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Does continue current meds qualify as moderate decision making for prescription management?

Overall MDM cannot be determined on just medication management. Prescription drug management meets moderate risk; however, another category (data or complexity) must also meet the moderate level. The provider must be managing those medications and the medications and dosage should be documented in the medical record. Best practice: provider should indicate what medications are being continued.

Can we get credit on "Complexity of Data" for ordering X-Ray if we own the X-Ray machine and took the X-Ray too?

If billing just the TC portion of the x-ray and not the professional portion, then yes, but remember you cannot take credit for review of the x-ray as it is assumed if ordered, it will be reviewed either that day or a subsequent day. Per CPT E/M guidelines, 2023 “The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M service when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.”

What is the best method to use to audit chart notes with the new E&M guidelines to confirm the level of service billed?

This is dependent on staffing. Panacea recommends a risk-based or focused audit approach versus a random audit approach. Panacea is happy to assist. We have a claims auditing software to assist in assessing and identifying areas of risk in compliance auditing.

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If you have a Medicare patient and you are billing under the PA, can you combine the PA time and the time from the physician?

Yes; however, this would now be a shared/split visit and the time should be added together and billed under the provider with greater than 50% of the total time. Modifier FS must also be appended to the E/M. Reminder: Shared/split visits are only applicable to facility (POS 19, 21, 22, 23) and cannot be used for POS 11.

MDM vs time for E/M codes - what is best practice? Is there a "best practice?" Are health systems allowed to use either model or picking one?

Either medical decision making (MDM) or time can be utilized for level of service selection. Time vs MDM should be considered based on the services provided at that visit. If the majority was spent performing services related to time (e.g. counseling), best practice would be time. Ultimately, it is up to the provider and the documentation. You do not need to "pick" a model. Similar to the old 95 vs. 97 guidelines, you can use whichever method is more advantageous for each encounter.

When can we give credit to a physician for review of each unique test if they did not order the test? For ex, ED MD (in a different group/specialty) orders 3 unique tests. Pt admitted by hospitalist later in the day and the hospitalist reviews & analyzes those unique tests (originally ordered by the ED MD). Can we give credit to hospitalist for review of 3 unique tests?

Yes, in this scenario, you can give credit for the review of the 3 unique labs. Remember, the hospitalist must also analyze the test results and the documentation must support analysis of the labs.

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Could you provide an example of what documentation would look like for discussion w/ an appropriate source?

An appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher)
Example: I had a discussion with the child's teacher who indicated Brian lacks the ability to stay on task throughout the school day and needs frequent redirection. He often distracts other students and acts out when redirecting. Due to this, I am increasing his Adderall today.

What are the requirements for APP documentation and billing for critical care?

Requirements for an APP are no different than for a physician. Critical care guidelines must be met. Time and services rendered during the critical care time must also be documented.

What documentation is required to bill strictly on time?

The documentation must include the total time. Best practice is to document the services performed for the time documented. A chief complaint, medically relevant history and/or exam and an assessment, and plan.

How do you code for a split shared critical care and exactly what are we looking for?

Critical care codes are time based. Both providers must document time. The provider with greater than 50% of the total critical care time is the billing provider. Modifier FS should be appended to the critical care code(s). Ensure the documentation supports critical care as defined by AMA and CMS. Best practice is for both providers to document start and stop time to ensure there is no overlap in minutes. Providers must also each individually document what they did during the critical care time and not “overlap” services.

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Consultant, a hospitalist attending, and a specialist consultant on the same DOS. How would this be reported to Medicare vs commercial payer

Medicare: initial visit: Hospitalist 99221-99223, consultant 99221-99223, specialist consultant (if not in same group/specialty of consultant) 99221-99223 – if same specialty/subspecialty as consultant, combine documentation and only submit one E/M. The admitting physician would append AI modifier. For subsequent visits: Hospitalist 99231-99233, consultant 99231-99233, specialist consultant 99231-99233 (if not in same group/specialty of consultant - if same specialty/subspecialty as consultant, combine documentation and only submit one E/M.

