HEALTHCARE BUSINESS MONTHLY

Coding | Billing | Auditing | Compliance | Practice Management

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Advancing the Business of Healthcare

July 2021

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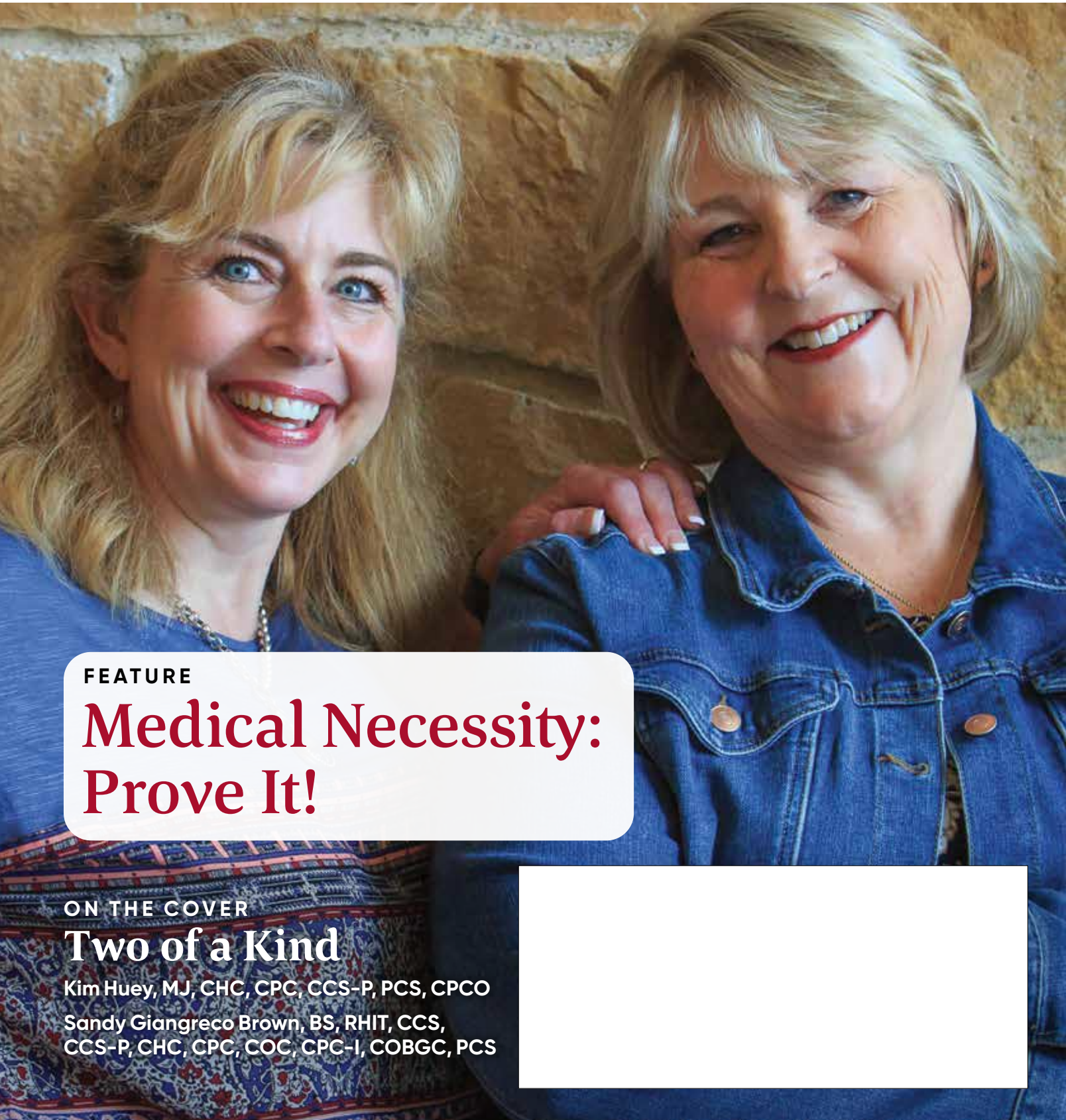

FEATURE

Medical Necessity: Prove It!

ON THE COVER

Two of a Kind

Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPCO

Sandy Giangreco Brown, BS, RHIT, CCS, CCS-P, CHC, CPC, COC, CPC-I, COBGC, PCS

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Do You Have the Success Gene?

People who are struggling in their careers often wonder how successful people got that way. Were they genetically predisposed to be successful? More likely, successful people recognize the need for life balance and work to achieve it. Employers know the value of this trait and actively recruit those who demonstrate it. Many companies, including AAPC, use assessment tools — Topgrading® being one of them — as part of their hiring process to identify applicants who have the "success gene."

Take a Good Look at Yourself

Topgrading®, founded by Brad Smart, PhD, is an assessment methodology for recruiting and managing high performers, or "A players." Smart's theory is that if you want to become a happy A player at the highest level, you must perform a periodic life-balance review and focus on becoming "good enough" in what he believes are seven critical life dimensions:

1. Career success
2. Wellness
3. Personal relationships
4. Giving something back
5. Financial independence
6. Spiritual grounding
7. Recreation

Fixing your weaknesses in these areas is the straightest path to success in life, according to Smart.

Time Well Spent

Smart also believes that the time you spend on professional development should be used on fixing any deficiencies you have across 50 competencies, which he categorizes as:

- Relatively easy to change
  - For example, education, experiences, communication
- Harder but doable
  - For example, resourcefulness, judgment, likeability
- And very difficult to change
  - For example, intelligence, integrity, passion

What you might think is a minor shortcoming could be a career derailer. For example, it doesn't matter how passionate and resourceful you are if you can't communicate, have poor judgment, or are dishonest.

Unlock Your Success

The key to success is to take a good look at yourself. Be honest with what you see. We all have flaws and weaknesses. What are yours, and are they holding you back from achieving your goals? Do what you must to fix your deficiencies and correct any life imbalances and you will overcome all barriers to success.

Best Regards,

Bevan Erickson
AAPC CEO

"What you might think is a minor shortcoming could be a career derailer. For example, it doesn't matter how passionate and resourceful you are if you can't communicate, have poor judgment, or are dishonest."

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Medical Necessity: Is It Really Necessary?

By AAPC's Auditing Advisory Committee

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DEPARTMENTS

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COMING UP:

- ER E/M
- CPT® vs. HCPCS Level II
- 2021 E/M Audits
- Sports Physicals

On the cover: AAPC features its first Member(s) of the Month. Read about these members on page 32. Photography by Jack Crone.

Advertiser Index

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July 2021

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#iamaapc

Sara Harvey, CPC, CEMC

I became an AAPC member because of my mom. She was a certified coder with a specialty certification in obstetrics/gynecology and worked in medical offices while I was growing up. I remember my sister and I watching her study for her certification. My dad, a registered nurse and auditor, is also a member of AAPC. Both of my parents instilled a deep love of learning in me.

In high school, I started helping out in offices, doing filing and any other odd tasks that were needed. I went to work as a secretary before starting classes at a local college: My ultimate goal was to become a coder. I sat for my Certified Professional Coder (CPC®) exam in 2008 and obtained my Certified Evaluation and Management Coder (CEMC™) credential in 2018. I became a general surgery professional fee coder and found that I have a deep interest in evaluation and management (E/M) coding. I have been able to code for many specialties over the years within my local hospital system and my AAPC credentials have been an enormous help in this.

Education Breeds Confidence

Being an AAPC member has helped me stay current with the yearly changes in coding and stay on top of my education. I have utilized a variety of webinars, the AAPC forums, and the AAPC Facebook group to become a well-rounded coder and increase my knowledge in areas outside of my daily tasks. The tools that are available on AAPC's website allow members to interact and help each other, as well as search for answers to the questions that come up during the course of a day. I know that there is always something new to learn or understand, and I always encourage new coders who I work with to become a member to make use of the networking opportunities available through AAPC.

Never Stop Learning

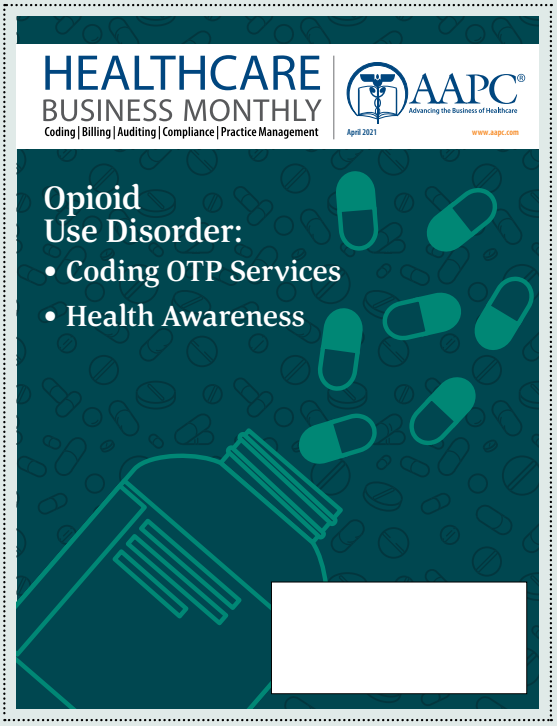
My favorite thing about being a coder is the chance to learn something new every day. I have transitioned into an educational role within my company and am now interacting with coders and providers regularly. I am helping providers and coders understand coding guidelines and teaching them the new 2021 E/M guidelines. It is really an exciting time to be a coder, as these new guidelines are a major change and require coders to adjust their thinking.

Better Together

My favorite thing about being an AAPC member is the freedom to network with others who are as enthusiastic about coding as I am. It is great to get into discussions with others to hear everyone's thoughts regarding some of the gray areas in coding. We can all see different perspectives and maybe learn something new from each other. HBM

"My favorite thing about being an AAPC member is the freedom to network with others who are as enthusiastic about coding as I am."

Please send your letters to the editor to:
letterstotheeditor@aapc.com



E-visit G Codes Deleted

Please note that G2061-63 have been deleted as of 1/1/21. You reference them in your chart [in the article "Is It an Audio-Only Phone Call or a Virtual Check-In?" (April 2021)].

— Jennifer Bresson

HCPCS Level II codes G2061-G2063 were deleted Jan. 1, 2021. Report e-visits on or after Jan. 1, 2021, for Medicare patients with CPT® codes 98970-98972.

