HEALTHCARE BUSINESS MONTHLY
Coding | Billing | Auditing | Compliance | Practice Management

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May 2023

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GOOD NEWS

Member Maynia Is Here!

MEMBER OF THE MONTH
Corella Lumpkins, CPC, CPCO, CDEO, CPB, CPPM, CPC-I, CHC, CCS, CCS-P

MEMBER MAYNIA

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Adapt and Grow in Changing Times

Nov. 30, 2022, was a pivotal moment in history. OpenAI, a San Francisco-based artificial intelligence (AI) company quietly released their "research preview" (as it was viewed in-house) of ChatGPT to the public with zero fanfare. They simply wanted to get users' feedback of the AI chatbot and learn about its strengths and weaknesses. A few days later, when I was first introduced to the tool, I experienced the most exciting (albeit unnerving) technology I had used in my lifetime. And I wasn't alone.

ChatGPT sprinted to 1 million users in five days. By January 2023, ChatGPT had 100 million active monthly users — making it the fastest-growing consumer application in history. "You need to understand," Craig Mundie, former chief research and strategy officer for Microsoft, warned in a March 21 *NY Times* article, "this is going to change everything about how we do everything. I think that it represents mankind's greatest invention to date. It is qualitatively different — and it will be transformational."

I agree that we have reached a pivotal moment in history — a time when technologies born through the ages have come together and sparked a wildfire of ingenuity. Now, it's up to us to use this tool for the greater good.

What Can AI Do?

ChatGPT is in its infancy. It only knows what it has been told. It may get things wrong, but it learns from its mistakes. And with proper nurturing, its potential is limitless. OpenAI says, "We believe our research will eventually lead to artificial general intelligence, a system that can solve human-level problems."

I asked ChatGPT to write a paragraph about potential uses for AI, to which it responded:

> Artificial Intelligence (AI) has a wide range of potential uses across various industries and fields. In healthcare, AI can be used to help diagnose diseases and create treatment plans, as well as analyze medical images and data to identify patterns and trends. In finance, AI can be used to detect fraud and automate financial analysis and trading. In manufacturing, AI can be used to optimize production processes and predict maintenance needs, while in transportation, AI can be used to improve traffic flow and optimize logistics. AI can also be used in education to personalize learning experiences for students and identify areas where additional support may be needed. Additionally, AI has the potential to improve customer service and create more personalized experiences in areas such as retail and hospitality. Overall, the potential uses for AI are vast and continue to expand as the technology evolves.

I couldn't have said it better myself.

How Can We Use AI?

Today, the ChatGPT tool has most of the business world rethinking AI and raising their bets — AAPC included. From training and tools to software and services, we're making significant technological investments in all aspects of our organization.

AAPC is already populating its own version of the technology powering ChatGPT (OpenAI) with its tremendous data stores. This proprietary AI will enable us to personalize learning experiences for students and identify areas where additional support may be needed. It will also allow us to provide quicker and more thorough answers to questions, be they related to customer service or revenue cycle management.

Our goal is to equip our members and their respective employers with the tools and skills they need to meet the growing demand of consumer expectations, ultimately elevating the standards we uphold for the business of healthcare. We are confident that AI will enable us to streamline internal processes and create an overall better membership experience.

Grow With Us Into the Future

AI is changing the world, compelling industries to adapt and evolve posthaste. This rapid change is both exciting and unnerving, as I said earlier, but if history is any indication, workers who adapt will flourish. Technology historically creates more new job roles than it displaces, and I believe the use of AI in healthcare will be no different.

Technology and automation will relieve you of the most mundane, routine, and simplistic parts of your work, allowing you to move on to the more interesting and challenging parts. There will also be new opportunities for career growth and advancement, and better pay for those who embrace technological progress and learn how to use the software and systems available to handle complex problem-solving. I foresee a much more fulfilling future of work for all.

Cheers to the future!

Bevan Erickson
AAPC CEO

Resource

www.nytimes.com/2023/03/21/opinion/artificial-intelligence-chatgpt.html

CODING/BILLING | 18

Billing a PA's Services Incident to a Physician's

By AAPC Documentation Advisory Committee

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COMING UP:

- Metabolism Tests
- Chronic Pain Management
- E/M Time Statements
- Compliance Tips

On the cover: It's time for Member Maynia! Pictured on the cover are AAPCCA BOD Chair Brenda Stevens, Vice Chair Robin Goudy, and Secretary/Treasurer Denise Garrett. Learn more about this annual local chapter event on page 10. Cover design by Colin Santos.

Go Green!

Why should you sign up to receive *Healthcare Business Monthly* in digital format?

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- You will save a few trees.
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HEALTHCARE BUSINESS MONTHLY

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Belinda Caballero, MBA, CPC

I always knew I wanted to work in the medical field; I just wasn't sure which aspect I wanted to concentrate on. After I graduated as a cardiovascular and X-ray technician in 1998, I took the Florida state exam to become a licensed X-ray technician and began working in healthcare. Throughout the next several years, I also worked as a phlebotomist, a medical assistant, a front desk assistant, and, in 2006, as a practice manager and medical biller. It was then that I knew I was where I wanted to be.

I forged ahead to receive my Certified Professional Coder (CPC®) certification and, in 2012, my Master of Business Administration in Healthcare. I went on to successfully open my own billing company, and I have been coding, billing, conducting and speaking at seminars, providing insurance contract services, and providing revenue cycle management consultation ever since. I cannot imagine doing any other job.

In Good Company

When I opened my billing company, I wanted my clients to feel confident that the person providing their coding was knowledgeable; after all, coding/billing is their bread and butter. The billers and coders in my company are required to have an AAPC certification when they are hired or obtain one within the first three months of employment, and my clients appreciate that. I offer my clients security and confidence in knowing that our staff is well equipped and trained to perform their jobs effectively and efficiently. Employing certified professionals exclusively has allowed for a high level of excellence in the services my company provides.

Making the Most of Membership and Resources

In my opinion, AAPC has the best certification programs in the medical billing industry, so when I decided on my career path, becoming a member was a no-brainer. AAPC offers great lessons, support, and knowledge. There is always valuable information in the forums and at local chapter events, and I love *Healthcare Business Monthly* magazine because it always has relevant information on healthcare topics and recent changes. I like to take advantage of the free information, webinars, workshops, learning tools, and access to industry-related continuing education units (CEUs), as well.

Healthcare is an ever-changing industry, and it's essential to keep up to date; success in this industry requires healthcare professionals to stay current in every aspect. For this reason, my staff and I attend conferences and seminars and subscribe to multiple industry magazines to keep current with changing trends and technologies. I encourage everyone to make the most of the resources out there. HBM

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"Employing certified professionals exclusively has allowed for a high level of excellence in the services my company provides."

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We want to feature you in *Healthcare Business Monthly*! Tell us in 350 to 500 words why you became a member of AAPC, how your AAPC credentials have helped you in your career, and the best part of being an AAPC member. Send your story and a digital photo of yourself to iamaapc@aapc.com.

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CMS Corrects Time Thresholds for Prolonged Services

The Centers for Medicare & Medicaid Services (CMS) issued a notice March 14 correcting several errors in the 2023 Medicare Physician Fee Schedule (MPFS) final rule. Most notably, CMS is correcting technical errors in the calculations of the time thresholds for reporting evaluation and management (E/M) prolonged inpatient/observation services HCPCS Level II code G0316.

CMS published the calendar year 2023 payment policies under the MPFS to Part B and coverage policies on Nov. 18, 2022. Since then, those in the healthcare industry have been scratching their heads, wondering how CMS did the math when calculating the time thresholds for G0316.

Per the amended final rule, a practitioner can bill G0316 with initial inpatient/observation visit code 99223 "when 90 minutes is furnished for an initial visit on the date of encounter," not 105 minutes as CMS originally stated.

Continue reading this article at www.aapc.com/blog/87562-cms-corrects-time-thresholds-for-prolonged-services. HBM

New COVID-19 Code for Bivalent Booster

On March 14, 2023, the U.S. Food and Drug Administration amended the emergency use authorization (EUA) of the bivalent Pfizer-BioNTech COVID-19 vaccine to allow providers to administer a booster to certain young patients. As a result, on March 17, the American Medical Association (AMA) released a new CPT® code for booster administration. Find out what you need to know at www.aapc.com/blog/87568-new-covid-19-code-for-bivalent-booster. HBM

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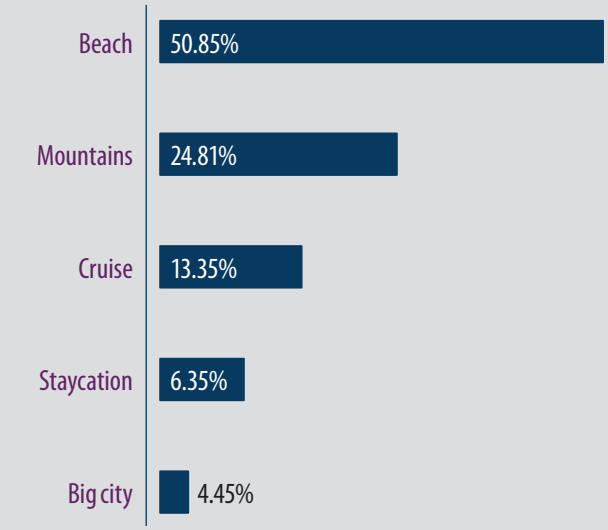
Online Poll

Your Vote Matters

If you frequent AAPC's Knowledge Center blog, you may have noticed the polls on our website. If you've already participated in one or more polls, thank you! New questions go up on the second and fourth Tuesdays of each month. View the latest poll at www.aapc.com/blog. Here are the results for polls posted in February 2023.

Poll Results - February 14, 2023

What is your dream vacation location?



Poll Results - February 28, 2023

Would you like to change the medical specialty you work in?

By Lee Fifield, BS

Member Maynia Is Here!

Don't miss out on this great member benefit.

MEMBER MAYNIA

One of the many benefits you receive with your AAPC membership is the opportunity to attend local chapter meetings. Local chapters provide a great place to network, learn, and grow in a professional capacity and host a variety of engagement opportunities. One of members' favorite local chapter events is the yearly Member Maynia celebration (formerly May MAYnia).

What Is Member Maynia?

Member Maynia is a time for chapter leadership to show members their appreciation for the continued success of the chapter and encourage new members to join. If you're new to AAPC, it's a great time to connect with other members and learn more about your member benefits. For seasoned AAPC members, it's a time to reengage, network with new members, and connect with AAPC at the local level.

Why Should I Attend?

Your local chapter's Member Maynia event is the perfect place to network, learn, and have fun. You can:

- Leave your screens behind and connect with others face to face.
- Meet others in your area who are just like you.
- Get advice about passing your next certification exam.
- Learn about job openings in your area.
- Form long-lasting professional relationships.
- Enjoy coding games, raffles, and free drawings.
- Listen to leading experts in the industry talk about the latest trends and developments.

During the rest of the year, AAPC chapters provide lots of free or low-cost educational opportunities, as well. Every chapter provides a minimum of two in-person meetings and four virtual meetings every year where members can earn continuing education units (CEUs).

Share Your Experience

If you have a great time at your local chapter Member Maynia event this year, we want to hear about it! Here are a few ways you can share your experience:

- AAPC Facebook group
- AAPC forums
- Other social media (be sure to include #AAPCmaynia)

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.

I quickly learned that workplaces value education, especially through AAPC. Another wonderful benefit is the local AAPC chapter and monthly meetings. The meetings are educational and give us the ability to network with local peers.

— Katherine Peacock, CPC, CPB

I began participating in local chapter meetings as a student to network and learn more about the industry. I made friends at that time whom I still interact with professionally today. It makes the job much easier when there is a friendly network of resources available.

— Donna Wagoner, CPC, CPMA, CPCO, COC, CRC, CEMC, NCICS

Thanks to the chapter meetings, I got my first job in HCC auditing, so I encourage everyone to participate in your local chapter meetings.

— Lisa Miller, CPC, CRC

YES. YOU. MAY.

Member MAYnia is here! Pop in on your local chapter.

- Meet fellow coders in your area
- Build/maintain your local network
- Get tips and advice from your peers

This is that time of year that we put the spotlight on AAPC Chapters — your connection to fellow members in your area. Local chapter meetings provide local networking opportunities as well as education and resources for local professionals.

Whether you are a current member or you're just curious about what AAPC membership has to offer, pop into your local Member Maynia meeting to see what's in it for you.

Learn more at **www.aapc.com/membermaynia**

By Rita Genovese, MHA, CPC, PCS

Officer Spotlight

adobestock / sergign

HONORING a Life of Service

Meet a mentor, educator, and friend whose enthusiasm and spark for teaching has inspired many.

A mentor is a person who functions as a coach, cheerleader, advisor, and teacher, offering expertise, knowledge, and support to others who seek guidance in their professional growth. A mentor's experienced perspective and status as a subject matter expert can help mentees learn about their job functions, workplace setting, and much more. There is trust that permeates throughout the mentor/mentee relationship.

A mentor must ooze enthusiasm, show their excitement for the learning process, and be approachable. These qualities can be found in many people, but the person I'd like to spotlight as an outstanding mentor is **Najwa Liscombe CPC, CPC-I**. Najwa is able to take her immense coding knowledge, explain it in a comprehensive yet easy way, and make it fun to boot!

Serving With a Friend

I had the pleasure of meeting Najwa when we both served on the AAPC Chapter Association Board of Directors (AAPCCA BOD) from 2015 to 2018. During our tenure on the board, I witnessed her involvement, support, charisma, and passion for our industry. She regularly assisted with officer training, often traveling to chapters in other states. She demonstrated passion and spunk for the role of trainer; encouraging, mentoring, and connecting with many officers over the course of our three years on the BOD.

Najwa retired this year after dedicating 26 years of her life to the Gainesville, Florida local chapter, which she cofounded in 1996 with only five members. I recently had the honor to take part in celebrating Najwa's dedication to her colleagues, profession, and AAPC.

Kind Words From So Many

There were many people who were eager to say a few words about Najwa. Here are just a few.

A Lasting Bond

Najwa and I have experienced many special moments together and developed a deep friendship since we first met. She has become a part of my family. I am grateful, honored, and so lucky to be able to call her my friend and soul sister. **HBM**

MariaRita Genovese, MHA, CPC, PCS, is the director of revenue cycle and business operations for MD Anderson Cancer Center at Cooper. She has over 30 years of experience in billing and practice management, most recently in the areas of family medicine and medical oncology. She is active in educating the physicians and staff in medical coding and compliance regulations. Genovese serves on the 2022-2025 National Advisory Board and is president of the Greater Philadelphia local chapter. She is a former member of the Chapter Association Board of Directors and 2019 Officer of the Year.

Najwa was a mentor to me when I first started at the University of Florida. She then became a peer and a friend. She has always been such a valuable coding resource to me and so many others. We served together as officers in the chapter, and while she did the necessary work, she also made serving as an officer a lot of fun. She's been such a huge part of our chapter it is hard to picture it without her. The Gainesville, Florida chapter has been so lucky to have her as an officer and champion all these years and we will definitely miss her!

—Cindy Welsh, CPC, CPC-I

Najwa encourages people to step out of their comfort zone and do other things and learn to grow. For instance, encouraging me to speak at chapter meetings, run for office, and grow as a leader. She is not afraid to lead and has done a wonderful job at growing other coders in the field. Najwa is a true mentor.

—Patricia Basa, CPC, CIRCC, CPMA, CPPM, CPC-I, CCVTC, CEMC, CGSC, and Gainesville vice president

Najwa is a mentor, advisor, and friend. She is always willing to help our chapter succeed. Our officers have large shoes to fill, but Najwa has led by example, teamwork, dedication, and commitment. Her networking has afforded us the ability to bring excellent speakers from across the U.S. to our Coding Fiesta.