Commercial: same as above except the consultant may report a consultation code (99252-99255) if the specialty consultant is not the same specialty as the consultant – both consultants may report consultation codes (99252-99255)

If you do not order a test - but you read the test and then later see the pt can you use the reading of the test. Example You read Vascular test for the hospital - you do not know the patient and just interpret the results then the patient is sent to you. Can you review the results now in relationship to symptoms etc. can you use the reading the results?

You cannot take credit for reviewing the results again as the provider has already billed for the interpretation, review and report.

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When billing observation services with CPT codes 99221-99223 & 99231-99233 would you use place of service 21 or 22?

POS for observation is 22. The new initial hospital codes are the same for inpatient and observation; however, reporting the appropriate place of service has not changed. Similarly, patients seen in long term nursing care (POS 32) and skilled nursing (POS 31) use the same E/M category; however, the place of service is different. The place of service will differentiate to the payer the location in which the services were provided.

Carried forward tests: If your provider has copied forward several lab tests and coming up with a conclusion that they see a pattern and changes his plan of care, would that count as a review for data?

Yes, if this is the first time they are reviewing these labs. Also, if another provider in the same specialty or subspecialty has already reviewed these labs you cannot "count" them towards the data to review again.

Do we use POS 12 for assisted living visits now instead of 13?

No, the POS codes have not changed. The correct POS for an assisted living facility is 13. Only the E/M categories have been combined.

With prolonged service codes for home/assisted living. Does this mean, we can use the time for meeting with family, when the patient is not present, as part of the time if this meeting was during the days before or after the patient appointment?

This varies based on payer. Medicare/Medicaid does not "pay" for any services if the patient is not present. Other payers may have different guidelines. There are codes for prolonged E/M services before and/or after direct patient care (99358, 99359).

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Did Split Shared Service change in 2023 to just be documented by time?

No, you can use either time or the history, exam or MDM. The change was delayed in the 2023 Final Rule to January 1, 2024.

When they say one day, does that mean 24 hours from the start time, or actual calendar date? Meaning if a patient was admitted at 9pm, does the day end at midnight, or 8:59 pm the next day (24 hours)

Days are calculated by actual calendar date.

Do you have a 2023 E&M coding tool or should I get it from the AMA?

We have the table outlining the complexity, data and risk to assist with coding and auditing. The table can also be found in the E/M guidelines in the CPT book.

If a NP hospitalist admits a patient overnight and during the same DOS an MD hospitalist (same group practice) sees the patient, can prolonged services be billed for the second service if time requirements and medical necessity are met?

Yes, as long as the NP utilized time for the admission code.

Where in the guidelines does it state it requires a chief complaint on every encounter? Chief complaint is part of history which is now what's medically appropriate.

The chief complaint can be located within the history of present illness/history. While the guidelines do not specifically state the chief complaint must be documented, the chief complaint does establish medical necessity for the visit. Medical necessity is the overarching criterion for payment.

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Where in the guidelines does it state split/shared is not allowed for consultations? Is it that a consult visit was performed or the code itself for those payers where consults are billed with the initial or subsequent E/M?

Shared/split care guidelines are developed by CMS. As CMS does not "cover" consultation codes (99252-99255 and 99242-99245), they cannot be shared/split. Commercial payer guidelines may vary. For those payers in which consultations are reported with initial or subsequent codes, shared/split care is allowed.

Split Share - I understand that time will be required in 2024. However, if the NPP adds their time and the provider only states Substantive Portion with no additional details. Who should we bill? The NPP or the Attending?

Per Shared/Split care guidelines, both providers must document time as well as the service(s) rendered by him/her individually. It would be difficult to ascertain what the physician performed for the substantive portion based on the above example. Without reviewing the documentation, I would recommend billing this scenario under the NPP.

Can the NPP Now Bill alone for an initial visit?