— HBM Editorial Team

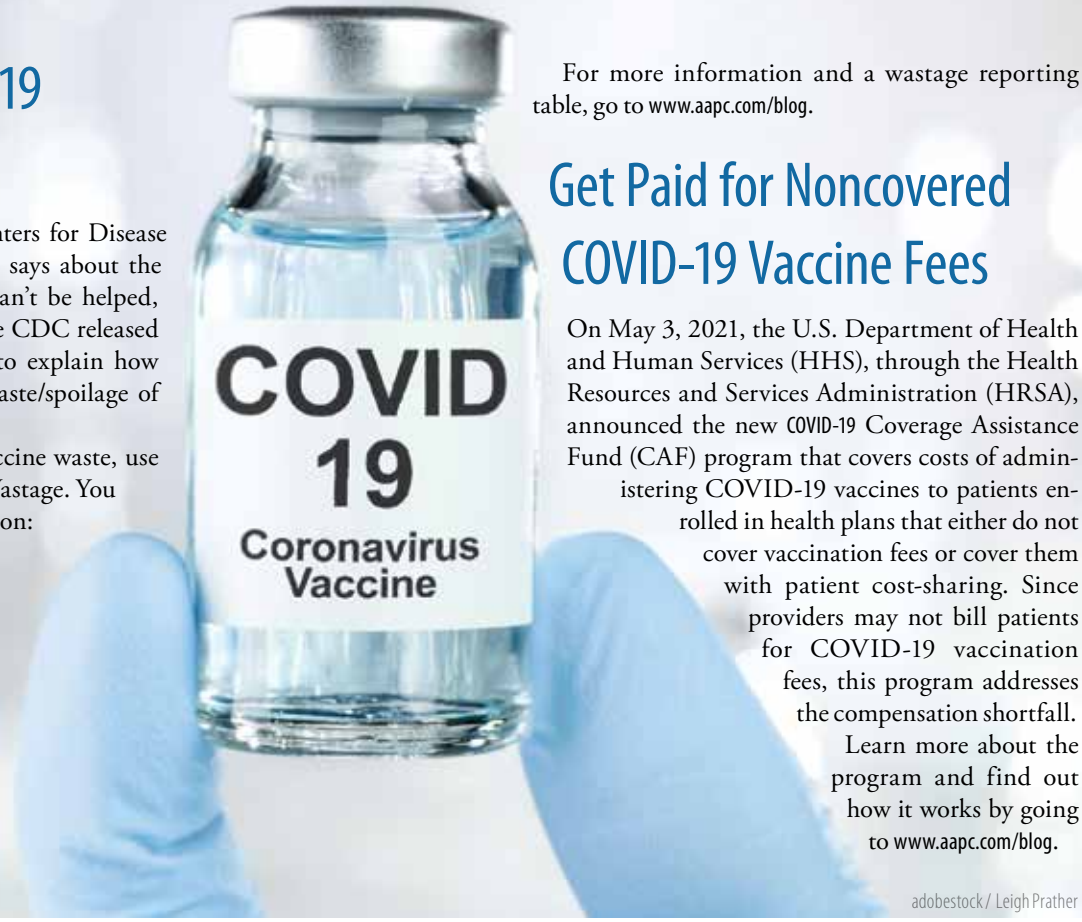
Reporting COVID-19 Vaccine Waste

"Waste not, want not," the Centers for Disease Control and Prevention (CDC) says about the COVID-19 vaccine. But if it can't be helped, they want to know about it. The CDC released updated guidance on May 18 to explain how providers should report drug waste/spoilage of COVID-19 vaccine vials.

To document COVID-19 vaccine waste, use the VTrckS ExIS Interface for Wastage. You will need the following information:

- Provider PIN
- National Drug Code
- Number of doses wasted
- Reason for waste

Note that as long as the vaccine is free, providers will not be compensated for reporting its waste. Reporting COVID-19 vaccine waste is required for inventory purposes only.



adobestock / Leigh Prather

For more information and a wastage reporting table, go to www.aapc.com/blog.

Get Paid for Noncovered COVID-19 Vaccine Fees

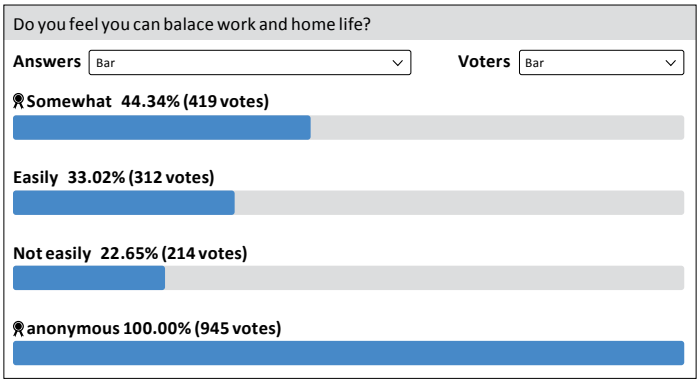
On May 3, 2021, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), announced the new COVID-19 Coverage Assistance Fund (CAF) program that covers costs of administering COVID-19 vaccines to patients enrolled in health plans that either do not cover vaccination fees or cover them with patient cost-sharing. Since providers may not bill patients for COVID-19 vaccination fees, this program addresses the compensation shortfall. Learn more about the program and find out how it works by going to www.aapc.com/blog.

Online Poll

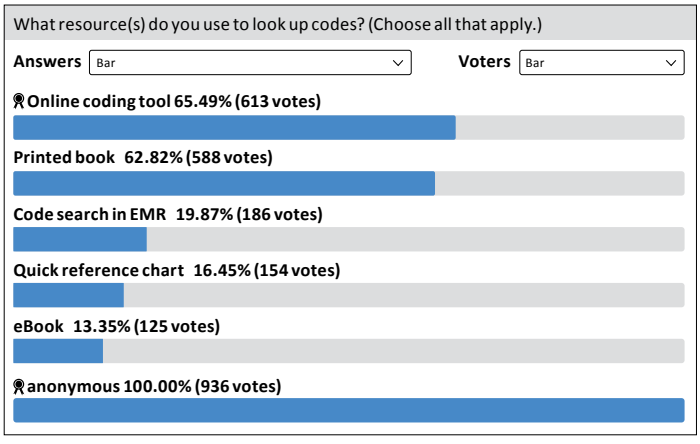
Your Vote Matters

If you frequent AAPC's Knowledge Center blog (www.aapc.com/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 Tuesday of each month. Here are the results for polls posted in March.

March 9, 2021



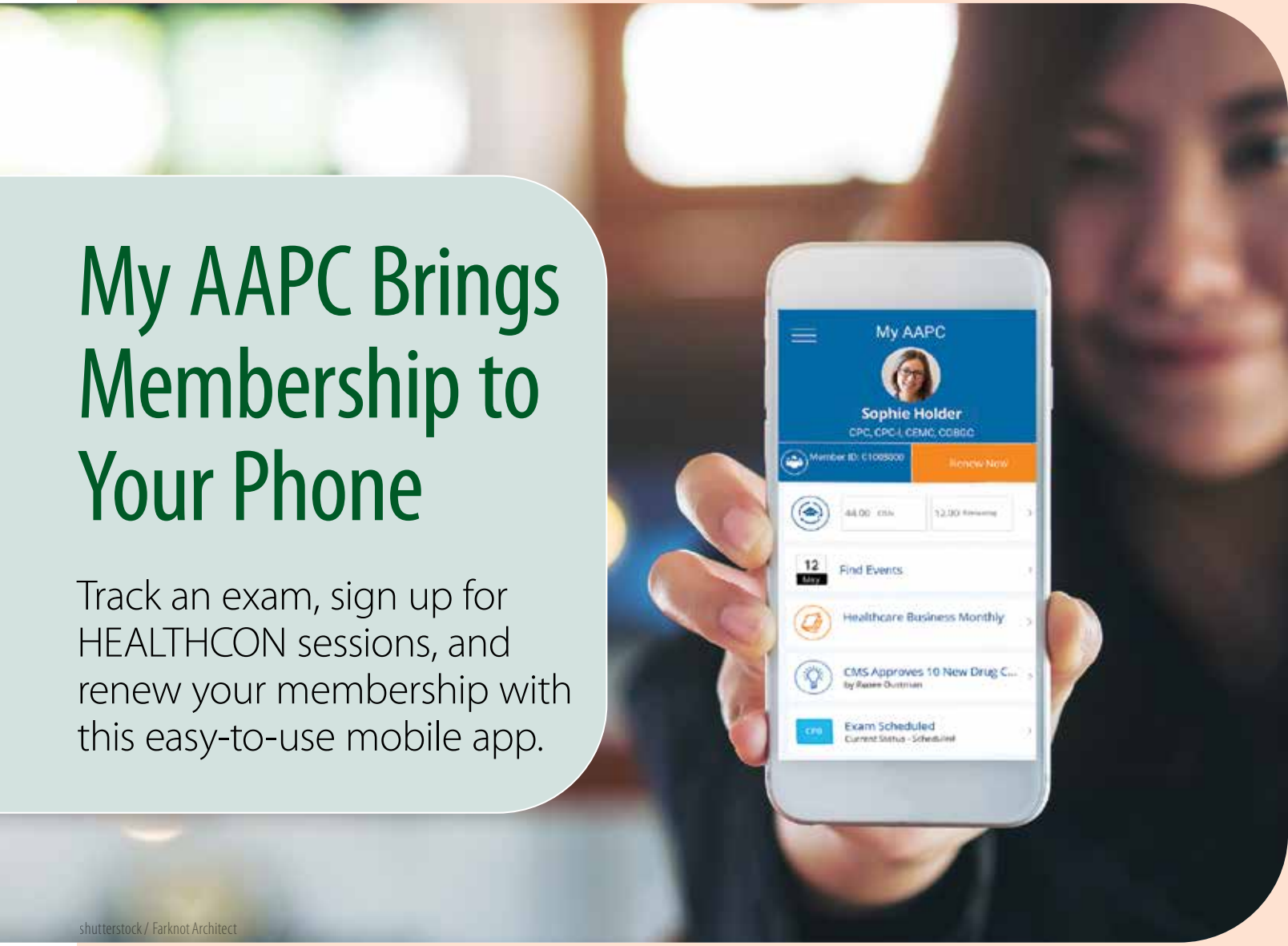
March 23, 2021



By Stacy Chaplain, MD, CPC

My AAPC Brings Membership to Your Phone

Track an exam, sign up for HEALTHCON sessions, and renew your membership with this easy-to-use mobile app.



shutterstock / Farknot Architect

Did you know that AAPC makes it incredibly easy to access membership-related information such as your membership renewal date, if you have enough continuing education units (CEUs), or whether you have signed up for any webinars lately? Effortlessly manage your membership and use AAPC's many educational offerings and work-related resources via the My AAPC app on your mobile device.

Easy Access Through My AAPC

My AAPC is a free application for your phone or tablet that allows you fast, easy access to your AAPC membership benefits, exam status and results, and more.

Using My AAPC, you can:

- Log in securely using your existing AAPC account. There's no need to create a new username and password.
- Review and update your AAPC profile.
- Quickly view your membership status and renewal information.
- View registered events and upcoming events.
- Quickly access *Healthcare Business Monthly* and AAPC's Knowledge Center.
- Browse AAPC certifications.
- Take *Healthcare Business Monthly* quizzes to earn CEUs.
- Scan QR codes on certificates to track your earned CEUs.
- Manage your CEUs through the CEU Tracker.

"Effortlessly manage your membership and use AAPC's many educational offerings and work-related resources."