—Elizabeth Edinger, COC, CPC, CPMA, CPEDC, and Gainesville president

I had the honor and privilege of meeting Najwa in March 2015 when we became a part of the AAPCCA BOD. From the moment we met, Najwa's passion for AAPC, for the members, and for the local chapters was obvious. Her enthusiasm and natural spark made every member she encountered feel welcomed. Najwa's passion for our chapters and for helping our officers to succeed was expressed during this time, as well. Najwa is a true example of what AAPC represents to our members. I am fortunate to call her my friend.

—Ruby O'Brochta-Woodward, BSN, CPC, CPCO, CDEO, CPB, CPMA, CPC-I, COSC, CSFAC

It was an especially monumental occasion as Najwa N. Liscombe was honored for her work in helping found this chapter and for her 26 years of service to the chapter and AAPC's members at both the local chapter level and by serving on the AAPCCA BOD. Rita Genovese flew in from Philadelphia to Jacksonville and together we traveled to Gainesville to surprise our friend. It has been my honor to get to know Najwa through her work with the chapter and Coding Fiesta. I am privileged to call her my friend."

—Maryann Palmeter, CPC, CPCO, CPMA, CENTC, CHC

By Brandie Maryanski, CPC, CRC

May Is Lupus Awareness Month

Show your support for patients with this elusive autoimmune disease.

What is lupus? Systemic lupus erythematosus (SLE), the most common type of lupus, is a chronic inflammatory disease that causes the immune system to attack its own tissues, which can lead to a host of health problems from mild to life-threatening. It causes swelling and pain throughout the body, with symptoms ranging from fatigue and joint pain to blood clots and organ damage. While there's no cure for lupus, there are treatments and medications available to help manage patients' symptoms and improve quality of life.

Diagnosing Lupus

Diagnosing lupus can be difficult. A person's symptoms may overlap with other common conditions, making the diagnosis process long and challenging. Typically, a provider starts by discussing family history and symptoms experienced. Imaging and a physical examination may be done, in addition to an antinuclear antibody (ANA) lab test that looks for things like low blood cell counts, anemia, and antibodies that indicate an autoimmune disease is present.

Lupus is a chronic condition that needs to be regularly managed, with the goal being remission (i.e., symptoms are not active) and to limit organ damage. Steroids, hydroxychloroquine, chemotherapy drugs, immunosuppressive drugs, and monoclonal antibody drugs may be used to manage symptoms.

Coding Lupus

If the type of lupus is not clear in the documentation, query the provider for clarification. For lack of a more specific code, SLE is assigned to one of these ICD-10-CM codes:

M32.9 Systemic lupus erythematosus, unspecified

M32.8 Other forms of systemic lupus erythematosus

The latter is used when the provider does not know the nature or specifics of the condition.

Cutaneous lupus erythematosus (CLE) is lupus that affects the skin. The three types of CLE are discoid lupus, subacute cutaneous lupus, and acute cutaneous lupus. In 10 percent of cases, people with discoid lupus later develop lupus in other organ systems, but these people probably already had SLE with the skin rash as the first symptom. Treatments include avoiding sunlight, fluorescent lighting, corticosteroid injections, Plaquenil, methotrexate, and topicals to reduce inflammation. Code CLE with:

L93 Lupus erythematosus

Drug-induced lupus, a lupus-like disease caused by certain prescription drugs, is assigned to ICD-10-CM code:

M32.0 Drug-induced systemic lupus erythematosus

The drugs most connected with drug-induced lupus are:

- Hydralazine (used to treat high blood pressure or hypertension)
- Procainamide (used to treat irregular heart rhythms)
- Isoniazid (used to treat tuberculosis)

Drug-induced lupus is more common in men because they take these drugs more often than women; however, not everyone who takes these drugs will develop the disease. Lupus-like symptoms usually disappear within six months after these medications are stopped.

For CLE and drug-induced lupus, use additional code T36-T50 with fifth or sixth character 5 to report adverse effects.

Lupus with organ involvement is assigned one or more of the following ICD-10-CM codes:

M32.10 Systemic lupus erythematosus, organ or system involvement unspecified

M32.11 Endocarditis in systemic lupus erythematosus

M32.12 Pericarditis in systemic lupus erythematosus

M32.13 Lung involvement in systemic lupus erythematosus

M32.14 Glomerular disease in systemic lupus erythematosus

M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus

M32.19 Other organ or system involvement in systemic lupus erythematosus

Other complications of lupus should also be coded when documented.

Neonatal lupus is rare, and not deemed as truly lupus. It's associated with anti-SSA/Ro and/or anti-SSB/La antibodies from a mother with SLE that affect the fetus. At birth, the baby may have a skin rash, liver problems, or low blood cell counts, but these symptoms typically disappear completely after six months with no lasting effects. The most serious symptom is congenital heart block, which causes a slow heartbeat. With proper testing, physicians can now identify most at-risk mothers, and the infant can be treated at or before birth. Most infants of mothers with lupus are entirely healthy. Neonatal lupus is coded with:

P00.89 Newborn affected by other maternal conditions

Use additional M32 code if known.

Show Your Support

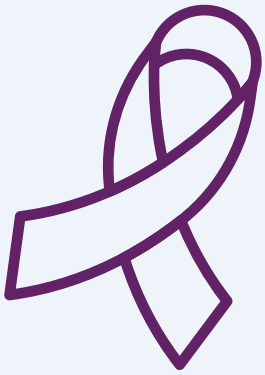
This month shines a spotlight on the impact that lupus has on the lives of those who suffer with the condition. It's an opportunity for the lupus community to join together across the country to raise funds and awareness for the 1.5 million Americans affected with the condition. So, don't forget to don your purple ribbon in May to show you support the fight against lupus. **HBM**

Brandie Maryanski, CPC, CRC, is a lupus warrior who was diagnosed with antiphospholipid syndrome (clotting disorder) in 1999 at the age of 17. A diagnosis of SLE followed at 19 and lupus nephritis with stage 5 kidney failure at 21. The next decade Maryanski was treated with hydroxychloroquine, chemotherapy drugs, and other immunosuppressive drugs, with Rituxan ultimately sending her lupus into remission and stabilizing her kidney disease between stages 2 and 3. Maryanski started her career as a medical coder in 2016 and says she never takes a single day for granted.

adobestock / Io Panuwat D

May is Lupus Awareness Month.

We're here to raise awareness about this often-misunderstood disease and help a little. Throughout May, a portion of proceeds from all CRHC® exam purchases will be donated to The Lupus Foundation of America.



What is Lupus?

Lupus is a chronic (long-term) autoimmune disease that can cause inflammation and pain in any part of your body. As an autoimmune disease, Lupus causes the immune system to attack healthy tissue.

1.5 million — An estimated 1.5 million Americans have a form of lupus

9 out of 10 adults with lupus are women

20 percent — 20% of patients with lupus are children

Sources

- Lupus Foundation of America
- American College of Rheumatology

Symptoms

Lupus can be hard to detect because it is a complex disease with various symptoms that can come on slowly. Here are a few of the symptoms:

- Headaches, low fevers
- "Butterfly" facial rash
- Extreme fatigue (feeling tired all the time)
- Sensitivity to sunlight or fluorescent light
- Chest pain when breathing deeply
- Pain or swelling in joints
- Swelling in hands, feet, or around the eyes

Be a part of the solution

If you have an interest in specializing your skills for rheumatology coding, this month a portion of your CRHC® exam purchase will be donated to The Lupus Foundation of America.

Learn more at aapc.com/crhc

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Common Abbreviations in Lupus Coding

Lupus is a chronic disease that can cause inflammation and pain in any part of the body. As an autoimmune disease, it causes the immune system to attack healthy tissue instead of fighting infection like it should. Lupus may affect the skin, joints, muscles, nervous system, digestive system, eyes, bones, and internal organs. There is no cure for lupus, but the condition can be managed. Here are some common abbreviations you may see when coding for lupus.

AAV	Anti-neutrophil cytoplasmic antibody (ANCA) associated vasculitis
AIHA	Autoimmune hemolytic anemia
ANA	Antinuclear antibodies
APLS	Antiphospholipid antibody syndrome
APS	Antiphospholipid syndrome
CCLE	Chronic cutaneous lupus
CNS	Central nervous system
CRP	C-reactive protein
DLE	Discoid lupus erythematosus
DIL	Drug-induced lupus
IBD	Inflammatory bowel disease
LAC	Lupus anticoagulant
LACC	Lupus activity criteria count
MCTD	Mixed connective tissue disease
POTS	Postural orthostatic tachycardia syndrome
SCLE	Subacute cutaneous lupus erythematosus
SLE	Systemic lupus erythematosus
SLCC	Systemic lupus criteria count
TTP	Thrombotic thrombocytopenic purpura
Th1/Th2	T helper cell 1/T helper cell 2

By Raemarie Jimenez, CPC, CDEO, CIC, CPB, CPMA, CPPM, CANPC, CRHC, CCS, AAPC Approved Instructor

Get Answers to Your E/M Questions

This month, we look at subsequent visits, split/shared visits, and place of service codes.

In the 2023 Medicare Physician Fee Schedule (MPFS) final rule, the Centers for Medicare & Medicaid Services (CMS) adopted the CPT® 2023 code and guideline changes for hospital inpatient and observations services (with some caveats). Although Medicare policies for billing evaluation and management (E/M) services are mostly unchanged, incongruities between CMS and CPT® can baffle even the most seasoned medical coder. Here are a few questions we recently received.

Q: *Can I please get clarification on inpatient/observation patients that our ear, nose, throat doctors (ENTs) see in the hospital? The patient is typically admitted by a hospitalist; our ENT is asked to see the patient (we don't bill consult codes). I'm confused if we are allowed to bill 99221-99223 for the initial consult in the hospital for that patient or if we should bill subsequent 99231-99233 like in years past. If none of our ENTs have seen the patient before and the patient is inpatient/observation status, can we bill 99221-99223 for first ENT evaluation and then, if another ENT in our practice rounds/sees that patient before the discharge date, would we bill 99231-99233 subsequent care codes?*

A: The answer for this question will depend on the payer.

When multiple practitioners furnish E/M services to the same patient in observation status on the same day, the practitioner who orders the observation care for a patient may bill for observation care. Other practitioners providing additional evaluations for the patient should bill their services as office/outpatient E/M.

Medicare policy states:

> Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
>
> For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

If the patient is admitted as an inpatient, the ENT provider seeing the patient for the first time during the admission can report the initial inpatient or observation care codes 99221-99223. The provider admitting the patient will append modifier AI *Principal physician of record*.

According to CPT® guidelines, the ENT provider can report the initial care codes (99221-99223). CPT® defines "initial" as "the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay."

Q: *I have a question related to a mid-level covering in the evening hours and performing the history and physical and then the physician follows the next morning to do medical decision making and discharge the same day (within 24 hours). Is this a split/shared visit since the providers both provided face-to-face on different dates of service even though it is within the Medicare 24-hour rule for initial and discharge the same day? How should it be billed?*

A: A split/shared visit is an E/M visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (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. Payment is made to the practitioner who performs the substantive portion of the visit.

The substantive portion can be one of the three key E/M visit components (history, exam, or medical decision making [MDM]), or more than half of the total time spent by the physician and NPP performing the split/shared visit. In other words, for calendar years 2022 and 2023, the practitioner who spends more than half of the total time or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split/shared E/M visit.

When one of the three key components is used as the substantive portion in 2022 and 2023, the practitioner who bills the visit must perform that component in its entirety to bill. HBM

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Resource

Medicare Claims Processing Manual (IOM 100-04), Chapter 12, section 30.6.8.A.
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

By AAPC Documentation Advisory Committee

Billing a PA's Services Incident to a Physician's

Use midlevel providers to maximize productivity and reimbursement in your physician office.

adobestock / rocketclips

Physician assistants (PAs) are a type of nonphysician practitioner (NPP) who may bill Medicare under their own national provider identifier (NPI). As of Jan. 1, 2022, PAs can bill and be reimbursed directly from Medicare where previously reimbursement could only be made to their employer. Other NPPs with billing rights include nurse practitioners (NPs), certified nurse midwives (CNMs), and clinical nurse specialists (CNSs). If you have any of these midlevel providers in your physician office, you need to be familiar with Medicare policy for billing midlevel services.

For example, Medicare will pay an NPP to see a patient independently if the services are allowable under their scope of practice as defined by their state's laws. When an NPP sees a patient independently, their services are paid at 80 percent of the lesser of the actual charge or at 85 percent of the physician's rate set under the Medicare Physician Fee Schedule (MPFS).

Is there a way to be paid more for an NPP's services? Potentially, yes, but you must follow Medicare's incident-to guidelines to the letter. The incident-to policy allows services performed by an NPP to be billed under the supervising physician's NPI and paid at 100 percent of the charge under the MPFS.

Medicare has six main provisions for incident-to billing. Let's look at these rules closely.

Rule 1

The NPP's services must be an integral part of the patient's normal treatment under a treatment plan that was initiated by the patient's primary provider. The patient's primary provider who is supervising the midlevel provider must remain actively involved in the care of the patient.

The supervising physician must have created the treatment plan for the condition being treated. This means that the patient must be established to the practice. If the patient is new to the practice, the midlevel provider can see and treat the patient (in accordance with state regulations). However, the services must be billed underneath the NPP's NPI since the patient is new and the supervising provider has not yet created a treatment plan.

Rule 2

The services performed are commonly provided without charge or included in the physician's or other listed practitioner's bill.

The services may be covered under the incident-to guidelines if they are not covered under a different benefit category under Medicare. Services, such as diagnostic testing and vaccines, fall under a separate benefit category for Medicare. Services with their own benefit category must be billed directly by the performing provider.

"Under the incident-to rules, the services must be performed under direct supervision."

Rule 3

The services provided must represent an expense to the physician under whom the services are billed.

The services must be billable or represent something for which the practice pays. If you are getting the service or the supply for free, you cannot pass the expense off to the insurance carrier. The midlevel provider employed by the practice represents an expense to the practice and, therefore, is permitted to bill services incident to the provider. If they are a free resource, or if they are employed by a group other than the practice (e.g., a midlevel provider who is employed by the hospital and placed in a physician practice), they do not qualify for incident-to billing.

Rule 4

The services must be commonly provided in the physician's office or clinic.

Services must be performed in the physician office or clinic and not in an institutional setting. If the office or clinic is part of the outpatient clinic at the hospital, whether on campus (POS 22) or off campus (POS 19), incident-to rules do not apply. Additionally, services performed in the emergency department (POS 23) are not covered as incident-to services. Services in these settings fall into a different category of benefits called split/shared services. (See *Healthcare Business Monthly*, November 2022, for a detailed discussion of split/shared services.)

Further, if your provider sees patients in a nursing facility/skilled nursing facility (NF/SNF), those services may count as incident to if the provider has a specific office space at the facility. If services are provided outside of their specifically designated office space, the services are not billable under the incident-to guidelines and instead fall into the NF/SNF payment rules.

Rule 5

The physician provides direct incident-to services supervision and only the physician who supervises the incident-to services may bill them.