If allowed by the hospital and state regulations, yes.

Can you clarify coding for the 8 hour rule for same day admit and discharge? Does this apply to both facility and professional coding?

The 8 hour rule is CMS guidance. It is not a CPT rule and was clarified by the AMA that the 8 hour rule is applicable only to facility coding.

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If the risk is documented by the provider, does that mean the coder could use their indication of low, moderate, or high for risk and would not need to determine it by using the elements on the audit tool?

Yes, it is recommended the provider indicate the reason why they are placing the patient at that level of risk.

CMS has a list of high risk drugs.

They do have a list of high risk drugs; however, just documenting patient's use of one or more of the drugs does not meet the guidelines for intensive monitoring for toxicity. The documentation must support the intensive monitoring.

Do you have the new Critical care coding guidance from CMS?

https://www.cms.gov/files/document/mm12982-medicare-physician-fee-schedule-final-rule-summary-cy-2023.pdf This link provides the guidance for time as defined by CMS.

Can you clarify, if a provider follows initial CCT 99291 45 mins say and then another physician same group & specialty later renders additional CCT 45 mins, if billing Medicare, does the other physician not get the 99292 because 104 mins was not met?

Yes, the following excerpt is from the Physician Fee Schedule final rule as published in the Federal Register.

"We issued a technical correction clarifying that the reporting threshold time for the add-on code for critical care services is the same for split (or shared) critical care as for critical care that isn't split (or shared). Use CPT Code 99292 to report additional, complete 30-minute time increments provided to the same patient, therefore it isn't reported until at least 104 minutes are spent (74 + 30 = 104 minutes)."

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What exactly has to be documented now in the note to be able to select a visit? HPI, Physical Exam, ROS? Do these have to be documented?

New documentation guidelines require a medically appropriate history and exam, and code selection is based on Medical Decision Making (MDM) or time. The extent of the history and/or exam documented is not used to determine level of service. Only the extent of MDM or time documented is used to determine the level of service.

If patient seen for 3 acute problems at same visit would level be moderate?

No, this would fall into the low category. The guidelines do not allow you to "level up" if you have more than one condition within a specific complexity category unless the guidelines explicitly states "2 or more." If one of the acute problems is either an acute illness with systemic symptoms or an acute complicated injury, then this would meet moderate complexity. As a reminder, level of service is based on 2 of the three elements; therefore, you would need to meet moderate in at least one additional element (data or risk) to meet the moderate category.

For inpatient services, is a chief complaint required for the 2023 E/M guidelines?

The chief complaint can be located within the history of present illness/history. While the guidelines do not specifically state the chief complaint must be documented, the chief complaint does establish medical necessity for the visit. Medical necessity is the overarching criterion for payment.

What CPT codes do consultants bill during OBS status? Inpatient codes 99221-99223/99252-99255 or 99202-99205/99242-99245?

Consultations rendered to an observation patient are reported with 99252-99255. If the payer does not recognize consultation codes, report 99221-99223 or 99231-99233.

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On slide 61, physicians can count toward MDM results only tests even if they are billing for them. Did I misunderstand your comment?

You cannot count tests ordered and billed (professional component, if applicable) by the same physician or group practice towards MDM. Per CPT, 2023 "The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M service when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level."

For shared visits, providers can still select level of service (LOS) based on MDM. More than 50% only addresses who the billing provider is and not the LOS. Would you agree?

For shared visits, either time or the substantive portion of the history, exam or MDM can be used for the level of service. If time, the provider with greater than 50% of the total time is the billing provider. If MDM, the billing provider is the individual who documented / performed the substantive portion.

Do they have any template design recommendations? Attestation recommendations?

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Can you discuss medication management mainly with an RX of an antibiotic? Exam is patient comes in for Strep. MD orders Strep Test, Flu Test, Throat Culture. Sends patient home with RX for Antibiotic for 14 days. based on the RX Management would either make the visit a level 4 or a level 3.