- Watch webinars/workshops in the on-demand library and earn CEUs.
- Access free tools for coding and billing.
- Track your exam status and get real-time updates for in-person and online exams.
- Select and view your sessions at regional and national conferences.
- Get reminders and notifications for exams, AAPC events, membership renewals, new issues of *Healthcare Business Monthly*, and recently posted articles.
- Quickly and conveniently access your AAPC membership card.

Best of all, it's part of enhancing your membership experience. All you need to do is download the free application.

Getting Started With My AAPC

Before you begin your free download, be sure your mobile device meets the minimum software requirements:

- Android version 5.0 or higher
- iOS version 9.0 or higher

If you don't know which software version your mobile device is using, check your settings or check with Apple or Google to find out. If your device is running a lower version than shown above, look for the "Software Update" option in your device settings. This will allow you to update your software to the latest version.

Once you've confirmed your device is ready, search for My AAPC in the Google Play Store or App Store. Once you've installed the app, simply log in using your current www.aapc.com username and password.

Stay Up to Date

My AAPC includes the most sought-after tools and features from the AAPC website in an easy-to-use mobile app, and AAPC is continually improving it. The app is updated periodically with new features and additional access to your account, education, and other resources to improve your workday and career.

Be sure to allow for automatic updates so that you're always getting the most from My AAPC. For Android devices, open the Google Play Store app, select Menu, "My apps & games," and My AAPC. Click on the three dots in the right corner and check the box next to auto-update. For Apple devices (iPhone and iPad), from the settings menu, choose App Store. Under Automatic Downloads, slide the button to the right of Apps Updates to turn on automatic updates.

My AAPC puts membership in your hands, making it easier than ever to connect with AAPC. **HBM**

Stacy Chaplain, MD, CPC, is a development editor at AAPC. She has worked in medicine for more than 20 years, with an emphasis on education, writing, and editing since 2015. Chaplain received her Bachelor of Arts in biology from the University of Texas at Austin and her Medical Doctorate from the University of Texas Medical Branch in Galveston. She is a member of the Beaverton, Ore., local chapter.

By Victoria Moll, CPC, CPMA, CRC, CPRC, AAPC Approved Instructor, AAPC Fellow

Lighten Your Chapter Record Retention Load

Convert important records into digital format to store and share chapter documentation with ease.

Seven years — that is how long a local chapter needs to keep all of its important records. This includes items such as bank statements, expense receipts, checkbook registers, deposit slips, and even attendance sheets and minutes. But this does not mean you need to retain boxes full of files or stacks of binders. There are great ways to store this information electronically so it is easily accessible for current and incoming officers.

While it is a team effort to make sure all records are accounted for, it is the responsibility of the current treasurer to pass on the data to the new chapter treasurer no later than December 31. Getting ready now will make the end-of-year transition a breeze.

Make the Switch to Cloud Storage

Local chapters looking for a better way to store and pass on records and documents should consider backing everything up and saving it to cloud storage. If a local chapter has a Google account, it can easily create drive folders that can be viewed and shared solely amongst the officers. These folders can contain all of the pertinent information, such as record keeping and other documents, that everyone needs to access. This is a great way to organize things like registration information for an upcoming seminar or contact information for meeting room rentals. It is recommended to back up the records in cloud storage to a USB drive periodically, as well, to prevent loss of information.

Go Digital

If your chapter has been stockpiling papers, it's time to get your scanner running. Organize those files into a tidier digital format. Break down the papers into manageable pieces and set a goal date of when to get them uploaded and organized. Save the files with names that clearly detail what is in the file and create folders for each year. A little bit of cleanup can save a lot of organizational time in the future. **HBM**

Victoria Moll, CPC, CPMA, CRC, CPRC, AAPC Approved Instructor, AAPC Fellow, has more than 10 years of multispecialty experience in coding, auditing, and healthcare management. She has spoken at various AAPC conferences, seminars, and meetings and is known for her infectious enthusiasm. Moll is a contributor to AAPC's *Healthcare Business Monthly* as well as various coding blogs and podcasts. She has served as president, vice president, and education officer of the Allentown, Pa., local chapter and serves as Region 2 representative on the 2020-2022 AAPC Chapter Association Board of Directors.

"It is recommended to back up the records in cloud storage to a USB drive periodically, as well, to prevent loss of information."

adobestock / tadamichi

By Leonta (Lee) Williams, MBA, RHIA, CCS, CCDS, CPC, CPCO, CRC, CEMC, CHONC

Covington, Georgia Reconnects at Spring Fling

For this chapter, thinking outside the box meant meeting outside four walls.

Saturday, May 1, 2021, was a beautiful spring day in the state of Georgia. In fact, much of the Southeast saw beautiful skies and felt the soft breezes nature had to offer. In the small town of Covington, Ga., AAPC local chapter officers were hosting their very first post-COVID, in-person meeting at a local park. Each officer, adorned in a custom red AAPC T-shirt and face mask, added another ray of sunshine as they enthusiastically welcomed members to the chapter's Spring Fling event.

If we have learned anything over the past year, it's that being adaptable and thinking outside the box is critical to overcoming what life throws at us.

When Opportunity Knocks, Open the Door

Members of the Covington, Georgia chapter were excited to see one another outside of the square Zoom picture video feed. They shared vaccination stories and gave updates on family, work, and accomplishments. This event gave members not only the opportunity to see one another in person again, but to also get their most critical coding and billing questions addressed. A coding roundtable included topics on observation and emergency department coding, documentation and billing guidelines for prolonged services, criteria for billing the numerous COVID-19 vaccines, inpatient coding, and more.

Local chapters have had to be flexible during the pandemic in order to continue providing the education many of us need to be the best at what we do. Some have been extremely successful in securing speakers not only in their area, but from various locations across the country. This has allowed for more diversity in topics and increased attendance. The Speakers Bureau, introduced by the AAPC Chapter Association Board of Directors last year, creates opportunities for local chapters to connect with speakers. If your local chapter is not taking advantage of this resource, you may be missing out on dynamic speakers.

Think Outside the Box

Many of us are ready to "get back to normal." To get there, a bit of imagination or inspiration may be needed. Take a nod from the Covington, Georgia chapter, whose regular meeting space at a local university is still not an option for them. Perhaps meeting in an area like a park, parking lot, or other open space may be an alternative until things get back to normal. For the remainder of the year, most of this chapter's meetings will be offered virtually, but the officers have vowed to schedule another in-person event very soon.

Don't Forget Your Pants

At some point, healthcare professionals will transition back to the office. For some, that transition has already begun. Just like it took some time to get settled with the concept of working from home, the shift back to the office may also take some time to get mentally adjusted. Personally, I just hope I don't forget to get out of my pajama bottoms when that day arrives. Getting up, getting motivated, getting dressed, and getting out can be practice for when your day comes, so if your local chapter hosts an in-person meeting or event, be sure to show up and stay connected! HBM

Leonta (Lee) Williams, MBA, RHIA, CCS, CCDS, CPC, CPCO, CRC, CEMC, CHONC, is director of education, AAPC, and healthcare management consultant, Karna, LLC. She has more than 18 years of health information management experience as a coding director, auditor, educator, trainer, practice manager, and mentor. She has provided coding leadership and oversight of programs sponsored by the Centers for Disease Control and Prevention, National Center for Health Statistics, the U.S. Consumer and Product Safety Commission, and Industrial Economics, Inc. Williams has extensive experience in regulatory compliance, CDI, and risk management. She is founder and past president of the Covington, Ga., local chapter and currently serves as secretary on the National Advisory Board.

By Lee Fifield, BS

AAPC Social Hour: Career Paths Beyond the CPC®

Advice on how to find your career path after earning your medical coding credential.

Finding your career path was the topic of the AAPC Social Hour on Facebook Live, April 28, at 11 a.m. MT (1 p.m. ET).

Moderator and AAPC Social Media Manager **Alex McKinley** was joined by National Advisory Board (NAB) member **Pam Tienter, CPC, CPC-P, COC, CPMA, CPC-I, CCS-P**, and **Brenda Edwards, CPC, CDEO, CPB, CPMA, CPC-I, CEMC, CRC, CMRS, CMCS**, to answer the question every new coder has asked themselves: How do I begin my career after earning my Certified Professional Coder (CPC®) credential?

As 30-year veterans in the healthcare industry, Tienter and Edwards provided great perspectives on the topic. They each spoke about their experiences starting out, their long and winding career paths, and what they learned along the way.

Keep an Open Mind

Both Tienter and Edwards encouraged newly credentialed members to be open to opportunities outside of the physician's office when starting out. Edwards wrote about the many avenues a new coder can follow in the May 2021 issue of *Healthcare Business Monthly*. In her article, "There's More to Coding Than Meets the Eye," Edwards illustrates that there are many types of employers that need your knowledge base such as career colleges, law firms, and government agencies.

Tienter said she started out as a health unit coordinator working at the nurses' station learning multiple roles, which proved to be a great benefit as she moved into different and unanticipated areas. Edwards said she never imagined that she would be doing what she does now, saying, "I just kind of came in the back door." She began her career path at a medical practice where she took a temp job. Edwards acted as backup for colleagues on vacation, and that experience gave her an understanding of how the entire healthcare process worked.

Expect the Unexpected

McKinley asked Tienter and Edwards, "Is what you are doing now where you expected your career path to take you?"

Tienter replied, "I think my path has just been connection after connection after connection that led me here. It wasn't necessarily what I saw myself doing." She went on to say, "Things just led me here. I found something that I was doing that I loved and I learned and learned and learned." She recognizes that what she is doing now may not be what she is doing when she retires.

Edwards agreed, saying, "It's all the right opportunities at the right time."

The Chicken or the Egg?

McKinley asked Tienter if she sought more credentials "to go in a direction or did a direction find you and you felt like you needed to have a certification to help support that career path?" Tienter answered that it has been more about continual learning. She

cautioned newly credentialed CPC®s to not see others with more credentials as more marketable and advised that getting experience with your CPC® first is more important than piling up credentials. As your career progresses, you can earn more credentials based on your job roles.

Edwards agreed and cautioned that your successful path is not necessarily going to be the same as others', so take all advice with a grain of salt and get credentials that are meaningful to you. Try new things, and if something doesn't work, don't get discouraged — move on to a new opportunity.

"Your successful path is not necessarily going to be the same as others', so take all advice with a grain of salt and get credentials that are meaningful to you."

Network, Network, Network

Next up was networking and its importance. Tienter said, "I am a true believer in networking with other coders because my path has taken the path it has because of people I knew, things I heard about, somebody coming to me."

When asked how to network in the days of COVID, Edwards said you start "right here. We are your network." Reach out to people on Facebook, go to chapter meetings, and attend other chapters' meetings. Attend HEALTHCON and don't be intimidated to reach out to people. Every experienced coder came up through the ranks just like you and understands your position.

Stay Positive

Tienter and Edwards assured the audience that there are plenty of opportunities out there, including employers who will give CPC-A®s a chance. Edwards ended by saying, "Remember, this is not a field that is going to be dwindling by any means." 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 more than 15 years.