Medicare has specific rules and levels of supervision under which all procedures fall. These levels of supervision are general, direct, and personal supervision. Details about the levels of supervision can be found in the Internet Only Manual, Benefit Policy Manual, Chapter 15, Section 30:

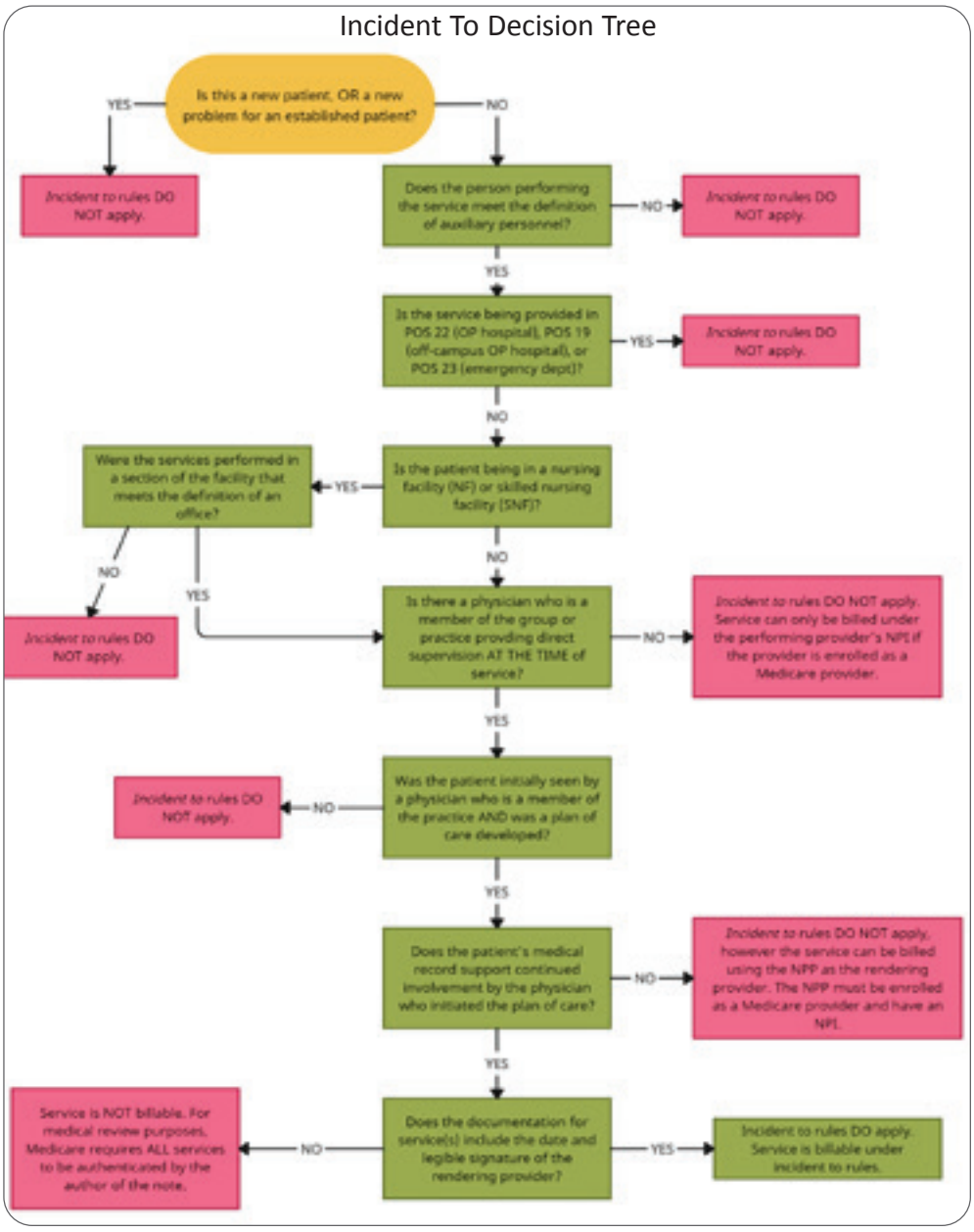
- **General Supervision** – Services are performed under the physician's general direction and control, but the provider does not need to be in the room during the procedure.
- **Direct Supervision** – The definition of direct supervision changes based on the location where the services occur; however, for incident-to services, which are only permitted in an office-based setting, direct supervision means that the supervising physician must be within the walls of the office suite and immediately available to assist if necessary. If the provider is not in the office suite while the services are being rendered, the services cannot be billed as incident to; they must be billed under the midlevel's NPI.
- **Personal Supervision** – The supervising physician must be in the room while the procedure is being performed.

Under the incident-to rules, the services must be performed under **direct** supervision. If the provider is, for example, out of the office and available by phone for consultation, this does *not* meet the definition of direct supervision and would not qualify the PA's services as being billed incident to the physician's services.

Under audit, one of the key pieces of information requested from a carrier will be both the midlevel's schedule and the supervising provider's schedule. It would be expected that the provider who is supervising has patients on the schedule on the same date of service. An auditor may request examples of the provider's presence in the office such as workstation login history for the date(s) in question. A co-signature of the supervising physician is *not* a requirement, but you may request it as a means of verifying the physician's availability for oversight.

Note: Per *MLN Matters* article MM13094, "The supervision requirements under the incident to benefit category aren't applicable to the diagnostic tests benefit category."

Decision Tree: Use this tool to help you determine whether an NPP's services can be billed under the incident-to rules.



Rule 6

Medicare requires general physician supervision when clinical staff provides services under incident-to provisions for transitional care management (TCM) and chronic care management (CCM). Only the supervising physician or other listed provider may bill services and supplies incident to TCM and CCM services.

This section of the rule also confirms that ancillary staff, such as medical assistants, can perform portions of the TCM or CCM services, and those services are billable under the supervising provider.

Reference our decision tree to visually walk through the steps for determining when incident-to rules apply.

Examples of When You Can and Can't Bill Incident-to Services

Now that we have walked through the rules, let's look at some examples for when it is or isn't appropriate to bill incident-to services.

Example 1

An established patient, Susie, comes into the office for follow-up on her hypertension. She shares her home blood pressure readings with the PA. The PA notes that her home readings are still running high and her blood pressure in the office today is 150/90. Based on the plan of care noted by the primary care physician (PCP), the PA increases her dose of lisinopril and asks the patient to follow up next month.

The provider established that if the patient's blood pressure continued to be high, the medication should be titrated up. This would qualify for billing the service incident to under the supervising physician's billing number as long as the supervising provider was in the clinic during the visit.

Example 2

Susie returns to the office one month later and sees the PA again. Today, her blood pressure is under better control. The increased dose of lisinopril seems to be adequate. Susie tells the PA that she is having difficulty obtaining her diabetes medication and asks if there is anything else that she can use. The PA discusses the situation with the PCP via phone, who agrees to a change in the diabetes medication. The PA writes a new prescription and asks the patient to follow up in a month.

There is a change to the medication made by the PA. The PCP was on the phone and not in the clinic at the time, so this visit is not billable as incident to. Even if the PCP was in the clinic, they did not see the patient and personally make the change. Further, if the PCP

was in the clinic, a "hallway consult" between the providers does not satisfy the requirements for incident-to billing, and this visit must be billed under the PA.

Example 3

An established patient comes to the office today after sustaining a fall down a flight of stairs over the weekend. He was treated in the emergency department and told to follow up with his PCP. He comes to the office today complaining of shoulder and hip pain from the fall. The PA orders an immediate CT scan and will see the patient again in the morning.

While the patient is established to the practice, this is a new problem being treated. This would not qualify for incident-to billing and should be billed under the PA.

Don't Forget the Payer's Policy

Check with your Medicare Administrative Contractor (MAC) to determine if they have any additional guidance regarding billing services under the incident-to benefit. For example, WPS Government Health Administrators posted on their website on Feb. 24, 2022, the following guidance (updated Feb. 15, 2023):

> We identified a Medicare vulnerability relating to "incident to" services paid under the Medicare Physician Fee Schedule (MPFS). We ask anyone billing "incident to" under the MPFS to complete a self-audit verifying services meet the Medicare rules.
>
> Medicare allows "incident to" services for both a physician and nonphysician practitioner (NPP). The basis for both types of payment is the MPFS. Medicare allows physicians' services at 100% of the MPFS, while it allows most NPPs' services at 85% of the MPFS. When a service pays to the physician but should pay to the NPP, you owe Medicare a refund.
>
> If you bill MPFS "incident to" services, complete a self-audit to confirm all the following apply:
>
> - Billing is under the correct provider
> - It meets the "incident to" requirements
> - Documentation meets Medicare's signature requirement
>
> Note: You must meet all "incident to" requirements in the Internet-Only Manuals (IOMs) and Code of Federal Regulation (CFR).
>
> If you identify a billing error, complete an Overpayment Claim Adjustment (OCA) or a voluntary refund. Once the claim is adjusted, resubmit the claim correctly.

This notice from one MAC highlights the importance of ensuring that your office handles all billing for midlevel providers correctly. **HBM**

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Prevent Fraudulent Incident-to Billing

Incorrectly billing services to obtain 100 percent of the provider's fees, rather than the 85 percent that midlevel providers are reimbursed, can be quite costly and not worth the risk. It is fraud and a violation of the False Claims Act when you knowingly charge Medicare a higher rate than allowed.

There are several cases that have already been settled for this fraudulent activity. These four cases were settled for over $1 million in total:

- United States ex rel. Menold v. Lotus Family Medicine
- United States; the States of California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Michigan, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, and Texas; the Commonwealths of Massachusetts and Virginia; and the City of Chicago ex rel. Grace v. Tenet HealthCare Corp., St. Francis Hospital-Memphis, Desert Regional Medical Center, Apollo MD, Shoaib Qureshi, MD; and Imran Mirza, MD
- United States and State of Tennessee ex rel. Forester v. Chang-Wen Chen, M.D. and Chang-Wen Chen, M.D., P.C.
- United States ex rel. Kimberly Elliott v. Peninsula Internal Medicine, LLC and the Estate of Candy Burns

Resources

Internet Only Medicare Claims Processing Manual, Chapter 12, Section 30.6.4

MLN901623 – Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants (cms.gov)

By Mike Shaughnessy, BA

Here's What You May Not Know About Artificial Intelligence

adobestock / NicoElNino

Find out why machine learning is the most important part of the AI puzzle.

Artificial intelligence (AI) is an ever-expanding field within the world of healthcare. While the possibilities for future expansion are seemingly endless, AI has already made an imprint on everything from coding and billing automation to the harnessing of patient data for chronic care management.

In fact, the government has even begun to use AI's ability to garner data as a means of tracking healthcare providers for fraud detection. To avoid falling under the crosshairs of one of these AI algorithms, it's essential that you're able to deconstruct the concept of AI into its respective elements.

"When a heart monitor collects stats on a patient and sends the data electronically to the doctor, that would be an example of the utilization of both IoMT technology and AI."

Keep reading for a breakdown of all the essential AI-related terms prevalent in healthcare.

What Is Artificial Intelligence?

AI refers to computers, machines, and devices acting intelligently and performing functions like human beings. There's no doubt that AI shapes and impacts healthcare daily. For example, you might be using AI in your practice when you do the following:

- Accumulate and discern data for research and clinical trials.
- Enhance diagnosis and treatment data from its compilation.
- Monitor patients' health via medical devices.
- Capture and collect office revenue.

Consider 7 Primary Components of AI

As more and more products are imbibed with AI, you may want to master the fundamentals and understand the lingo. Pocket these seven baseline terms to improve your AI glossary.

1. Algorithm: Simply put, an algorithm is a set of rules or instructions that are the foundation for AI. Machines follow these mathematical sequences, build on them, and learn from them.

2. Data mining: According to the National Institute of Standards and Technology (NIST), this "analytical process attempts to find correlations or patterns in large data sets for the purpose of data or knowledge discovery." In healthcare, this might mean connecting the dots in clinical trials to discover a treatment or cure for a disease.

3. Internet of Medical Things (IoMT): The IoMT relates specifically to the array of medical devices and applications in healthcare and their connection to the internet and each other. For example, when a heart monitor collects stats on a patient and sends the data electronically to the doctor, that would be an example of the utilization of both IoMT technology and AI.

4. Machine learning: This may be the most important part of the AI puzzle because machine learning happens when algorithms are introduced and the machine — without any further programming or information — learns from the patterns and predicts future outcomes. For providers, machine learning could be used to predict future illnesses and treatments based on a patient's past experiences and history.

5. Natural language processing (NLP): NLP assists machines in understanding human language. When a physician dictates notes and the device uses voice recognition to document the service and offer solutions, that is an example of NLP.

6. Real-time health systems (RTHS): This is the culmination and coordination of computer applications, devices, and electronic health record technology to offer healthcare advice in real time. RTHS uses AI to quickly assess problems, provide solutions, and revolutionize the industry.

7. Robotic process automation (RPA): The utilization of RPA allows workers to pass on repetitive, simple, and sometimes annoying work to bots, allowing healthcare workers to focus on patients. HBM

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adobestock / Alex

This article is reprinted from *Tech & Innovation in Healthcare*. For more articles like this, as well as other specialty-specific articles, check out AAPC's full line of newsletters at www.aapc.com/newsletter.

By Srivalli Hariharamuthukrishnan, CPC, CCS, PGP-AIML

Code von Willebrand Disease With Clarity

New diagnosis codes more accurately describe the disease type.

Von Willebrand disease (VWD) is a genetic disorder that affects the ability of blood to clot properly, creating risk for excessive bleeding. It's caused by a deficiency or malfunction of a von Willebrand factor (VWF) protein, which plays a crucial role in clot formation. VWD is the most common inherited bleeding disorder and affects both males and females equally.

Determine Type

VWD is classified into three main types based on the severity of symptoms and the amount of VWF in the blood.

Type 1: This is the mildest form of VWD and accounts for about 75 percent of all cases. People with Type 1 VWD have low levels of VWF, but it functions properly. They usually experience mild to moderate bleeding symptoms such as easy bruising, nosebleeds, and prolonged bleeding after injury or surgery.

Type 2: This type of VWD is further classified into four subtypes: 2A, 2B, 2M, and 2N. People with Type 2 VWD have normal or reduced levels of VWF, but the protein does not work correctly. The symptoms of Type 2 VWD vary depending on the subtype. For example, in Type 2A, the VWF is not the right size, which prevents platelets from forming a good blood clot. In Type 2B, the VWF is too active and attaches to platelets in the blood when it's not supposed to. In Type 2M, the VWF cannot attach to platelets, which also affects clot formation. In Type 2N, the VWF attaches to platelets normally but doesn't attach to factor VIII (antihemophilic factor A), which is necessary for clot formation.

Type 3: This is the most severe form of VWD, where the person has little or no VWF in their blood. Type 3 is relatively rare, occurring in less than 1 percent of people with VWD. It causes severe bleeding symptoms that can be life-threatening, including joint bleeds, nosebleeds, and prolonged bleeding after injury or surgery. Because the symptoms are so severe, Type 3 VWD is usually diagnosed when the person is very young; although, due to the low factor VIII, the condition can be misdiagnosed as hemophilia A.

Select Code by Type

ICD-10-CM code D68.0 *Von Willebrand disease* was expanded, and new codes were created for fiscal year 2023 to identify the disease by type. VWD is now classified into six categories or subtypes based on the differences in clinical features and therapeutic requirements.

D68.00 Von Willebrand disease, unspecified
D68.01 Von Willebrand disease, type 1
D68.02 Von Willebrand disease, type 2
- **D68.020** Von Willebrand disease, type 2A
- **D68.021** Von Willebrand disease, type 2B
- **D68.022** Von Willebrand disease, type 2M
- **D68.023** Von Willebrand disease, type 2N
- **D68.029** Von Willebrand disease, type 2, unspecified

D68.03 Von Willebrand disease, type 3
D68.04 Acquired von Willebrand disease.
D68.09 Other von Willebrand disease

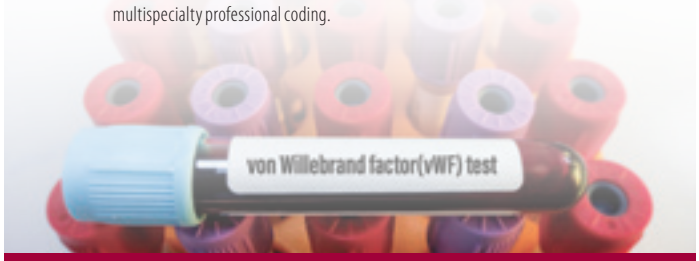
Coding advice: When the patient has both VWD, type 1, and factor VIII (functional) deficiency and the provider noted that the factor VIII deficiency was due to von Willebrand disease, assign D68.01. Factor VIII deficiency that occurs as a part of VWD is not a separate condition and is not coded separately.

