARNP

Physician & NPP Documentation

NO!!

- NPP performs the initial visit. Supervising physician documents a note along the lines of:
  - “I have reviewed the Physician Assistant’s note, examined the patient and agree with…”
  - “Nurse practitioner performed the history and physical and I was present for the entire encounter and my treatment plan is as follows…”

The above are common findings to support the incident to guidelines for initial/new patient visits. But, do they support these?

Physician & NPP Documentation: Initial Visit

- Although the physician is documented as being present and immediately available, the physician **must** perform the initial service.
  - OVs starting 1/1/21: All the MDM.
- Bottom line: Incident to billing does not apply to a new patient or a new problem for an established patient.

American Academy of Family Practice
Fam Pract Manag. 2022;29(3):33

Q: Under Medicare's new rules for split/shared visits in institutional settings, do all office visits performed jointly by a physician and advanced practice provider (APP) now have to be reported by the APP?

A: No. The new guidelines do not apply to E/M services in the office or other non-facility setting. The Centers for Medicare & Medicaid Services said it did not see a need for split (or shared) visit billing in the office setting because "incident-to" regulations apply there. Under Medicare's incident-to policy, APPs may report services using the physician's name and National Provider Identifier (NPI) if the following are true: The patient is established with the physician, The service addressed an established problem and was a continuation of a care plan initiated by the physician, The physician was in the office and readily available during the portion of the service provided by the APP, The APP is an employee (direct or contractual) of the physician's practice. Physicians may ask their region's Medicare Part B administrative contractor for more guidance on incident-to services, if necessary. In the office setting (place of service code 11), either the physician or APP could bill a service performed jointly based on the work that the physician or APP personally performed and documented (e.g., medical decision making or total time on the date of the encounter). When a physician joins a visit initiated by an APP, the physician's level of medical decision making (independent of the service documented by the APP) equals that of the combined services, negating the need to meet incident-to regulations. [emphasis added]

Questions?

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