By Jennifer Hill, CPC, CPMA, CRC

Leveraging Telehealth

Stay on top of the latest telehealth risk adjustment requirements and guidance to ensure continued compliance.

adobestock / agenturfotografin

It has been more than a year since the rapid expansion of covered telehealth services due to the public health emergency (PHE) for COVID-19. According to the Department of Health and Human Services (HHS), we can bask in the telehealth light at least through July 23, 2021, with discussion of expanded coverage and relaxed regulations lasting through the end of this year. The PHE has affected risk adjustment organizations and payers greatly.

In 2020, we saw a postponement of hierarchical condition categories (HCC) submissions for Calendar Year (CY) 2019 and a postponement of 2019 Risk Adjustment Data Validation (RADV) audits, as well. 2021 will pose a challenge to some organizations and plans as it will be a dual submission year. HHS has rolled out an updated RADV timeline for both CY 2019 and 2020 submissions.

With the postponement coming to an end, are you "in the know" on your telehealth risk adjustment requirements and guidance?

Medicare Advantage, Medicare Cost Plans, PACE, and Demonstration Organizations

According to a Centers for Medicare & Medicaid Services (CMS) letter regarding "Applicability of Diagnoses from Telehealth Services for Risk Adjustment," the agency expanded their telehealth services for Medicare Advantage (MA), Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and demonstration organizations. However, diagnoses resulting from telehealth services must be "provided using an interactive audio and video telecommunications system that permits real-time interactive communication" to meet the risk adjustment face-to-face requirement. MA plans do not accept telephone-only visits as a valid risk adjustment documentation source as they do not fulfill the face-to-face requirement.

Table A: Telehealth services applicable for risk adjustment

Type of Service	What Is the Service?	HCPCS Level II/CPT® Code	Patient Status
MEDICARE TELEHEALTH VISIT	A visit with a provider that uses telecommunication systems between a provider and a patient	• G0425-G0427 (Telehealth consultations, emergency department, or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities) • G0459 (Inpatient telehealth pharmacologic management) • G0508-G0509 (Critical care telehealth communicating with providers and patients)	New or established patient
E-VISIT	Communication between a patient and their provider through an online patient portal	• 98970-98972 (Patient initiated – qualified nonphysician healthcare professional online digital evaluation and management (E/M) service up to 7 days) • 99421-99423 (Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days) • G2061-G2063 (Valid for 2020 DOS only)	Established patient
TELEPHONE VISIT	Non-face-to-face E/M	• 98966-98968 (Other qualified professional, PT, OT, LCSW, etc.) • 99441-99443 (Physician, mid-level)	Established patient

"Diagnoses resulting from telehealth services must be 'provided using an interactive audio and video telecommunications system that permits real-time interactive communication.'"

HHS-Operated Risk Adjustment Programs

CMS published Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs in April 2020 and updated the document in August 2020. CMS reiterates that a telehealth service must be "descriptive of a face-to-face service furnished by a qualified healthcare professional and is an acceptable source of new diagnoses." The FAQs go further to specify "telehealth visits are considered equivalent to face-to-face interactions, but they are still subject to the same requirements regarding provider type and diagnostic value." **Table A** breaks down allowable telehealth services.

When submitting telehealth diagnoses for Medicare, the place of service (POS) in the EDS/RAPS system must be either "02" designating the visit as telehealth or modifier 95 with the applicable POS code identifying a telemedicine service was rendered via a real-time interactive audio and video telecommunications system or telephone service.

Will Telehealth Stay Around?

The expansion of telehealth due to COVID-19 opened the flood gates of technology use and advancements that will not be going away any time soon. The quick adaptation has resulted in a knowledge that, if chosen, things can be done differently. There will be some limitations and guidelines reinstated; however, the door of telehealth can never be fully shut again. Organizations and payers should research state and federal restrictions, ask questions, and develop their own telehealth sections for their risk adjustment audit and compliance plans to stay ahead of changes and auditing. HBM

Jennifer Hill, CPC, CPMA, CRC, is a risk adjustment specialist who has worked on a variety of client projects, both big and small, from Medicare to private insurance companies. Hill serves as regional director for AAPC Services, where she uses her passion for project management, coding, and auditing to develop curriculum and provide quality education and training to coders, auditors, and providers across the country.

Resources

2019 Benefit Year HHS-RADV Activities Timeline

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQ's – updated Aug. 3, 2020

Medicare Telemedicine Health Care Provider Fact Sheet

Center for Connected Health Policy

Applicability of Diagnoses from Telehealth Services for Risk Adjustment

By Brett Rosenberg, MA, CPC, COC, CCS-P

Ultrasounds: Rely on Essential Guidelines for Compliant Vascular Duplex Scan Coding

Check for eligible LCD diagnoses to streamline the billing process.

Correctly coding for non-invasive vascular diagnostic studies means adhering to a strict set of authoritative guidelines and instruction. You've also got to take diagnostic considerations into account to ensure the claim has an optimal chance at reimbursement.

Let's address the coding mechanics surrounding extracranial artery and extremity vein duplex scans. Ensure your coding workflow is free from any obstruction by adhering to these practical tips and tricks.

Meet Key Criteria Parameters for Duplex Scan Coding

You'll report extracranial duplex scans using the following codes:

93880 Duplex scan of extracranial arteries; complete bilateral study

93882 unilateral or limited study

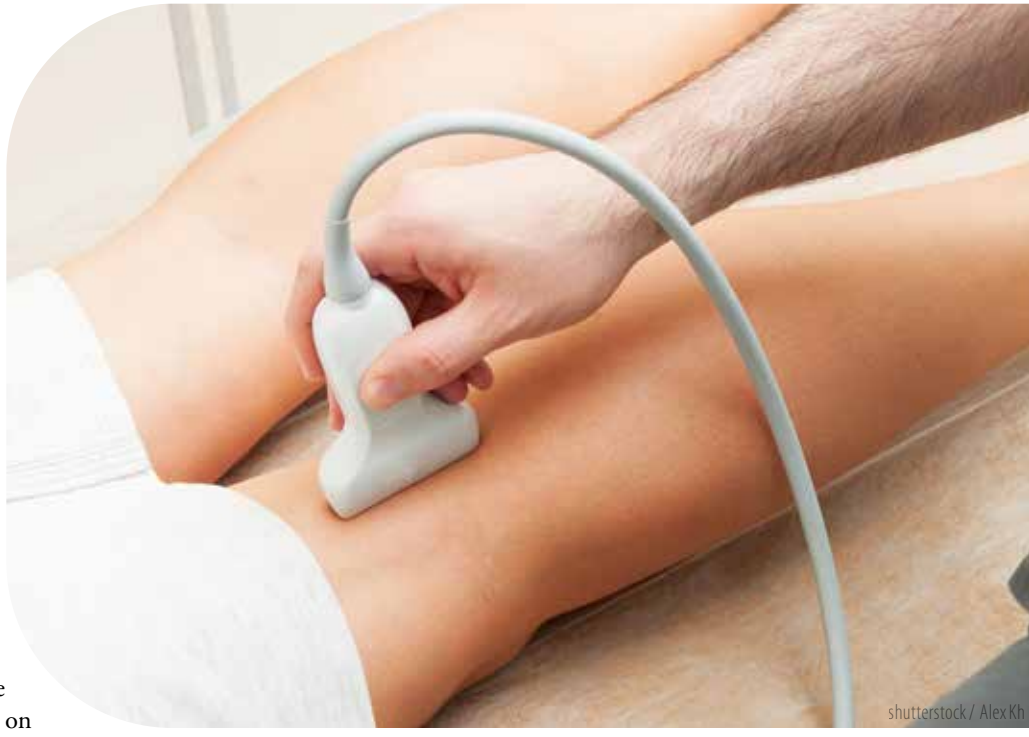
You won't find any guidelines that instruct you on any sort of criteria for reporting 93880-93882 beyond the scope of what's needed to report Doppler (duplex) scans.

There are two ways in which your documentation can meet the criteria for duplex scan reporting. The first, and most convenient, method is for the report to simply state that a duplex study was performed. You'll typically find documentation supporting this in the findings of the dictation report. Otherwise, you'll need to confirm documentation of two specific terms: color Doppler and spectral Doppler (or spectral analysis). While you'll need the documentation to support the use of color Doppler specifically, you can rely on the following terms, among others, to be used interchangeably with spectral Doppler:

- Acceleration rate;
- Bandwidth broadening;
- Waveform analysis; and
- Peak systolic velocity.

Note: These criteria apply to reporting for all duplex Doppler studies.

"While there are no strict guidelines in place that determine what constitutes a complete bilateral study outside of bilaterality, this study will typically include an examination of the internal, external, and common carotid arteries in addition to the vertebral arteries," explains Barry Rosenberg, MD, chief of radiology at United Memorial Medical Center in Batavia, N.Y. Only if two or more of the aforementioned arteries are not included, or the provider indicates



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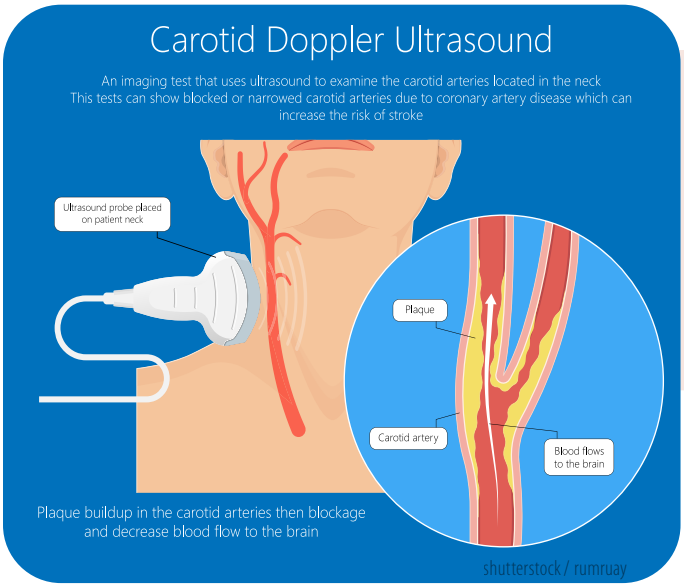

other reasons for a limited study, should you consider 93882 reporting for a bilateral service.

LCD considerations: The majority of Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs) include most of the generalized diagnoses you might associate with extracranial duplex scans. However, submission of diagnoses such as R51.- *Headache* and M54.2 *Cervicalgia* will typically result in a denial from MACs and most commercial payers. Furthermore, cautions Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians, "If the documentation only allows for signs and symptom coding that includes a headache, don't forget that coding this common symptom will now require a fourth digit."

Take Other Factors Into Account for Venous Duplex Scan Reporting

Guidance on reporting for duplex scans of extremity veins is a little more nuanced than what you'll encounter for extracranial artery duplex scans. On top of the generalized duplex scan guideline reporting, there are a few sets of criteria you should consider for accurate coding of the following services:

93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

93971 unilateral or limited study

According to the American College of Radiology (ACR) Ultrasound Coding User's Guide, criteria for 93970 lower extremity reporting includes examination of the common femoral, femoral, proximal deep femoral, great saphenous, and popliteal veins. Examination of calf veins may also be included and should not be considered additional work. Criteria for 93970 upper extremity reporting should include examination of the subclavian, jugular, axillary, brachial, basilic, and cephalic veins. Forearm vein imaging is also included, when performed.