Diagnosing and Treating VWD

VWD is usually diagnosed based on a physical examination and blood tests. Treatment for VWD aims to control bleeding episodes and prevent complications. It may include medication to increase the levels of VWF in the blood such as desmopressin or clotting factor replacement therapy. In some cases, surgery may be required to control bleeding.

People with VWD should take steps to prevent bleeding episodes and manage their symptoms. They should avoid activities that increase the risk of injury and take extra precautions to prevent bleeding. For example, they should wear protective gear, such as helmets and knee pads, during sports activities. It's also essential to have regular checkups with a healthcare provider to monitor the disease and adjust treatment as necessary. **HBM**

Srivalli Hariharamuthukrishnan, CPC, CCS, PGP-AIML, has worked extensively in the coding and education realm over the last 14 years. Her true passion is automation, coding education, and making sure coders are equipped to do their job accurately and with excellence. Harihara is a senior manager of coding education and operations excellence for Coronis Health. She has experience in anesthesia, same-day surgery, evaluation and management, and multispecialty professional coding.



Resources

https://elearning.wfh.org/elearning-centre/von-willebrand-disease
www.cdc.gov/ncbddd/vwd/facts.html
www.nhs.uk/conditions/von-willebrand-disease
https://ghr.nlm.nih.gov/condition/von-willebrand-disease

AHA Coding Clinic, ICD-10-CM, 4th qtr 2022

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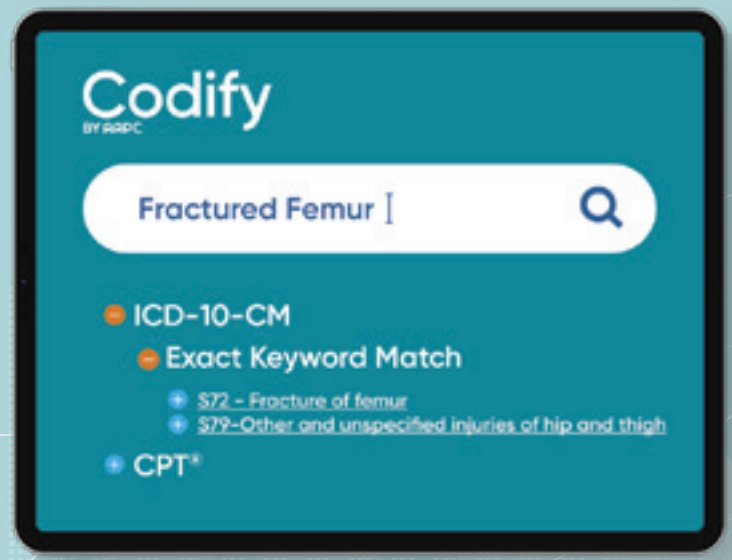

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By Terry A. Fletcher, BS, CPC, CCC, CEMC, CCS, CCS-P, CMC, CMSCS, ACS-CA, SCP-CA, QMGC, QMCRC, QMPM

Telehealth Services After the PHE

Reimbursement will require you to know which waivers to Medicare coverage and payment policies end May 11.

Once the end of the public health emergency (PHE) for COVID-19 was announced by the White House and then by Department of Health and Human Services Secretary Xavier Bacerra, everyone jumped to mixed conclusions about what that meant for telehealth. Would the expanded coverage granted during the PHE remain in place under the Consolidated Appropriations Act of 2023?

The Centers for Medicare & Medicaid Services (CMS) has since published a staggering amount of information regarding continuing and ending coverages that will impact the payment policies of services and supplies under its purview. Let's look at some key changes that apply to physicians and nonphysician practitioners.

Facts About Coverage Post PHE

Here are some highlights of what is changing on May 11, 2023, (or later) for telehealth services billed under Medicare Part B:

- Virtual check-in codes (G2012, G2010, G2252) and remote patient monitoring codes will only be allowed for established patients after the PHE ends.
- Medicare will continue to pay for audio-only telephone services billed with CPT® codes 99441-99443 through Dec. 31, 2024, when appropriate and all required elements in the code descriptions are met. The payment parity to CPT® codes 99212-99214 is also extended through Dec. 31, 2024.
- Behavioral and mental health services (CPT® 90785-90840) are now permanently added to the Medicare Telehealth Services List and may be provided using audio-only equipment through Dec. 31, 2024.
- All other services on the Medicare Telehealth Services list, unless otherwise indicated, require audio-video equipment permitting two-way, real-time interactive communication. CMS will update the list for 2024 using standard protocols.
- Incident-to services via virtual supervision will no longer be allowed after Dec. 31, 2023.
- When the PHE ends, CMS will continue to allow for a total deferral to state law regarding licensure requirements for billing Medicare for services provided outside of their state of enrollment. State laws may override this freedom, however.
- Practitioners must resume reporting their home address on the Medicare enrollment beginning Jan. 1, 2024.
- All telehealth platforms must be HIPAA compliant starting the day after the end of the PHE (May 12). Smart phone video options such as FaceTime and Skype will no longer be an option for telehealth after the PHE ends, per the Office of Civil Rights.
- Place of service (POS) codes will continue to be used based on where the patient would have been seen had they been seen in person. However, POS 02 *Patient not in their home when telehealth services are rendered* or POS 10 *Patient in their home when telehealth services are rendered* may be reported, as appropriate. Reporting these specific POS codes will result in facility reimbursement.
- Modifier 95 *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system* will continue to be used for audio and video services for Medicare telehealth through 2024.
- Modifier 93 *Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system* must be used, as of Jan. 1, 2023, for all audio-only services. Many commercial payers have instructed providers to append this modifier to services listed in Appendix T of CPT® 2023.

Remember that this guidance applies to Medicare Part B only. Make sure to check other payers' policies to ensure compliance.

Audit Concerns

Ongoing Office of Inspector General audits for Medicare fraud, waste, and abuse will continue, and modifier 93 could provide data mining for CMS and other payers to make sure phone call services are not abused or over-utilized.

Example: A patient calls into your pharmacy line for a refill of their prescriptions. Your mid-level provider refills the prescriptions that day and either your nurse practitioner or medical assistant calls the patient back to let them know their prescriptions were refilled. That is not a billable service. That is part of the cost of doing business and part of patient triage.

There is an interesting caveat in the Consolidated Appropriations Act that could be a trap for a future audit of your audio-only telehealth services.

Per a CMS Feb. 27, 2023, fact sheet:

"The Consolidated Appropriations Act, 2023, extended many telehealth flexibilities through December 31, 2024, such as:

- People with Medicare can access telehealth services in any geographic area in the United States, rather than only those in rural areas.

adobestock / Andrey Popov

- People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
- Certain telehealth visits can be delivered audio-only (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer."

This last bullet is important because the patient's medical record will need to reflect why the patient was not able to get on an audio and video telehealth call and instead settled for an audio-only call. I would be willing to bet that aesthetic excuses will not fly with the federal government.

With the PHE going on three years now, providers should not be allowing the convenience of the phone call (audio only) over the medical appropriateness of the in-person and/or audio and video encounter. There should be a telehealth facilitator in your practice for those who need assistance with technology; any front desk, back office, or billing office employee can take this on to ensure appropriate connections for patients, like internet and the video connection on HIPAA-approved devices.

There is a time for audio-only, but those should be rare. If your providers did not conduct telephone services prior to PHE, it will appear suspect for them to start now. **HBM**

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Resources

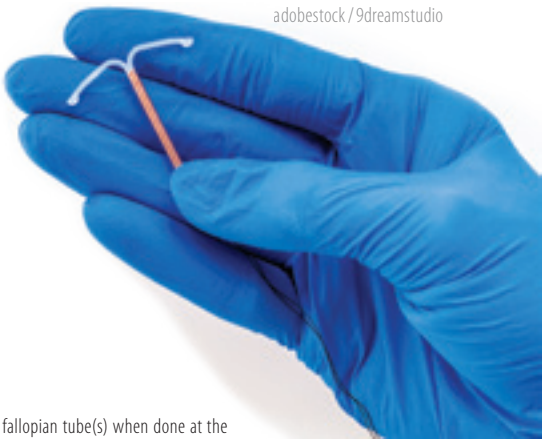
CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency. Feb. 27, 2023. **www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency**

H.R. 2617 – Consolidated Appropriations Act, 2023. **www.congress.gov/bill/117th-congress/house-bill/2617/text**

www.cms.gov/coronavirus-waivers

By Dawson Ballard Jr., CPC, CPC-P, CPMA, CCS-P, AAPC Fellow

Coding for Contraceptive Procedures and Devices



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Protecting your practice from revenue loss is easy when you have all the facts.

In this everchanging world where more and more options are available for birth control, it's important that we stay abreast of the latest coding. As you know, correct coding is the only way to ensure our providers receive proper reimbursement for their time and expenditures. To that end, let's review procedure, supply, and diagnosis coding for some of the more common contraceptive services.

Vasectomy Coding

Vasectomies are common contraceptive procedures performed on males, usually in a urology office. According to the Mayo Clinic, vasectomies are "done by cutting and sealing the tubes that carry sperm. Vasectomy has a low risk of problems and can usually be performed in an outpatient setting under local anesthesia."

Report the following code for a vasectomy performed in the outpatient setting:

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

It's important to remember that the code description includes the term "bilateral." If the procedure is performed bilaterally, it would not be appropriate to append modifier 50 *Bilateral procedure* to the code. Also, the procedure includes postoperative semen examination(s), but you should be able to separately bill an office visit evaluation and management (E/M) or consultation for a pre-vasectomy visit, if performed.

Tubal Ligation Coding

Per the Mayo Clinic, "Tubal ligation — also known as having your tubes tied or tubal sterilization — is a type of permanent birth control. During tubal ligation, the fallopian tubes are cut, tied, or blocked to permanently prevent pregnancy."

Tubal ligations are usually performed separately or immediately after or during the same hospital stay of labor and delivery. For the physician's services, look to these tubal ligation codes and make your selection based on the procedure performed:

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

+58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)

58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach

When a physician performs a tubal immediately following a typical vaginal delivery, report the appropriate tubal with modifier 59 *Distinct procedural service* in conjunction with the delivery package code. If the tubal occurs during the hospital stay for the delivery, but not on the same day, append the appropriate tubal code with modifier 79 *Unrelated procedure or service*....

IUD Insertion Coding

Intrauterine devices (IUDs) can be used as a non-surgical form of birth control. They range from hormonal (Mirena®, Kyleena®, Skyla®, and LILETTA®) to copper (Paragard®).

The hormonal devices are a T-shaped plastic frame that is inserted into the uterus, where it releases the hormone progestin. To prevent pregnancy, progestin:

- Thickens mucus in the cervix to stop sperm from reaching or fertilizing an egg; and
- Thins the lining of the uterus and partially suppresses ovulation.

Mirena® prevents pregnancy for up to 7 years after insertion. Kyleena® has a 5-year duration. Skyla® has a 3-year duration, and LILETTA® has a 6-year duration.

Paragard® is sometimes referred to as a nonhormonal IUD option. The Paragard® device is a T-shaped plastic frame that's inserted into the uterus. Copper wire coiled around the device produces an inflammatory reaction that is toxic to sperm and eggs, preventing pregnancy. Paragard® is the only copper IUD available in the United States. It can prevent pregnancy for up to 10 years after insertion.

There are two CPT® codes for IUDs: One is for insertion and one is used specifically for removal:

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

"When a physician performs a tubal immediately following a typical vaginal delivery, report the appropriate tubal with modifier 59 in conjunction with the delivery package code. If the tubal occurs during the hospital stay for the delivery, but not on the same day, append the appropriate tubal code with modifier 79."

These codes only cover the procedure itself. Report the actual device separately using the appropriate HCPCS Level II J code:

J7296 Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg

J7297 Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg

J7298 Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg

J7300 Intrauterine copper contraceptive

J7301 Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg

If an IUD is removed and a new one inserted in the same encounter, append modifier 51 *Multiple procedures* to the claim.

If removal or insertion of an IUD is discontinued mid-procedure, append modifier 53 *Discontinued procedure*. If the discontinued IUD procedure occurs in an ambulatory surgery center (ASC) setting, append modifier 73 *Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia* or 74 *Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia*, as appropriate, instead of modifier 53.

Etonogestrel Implant Coding

Etonogestrel is a form of birth control that contains a hormone in a flexible plastic rod about the size of a matchstick that is inserted just beneath the skin of the upper arm. The hormone stops the release of an egg from the ovary and mucus in the cervix thickens to help prevent sperm from reaching the egg. It's effective for about 3 years.

The CPT® code set includes three specific codes for reporting etonogestrel implantation, removal, or removal with reimplantation:

11981 Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)

11982 Removal, non-biodegradable drug delivery implant

11983 Removal with reinsertion, non-biodegradable drug delivery implant

As with IUD procedures, codes 11981-11983 are reported for the procedure only. You will also report the etonogestrel implant device. The correct HCPCS Level II code is:

J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

Coding for E/M With Contraceptive Services

Most E/M services performed during the same encounter as vasectomies, tubal ligations, IUD insertions/removals, and etonogestrel insertion/removal/reinsertion are bundled into the procedure(s) and are not separately reportable. If, however, the physician performs a significant, separately identifiable E/M service during the encounter of one of these procedures, you may be able to separately bill the E/M service using modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service*.

ICD-10-CM Codes for Contraceptive Services

Most of the ICD-10-CM codes for contraceptive services will be in category Z30 *Encounter for contraceptive management*. HBM

Dawson Ballard Jr., CPC, CPC-P, CPMA, CCS-P, AAPC Fellow, has over 18 years of experience in coding and auditing. His specialties include E/M, chiropractic, family practice, orthopedics, and ob-gyn. Ballard is currently the audit and compliance specialist for LMH Health in Lawrence, Kan., and has authored several articles for *Healthcare Business Monthly* magazine.

Resources

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By Deborah Marsh, JD, MA, CPC, CHONC

Check ICD-10-CM Official Guidelines Without Leaving Codify

Diagnosis coding accuracy depends on applying these authoritative rules.

The ICD-10-CM Official Guidelines for Coding and Reporting include many hidden gems that are essential to reporting diagnosis codes correctly. You can access these guidelines from within Codify and keep them open for easy access.

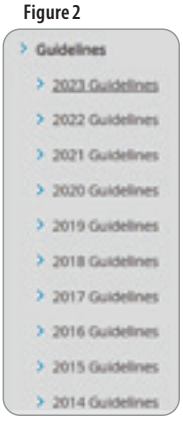
Step 1: On the Codify home page, click "ICD-10-CM" in the left menu. (**Figure 1**)

Step 2: Scroll down and click "Guidelines" to access a PDF of the ICD-10-CM Official Guidelines. Select the year, from 2014 to the present. (**Figure 2**)

Bonus tip: Use the Find function within the searchable PDF to find the guidelines you need quickly. Or, click an entry in the ICD-10-CM Official Guidelines table of contents to reach that information directly. **HBM**

Figure 1

Figure 2



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By Lori Cox, MBA, CPC, CPMA, CPC-I, CEMC, CGSC, CHONC

Train Your Auditors to Think Clinically

Everybody wins when you bridge the divide between auditors and providers.

Whether you're a medical auditor, coder, or other healthcare professional, you've probably heard some form of this conversation in a provider's office:

Physician: "I'm not an auditor!"

Auditor: "Well, I'm not a doctor!"

Both statements are true: Most auditors are not trained clinicians and most clinicians are not trained auditors. There are several things that managers can do, however, to help their auditors (and coders) see things from a clinical perspective. With the proper training, you can give your auditors the clinical skills they need to complete their audits and provide meaningful feedback to physicians that produces optimum results.