Yes, because the data would be 3 unique tests with rx management would be overall MDM of moderate.

Does a physical H & P need to be done each visit because we have a template that we go down the list and ask the patient questions?

No, the new guidelines indicate a medically appropriate history and examination.

Can you please clarify seemingly conflicting directives: (1) Do NOT include time in activities normally performed by clinical staff (e.g., vital signs, recording history, etc.) and (2) Activities INCLUDED when using time: (a) Obtaining and/or reviewing separately obtained history; (b) Performing a medically appropriate examination and/or evaluation; and (c) Documenting clinical information in the medical record

The difference is who performed the service(s). Time spent by ancillary staff cannot be utilized for time based coding. Time spent by the billing provider reviewing documentation already completed, performing the examination and documenting in the medical record can be utilized for calculating time for selection of the level of service.

For outpatient observation codes, we no longer use 99212-99215 or 99202-99205 with POS 22 correct?

Correct, all providers now report initial and subsequent inpatient or observation services.

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Does the Modifier AI need to also be appended to Observation admission?

Yes

Is -FS only for CMS or all insurances?

It is a CMS guideline; however, other payers may also require this modifier. Recommend checking with payers.

Can the Chief Complaint from the appt schedule be used?

As long as the billing provider "reviews and verifies" the chief complaint and the documentation supports this was reviewed and verified, yes.

We have internal medicine providers that are providing telemedicine initial visits for inpatient/observation patients. The hospitalist is seeing the patients, either that same day or on the following day. On the first day "initial" can the hospitalist charge for their visit? They are in different specialties, and we are billing under different NPI's. One is billed through the hospital, and one is billed through our physician clinic.

The one area of concern with billing for both is medical necessity. The documentation must indicate why both are treating the patient.

In regard to 1 E&M per day; the guidelines do allow for a Critical Care E&M in addition to a non-critical care E&M if services provided demonstrate distinct encounters and critical care services? Is that correct?

Yes. The guidelines do indicate the non-critical E&M must be provided first. Example: patient is stable in the morning and "codes" in the afternoon. Code the visit in the morning and critical care for the afternoon visit (assuming the documentation supports both).

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If a doctor documents for his time on his discharge summary as greater than 30 minutes without the exact time. Is this coded as 99238?

This would meet the requirement for 99239. Documenting the exact time is a best practice recommendation; however, it is not stated as a requirement in the guidelines.

If an NP and the doctor have split shared time on a consult. Do you bill the doctor with the FS modifier?

The billing provider is the individual who performs the substantive portion of the visit or has greater than 50% of the total time documented. Ensure the payer accepts consultations performed as shared/split care.

We just got a new NP in our office and I am not sure of how we would code and process hospital charges meeting the required guidelines. Can they only see establish visits when in order to report shared/visits, can they see new H&P visits as well? Are they able to bill under their own NPI in the hospital setting? Hospital visits would be shared/split vs incident to in the office, correct?

Most of these questions are based on state guidelines and if the NP has hospital privileges. For shared/split care in the facility setting, the patient can be new or established. In the office setting, incident to guidelines must be met.

The presenter mentioned AI modifier with Observation. I thought AI modifier was only used for provider admitting to Inpatient. Thank you.

CMS is in the process of updating their policies, so this has not been clarified yet; however, as of today, AI modifier is indicated for all initial visits. There is no clarification if the place of service will impact the use of this modifier.

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Physicians in same group practice. One is a hospitalist and another cardiologist. Is it appropriate for them to both report an initial hospital care visit (99221-99223) for their first visit with the patient?

Yes, they are different specialties. If one is the admitting physician, the admitting physician should append modifier AI.

Could share what counts in physician's time after care relative to coding. Could you let me know?

Activities included when using time include:

- Preparing to see the patient (review of tests, records, etc.)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient / family / caregiver
- Ordering medications, test, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the medical record
- Independently interpreting results (not separately reported)
- Communicating results to patient / family / caregiver
- Care coordination (not separately reported)

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