"If the documentation only allows for signs and symptom coding that includes a headache, don't forget that coding this common symptom will now require a fourth digit."

For bilateral services that don't meet the above criteria, you will code the service as a limited examination, 93971. You will also report 93971 for unilateral (complete or limited) imaging of upper or lower extremity veins. When you have all the criteria for 93970 or 93971 reporting, but the report does not include enough documentation to support a duplex scan, you should first query the provider. If the imaging does not include color or spectral Doppler, you should report the service using 76882 *Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, periarticular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation*.

LCD considerations: For purely diagnostic purposes, you won't find any LCD guidelines on primary diagnosis reporting for generalized extremity venous evaluations. However, most MACs and commercial payers require different primary code reporting for 93970 or 93971 when performed for the following reasons:

- Pre-surgical conduit mapping for coronary artery bypass graft procedures
- Pre-surgical vein mapping for peripheral artery bypass
- Vein mapping for dialysis access

For duplex scans of extremity veins performed for pre-surgical conduit mapping for coronary artery bypass graft procedures, list either Z01.810 *Encounter for preprocedural cardiovascular examination* or Z01.818 *Encounter for other preprocedural examination* as the primary diagnosis.

For pre-surgical vein mapping for peripheral artery bypass or vein mapping for dialysis access, report Z01.818 as the primary diagnosis. Findings and any other clinical indications should be reported as secondary diagnoses for all three services. **HBM**

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This article is reprinted from the *Radiology 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 Raemarie Jimenez, CPC, CIC, CPB, CPMA, CPPM, CPC-I, CDEO, CANPC, CRHC, CCS

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Unraveling 2021 E/M Guidelines

AAPC's senior VP of products answers your questions about coding for office and other outpatient services.

Ever since the release of the new 2021 evaluation and management (E/M) guidelines for office and other outpatient services, AAPC has been conducting numerous trainings through webinars, virtual workshops, conference sessions, online courses, and multiple articles in *Healthcare Business Monthly* and the Knowledge Center blog. In the May and June magazines, we started to answer your questions about how the E/M guideline changes have affect documentation and coding. In this article, we answer 10 more.

Your Questions Answered

1. *Using the new medical decision making (MDM) table, how would you score out an encounter for a patient who presents for a COVID test in order to return to work?*

   If the patient was asymptomatic, this would be a straightforward visit. There would be credit given for the one lab test and minimal risk to the patient.

"Because the 2021 guidelines are printed in CPT® and finalized by the Centers for Medicare & Medicaid Services (CMS) through rulemaking, all payers need to comply with the new coding guidelines, unless they release a payment policy that states otherwise."

2. *If we perform a urinalysis (unique test ordered) in our office, is this one test we can count toward the data component? We are hearing conflicting answers. I know you cannot count the one test as two (ordered and read). I just want to confirm we can count as one test.*
When the new guidelines were originally released, if you billed for a test you could not count it as an order toward data in MDM. With the release of the technical corrections to the 2021 E/M guidelines in CPT®, that guidance was changed. If it is a test only that you are not separately billing the professional component for, you can count it as an order.

3. *If commercial payers are not using the new guidelines, how do we implement this? We can't have one set of documentation for Medicare and another for commercial payers. Any advice on how to resolve this?*
Commercial payers will usually either follow CPT® coding guidelines or Medicare payment policies. Because the 2021 guidelines are printed in CPT® and finalized by the Centers for Medicare & Medicaid Services (CMS) through rulemaking, all payers need to comply with the new coding guidelines, unless they release a payment policy that states otherwise.

4. *We see workers comp patients, and the providers are asking if they can count the creation of the state-mandated documents towards time billing.*
There are CPT® codes specific for form completion. See CPT® code 99080.

5. *I'm seeing a jump in levels of service based on total time. Is this going to be normal when we are seeing that medical necessity for the time is documented?*
The medical necessity must be supported. If, in an audit, it is found that the time stated does not support the activities performed or time that would be considered medically necessary, it could result in an unfavorable finding by the payer.

6. *Does podiatry follow the new guidelines?*
Yes. All specialties reporting codes 99202-99215 will use the new guidelines.

7. *If a physician is doing a prior authorization, does it count in total time?*
If the provider is personally calling for the prior authorization on the date of service on which they saw the patient, yes, it would be counted in total time. If performed by clinical staff it would not.

8. *We have a physician who likes to wait and sign her charts a day or two later. She has been told that she cannot bill based on time due to the "date stamp" entered thru the electronic medical record (EMR). Is this correct?*
Only count the time performed on the date of the visit, not the time to review and sign the chart on a different day.

9. *Can a level 5 visit be billed even if the patient is stable or not sick, but based on time only?*
It would depend on what caused the increase of time to meet a level 5. If the amount of time was required to properly treat the patient, it could be supported. For example, some visits may take longer due to multiple patient or caregiver questions or the review of multiple treatment options. The level 5 will also need to be supported by medical necessity.

10. *Can virtual visits (not telephonic) also be level 5 if decision making or time components are documented?*
For Medicare, you can look on the list of approved telemedicine visits at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Level 5 visits are on the list. Please check with your other payers for their policies. **HBM**

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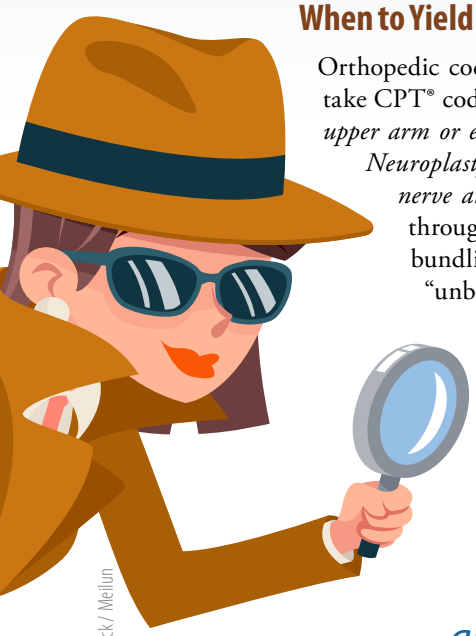
By Deanna L. Blalock-Polley, COC, CPC, COBGC, COSC

MODIFIER 59: Don't Stop! Yield and Investigate

A quick check of the NCCI PTP edits can pay off in a big way.

Let's say you're cruising along in what I call the "coding world." You're using your bundling matrix software and come across two codes that have a National Correct Coding Initiative (NCCI) edit bundling them (one code includes the other). What do you do? Drop one code and only bill the primary procedure? No! You yield on the coding and investigate the relationship between the two codes. What coders have been taught is that modifier 59 *Distinct procedural service* should only be applied to a secondary procedure when it follows the "separate" rule (e.g., separate incision, area, organ, etc.). However, the NCCI Policy Manual (great reading) gives us some exceptions to that rule.



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When to Yield

Orthopedic coding is a great example. Let's take CPT® codes 24305 *Tendon lengthening, upper arm or elbow, each tendon* and 64718 *Neuroplasty and/or transposition; ulnar nerve at elbow.* You run these codes through your software and there is a bundling issue; however, it does note "unbundling allowed with appropriate modifier." You need to yield at this point; it is time to investigate.

You turn to your specialty society information (the American Academy of Orthopaedic Surgeons uses Code-X/Global Service Data) and pull up the information for both codes, but no specific information is available under "services not included."

At this point, you should look for any other specific information in the NCCI Policy Manual. In the narrative for Chapter 4, pages IV-21 and 22 (revision date, Medicare 1/1/2021), it states, "If a provider performs the tendon lengthening described by CPT 24305 and performs an ulnar nerve transposition 64718, the NCCI PTP [procedure to procedure] edit may be bypassed by appending modifier 59 or XU to either column code."

There you have it! After investigation, the NCCI narrative tells you it is OK to bill these two codes with modifier 59 appended. You aren't just slapping a modifier 59 on there as a "pay me" modifier; you've investigated and have the backup to code and, if necessary, appeal a denied claim with that code combination.

Look for the Right of Way

Another issue with orthopedic coding and bundling comes up with arthroscopic shoulder procedures. This area has been a coder's nightmare for years with CPT® 29823 *Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])* becoming the "bad guy" with modifier 59.

"If your surgeon is performing debridement of the labrum, another separate tendon, or chondroplasty of glenoid/humeral head, you should investigate, regardless of the lack of an NCCI edit."

adobestock / Andrey Popov

In 2017 (revision date 1/1/2017), the Centers for Medicare & Medicaid Services updated the NCCI Policy Manual to indicate that 29823 was allowed when coded with other arthroscopic procedures on the ipsilateral shoulder.

The revision gave leeway to the shoulder having "separate/different areas" and indicated that debridement "performed in a different area of the same shoulder" may be reported separately, with three exceptions: 29824, 29827, and 29828. At that point, these code combinations were removed from bundling software and coders had a green light to proceed.

This doesn't mean that you should always code 29823 with an arthroscopic rotator cuff repair (29827) or a biceps tenodesis (29828). But if your surgeon is performing debridement of the labrum, another separate tendon, or chondroplasty of glenoid/humeral head, you should investigate, regardless of the lack of an NCCI edit. Especially since, effective January 1, the description for CPT® 29823 is revised considerably.

Pass Go and Collect

Don't be afraid! Yield and investigate the possibility of using modifier 59 to unbundle a code pair. A short investigation could result in a higher reimbursement for your surgeon. **HBM**

Deanna Blalock-Polley, COC, CPC, COBGC, COSC, has over 30 years of healthcare experience. Starting in a facility as a COR scheduling coordinator, she then became a reimbursement specialist and has been a physician coder for the last 10 years, currently as an orthopedic surgical coder independent contractor. Blalock-Polley is a member of the Madison, Wisc., local chapter.

"Don't be afraid! Yield and investigate the possibility of using modifier 59 to unbundle a code pair."

By Rachel Dorrell, MA, MS

Security and Compliance: Dig Deep on Business Associates' Behavior

Don't take BAs at their word when their actions affect your business.

"HIPAA-compliant" is a descriptor that vendors believe is worth its weight in gold, but can you really purchase HIPAA compliance? Telling authorities that the business associate (BA) you contracted with billed its services as compliant won't save you. Do your due diligence to make sure your organization won't have extra headaches if any federal agencies investigate for a violation or data breach.

Background

In December 2020, the Federal Trade Commission (FTC) announced a settlement with SkyMed International Inc., a Scottsdale, Arizona-based firm that sells travel and medical emergency services, for exposing consumers' personal information in a data security breach. After a 2019 complaint, the FTC discovered that SkyMed failed to protect individuals' data, including health information, when an unsecured cloud database exposed 130,000 membership records on the internet. In addition, the FTC found that the organization didn't properly assess its risks "by performing penetration testing and other measures, and failed to monitor its network for unauthorized access," an FTC release says.