Provide Auditors With the Proper Tools

Auditing without the proper tools is like trying to build a house without tools — it's not going to go well, if at all. Current code books and coding software are a must. Anatomy, terminology, and pathophysiology knowledge is also crucial for clinical auditors. But an auditor who can decipher clinical notes is invaluable.

To learn the language, it helps to narrow the vocabulary by focusing on a particular medical specialty. If an auditor has an interest in gastroenterology, for example, have them focus on those disease processes, work with a gastrointestinal (GI) clinician, take a deep dive into their documentation, ask questions, read associated materials, and watch webinars that are GI related. They can also check into the GI specialty societies for free resources and study to become a specialist.

Focus on Documentation

When physicians get busy, documentation may get pushed to the back burner. This is where clinical auditors can be of great importance. It's important for a physician's records to be complete, concise,

"When physicians get busy, documentation may get pushed to the back burner. This is where clinical auditors can be of great importance."

and relevant. When taking a deep dive into documentation, clinical auditors should ask themselves these questions:

- What was the intent of the visit?
- What observations did the physician make? Why were those observations notable?
- What actions were taken? What plans were devised? Options discussed?
- What were the reasons for taking those actions?

If documentation is incomplete, it's the clinical auditor's job to query the provider for the required information.

Understand the Medical Record

Let's look at an example: Medical record documentation states that the provider ordered an a1c lab test; however, the record does not show a diagnosis of diabetes, a previous glucose test, or complaints of signs or symptoms suggestive of diabetes.

In this case, the auditor should question whether the test was medically necessary. If the auditor does not know what an a1c lab test is, however, it may not come into question at all. Without a relative diagnosis attached to the a1c test, the claim will be denied.

For each encounter, the provider should document an assessment, clinical impression, and/or diagnosis. This information may be clearly stated or implied throughout the note. It's the word "implied" that causes problems for auditors. It's not within a coder's purview to question the clinical knowledge of a provider or to change a diagnosis based on evidence in a note. Nor should they ask leading questions that a provider can use to document something just to get the claim paid. In this example, the auditor should simply ask what sign, symptom, or diagnosis led to the order of the a1c.

To qualify as a problem addressed (or managed), the provider must evaluate or treat the problem. A simple note that another professional is managing the problem does not count as "addressed." Therefore, if the medical record documentation states "patient has hypertension," the auditor must then figure out if the problem was evaluated or treated at that visit. This information may be documented in the exam as the patient's blood pressure findings when their vitals were taken. It could also be documented in the history, indicated with a statement such as, "The patient is keeping a blood pressure log at home." If the auditor can't find information to support the diagnosis, then they can't count it toward the level of service.

Use the 3-Pronged Approach

In 2021, AAPC Audit Services came up with a three-pronged approach to use when training auditors and clients on how to think clinically. Here are examples for how you can use this approach when training your auditors.

1. Understand the Patient

Age – How old is the patient? Age factors into the risk portion of medical decision making (MDM). For example, a teenager with a splinter embedded in their skin is likely easier to treat than a newborn with the same issue.

Reason for the visit – Look beyond the chief complaint. The patient history tells the full story. Has the splinter been embedded long? If so, there could be a potential risk of infection. Where is the splinter? Some anatomical locations are harder to get to than others, or pose possible nerve damage.

Past family social history (PFSH) – Is the patient on medications that could add risk? An anticoagulant, for example, could cause the patient to bleed more when the splinter is removed. Are there any diseases that could be impacted by this pesky splinter? What if the patient has had a transplant? They could be on drugs to suppress the immune system, causing them to be at greater risk of infection. Smoking and drug abuse may also complicate the procedure.

2. Understand the Problem

Acuity – Just how bad is the problem? Obviously, a patient with a severed hand is more critical than a patient with a splinter. Many diseases aren't as obvious, however, and may be chronic, acute, or both.

Severity – The severity of the problem may not always be stated in layman's terms, so clinical auditors often have to be detectives.

"There are several things that managers can do to help their auditors (and coders) see things from a clinical perspective."

Listen to **Lori Cox** discuss this article and get a chance to ask her questions at AAPC's Social Hour on Facebook Live, May 10, 11 a.m. MT.

Look at the patient's vital signs. Is their blood pressure high? Are they running a fever? Is their white blood cell count up? What is their pain scale? All these indications could be a sign of a more complex problem that the provider has failed to illustrate.

Comorbidities – Some diseases may affect the problem and some may not. It's best to train providers to document how reported conditions affect the problem for which the patient is being seen, but this is frequently missed.

Differential diagnoses – Although problems that are not definitive shouldn't be coded, they may provide clues to the provider's clinical thought process. For example, if a patient comes in with a scalp laceration, the provider may question the patient about dizziness, frequency of falls, or abuse or neglect. In other words, the provider is looking for anything that may have contributed to the laceration.

3. Understand the Risks

Assessing risks – What are the risks if the patient is or isn't treated? A urinary tract infection (UTI) in a healthy 20-year-old is different than a UTI in a senior. Many elderly people can have alterations of mental status with UTIs, so their treatment may be very different.

Over-the-counter medications – Taking medications incorrectly adds to a patient's risk level. Look for clues in the documentation such as a patient being prescribed a medication and instructed to take it separately from their insulin. Or, the patient was given information regarding the use of antibiotics with birth control pills.

Complicating problems – Surgery almost always complicates matters. If the provider doesn't mention any potential complications other than the usual risks of surgery (infection, bleeding, etc.), than the risk is low. If the patient needs additional testing, like an electrocardiogram (EKG), that's an indication that this patient's risk is high for complications due to surgery.

Social determinates of health (SDOH) – We've heard a lot about SDOH since 2021 when the American Medical Association incorporated them into MDM. Auditors may need to review the patient's social history and elsewhere to find this information. Is the patient experiencing homelessness? If we look at our splinter example, a homeless patient with a splinter may not have sought care until the wound became infected. They also may not be able to take medications or return for follow-up. Patients with current tobacco, alcohol, or drug dependencies are at more risk than nondependent patients. These are all risk factors that could affect a patient's outcome.

Educate Providers

A thorough review of the medical record takes time, but auditors can work smarter by presenting the examples in this article to their providers in an educational session. Explaining what information is missing and why it's needed will help providers improve their clinical documentation. Be ready with helpful suggestions that won't add to a provider's time, such as an electronic medical record (EMR) template that assists the provider with missing documentation elements, or tools that can help with consistency. If claims are being denied due to insufficient documentation, show the provider the missed revenue and explain how to fix it. The objective is to identify and remedy the deficiencies, eliminating the number of case-by-case queries.

Cultivating a learning environment between auditors and providers is essential for smooth business operations and excellent patient healthcare. Providers can teach auditors to think clinically, and auditors can teach providers to think like an auditor. A spirit of learning helps ensure patients receive quality care and providers are properly reimbursed for their work. **HBM**

Lori Cox, MBA, CPC, CPMA, CPC-I, CEMC, CGSC, CHONC, is the director of client engagement at AAPC services. She has over 20 years of experience working in the business side of medicine. Cox began her career in patient accounts and then moved into billing and coding for a multispecialty clinic. She was promoted to billing supervisor and then to compliance officer, where she wrote, maintained, and trained employees and providers on fraud and abuse. In 2015, Cox received her MBA from Quincy University in Quincy, Ill. She has traveled the country educating coders and physicians on complex coding topics such as hematology and oncology and E/M guidelines. Cox is the past member relations officer for AAPC's National Advisory Board and an active member of her AAPC local chapter.

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By Amy Pritchett, CPC, CPCO, CDEO, CPMA, CRC, CPC-I, CANPC, CASCC, CEDC, AAPC Fellow

Learn What's New for ASCs in 2023

Weed through the rhetoric to understand the impact of this year's fee schedules.

Changes to the Ambulatory Surgery Center (ASC) Payment System (PS) from calendar year (CY) 2022 to 2023 are considerable. Complicating matters, the Centers for Medicare & Medicaid Services (CMS) updated the 2023 ASC final rule for April 1. If all the copious amounts of data contained in the final rule and update make your head swim, there is help. Here's a summary of the major changes for ASCs this year.

ASC Payment Update

CMS made history in the CY 2022 final rule by utilizing claims data prior to the pandemic for rate-setting. CY 2019 data was used because CMS believed the 2019 data was a better approximation of expected costs for rate-setting for CY 2022. For CY 2023, however, the payment rates set by CMS are driven by 2021 claims data. As a result, the ASC payment rate update for CY 2023 is 3.8 percent. This is based on the hospital market base rate increase of 4.1 percent, reduced by a 0.3 percent point productivity adjustment.

ASC Covered Procedures

CMS added four codes to the ASC covered procedure list:

- Mastectomy
- Retrieval of intravascular vena cava filter
- Biopsy or excision of lymph node(s)
- Laparoscopic removal of lap band / revision of laparoscopic sleeve gastrectomy

CMS also finalized the 2023 Medicare Physician Fee Schedule (MPFS) with a decrease in physician reimbursement from $34.61 in 2022 to $33.06 in 2023. They expanded the temporary telehealth services through the end of the year in which the public health emergency ends, which is slated for May 11, 2023, as of this writing.

Also, in the 2023 MPFS final rule, CMS expanded coverage for colorectal screening, lowering the age requirement for when it will begin paying for preventive services from 50 years to 45 years and expanding the definition of a colorectal cancer screening test. The final rule also adopted most of the American Medical Association's CPT® code and guidelines changes for hospital and evaluation and management (E/M) visits.

adobestock / Gabriel Trujillo

New Provider Type

CMS also established a new provider type under direction of the Consolidated Appropriations Act (CAA) of 2021. The new provider type will be known as rural emergency hospitals (REHs) effective Jan. 1, 2023. REHs will be paid for furnishing services at a rate that equals the Outpatient Prospective Payment System (OPPS). REHs cannot charge coinsurance, as they are receiving an additional 5 percent across the board for payment. REHs may provide services such as clinical laboratory and will receive a monthly facility payment that will increase in subsequent years based on the hospital market basket percentage.

> *"REHs will be paid for furnishing services at a rate that equals the Outpatient Prospective Payment System (OPPS)."*

Along with the establishment of the REHs, CMS maintained established conditions of participation (CoPs). The REH must always have a clinician on call and available within 30-60 minutes. The emergency department must be staffed 24/7 and develop, implement, and maintain effective, on-going Quality Assurance and Performance Improvement (QAPI) programs to address outcome indicators related to staffing. The average per-patient annual length of stay cannot exceed 24 hours with the calculation of time commencing with registration, check-in, or triage of the patient, and ends when the patient is discharged. The REH must have an infection prevention and control program and adhere to all nationally recognized guidelines.

Discarded Drug Reporting

Another important guideline that came out of the 2023 ASC final rule is the requirement for ASCs to report discarded amounts of certain drugs. The Jobs Act requires drug manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use packaged drug. ASCs are now required to report modifier JW *Drug amount discarded/not administered to any patient* or any additional modifier that identifies discharged amounts of refundable drugs that are separately payable under OPPS.

The designated HCPCS Level II codes are assigned to a status indicator (SI) of K2 *Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate*. Modifier JW must be used to determine the number of single-dose or single-use container packages that were discarded beginning no later than July 1, 2023. ASCs must also append modifier JZ *Zero drug amount discarded/not administered to any patient* in cases where no billing units of drugs were discarded and where modifier JW would be required for drugs that were discarded; the claim edits for JW and JZ will begin Oct. 1, 2023.

Please join me and **Kristen Taylor, CPC**, at AAPC's HEALTHCON in Nashville, Tennessee, May 20-24, at our session "The ABCs of ASCs" to learn how to keep your ASC compliant and risk free. HBM

Amy Pritchett, CPC, CPCO, CDEO, CPMA, CRC, CPC-I, CANPC, CASCC, CEDC, AAPC Fellow, is a senior consultant with Pinnacle Enterprise Risk Consulting Services with more than 20 years of medical billing and coding experience. Prior to working at Pinnacle, Pritchett held several director, management, and lead educator positions, where she was responsible for facility coding, auditing, review, P/L, revenue cycle, and the managing of pro-fee audit for specialty clients including physician E/M leveling. She is a certified ICD-10-CM/PCS instructor and serves as an adjunct professor of medical billing and coding within the University of South Alabama Medical Billing and Coding program and has had several speaking engagements with AAPC.

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www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1772-fc

By Bruce Pegg, MA, CPC, CFPC

adobestock / Monkey Business

Add to Your Prolonged Service Coding Understanding With This Guide

CMS and CPT® still at odds over when to add extra time.

The 2023 Medicare Physician Fee Schedule (MPFS) final rule instituted significant changes to prolonged service coding. If you want to stay ahead of those changes, or you're still confused by the different ways Medicare and payers that follow CPT® guidelines code for prolonged services, you've come to the right place. We've gathered all the new codes and guideline changes into this one handy guide.

Refresh Your +99417 Understanding

For 2023, CPT® has changed the descriptor for +99417 to now read: *Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service).*

Fortunately, the guidelines for using the code remain the same. CPT® instructs you to use +99417 when service times for 99205 *Office or other outpatient visit for the evaluation and management of a new patient … 60-74 minutes of total time is spent on the date of the encounter* or 99215 *Office or other outpatient visit for the evaluation and management of an established patient … 40-54 minutes of total time is spent on the date of the encounter* go 15 minutes beyond the minimum for the 99205/99215 time ranges — 75 minutes for a new patient visit and 55 for an established patient — and additional units for every 15 minutes beyond those times.

Note These New +99417 CPT® Updates

For 2023, CPT® also deleted prolonged service codes 99354 and 99355. In their place, you'll now use +99417 to report prolonged services with:

- 99245 *Office or other outpatient consultation for a new or established patient …* when the time meets or exceeds 55 minutes
- 99345/99350 *Home or residence visit for the evaluation and management of a new/established patient …* when the times meet or exceed 75 or 60 minutes, respectively
- 99483 *Assessment of and care planning for a patient with cognitive impairment …* when the service goes beyond its typical time of 60 minutes

Add This New CPT® Prolonged Service Code

CPT® also deleted prolonged service codes 99356 and 99357 for 2023 and introduces another code: +99418 *Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time …*, which had been previously given the placeholder code of 993X0.

In addition to the highest level initial and subsequent nursing facility care evaluation and management (E/M) codes 99306 and 99310, you'll use +99418 with the following revised codes:

- 99223 *Initial hospital inpatient or observation care … 75 minutes must be met or exceeded*
- 99233 *Subsequent hospital inpatient or observation care … 50 minutes must be met or exceeded*
- 99236 *Hospital inpatient or observation care … 85 minutes must be met or exceeded*
- 99255 *Inpatient or observation consultation … 80 minutes must be met or exceeded*

Master G Codes for Medicare Patient Prolonged Services

In the 2021 MPFS final rule, the Centers for Medicare & Medicaid Services (CMS) argued that you should use +99417 when the total time for visits hits 15 minutes beyond the maximum time range for 99205 (i.e., 89 minutes) and 99215 (i.e., 69 minutes). To avoid potential confusion with CPT® guidelines, CMS created a new prolonged service code, recognized by Medicare and payers following Medicare payment rules, to take its place: G2212 *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact ….*

For the 2023 MPFS final rule, CMS has taken a similar view of +99418, believing that the billing instructions for the code "would lead to administrative complexity, potentially duplicative payments, and limit our ability to determine how much time was spent with the patient using claims data." In its place, they have introduced three more G codes:

- G0316 *Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service … each additional 15 minutes …* for prolonged inpatient or observation E/M services documented with 99223, 99233, and 99236
- G0317 *Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service … each additional 15 minutes by the physician or qualified healthcare professional …* for prolonged nursing facility E/M services documented with 99306 and 99310
- G0318 *Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service … each additional 15 minutes …* for prolonged home or residence E/M services documented with 99345 and 99350

Mind This Medicare Muddle

For 99483, the time requirement is 60 minutes. To use G2212 with 99483, the practitioner must surpass the 60 minutes by a full 15 minutes (75 minutes) and then G2212 requires an additional 15 minutes. This makes the threshold 90 minutes, not 100 minutes, as stated in the Medicare Internet Only Manual, Pub. 100-04, Chapter 12, Section 30.6.15.3. Unless CMS addresses this discrepancy, however, the 100-minute threshold stands. **HBM**

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This article is reprinted from the Dec. 27, 2022, *Oncology & Hematology Coding Alert*. For more articles like this, as well as other specialty-specific articles, check out AAPC's full line of newsletters at www.aapc.com/newsletter.

By Dawn Cook, RN, CLCP, CNLCP

How to Craft a Surgical Letter

Understanding the costs associated with surgery upfront is important for both patients and payers.

A surgical letter includes the expected costs a surgeon anticipates for a specific surgery. The purpose of the letter is to provide a budget for preoperative care, costs on the day of surgery, and postoperative care. The letter may be created for a cash-paying patient, as an insurance requirement, or for insurance settlement purposes.

When tasked with crafting a surgical letter, it's important to ask yourself:

- What do I need to include in the letter?
- How do I learn the medical-specific codes?
- Where do I find the costs for each item?

This article will instruct how to address these questions in all stages of care when compiling a surgical letter.

Gather Essential Information

As an employee of a surgeon's office, you have an advantage when trying to locate direct charges for surgery. Your surgeon has a relationship with other physicians, therapists, and facilities who will likely give you information that would be difficult or impossible to learn otherwise. When contacting other facilities for pricing, emphasize that you are calling from your physician's office and be prepared to name the patient, their date of birth, the proposed surgery, and the reason for the request.

Once you have what you need, you can create a letter that includes each item and a cost estimate (including where you found the cost). Once the letter is approved by your office, your physician can then determine the best way for the patient to receive the letter. They may wish to review it with the patient at their next office visit or send it to them immediately.

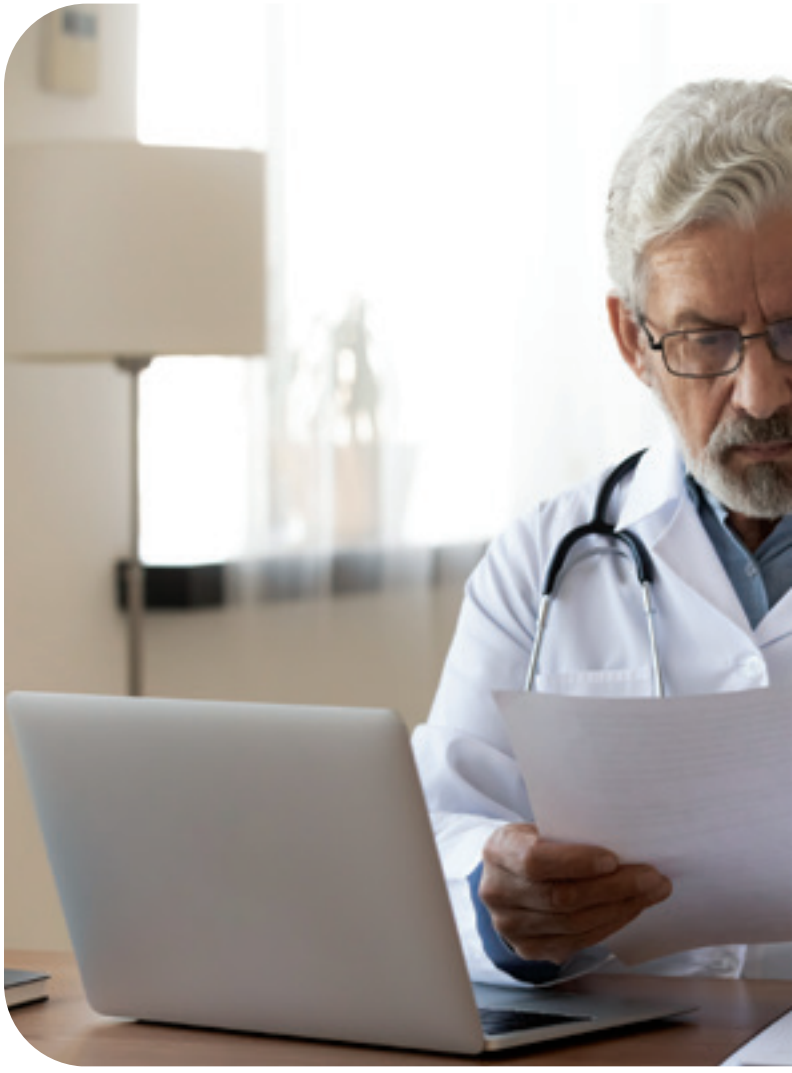
Find the Costs and Codes

When crafting a surgical letter, you will need to have a list of all pre- and postoperative care that your surgeon is recommending, details concerning the type of facility, and the CPT® codes associated with the specific surgery. Prepare a list of questions and then talk with the medical assistant or surgeon about each state of care.

Preoperative Care:

1. Preoperative assessment by a surgeon, usually a consultation, is usually coded with:

   99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded



If you work in a medical office, you can determine the cost that your office charges by consulting your chargemaster or billing department.

2. Preoperative clearance by a primary care provider (PCP) or a pediatrician in the case of a child is needed. This is usually a consultation, even if the patient usually sees this provider regularly, to accommodate the extended nature of the visit. The usual CPT® code is 99244. If your office does not provide this service, contact the office of your patient's PCP and ask for help determining the usual charge for this.

"The letter may be created for a cash-paying patient, as an insurance requirement, or for insurance settlement purposes."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3. For labs and radiology or diagnostic imaging contact your local laboratories and ask for their direct pay charge sheet, explaining that you are preparing a surgical projection and need their charges. You will need to give the CPT® codes for each item that your patient will need, and you may need to give this verbally over the phone or in writing by email or fax. For inpatient surgery, labs and radiology may need to be done at the facility where the surgery will be done. You can ask about these costs when you call for facility costs.
4. Cardiac and respiratory assessments are consultations with the respective physician specialists. You can call the office that you will be referring the patient to to determine the consultation fee, any testing fees, and any follow-up charges.
5. A physical therapy (PT) preoperative evaluation is reported with:

   97162 Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family

   Call the PT office that you usually refer your patients to and ask for help with direct pay charges. Ask whether more than one visit will be needed if additional equipment evaluations are needed.
6. Most durable medical equipment and supplies can be purchased from department stores and larger pharmacies. Do an online search for well-known retail providers to determine the cost for each item. If there are unusual items, such as scooters, ice machines, or continuous movement machines, you may need to call your local medical supplier.

Day of Surgery:

1. Facility costs may be available to your office if your surgeon regularly does surgery there. Determine if you should call the billing department, the operating room, or another department. Be prepared to give information on the specific surgery and the patient's comorbidities. ICD-10 codes may also be needed.
2. Ask the surgeon what specific surgery they are planning, including any additional procedures that might be needed. Ask if an assistant to the surgeon is needed for this surgery. Then use your own chargemaster for the associated CPT® codes. If your surgeon uses an outside medical group for providing an assistant, call them for an estimate.
3. If the patient will receive a pass-through implant, such as a pulse generator, there will be additional charges from the facility for this equipment if done at an outpatient facility. This is usually included in the hospital charge for inpatient care.


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4. If it's anticipated that there will be any equipment, such as a leg brace or ice pad placed on the patient immediately following surgery, be sure to get the cost for this, as it usually constitutes an additional charge.
5. Hospitalists may be needed if the patient is staying overnight to manage other medical conditions they may have. Call your local hospitalist group to determine their costs — they usually charge more for the admission date and the discharge date than they do for daily visits. The usual CPT® codes for this care are:

99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter

6. Anesthesia costs are best determined by calling the anesthesia group that works with your surgeon. You will need to provide the CPT® codes for surgery and information on any comorbidities (usually by providing the ICD-10-CM codes).
7. Neuromonitoring for spine, brain, or other surgery is sometimes needed. There may be a group that provides these services at your facility. Call them and ask what the charge will be for the service, providing all CPT® codes for the surgery and the patient's comorbidities or ICD-10-CM codes.

Postoperative Care:

1. Medication prices can be obtained by calling the patient's usual pharmacy or using an online service such as www.GoodRx.com.
2. Follow-up physician office visits are included in the global period (90 days for most surgeries). Determine how often your surgeon will want to see the patient back in the office and whether X-rays will be done there. Although the office visit in the first 90 days has no charge, site-specific X-rays may be charged for. Check your office's chargemaster to determine the usual charge for X-rays and the cost for any office visits that may occur past the 90-day global period.
3. Physical or occupational therapy evaluation and the number of sessions can usually be determined by the surgeon ahead of time. Sessions are usually 1 hour. Call the PT office that you usually refer your patients to and ask for help with direct pay charges.
4. Possible home nursing and therapy is based on the patient's condition and whether they have support at home. The patient may need additional help in the first two weeks, including having their dressings checked by a nurse at home, as well as the initial PT evaluation and therapy done at home. Call your usual PT office for costs. Nursing home visit costs can be obtained from home health or nursing agencies.

"To get a cost estimate for housecleaning and meal preparation, do an internet search or ask the patient if they sometimes use a cleaning agency."

5. It is possible that a rehab hospital will be needed for those with comorbidities or lack of assistance at home. Ask your surgeon approximately how long the patient should be in rehab and whether they will need help at home. Call the usual rehabilitation facility that your surgeon uses to determine their costs. They may have a daily rate plus additional therapy charges.
6. Depending on the surgery, the patient may not be able to bathe or do housework without assistance for a period of time following their return home. Consider that an agency may need to send a home health aide to assist with personal care. This can be determined by a phone call to a few agencies in your area. To get a cost estimate for housecleaning and meal preparation, do an internet search or ask the patient if they sometimes use a cleaning agency.

These lists may not be all-inclusive depending on the surgery in question. Consider any additional medical needs not outlined here. For those anticipating that insurance may cover some of these costs, talk with your billing specialist. Many of the above items are not covered or only partially covered.

Reap the Rewards

A surgical letter must include all the components needed for surgery — nothing is to be left out. Learning how to craft a surgical letter is a lengthy process, and creating a complete surgical estimate is time-consuming; however, the benefits to patients and payers is well worth the hard work. **HBM**

Dawn Cook, RN, CLCP, CNLCP, is a registered nurse and life care planner with 45 years of experience. She has completed over 700 life care plans and 450 medical bill reviews. Cook will present "Crafting Surgical Letters and Cost Estimates" at HEALTHCON 2023.

By Michelle A. Dick, BS

Unlock the Mysteries of Claims Data

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Understanding how health information is created and used is key to quality reporting.

Health information management is not just about analyzing medical charts and assigning codes to make sure providers get paid in a timely manner. It requires an understanding of how the data is used.

At AAPC's REVCON 2023 virtual conference, held Feb. 7-8, speaker **Catherine Butterfield, MBA, CPC, CRC**, took a deep dive into claims data and what coders, billers, and others in the medical field need to be responsible for in her session "Claims Data – How is it Used?" She discussed the basics of claims trends, health plan data usage, the nuances of Medicare Advantage (MA) claims data, value-based care versus fee-for-service, patient-centered medical homes (PCMH), building partnerships with health plans, the role of data in healthcare, its future and how to use it, and much more.

This article focuses on Butterfield's presentation of the basics of claims data, how health plans use it, why partnering with health plans will improve outcomes, and the future of healthcare data.

Begin at the Root

Butterfield began by defining the various code sets used for appropriate patient treatment, clinical decision-making, revenue, reimbursement, financial justification, research, special findings, and worldwide comparative trending.

CPT® – Current Procedural Terminology codes are managed by the American Medical Association and used to identify services rendered by physicians and other qualified healthcare professionals for the care and treatment of patients. There are three categories of CPT® codes:

- **CPT® I** – Code range 00100-99499. Each code corresponds to a specific procedure or service. Except for evaluation and management services, these codes are generally categorized by body system and then further organized into sub-categories based on the procedure and anatomy.
- **CPT® II** – Supplemental codes (range 0001F-9007F) are used for performance measurement. Using them is optional because they are generally not tied to revenue. They are, however, important for quality care and health data tracking.
- **CPT® III** – These are temporary codes used for data collection, assessment, and sometimes payment of emerging technologies, services, and procedures. These are new services that don't meet Category I code criteria, although they may in the future.

ICD-10-CM – The International Classification of Diseases, Tenth Revision, Clinical Modification codes are managed by the ICD-10 Coordination and Maintenance Committee (C&M), which is composed of representatives from the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention's National Center for Health Statistics. These codes are part of the clinical coding process alongside intervention codes (i.e., vaccines, nutritional interventions, behavioral changes, injury prevention, environmental alterations, etc.).

For data management purposes, ICD-10-CM:

- Provides a common language for recording, reporting, and monitoring diseases;
- Allows a way for the world to compare and share data in a consistent, standard way;
- Compares hospitals, regions, and countries over time;
- Helps insurance payers and government officials use data to predict future healthcare costs and to improve prevention and care for patients and communities;
- Tracks government analytical trends and usage for disease tracing, causes, demographics, outbreaks, etc.; and
- Helps state and federal agencies plan budgets for Medicare and Medicaid costs and plan the needs of other government agencies such as the Centers for Disease Control and Prevention (CDC) and National Committee for Quality Assurance (NCQA).

ICD-10-CM codes capture data that is important for tracking COVID-19 cases, deaths, hospitalizations, vaccinations, and those who receive care. The CDC makes the data publicly available on their website. See **Figure A** for an example of how COVID-19 is tracked by the CDC. On March 8, only 16.2 percent of the population had the updated booster dose. Butterfield pointed out that we are "a little hesitant when it comes to the booster dose, and this shows very, very clearly on the CDC trends."

Bonus Video: Learn best practices and benefits of risk adjustment coding by watching a 5-minute clip from Butterfield's session.

HCPCS Level II – Healthcare Common Procedure Coding System Level II codes are for reporting procedures, durable medical equipment (DME) supplies, products, and services. HCPCS Level II codes provide specific details regarding a patient's care such as the specifics of DME, injections, and immunizations.

Technically, there are three HCPCS levels: Level III has been eliminated by CMS. When medical coders and billers talk about HCPCS codes, they're typically referring to HCPCS Level II codes. "Level II represents the primary items and nonphysician services not represented in Level I," Butterfield said. HCPCS Level I codes are generally referred to as CPT® or CPT-4 codes.

How Health Plans Use Data

Commercial payers, Medicare, and Medicaid use claims data for many reasons. Some uses for claims data by health plans include:

- Combine and register information;
- Determine costs of care, future investment strategies, and payment for healthcare locations;
- Assist in budgeting for future patient care;
- Track diseases and illnesses nationwide, demographics, and geographic data;

Figure A: ICD-10-CM claims data reveals COVID-19 trends.

- Predict potential threats and illness;
- Assist in coordinating supply chain needs;
- Provide feedback for awareness and education; and
- Improve outcomes and quality of life for patients.

The focus of the data is to keep patients healthier longer and, thereby, reduce the cost of insuring them. Through claims data, government payers "may find we all need to be taxed more," said Butterfield. "They may have to increase the cost of healthcare. They may have to cut funding in certain locations that are not providing the care that's needed, so that others can get it. There is government activity when tracking diseases, like strategies, taxing, and budgeting. Unfortunately, that's the bottom line of it," said Butterfield.