Though SkyMed alerted current and former customers that their payment and health information wasn't compromised in the breach, the firm didn't actually review the data nor look into unauthorized access of the database materials, the FTC asserts. "Instead, after confirming that the data was online and publicly accessible, SkyMed deleted the database," the release says.

Don't Make Noncompliance Worse

But, on top of risk analysis fails, a data breach, and botched investigation of said incident, SkyMed also duped consumers into believing that its services were HIPAA compliant.

"SkyMed deceived consumers by displaying for nearly five years a 'HIPAA Compliance' seal on every page of its website, which gave the impression that its privacy policies had been reviewed and met" HIPAA security and privacy requirements, the FTC alleges.

Many third-party firms say that their products or tools are "HIPAA compliant," but the Department of Health and Human Services (HHS) and its auxiliary agencies don't certify or endorse vendors' products as HIPAA compliant.

Reminder: "HHS does not endorse or otherwise recognize private organizations' 'certifications' regarding the Security Rule, and such certifications do not absolve covered entities of their legal obligations under the Security Rule. Moreover, performance of a 'certification' by an external organization does not preclude HHS from subsequently finding a security violation," HHS Office for Civil Rights (OCR) guidance says.

Seek Your Vendors' Standards

It's important for covered entities (CEs) and their BAs to thoroughly vet their third-party partners and vendors before they enter into business with them. This might involve an initial scorecard to test

"Misspelling HIPAA can be a real red flag."

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knowledge of the HIPAA basics, followed by a more comprehensive investigation of their compliance practices, breach history, and incident response protocols.

Why? As required by HIPAA, CEs and BAs must secure patients' protected health information (PHI), and they "would be wise to use caution in evaluating companies that promise 'HIPAA compliance,'" advises attorney Shannon Hartsfield, an executive partner with Holland & Knight LLP in Tallahassee, Florida.

"A lot of customers want to see that characterization, and companies selling their services want to provide it. In my view, because HIPAA compliance is an ongoing process, it would be wise to avoid making representations that attempt to ensure 100 percent compliance," Hartsfield says.

TIP: Advertisements that claim products are "HIPAA compliant" or "HIPAA certified" should always be questioned.

"If a healthcare provider is evaluating a company that says they're 'HIPAA compliant,' it would be important to try to get a full understanding of what the vendor means by that," Hartsfield says. "And if a vendor says it's 'HIPPA compliant,' you may need to run the other way! Misspelling HIPAA can be a real red flag," she adds.

Look to Possible Corrections

According to the proposed settlement, the FTC requires SkyMed to take several actions to correct its compliance issues. Here's a short sampling of what the proposed settlement entails:

- Contact the individuals impacted by the data breach.
- Implement an information security program, including the adoption of a compliance officer, written policies and procedures, and risk analysis and management.
- Ensure security measures are assessed by a third party.

Another component of the settlement relates to SkyMed's "HIPAA-compliant" pledge. "The proposed settlement prohibits misrepresentations about how SkyMed secures consumer information, how it responds to data breaches, and whether the company has been endorsed by or participates in any government-sponsored privacy or security program," notes the FTC release. **HBM**

Rachel Dorrell, MA, MS, writes about the Minimum Data Set, practice management, and ICD-10 coding for AAPC, focusing on the issues that keep nursing facility and medical office personnel up at night. She has a Master of Science in narrative medicine from Columbia University and a Master of Arts from York University, in the U.K. She also runs an organic farmstead in the New York Finger Lakes region, focusing on sustainably raising happy, healthy heritage-breed livestock.

Resource

www.ftc.gov/system/files/documents/cases/skymed_-_consent_order_ftc_signed.pdf

This article is reprinted from the *Practice Management 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 Renee Dustman, BS, AAPC MACRA Proficient

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10 Service/Supply Claims Under Review

If your provider furnishes Medicare patients with any of the services or supplies on this list, expect an ADR.

Ever wish you had a crystal ball to foresee when a Recovery Audit Contractor (RAC) might send your office an Additional Documentation Request (ADR) letter? Luckily, all you really need is the World Wide Web; RACs post the issues they are reviewing on their websites. If your provider bills for any of the procedures or durable medical equipment (DME) on their radar, it may be a good time to conduct an internal audit on those claims. Here are the 10 most recent issues the Centers for Medicare & Medicaid Services (CMS) has approved for RAC complex review.

What Is a RAC?

CMS created the Medicare Fee-for-Service (FFS) Recovery Audit Program to identify and correct improper payments. RACs are third-party companies that review claims on a post-payment basis to detect and correct past improper Medicare payments.

RACs in Regions 1-4 perform post-payment reviews to identify and correct Medicare Parts A and B claims. The Region 5 RAC is dedicated to national review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and home health agencies (HHAs)/hospice claims.

"Each approved RAC topic includes a description, affected codes, and applicable policy references."

To date, the RACs are:

- Performant Recovery, Inc.
  - Region 1 (Conn., Ind., Ky., Mass., Maine, Mich., N.H., N.Y., Ohio, R.I., and Vt.) (Performant was awarded region 1 on March 26)
  - Region 5 (Nationwide for DMEPOS/HHA/hospice)
- Cotiviti
  - Region 2 (Ariz., Colo., Ind., Ill., Kan., La., Mo., Minn., Miss., Neb., N.M., Okla., Texas, and Wis.)
  - Region 3 (Ala., Fla., Ga., N.C., S.C., Tenn., Va., W.Va., Puerto Rico, and U.S. Virgin Islands)
- HMS Federal Solutions
  - Region 4 (Alaska, Ariz., Calif., D.C., Del., Hawaii, Idaho, Md., Mont., N.D., N.J., Nev., Ore., Pa., S.D., Utah, Wash., Wyo., Guam, American Samoa, and Northern Marianas)

RAC reviews usually result from referrals made by Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), and federal investigative agencies such as the Office of Inspector General (OIG) and the Department of Justice (DOJ).

Top 10 List

The following top 10 approved issues are for complex review of medical necessity and documentation requirements:

1. Spinal cord neurostimulation (CPT® 63685, 63650, 63655) for outpatient, inpatient, ambulatory surgical center (ASC), and professional services claims
2. Positron emission tomography for initial treatment strategy in oncologic conditions (CPT® 78608, 78811-78816, A9552) for outpatient and professional services claims
3. Next generation sequencing (CPT® 81455, 0111U, 0022U, 0037U) for laboratories
4. Hospice continuous home care (revenue codes 0652 *Continuous home care*, 0551 *Skilled nursing visit*, 0571 *Home health aide visit*, and HCPCS Level II codes G0299, G0300, G0156)
5. Vagus nerve stimulation (CPT® 64568, 64569, 61885) for outpatient, ASC, and professional services claims
6. Air ambulance for rotary wing (helicopter) aircraft claims (HCPCS Level II A0431, A0436)
7. Deep brain stimulation (CPT® 61885, 61886, 95970, 95972, 95973) for outpatient claims
8. Immunosuppressive drugs (HCPCS level II J7507) for DME claims
9. Implantable automatic defibrillator (ICD-10-PCS 0JH608Z, 0JH609Z, 0JH638Z, 0JH639Z, 0JH808Z, 0JH809Z, 0JH838Z, 0JH839Z) for inpatient claims
10. Polysomnography (CPT® 95810, 95811) for outpatient claims

If you go to the CMS website, you can review all approved RAC topics. Each approved RAC topic includes a description, affected codes, and applicable policy references. The applicable policy references section is very helpful as it lists all the regulatory guidelines RACs will use to perform their reviews.

For example, for Next Generation Sequencing reviews, RACs will consider 17 applicable resources including the Social Security Act, Title 42 Code of Federal Regulations, the Medicare Benefit Policy Manual, the Medicare Program Integrity Manual, the Medicare National Coverage Determination Manual, and the CPT® and ICD-10-CM code books.

Use these same references in your internal audits to ensure your claims are coded correctly and that you have documentation to back up those claims. **HBM**

Renee Dustman, BS, AAPC MACRA Proficient, is managing editor of Content and Editorial for AAPC and a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

Resource

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

By Jean Pryor, CPMA, CPC, CPB, CPC-I, CRC, CCS-P, CHAP, AAPC Fellow

What's Included in an AWV?

Set the record straight with patients to prevent surprise billing.

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If you work in a medical billing office, you know how frustrating it can be to get a phone call from a patient asking why they are getting a bill for their "free" visit. The patient is frustrated because they do not understand the components of an annual wellness visit (AWV) for Medicare patients. "You know that laundry list of health issues you created over the year and addressed with the clinician during your visit? Sorry, but that's not included in the AWV," you tell the patient. Invariably, this does not go over well. Ultimately, it's your job to prevent this sort of misunderstanding from the get-go.

In this article, we'll review what Medicare AWVs include and don't include and their frequency limitations. This information is changeable, so even the most experienced coders, billers, and auditors should periodically review the definitions for Medicare's physical exams coverage.

The Initial Preventive Physical Exam

It's important not to confuse the various types of physical exams Medicare allows because they are coded differently and coverage may vary, as well.

"Advance care planning (ACP) can be provided during an AWV or covered as a separate Part B service, when medically necessary."

When an individual initially signs up for Medicare, they have the option of receiving an initial preventive physical exam (IPPE) at no extra cost to them. They are eligible for this "Welcome to Medicare" preventive visit within the first 12 months of enrollment. This benefit is a once-in-a-lifetime "use it or lose it" service. Patients should be encouraged to take advantage of the IPPE, as it is a beneficial service. The IPPE aims to promote a healthy lifestyle, prevent and detect disease, identify areas of concern, and provide education and counseling to ensure the patient is well informed and understands what services are covered by Medicare. The IPPE can be performed by a physician or other qualified healthcare professional (QHP).

There are eight areas in the IPPE that the provider is supposed to address and document, as shown in **Table A**.

What Codes Are Billed for the IPPE?

The IPPE is a proprietary Medicare service for which you will bill the contractor using HCPCS Level II codes.

G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and reportG0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

G0468 Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

There is not a specific ICD-10-CM code designated by Medicare to use with the IPPE. You may choose a diagnosis code addressed during the visit or use a code from category Z00-Z09 *Factors influencing health status and contact with health services.*

The Annual Wellness Visit

The purpose of the AWV is to develop or update a personalized prevention health plan and perform a health risk assessment (HRA). As with the IPPE, the patient will not cost share (if the provider accepts assignment) and the deductible does not apply. New Medicare beneficiaries are eligible for one initial AWV. The patient can receive this service one time after the first 12 months of their Medicare enrollment. It does not have to be in the second year of enrollment. It could be years later, but they only receive it one time.

After the initial AWV, the patient qualifies for subsequent AWVs each year (after a full 11 months have passed from the previous AWV). Many get confused about the timing of the subsequent visit. The easiest way to explain it is that patients can have their next subsequent AWV anytime within the same month of their previous visit the year before, or later.