One thing that commercial payers and health plans carefully look at is Star Ratings data, which pertains to patients enrolled in both MA Part C and prescription drug Part D plans. CMS publishes Star Ratings data every year (http://go.cms.gov/partcanddstarratings). The program enables MA consumers to compare the quality of Medicare health and drug plans with others being offered using a star rating, with five stars considered excellent. Data from the Star Ratings comes from four sources:

- **Consumer Assessment of Healthcare Providers and System (CAHPS)** – CAHPS are CMS surveys that tell a lot about a provider and how well they are doing. They ask patients to report their experiences with a range of healthcare services at multiple levels of the delivery system. CAHPS surveys may be used for value-based purchasing (pay-for-performance) initiatives and Merit-based Incentive Payment Systems (MIPS) measures.
- **Health Outcomes Survey (HOS)** – HOS is a patient-reported survey consisting of outcome measures in MA-managed care, and all managed care organizations with Medicare contracts must participate. "The goal is to gather valid, reliable, and clinically meaningful health status data," according to Butterfield. HOS gathers data for quality improvement activities, pay-for-performance, program oversight, public reporting, and health outcomes improvement.
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – HEDIS is developed and maintained by the NCQA and used to measure performance in healthcare where improvements can make a meaningful difference in people's lives. The goal is to ensure timely and appropriate patient care and provide reliable comparison information on health plan performances. The data impacts healthcare providers, insurance companies, and the consumers they serve.
- **Part C and D Performance Data** – These are reporting requirements and measures for MA and prescription drugs covered by MA plans. Butterfield gave the following example: "If you go to your primary care office for a routine visit and your provider administers a SHINGRIX or Tdap vaccine, even though the patient did not have a scratch or an animal bite, the claim needs to be sent to Part D, but Part C will cover it."


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Partner With Health Plans to Improve Outcomes

"The bottom line is providers seek to administer the best care for patients," Butterfield said. "Yeah, they're trying to make money, too. … However, your insurance company is looking at seeking managed care while also managing the cost." So, the goal in partnering with health plans is to make sure the best patient care is administered while providing cost-effective treatment.

One benefit of providers building partnerships with health plans is that they improve and increase cost-effective health outcomes. Other benefits include improving:

- The patient experience by being able to resolve claims and insurance coverage issues;
- Coordination of pay-for-performance measures reported to payers; and
- Authorization delays for patient referrals.

Coders and billers should never think they are out of line when asking insurance companies for help or when asking, "I have a claim that should be paid. Why are you not paying it when I've coded it right?" said Butterfield.

Maybe there is a larger problem with claims not being paid by the health plan and a different question is needed. Try saying, "I'm getting feedback from my locations that this code is not getting paid. What's going on?" Butterfield suggests. There may be a glitch in the system that nobody is catching. Never hesitate to voice an opinion when an answer is needed.

"Take a look at your own healthcare organization to see if you're supporting the best use of claims data."

Four ways to partner with health plans are:

- **Welcome provider relations health plan staff into your office** – This could be as simple as sharing handouts and listening to their messages or getting their name and business card to reach out and build a relationship.
- **Set up meetings with different plans** – Call the help lines, ask questions, and visit their websites for updates.
- **Expand the insurance plans your practice accepts** – Provide records when requested by new plans and cooperate with HEDIS and Risk Adjustment Data Validation (RADV) chart audit requests.
- **Become a value-based provider group** – The majority of value-based providers receive ongoing support from plans via education, documentation advice, coding and risk adjustment assistance, and practice audits to review value-based care improvement opportunities.

The Future of Healthcare Data Is Bright

Butterfield also discussed the future of data enhancements. She predicted the future of claims data will include:

- Trusted technology for data-driven decision-making;
- Enriched disease registries for research centers to better track where diseases are and to find cures faster;
- Increased metric tracking and provider engagement;
- More private philanthropies, medical and disease societies;
- Accelerated discoveries to improve patient care; and
- Increased data partnerships within the industry and societies.

Increased data partnerships will allow for data to be moved in hours, rather than days. There will be multi-site collaboration for data use and real-time data communication from one location to another, Butterfield said.

Use and Support Claims Data in Healthcare

Take a look at your own healthcare organization to see if you're supporting the best use of claims data. Here are some things Butterfield said you can ask yourself to help enrich its use in your practice:

- Does your healthcare organization treat at-risk populations?
- Are you or your healthcare location reviewing outcomes?
- Is your healthcare organization billing value-based or fee-for-service?
- Does your practice have shared data access?
- Is your practice accredited with PCMH?
- Are you cooperating with HEDIS and RADV chart requests?
- Are you tapping into AAPC resources? (i.e., participating in local chapter activities; attending conferences; and reading Knowledge Center blogs, Healthcare Business Monthly, and forums)
- Are your health outcome metrics reviewed with providers and staff monthly, and do your providers follow scoreboard expectations?
- Does your healthcare organization welcome payer staff and listen to their updates?

Butterfield stressed the importance of analyzing and fostering new ways to use claims data to improve processes, patient outcomes, and costs. **HBM**

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By Sandy Giangreco Brown, MHA, BS, RHIT, CCS, CCS-P, CHC, CPC, COC, CPC-I, COBGC, PCS, AHIMA Approved ICD-10-CM Trainer, AAPC Approved Instructor, and Hailey Marsh, CPC, CDEO

Top 4 Compliance Policies and Procedures

Your healthcare entity is at risk if these elements aren't part of its compliance plan.

As healthcare workers, it's our responsibility to know and understand that the Office of Inspector General (OIG) expects all healthcare entities to follow and abide by its self-proclaimed seven elements of an effective compliance program. The first element, implementing written policies, procedures, and standards of conduct, is the focus of this article. We will review four compliance policies and procedures all healthcare entities should have in place to protect their practices from the repercussions of noncompliance.

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Plan for Compliance

It's recommended that every healthcare entity have a working compliance program, even if it isn't mandatory for the provider to have one (see sidebar). Policies and procedures are the key to ensuring that guidelines are established for patient and employee safety, that federal and state laws and guidelines are followed, and to help promote consistency in practices.

It's also important for all employees to have knowledge that a compliance program exists. Employees should have an in-depth knowledge of the compliance program through a team review or individual testing. This will help employees know how to respond when an allegation or concern is raised by another employee or third party, or when they feel the need to report a concern.

Not every allegation or concern raised will result in an investigation, but all allegations or concerns should be taken seriously and logged by the compliance officer for tracking purposes. If an allegation or concern results in an investigation, there may be other departments that will need to be involved such as human resources, finance, and clinic/hospital leadership.

Having a written compliance program in place that is shared with all employees and adhered to sends a clear message that there is a high ethical standard and that employees are encouraged to come forward to share a potential compliance risk or concern.

Key Elements for Compliance

If your organization is audited by the Department of Justice (DOJ), it will ask to see your company's compliance program. A DOJ review may consist of ensuring proper updates have been made to the program, that it contains the required safeguards in place to protect employees who come forward with concerns, and that proper follow-up has occurred and is documented. Here are four elements your compliance plan should contain:

1. **Investigation policy** – A good investigation policy should be clear on its purpose and intent, what the protocol is when an allegation or concern is raised to the compliance department, and the corrective action process, if proven necessary. It should also be abundantly clear that no retaliation will be taken against a person who comes forward with a

"If your organization is audited by the Department of Justice (DOJ), it will ask to see your company's compliance program."

suspected allegation or concern and that they will remain anonymous, if possible.

It's important to state in the policy who will handle investigations and at what levels additional outside counsel will be brought in. (It's also recommended that legal counsel be well-versed in the potential issues.) All investigations should include reviewing and preserving all documents related to the allegation, interviewing all appropriate individuals, and reviewing policies and procedures applicable to the allegation. Any corrective or disciplinary action that will take place, if necessary, should also be defined in the policy.

To safeguard compliance, it's key to outline the general steps in a clear and specific way. However, these steps should not be so detailed that the investigation process might put the organization at risk for noncompliance if the steps are not followed to the letter. Since not all investigations will have the same level of severity, having a flexible investigation policy is advisable.

2. **Overpayment or self-disclosure policy** – At some point, every practice will identify a compliance issue that will result in a payback. Your compliance plan should outline how to identify when there is a need for a payback. It should outline the process of identifying the universe of claims that may need to be included in the sample and when a statistician may be required. Many think they can handle this step themselves, but the OIG recommends someone who is a statistician (or equivalent) to perform the statistically valid sampling to facilitate the appropriate payback. The sample may need to go back as many as six years if the situation has been going on that long.

Questions to ask when determining the sampling universe are:

- When did the provider join the practice?
- Has this been a recent acquisition and/or is this is a new service or service line added recently?
- Are there multiple providers involved or one particular provider?

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It's also important for practices and hospitals to identify whether an error is truly a mistake or more egregious and potentially an intent to defraud the government. Mistakes will happen, no one is perfect; the most important thing is how the practice or facility responds when an issue is discovered. This may be a good time to reach out to internal/external legal counsel. Note that even if you discuss the matter under attorney client privilege (ACP), any data analytics and information that have already been obtained is discoverable. It depends on the situation as to whether a situation should be put under ACP. Some practices want everything discussed and discovered under ACP and others prefer full disclosure.

3. **Coding compliance policy and procedure** – All health information management, coding, compliance, and billing departments should have written policies and procedures that designate who will assign the medical coding. Policies should also describe who will append modifiers, when necessary, and what the process will be to carry these actions out. Are the billers allowed to append modifiers or does the encounter need to be returned to coding so they can append the modifier if the documentation supports it?

To ensure proper code selection, all personnel who hold a position where they will be selecting or reviewing medical coding should be certified by an accrediting body. It's equally important to provide continuing education opportunities for individuals who hold this position because codes and guidelines are updated frequently.

"Employees should have an in-depth knowledge of the compliance program through a team review or individual testing."

4. **Screening for individuals excluded from the federal healthcare programs** – Every healthcare entity performs background checks; however, some have not fully understood the importance of screening for those individuals who have been excluded from the federal healthcare programs (e.g., Medicare). If an excluded individual has been involved with the care of patients, even running their labs, all the monies received for that care must be refunded. One of the sites you can check for excluded individuals is https://exclusions.oig.hhs.gov.

The OIG recommends healthcare entities screen all new hires, as well as check the national databases on a monthly cadence to identify excluded providers who may

Are Compliance Programs Mandatory?

The government has yet to make compliance programs mandatory on a federal level, but there are state laws. The Office of Medicaid Inspector General (OMIG) finalized New York Social Service Law Section 363-D on Dec. 28, 2022, to update compliance program regulations. This law outlines expectations for mandatory compliance programs in New York, identifying the organizations required to comply, the required components of a compliance program, and the fines and penalties for not having a working compliance program. Clinics and Medicaid Managed Care Organizations and an entity that has at least $1 million of Medicaid revenue in a 12-month period are required to have compliance programs in New York. Check your state's OMIG for similar regulations.

not have been in the federal databases when the person was first hired. Healthcare entities should also keep a log (either electronically or on paper) of these monthly checks as evidence. Should an issue occur, this record will prove that you performed due diligence.

Should you discover an excluded provider, consult your legal counsel for next steps. These steps should also be outlined in the compliance policy. One recommendation is to stop billing claims for patients with which this provider has potentially been involved or encountered. While there are some instances where an excluded individual can be employed, the OIG has been clear about the positions they cannot hold in a healthcare entity.

An excluded individual is not prohibited by the OIG from owning a healthcare entity participating in a federal healthcare program. The individual must own less than 5 percent of the entity and cannot hold a management or administrative position within the organization, however, or face the possibility of civil monetary penalties.

Scraping the Surface

The first of the OIG's seven elements of an effective compliance program is probably the hardest. Once that is done, you can work on the other six steps:

1. Designate a compliance officer and compliance committee.
2. Conduct effective training and education.
3. Develop effective lines of communication.
4. Conduct internal monitoring and auditing.
5. Enforce standards through well-publicized disciplinary guidelines.
6. Respond promptly to detected offenses and undertake corrective action.

"Policies should also describe who will append modifiers, when necessary, and what the process will be to carry these actions out."

Although only certain healthcare providers are required to adopt compliance programs, the OIG recommends all healthcare entities make compliance plans a priority. **HBM**

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Hailey Marsh, CPC, CDEO, joined WCP in 2021 to advise its healthcare portfolio companies regarding coding and billing compliance. She continues to assist portfolio companies by performing coding and documentation reviews, education, data analytics, and general compliance support.

Resources

HHS OIG Issues Exclusion Advisory (2018), www.policymed.com/2013/06/hhs-oig-issues-exclusion-advisory.html

https://oig.hhs.gov/compliance/compliance-guidance

HCCA OIG Resource Guide (2017), https://oig.hhs.gov/documents/toolkits/928/HCCA-OIG-Resource-Guide.pdf

OIG Compliance Program for Individual and Small Group Physician Practices (2000), https://oig.hhs.gov/documents/compliance-guidance/801/physician.pdf

OIG's Health Care Fraud Self-Disclosure Protocol (2021), https://oig.hhs.gov/documents/self-disclosure-info/1006/Self-Disclosure-Protocol-2021.pdf

U.S. Department of Justice Criminal Division, Evaluation of Corporate Compliance Programs (revised June 2020), www.justice.gov/criminal-fraud/page/file/937501/download

By Isaac James

5 Qualities of a Great Physician Billing Solution

Make an informed decision when choosing a company responsible for your reimbursement.

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If you're a physician looking to boost your reimbursement rates, increase your financial performance, save on operating costs, or devote more time to patient care, outsourcing your billing needs is the way to go. Not all physician billing services are the same, however. Selecting the best one for your practice can be difficult. Since medical billing and coding are essential to every healthcare business, it's critical to look for specific traits in a billing and coding service provider.

Learning which qualities successful physician billing professionals have will help you make an informed decision when choosing a billing solution. Here are the top five.

1 Effective Communication Skills

People often wrongly believe that medical billers sit at a desk all day and punch in numbers. In the ordinary course of their work, billers must communicate with a wide variety of people and organizations, including:

- Patients
- Clients
- Physicians and other medical experts
- Agents and insurance agencies

One of the main activities of a medical biller is talking on the phone. Calls from patients or their insurers about payments or balances are common. In addition to being patient and kind, a biller with excellent communication skills will be able to articulately answer all inquiries and clearly explain policies to help customers understand what actions need to be taken.

Good billers must, therefore, be excellent communicators, as they serve as a bridge between their employer, patients, and insurance companies. Physician reimbursement specialists (PRS) may help you assess whether or not your existing physician billing solutions are communicating well and taking all necessary steps to maximize your reimbursements. PRS are primarily responsible for working with insurance companies and medical billing staff to manage the billing/reimbursement process. These professionals specialize in tasks related to ensuring that physicians and other medical professionals are paid appropriately for their services.

2 Capacity for Analysis and Problem Solving

A unique individual with a formidable collection of skills is required to achieve success in a field that involves codes, numbers, and people. The process used in physicians' billing services resembles the resolution of a complex puzzle. It's necessary to recognize and decipher many numbers and codes, especially as they relate to the processing of claims. Since the billing and coding process is rarely without bumps, it's imperative that billers have a firm grasp on how to maneuver through it. The timely and proper processing of claims relies on the biller's ability to investigate, troubleshoot, follow up, and resubmit claims as necessary.

You can tell if a biller has strong analytical skills by observing the way they deal with problems. They should be able to handle even the slightest invoice discrepancy without being sidetracked by phone calls or emails. Inconsistencies are usually symptoms of a deeper systemic problem; fixing even a minor hiccup in your business's procedures can boost profits significantly and secure your company's future.

Analytical abilities are also useful for deciphering the reasoning behind claim denials, which is especially important since such

"The timely and proper processing of claims relies on the biller's ability to investigate, troubleshoot, follow up, and resubmit claims as necessary."

reasoning is not usually provided. A competent biller can look back at similar claims they've processed and figure out what needs to be done to have the second submission approved and paid.

3 Expertise and Knowledge

To succeed in the field of physician billing solutions, it's necessary for billers to possess a specific set of technical abilities such as the ability to use medical billing software and systems effectively. Good billers will be able to maximize software for efficiency and productivity since they will be familiar with various programs and their shortcuts. Billers not only need to be familiar with accounting principles, spreadsheet programs, and word processors, but also with hospital and institutional coding. Aside from that, they need to keep up with the ever-changing world of revenue cycle management and billing codes. Keeping up with these shifts through continuing education is essential for any successful practice to endure.