Table A: Eight elements of an initial preventive physical exam

IPPE Element	Description
Review medical and social history	At a minimum, document information regarding: Past medical and surgical history, current medications and supplements, family history, diet, physical activities, history of alcohol, tobacco, and illicit drug use (such as opioid use by patient or family members)
Review risk factors for depression or other mood disorders	Use a standardized screening tool (e.g., PHQ-9)
Review functional ability and safety level	Activities of daily living, fall risk, hearing impairment, home safety
Exam	Height, weight, body mass index, vital signs (e.g., blood pressure), visual acuity screening, other appropriately deemed factors
End-of-life planning	Discuss, if patient consents, advanced care planning, providing written information and documentation, as appropriate
(NEW) Screening for substance abuse	Review any current opioid prescriptions
Educate/counsel/refer	Based on above findings, give education/counseling/referral
Educate/counsel/refer on preventive services they may benefit from	Supply a brief written checklist for the patient to receive a once-in-a-lifetime EKG and other preventive services covered by Medicare in the AWV

"After the initial AWV, the patient qualifies for subsequent AWVs each year (after a full 11 months has passed from the previous AWV)."

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For example: If a patient receives their subsequent AWV on June 15, 2021, they will be eligible to receive their next subsequent AWV on June 1, 2022. You do not count June 15, 2021, because it is not a "full" month. You start counting in July and stop the end of May for 11 full months.

Who Can Perform an AWV?

Only certain practitioners are permitted to perform AWVs. These include:

- Physicians
- Qualified non-physician practitioners (NPPs)
- Other QHPs – health educator, registered dietician, nutrition professional, other licensed practitioner, or a team of medical professionals directly supervised by a physician

As usual, state licensing applies, as well.

AWV FAQs

Here are answers to a few frequently asked questions about annual wellness visits (AWVs) and initial preventive physical exams (IPPEs).

Are the IPPE and AWV the same as the routine yearly physical exam?

No. Bill routine yearly physical exams using the CPT® Evaluation and Management (E/M) codes. Medicare does not cover routine yearly physical exams.

Can the AWV and IPPE be performed via telehealth?

The IPPE cannot be performed via telehealth, but initial and subsequent AWVs may be performed via telehealth.

Can AWVs and IPPEs be performed at the same time as another E/M service to address medical conditions?

Yes, if the additional visit documented supports a significant separately identifiable service, you can report 99202-99215 in addition to the AWV. Best practice is to let the patient know that if the provider addresses additional conditions, they may receive a bill for the added service.

What Codes Are Billed for the AWV?

G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit
G0468	

There is not a specific ICD-10-CM code designated by Medicare to use with the AWV. You may choose a diagnosis code addressed during the visit or use a code from Z00-Z99.

See **Table B** for a comparison of what is required for the initial AWV versus subsequent AWVs.

Advance Care Planning May Be Separate

Advance care planning (ACP) can be provided during an AWV or covered as a separate Part B service, when medically necessary. In either case, when performed at length (30 minutes or more), it is separately billable.

This service is when the provider and the patient discuss the patient's end-of-life treatment wishes in the event a time comes when the patient cannot speak or make their own decisions about the care they wish to receive or not receive. There is no limit on the number of times a provider can report ACP for a patient, but the service may only be provided when the patient agrees to receive the service.

Make sure the patient understands when ACP is non-covered; ACP is covered once per year with no cost sharing to the patient; if the ACP is provided outside of the timeframe, the patient will cost share and pay their deductible and coinsurance (if applicable). Medicare will waive the coinsurance and deductible when provided during an AWV if the following occur:

- ACP is provided on the same date as the covered AWV.
- ACP is provided by the same provider as the covered AWV.
- ACP is billed with modifier 33 *Preventive services*.

The provider must document the change in the patients' health and wishes for end-of-life care.

Table B: Comparison of requirements for initial AWV and subsequent AWVs

Component	Initial Annual Wellness G0438	Subsequent Annual Wellness G0439
Perform a health risk assessment (HRA) and, at a minimum, obtain: Demographic information; health status self-assessment; psychosocial risks such as depression, anger, stress, pain, fatigue, etc.; behavioral risks such as tobacco use, physical activity, nutrition, oral health, alcohol use, sexual health, etc.; activities of daily living such as dressing, feeding, grooming, toileting, ambulation, risk of falls, etc.	X	Review and update
Establish the patient's medical and family history: Obtain medical history of the patient's parents, siblings, and children; hereditary conditions; past surgical history, allergies, injuries, and treatments; use of or exposure to medications including opioid use, calcium, and vitamins.	X	Update
Establish a list of current providers and suppliers: If the patient receives regular care from a provider or supplier that provides medical care, list their names.	X	Update
Measure: This includes height, weight, body mass index or waist circumference, if appropriate; blood pressure; and any other measurement deemed appropriate based on findings in medical and family history.	X	X
Cognitive impairment: Detect by observation, information obtained from friends, family members, caregivers, etc., or administer a brief cognitive test.	X	X
Risk factors for depression and mood disorders: Use a standardized screening tool such as a PHQ-9 or other recognized tool.	X	Update
Functional ability and level of safety: Use direct observation or a questionnaire to obtain, at a minimum, the patient's ability to perform activities of daily living, fall risk, hearing impairment, and home safety.	X	Update
Establish an appropriate written preventive screening schedule for the next five to 10 years.	X	Update
Establish a list of conditions and risk factors for which the provider recommends or has initialed intervention such as mental health conditions, substance use disorder, IPPE risk factors identified. This should include the risks and benefits of the various treatment options.	X	Update
Supply personalized health advice, referrals for education and counseling or programs to assist with lifestyle interventions, such as fall prevention, nutrition, physical activity, tobacco use cessation, weight loss, and cognition, aimed at wellness promotion and health risk reduction (Personalized Prevention Plan Services).	X	Update
Provide advance care planning: If the patient approves, explain advanced directives, identifying a caregiver, notifying others about healthcare preferences and future care decisions, and completing forms.	X	Update as necessary

What Codes Are Billed for Advance Care Planning?

When reporting ACP services beyond what is included in the AWV, you will report the following CPT® codes, as applicable:

99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health are professional, first 30 minutes, face to face with the patient, family member(s), and/or surrogate

99498 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health are professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Report the diagnosis code(s) in support of this service based on the patient's documented exam findings.

Preventive Care Starts With You

Medicare eligible patients should be encouraged to take advantage of the Medicare AWV each year to help detect or prevent diseases that may otherwise go unnoticed or untreated. Many patients do not understand that their "free" visits have limitations, however. Although patients may not like to be billed for added services performed during the AWV, they will be far less upset if they know what to expect. On the bright side, you can say, having the additional conditions addressed at the same time as their AWV will prevent them from having to return to the office on a later date. HBM

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Resources

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

www.cms.gov/Medicare/Medicare-General-Information/Telehealth

By Lee Fifield, BS

Two of a Kind

Meet AAPC's first members of the month: Kim Huey and Sandy Giangreco Brown.

Wondering who the ladies are on the cover? Meet Kim Huey and Sandy Giangreco Brown. We met them at HEALTHCON this past March in Dallas and loved their story so much we decided to put them on the cover of *Healthcare Business Monthly*. In fact, we've incorporated a new column, Member of the Month, starting with this issue. Going forward, we will be featuring members (or other VIPs) on the cover of the magazine.

Huey and Brown met over 15 years ago, and since then, they have not only become colleagues but good friends, as well. Here is their story.

Starting Out

Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPCO, COC, recalls meeting **Sandy Giangreco Brown, BS, RHIT, CCS, CCS-P, CHC, CPC, COC, CPC-I, COBGC, PCS**, when they happened to sit next to each other at the American Medical Association (AMA) CPT® Symposium more than 15 years ago. They kept running into each other at various conferences for the next few years and finally decided to introduce themselves. Little did they know that they would become co-educators and author journal articles together over the next decade. Huey even did some sub-contracting work with Brown's company.

Working Together

Huey and Brown both point to their complementary styles and backgrounds as part of the secret to their success as an educational duo. Huey's background is in coding and compliance on the physician's side (she has a master's in health law), while Brown comes from a clinical background with some facility and inpatient experience (she is finishing up her master's in healthcare administration with an emphasis in population health).

They each appreciate that they can bounce ideas off each other when they need advice or an opinion, and their rapport shows. "We have had clients say that they love 'Kim and Sandy' doing the education, and others have told us that they would love to duplicate how we work together," said Brown. "When we blend our styles together, our overarching passion for helping others comes through."

Huey lives in Alabama, while Brown resides in Colorado, which doesn't make it easy to coordinate. Huey said, "We joke that on some days we use all modes of communication — phone, text, Facebook Messenger, and Teams meetings!" It's easy to tell when they have been together, however, because they pick up each other's way of speaking. Huey jokes that Brown now knows what it means to be "worn slap put," and she has been known to say, "What the what?" after spending time with Brown.

A Mutual Appreciation

After witnessing the way Huey and Brown interact, their mutual admiration, respect, and friendship were clear. "Having a long-time colleague and friend like Kim has been such a blessing, both professionally and personally," said Brown. Huey replied, "We are truly blessed to have each other — as colleagues and friends — and coding brought us together!" 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 more than 15 years.

HEALTHCON 2022
WASHINGTON, DC

Search, Solve & Spring Ahead!

HEALTHCON 2022 registration is now open at **healthcon.com**. The conference is scheduled for March 27-30 in Washington, D.C./Maryland at the Gaylord National Resort & Convention Center. Come together with your AAPC community for four days of learning, fun, and adventure in one of the most beautiful cities in America — especially when spring comes around.

Spring ahead with your colleagues as you indulge in the historic beauty of our nation's capital. Attend in person or virtually. Just don't miss out on the fun!

By AAPC's Auditing Advisory Committee

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Medical Necessity: Is It Really Necessary?

Come to terms with payers to protect your provider's revenue stream.

"Medical necessity" is an important concept for medical coders and auditors to understand. Health insurance companies (payers) use criteria to determine whether items or services provided to their beneficiaries or members are medically necessary. As a rule, payers will not reimburse for medical procedures, treatments, or even prescriptions that don't meet their criteria for medical necessity. That criteria may vary from payer to payer and even from one payer's plan to another. Understanding a payer's definition of medical necessity is essential to getting claims paid. Here's what you need to know.

What Criteria Are Used to Determine Medical Necessity?

Insurance providers, hospitals, and some government auditing agencies use evidence-based criteria designed by Milliman or Interqual and/or the Centers for Medicare & Medicaid Services (CMS). (Use of either Milliman or Interqual comes down to preferences set by the user.) The criteria are used to help control costs by determining the medical necessity of the inpatient stay, service, or item. It is important to note that these criteria are not meant to replace a provider's professional opinion. A physician can request a peer-to-peer review, which may result in an overturn of a denial.

Cigna, for example, defines medical necessity for providers as "health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms in accordance with the generally accepted standards of medical practice."

Cigna goes on to state, "Clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for

the patient's illness, injury, or disease. Is not primarily for the convenience of the patient, health care provider, or other physicians or health care providers and is not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease."

CMS uses a variety of programs to maximize accessibility to benefits while reigning in improper billing and payments such as prior authorization and pre-claim review initiatives.