Physician billing services for hospitals need to prove their worth to clients by presenting a solid portfolio of their previous work. Ask for reviews and testimonials from those who have already worked with the company.

4 Integrity

On a regular basis, medical billers deal with sensitive information about their patients, including their names, addresses, insurance coverage, and medical histories. Discretion is required if any time-sensitive patient information is shared. In order to safeguard their clients' and patients' personal information, medical billers must adhere to HIPAA regulations. It's critical to choose only honest medical billers who can demonstrate superior judgment and ethics. A breach of patient privacy protected by HIPAA should be avoided at all costs.

5 Proficient In Planning and Organization

A physician billing service's process for hospitals is complex. A large number of documents may be received by billers in a single workday. In addition, medical billers can't be expected to remember the thousands of codes used in the sector. Having a robust organizing structure in place is crucial for working productively with various clients. If patients or insurance companies have questions about a particular claim, for example, billers must be able to swiftly and readily retrieve any and all relevant information, no matter how minute. A medical biller's duties also include maintaining accurate records of all payments received, any outstanding balances, and the total outlay of funds for the practice as a whole. A biller's ability to access any and all relevant data depends on the efficiency of their billing system. Making important files accessible in case the biller is away from the office will keep things running smoothly and efficiently. Everybody will benefit greatly from an understanding of the filing and storage systems in place.

Organization is essential for physician billing solutions since being extremely organized allows billers to perform multiple tasks at once, which is a useful talent. An organized system will ensure that all files and information are preserved appropriately when medical billers have to juggle several claims and keep tabs on said claims.

Are You Ready to Decide?

It's essential that healthcare providers remain adept at keeping up with the ever-changing demands of medical billing and coding in today's dynamic healthcare market. You may maximize your financial return in the least amount of time possible by working with physician billing solutions that have efficient procedures, superior systems and technologies, and a team with specialized knowledge and experience. Therefore, it's crucial to know which qualities to look for. HBM

Isaac James has worked as a medical billing expert for the past 5 years with reputed medical billing services provider Medcare MSO. James is known for his expertise in healthcare information technology, revenue cycle management training, and healthcare management, as well as his unique tactics for dealing with medical billing claims.

By Renee Dustman, BS

10 Tips for Clean Claims

Don't let avoidable errors muck up your revenue cycle.

A "clean" claim is one that does not require the payer to investigate or develop the claim before it can fully process it. The claim is received on time, passes all edits, is appended with any required medical evidence and supporting documentation, and includes all the basic information necessary for the payer to adjudicate the claim.

Here are 10 tips for ensuring your Medicare Part B claims are squeaky clean.

adobestock / FranMarin

1 Credential Providers

Providers and suppliers of durable medical equipment must have a national provider identifier (NPI) and be enrolled in Medicare before they can bill Medicare. For details, see Medicare Program Integrity Manual, Pub. 100-08, Chapter 15 – Medicare Enrollment.

2 File the Right Claim Form

Part B claims are submitted electronically or via the CMS-1500 paper form. The Administrative Simplification Act requires providers to submit claims electronically unless they meet an exception such as fewer than 10 full-time employees, roster billers, dental claims, etc.

Use the Centers for Medicare & Medicaid Services (CMS) Administrative Simplification Compliance Act Self Assessment tool to determine if you are required to submit claims electronically (see Resources for link).

3 Get the Dates Right

You can use either a six- or eight-digit format (MMDDYY or MMDDCCYY) for all dates, but be consistent. The exception is the patient's birthdate, which must always be eight digits. Regardless of whether you use six or eight digits, on the CMS-1500, you must enter a space between the month, day, and year (e.g., 05|01|23 or 05|01|2023).

Generally, you must enter the exact date a service is rendered. For care plan oversight, enter the last date of the month or the date on which at least 30 minutes of time was completed. For home health certification dates of service, enter the date the physician or nonphysician practitioner (NPP) completed and signed the plan of care.

4 Know Your Options

On the CMS-1500 claim form, there are fields that are required, conditional, and optional. There are also fields that must be left blank. For example, items 1-8 are patient demographics and are required fields. Not only must you complete these fields, you must also make sure to enter the information *exactly* as it appears on the patient's Medicare card.

An example of a conditional field is item 17. All physicians and NPPs who order services or refer Medicare beneficiaries must complete fields 17 and 17b. If Medicare policy requires it, you will alternatively use these fields to enter the name of the supervising physician for the service(s) rendered and their NPI. Leave 17a blank.

Block 19 of the CMS-1500 claim form (or electronic equivalent) is another required field when reporting Not Otherwise Classified (NOC) codes. You must enter the description of the NOC code into block 19 or the claim will be denied.

Reporting information in the shaded areas located in fields 17a, 24j, 32b, and 33b could cause your claim to be rejected, according to Novitas Solutions, a Medicare Administrative Contractor (MAC).

5 Identify Who's on First

Medicare cannot pay a claim that has already been paid or is expected to be paid by a primary plan. When Medicare is the secondary payer, submit the claim to the primary payer first. On the CMS-1500, enter the primary payer's information in fields 4, 6, 7, 10, and 11-11c (11d is not required). If Medicare is the primary payer, enter "None" in field 11.

6 Sequence and Point to Diagnosis Codes Correctly

Field 21 on the CMS-1500 claim form is where you list the diagnosis codes related to line items in block 24. It's important to list the diagnoses in order of priority. Also make sure the diagnosis code reference letter in block 24E points to the correct diagnosis code in field 21.

TIP: ICD-10-CM codes appear in your code book or coding software with decimal points (eg., 59.01). Do not use a period or any other special character on the CMS-1500 claim form.

It's a good idea to run claims through a "scrubber" before submitting them to the payer. Scrubber software can be used to catch problems that could keep your claims from being held or denied.

7 Check Units of Service

A common billing error is calculating the number of units incorrectly. Read the code descriptors carefully — some indicate "per day," which means that only one unit can be billed on the date of service no matter how many times the service was performed that day.

8 Identify the Billing and Rendering Providers

If the billing provider is different from the provider who is rendering the services, note both on the claim. On the CMS-1500 claim form, enter the rendering provider's NPI in the lower unshaded portion of 24j and the billing provider's information and NPI in fields 33 and 33a.

9 Don't Forget the Signature!

The patient or authorized representative must sign and date the claim unless the signature is on file. The patient's signature or the statement "signature on file" authorizes payment of medical benefits to the physician or supplier.

10 File Claims on Time

Submit claims to the MAC no later than 12 months, or one calendar year, after the date the services were furnished. For exceptions, see Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, Section 70.7.

Mark your calendars! 2024 is a leap year, which means claims for services furnished on Feb. 29, 2024, must be filed by Feb. 28, 2025, to be considered timely. HBM

Renee Dustman, BS, is the managing editor of content and editorial for AAPC's Publishing Department. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

Resources

CMS Administrative Simplification Compliance Act Self Assessment; www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment

Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, Sections 70.7, 80.2; www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Medicare Program Integrity Manual, Pub. 100-08, Chapter 15 – Medicare Enrollment; www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf

By Corella Lumpkins, CPC, CPCO, CDEO, CPB, CPPM, CPC-I, CHC, CCS, CCS-P

AAPC Honors Corella Lumpkins

Her success comes from never passing up an opportunity to learn.

I would have never known what an amazing journey the healthcare field would take me on if I had passed on that Kelly Girl® services temporary assignment in 1987. Following my high school graduation, and with my family not able to afford college, I needed to find a job. I signed on with the staffing agency and performed various jobs, from stuffing coupon packets into newspapers to operating a telephone switchboard. With every assignment I accepted, I would try to imagine doing that task for a living. I never seemed to develop enough interest in anything, however. Despite that, I showed up, worked the jobs, and became very dependable for the staffing agency.

I remember receiving the morning call from the agency with a choice of assignments; one was for filing medical records at a physician's office. I did not hesitate to take it, as I had always had respect for people who worked in healthcare. Back then, I thought only of the clinical aspects of healthcare and knew nothing of the administrative functions. That was my introduction to the business of medicine, which jump-started a career that I have enjoyed for over 35 years.

In the Right Place at the Right Time

Young, eager, and wanting to learn everything, I took nearly every opportunity given to me. I worked in large academic medical organizations and hospital healthcare systems, as well as the small mom-and-pop neighborhood doc shop. Along the way, I performed every job function of the healthcare revenue cycle.

"My career success is owed to others who took a chance on me early and gave me opportunities."

The day I got an opportunity to learn medical coding, I was in the right place at the right time. The general surgery coder in the business office where I was working had just put in her two weeks' notice. The manager needed to find and train someone quickly. She walked out of her office and looked around the department. I just happened to be standing up scanning records at the time and caught her eye.

I fell in love with medical coding instantly. However, with only two weeks of training in dissecting surgical operative reports, I needed to keep learning. This was around the time I discovered AAPC.

Thirsty for Knowledge

The constant changes in code sets, guidelines, and payer policies each year fueled my quest for knowledge. As my passion for the field grew, so did my aspirations. I had worked over a decade before I sought my first credential, AAPC's Certified Professional Coder (CPC®), in 2001. Since then, I've earned credentials in billing, coding, compliance, clinical documentation improvement, instruction, and practice management, as well as my bachelor's degree in Health Services Administration. I am now working on my master's.

Staying involved with my local AAPC chapter helps me stay current in my knowledge of the industry. As the education officer and past president of the Leesburg, Virginia local chapter, I try to take advantage of every opportunity to gain knowledge and network with my peers. I feel like the heartbeat of our organization thrives through these local connections. My career has evolved to include publications and local chapter and national speaking engagements, as well as a seat on the 2022-2025 AAPC National Advisory Board, which is both an honor and a privilege.

A Teaching Moment

Currently, I manage the coding, compliance, and provider education functions of an accountable care organization in Northern Virginia. I get to utilize my education and experience to provide training and solutions to the physicians, advanced practice practitioners, coders, business office, practice staff management, and C-suite. I am also an adjunct instructor for the dual coding/billing certification course at a Maryland community college.

My career success is owed to others who took a chance on me early and gave me opportunities. It was not perfect. Over 35 years, I have made career mistakes, but I was able to turn those mistakes into learning experiences. I share this knowledge when I mentor others and give back in every way I can. Since 2008, I have helped many gain careers in this field by teaching classes as an approved instructor and through my support of AAPC's Project Xtern program. The program's a win-win for both the newly certified coders who gain real work experience and the employer who gets a certified coder at no cost. In my experience with this program, over 98 percent of all my xterns were employed within six months. I have hired a few xterns myself; however, the vast majority have been able to find employment on their own after their work exposure. This is the accomplishment I am most proud of; these results are my biggest motivation.

Never Pass Up an Opportunity

The healthcare field is open to everyone. I have seen students come from all levels of society, from all other industries, and transition to successful careers as medical coders, billers, and other healthcare revenue cycle occupations. If I could pass on any advice to others it's to get involved, stay in network with local connections, and always keep learning! You can take your career anywhere, to any level you can imagine. **HBM**

Corella Lumpkins, CPC, CPCO, CDEO, CPB, CPPM, CPC-I, CHC, CCS, CCS-P, has over 30 years of experience working in every area of the healthcare revenue cycle. She has a bachelor's degree in health science administration and is a mentor to her students.

By Lee Fifield, BS

Advice From a CRHC™

AAPC member **Samantha Patterson, CPC, CRHC**, works as a healthcare compliance coordinator for Hendrick Clinic in Abilene, Texas. She has worked in the healthcare field for 20 years.

AAPC asked Patterson about her experience with earning the Certified Rheumatology Coder (CRHC™) credential, how it has helped her career, and what sort of advice she has for anyone considering the specialty certification.

What led you to obtain the CRHC™ credential?

When I first started in rheumatology, I was working on denials as well as learning the coding. I had been coding cardiology, internal medicine, and family practice, so when my practice needed a rheumatology coder, I was chosen. I was immediately hooked on learning as much as I could to assist in appeals and denials and to send out clean claims. With the CRHC™ under my belt, I feel more confident in my ability to capture lost revenue and ensure claims are coded based on what was provided, documented, and covered under each insurance policy.

Do you have any tips for individuals preparing for the CRHC™ exam?

Reach out to your rheumatologists and ask questions. Learn the diagnosis codes to the fullest extent you can. Understand the clinical distinction between rheumatoid arthritis and osteoarthritis, along with the stages of gout. Learn the symptoms of systemic lupus erythematosus. Make sure you understand the coding rules for injections, infusions, and each joint. Practice coding the drugs administered to patients, along with billing the correct dosage (this is an area where I see a lot of revenue loss). Finally, watch out for trigger point injections. Read both the codes and the note to make sure you are coding based on the number of muscles and NOT the number of injections. This is a BIG one.

How has the CRHC™ credential helped you in your job/career?

In addition to coding rheumatology, having the CRHC™ credential has helped me to better code and bill for family and internal medicine. Since they deal with injections in the joints, if someone does not have a clear understanding of the procedure in detail, it can impact the coding. It has also helped me to provide better education for coders, billers, and physicians when working in auditing and compliance.

Who do you think would most benefit from the CRHC™ credential?

Everyone who is part of the process for injections and infusions, from front office staff to coding managers, would benefit from this credential. If your practice offers pain management and family medicine, I believe the CRHC™ would be a great tool to have in your toolbox.

What resources do you use most to earn your continuing education units (CEUs)?

I earn most of my CEUs through my local chapter. I also attend webinars with the National Organization of Rheumatology Management (these are open to everyone) and the Practice Management Institute, which hosts webinars and classes locally in my region. **HBM**

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.

"In addition to coding rheumatology, having the CRHC™ credential has helped me to better code and bill for family and internal medicine."

By Lara Kline, AS, BS

Prepare Your Practice for a Post-PHE Environment


adobestock / DragonImages

What can our practice do to prepare for the public health emergency (PHE) ending in May?

May 11, 2023, is right around the corner. If you haven't yet, it's definitely wise to start getting your practice ready for the undoing of two years of flexibilities. Attorney Robert Markette Jr. with Hall Render in Indianapolis suggests practices do the following things:

1. Start right away and identify affected policies that your practice changed due to PHE waivers. Assess whether you will need to change them back or transition to a new policy. Remember, too, that some changes may have been permanent, and others were temporary due to legislation or Medicare rulemaking, such as telehealth flexibilities.
2. Draw up a plan and set clear deadlines to make sure everything gets done efficiently.
3. Train staff. Educate everyone on new policies and make sure to shoot for compliance before the PHE expires.
4. Perform internal audits to verify the trainings were effective. Provide follow-up training based on the findings of that audit.

With a little organization and planning, you can avoid fraud violations post-PHE. **HBM**

Lara Kline, AS, BS, is the development editor for the *Family Practice Coding Alert*, *Pediatric Coding Alert*, and *Gastroenterology Coding Alert*. She is also an internationally published writer with a commitment to lifelong learning and mental health advocacy.

This article is reprinted from the *Pediatric Coding Alert*. For more articles like this, as well as other specialty-specific articles, check out AAPC's full line of newsletters at www.aapc.com/newsletter.

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Jill Gorman, **CPC-A**
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Sneha Reji, **CPC-A**
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Soumya Jesudasan Wills, **CPC-A**
Soumya Kr, **CPC-A**
Soumya Thankappan, **CPC-A**
Sreedevi A S, **CPC-A**
Sreejith M, **CPC-A**
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Sreelakshmi V S, **CPC-A**
Sreeramula Pavan Kumar, **CPC-A**
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Sreevidhya Vinodhan, **CPC-A**
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Anah Zeruiah Tabangcura, **CIC**
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Ma Elieza Joy Rondolo, **CIC**
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Mahalakshmi V, **CRC**
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