Medicare's Criteria for Medical Necessity

CMS allows its Medicare Administrative Contractors (MACs) to determine whether services provided to their beneficiaries are reasonable and necessary, and therefore medically necessary. MACs use the following criteria to determine if an item or service is medically necessary:

- It is safe and effective.
- It is not experimental or investigational.
- It is appropriate when:
  - Furnished in accordance with accepted standards of medical practice.
  - Furnished in a setting appropriate to the medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - Meets the medical need of the patient.

Note: There are some exceptions to the general medical necessity requirements spelled out in CMS' regulations.

Diagnosis Impact on Medical Necessity

A patient's diagnosis is one criterion that drives medical necessity from a payer's perspective. From a clinical perspective, medical necessity is determined by the provider based on evidence-based medical data. This data may be used to order further testing to diagnose a patient's condition or provide additional procedures to treat a patient's condition.

Issuing an Advanced Beneficiary Notice of Noncoverage (ABN)

Claim denials are the responsibility of the provider and/or patient to cover. If a provider feels a service is medically necessary for a Medicare patient and, upon policy review, the payer denies medically necessity, an ABN will protect the provider from loss of revenue. The patient should be given the ABN form to complete in its entirety and sign prior to having the service rendered. Be sure to give the patient enough time to make an informed decision.

When discussing medical necessity denials or potential denials with a clinician, present the medical necessity criteria the payer used to make the determination. This will prevent the debate of why non-clinical personnel can tell a provider a service is not medically necessary.

Any time a procedure or test is ordered, the provider must first get approval from the patient's payer before performing the test or procedure. In giving this approval, the payer is saying the test or procedure meets their established medical necessity criteria. Prior authorization is not a guarantee of payment, however.

From an insurance perspective, medical necessity is determined by either the diagnosis code(s) and/or clinical condition(s) that are defined in the payer's policy. The pre-approval process typically involves submitting to the payer:

- the patient's diagnosis; and
- the procedure to be performed.

A provider should also include:

- the severity of the diagnosis;
- the risk of not performing the procedure; and
- any diagnostic studies or interventions tried previously.

It is important for the physician, coder, biller, and insurance company to all be on the same page when it comes to medical necessity. A provider may feel specific procedures or tests are medically necessary for a patient, but the insurance company can also make that determination based on their clinical policies. Problems ensue when medical necessity is defined differently by the two parties.

Frequency Impact on Medical Necessity

Another component of medical necessity is frequency — how often can a procedure be performed over a predetermined length of time? Payers often set frequency limitations on certain services. For instance, preventive services are generally limited to one per year.

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To protect the provider's or facility's revenue stream, due diligence must be taken to properly identify any coverage limitations ahead of the patient's encounter. This is not always easy to do as patients may receive care from several providers. To get ahead of this potential payment barrier, contact your MAC or verify through the HIPAA Eligibility Transaction System. You may also be able to gather this information from the patient, but this is a less reliable source and requires confirmation.

What Is Prior Authorization and Why Do We Need It?

The America's Health Insurance Plans (AHIP) explains, "Prior authorization is a process whereby a provider, on behalf of a patient, requests approval or authorization from the health plan before delivering a treatment or service in order for the treatment or service to be covered by the health plan." From a payer's point of view, prior authorization ensures that all delivered care is medically necessary; it also addresses and prevents overuse and misuse of treatments and services.

Other purposes of preauthorization, according to AHIP, include:

- Ensure that providers adhere to nationally recognized care criteria (e.g., ensure opioid prescribing consistent with federal guidelines).
- Promote appropriate use of medications and services to ensure that they do not interfere with other types of medications or potentially worsen existing conditions.
- Make sure that medications are not co-prescribed with other drugs that could have dangerous, even potentially fatal, interactions.
- Ensure that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications in children and adolescents).
- Make sure that drugs and devices are not used for clinical indications other than those federally approved or supported by medical evidence.
- Ensure that the administering clinician has the appropriate training to do so (e.g., limiting prescribing of chemotherapy medications to oncologists).
- Promote dialogue with clinicians to ensure tailored, patient-focused treatment programs to promote adherence and improve outcomes.
- Ensure that members with a newly prescribed medication receive services such as counseling, peer support, or community-based support if appropriate (e.g., medication-assisted treatment).

As you can see, preauthorization is an important safety measure. It is not meant to be a barrier to healthcare.

Meeting Medical Necessity Criteria

To reinforce medical necessity and meet payer guidelines, documentation should be complete, support the service(s) billed, and validate the need for the level of care/treatment provided. For Medicare patients, billing providers should refer to local and national coverage determinations for medical necessity criteria. Commercial insurances may also have their own policies.

Providers should document the patient's progress, response to treatment, and any necessary change(s) in diagnosis or treatment. When patients fail to comply with treatment recommendations, this should also be included in the medical record.

Remember, each outpatient encounter should stand alone. Documentation should include the patient's name, date of service, relevant history and exam, along with an assessment and plan. Clinical findings from diagnostic and laboratory tests should be included to provide further evidence for treatment.

Medical Necessity Example – Medicare

Novitas has a Local Coverage Determination (LCD) for wound care. Within this policy, this MAC identifies coverage indications for different wound care services, limitations for different wound care services, summary of evidence, documentation requirements, and utilization guidelines. The MAC considers all of these items together to determine if a service is reimbursable. An approved diagnosis alone will not support reimbursement, so it is important that you read further than just the diagnosis list.

Medical Necessity Example – Aetna

Some commercial insurance companies follow Medicare's policies, but many have their own. Aetna has a policy with a list of acceptable diagnoses for hyperbaric oxygen therapy (HBOT), if criteria are

"To reinforce medical necessity and meet payer guidelines, documentation should be complete, support the service(s) billed, and validate the need for the level of care/treatment provided."

"To reinforce medical necessity and meet payer guidelines, documentation should be complete, support the service(s) billed, and validate the need for the level of care/treatment provided."

met. The policy identifies medically necessary versus experimental and investigational. For a patient with actinic skin damage, the treatment is considered experimental/investigational and not covered.

Depending on the patient's condition, HBOT would be medically necessary for a patient with compromised skin grafts and flaps, where hypoxia or decreased perfusion has compromised viability acutely (not for maintenance of split-thickness skin grafts or artificial skin substitutes). Required documentation includes photograph (with ruler) of wound, type of flap, name of surgeon performing graft or flap, whether there was surgical exploration, and transcutaneous oxygen tension testing demonstrating hypoxia of flap or graft (TcPO2 less than 40 mmHg on room air).

Wounds must be reevaluated, with photographic documentation (with ruler), every 15 treatments, and/or at least every 30 days during administration of HBOT. Continued treatment with HBOT is not considered medically necessary if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

What Medical Necessity Is About

The healthcare landscape requires providers to not only establish medical necessity, but also to clinically validate it. This requires the right documentation, processes, and procedures. U.S. healthcare costs are at astronomical levels, with spending hitting an all-time high of just under $4 trillion in 2019. Federal, state, and private insurance carriers are all looking for ways to cut costs while improving care quality. These measures have led to increased scrutiny of services rendered to patients and whether these services are justified. Providers should be keenly aware of medical necessity requirements as defined by the payers and work towards closing any gaps within the revenue cycle that opens them up to increased medical record reviews, denials, and overpayment requests. **HBM**

The AAPC Auditing Advisory Committee is one of six committees, each made up of subject matter experts. AAPC formed these committees to advance thought leadership and engage experts in work supporting AAPC members' pursuit of lifelong learning. Members of the Auditing Advisory Committee include:

Angela Clements, CPC, CPMA, CEMC, CGSC, COSC, CCS, physician coding auditor/educator consultant

Leonta (Lee) Williams, MBA, RHIA, CCS, CCDS, CPC, CPCO, CRC, CEMC, CHONC, AAPC director of education, Auditing Advisory Committee chair

Lindsey Motter, LPN, CPC, CPMA, senior provider reimbursement administrator

Wanda F. Register, MBA, CPC, CCS-P, emergency department audit analyst

Meet **Leonta (Lee) Williams, MBA, RHIA, CCS, CCDS, CPC, CPCO, CRC, CEMC, CHONC**, director of education at AAPC. Learn more about Williams and her outlook for AAPC education in the digital version of *Healthcare Business Monthly*, available in your My AAPC account.

Resources

https://www.cms.gov/apps/glossary/default.asp?Letter=M&Language=English

https://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx?redirect=Y

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

https://www.cigna.com/health-care-providers/coverage-and-claims/policies/medical-necessity-definitions

https://www.humana.com/member/plain-language-policy

http://www.aetna.com/cpb/medical/data/100_199/0172.html

https://www.psqh.com/analysis/what-you-need-to-know-about-the-utilization-review-process/

https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives

https://www.ahip.org/wp-content/uploads/Prior-Authorization-FAQs.pdf

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp

By Stacy Chaplain, MD, CPC

Hypertensive Chronic Kidney Disease

Check your diagnosis coding for this patient encounter.

adobestock / dream@do

A patient presents today for a follow-up for her hypertension. At her last visit, she was complaining of swelling in her feet and ankles, back pain, trouble sleeping, and having to get up at night to urinate. She has a family history of chronic kidney disease (CKD). She presents to the office today for the results of her estimated glomerular filtration rate (eGFR) test, a key indicator of renal function.

ROS: As above, otherwise negative.

PFSH: As above. She does not drink or smoke.

The eGFR test measures how well your kidneys are filtering the waste product creatinine produced by muscles. When the kidneys are working well, they filter out waste and excess fluid, which become part of the urine your body makes each day. When the kidneys aren't working well, they do not remove enough wastes and fluids to keep you healthy, and creatinine builds up in the blood.

If your eGFR number is low, your kidneys are not working as well as they should. As chronic kidney disease (CKD) progresses, your eGFR number will decrease. eGFR levels below 60 ml/min/1.73 m2 for three or more months are indicative of CKD.

Her test results show an eGFR of 50 ml/min/1.73 m2. We discussed the fact that the results classify her as being in stage 3a CKD. We discussed a referral to the nephrology department for recommendations and a treatment plan. She has a positive attitude about her diagnosis as she has family members with CKD who take care of themselves and function very well. She wants to see the nephrologist as soon as possible. We called the nephrologist's office of Dr. Jones today and scheduled an appointment for her before she left our office. Dr. Jones will send me her recommendations and we will move forward from there.

ASSESSMENT/PLAN: Hypertension. CKD, stage 3a. The visit today was strictly counseling and coordinating care and a total face-to-face time of 40 minutes was spent with the patient discussing her condition, prognosis, outcomes, and referral to nephrology.

Code the Diagnosis

I12.9 *Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*

N18.31 *Chronic kidney disease, stage 3a*

Rationale: According to the 2021 ICD-10-CM Official Guideline 1.C.9.a.2, "Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present." ICD-10-CM presumes a cause-and-effect relationship and classifies hypertension with CKD as hypertensive chronic kidney disease unless the provider indicates otherwise. Use the appropriate code from category N18 as a secondary code with a code from category I12 to identify the stage of CKD. When you go to the Tabular List to confirm the code, it indicates that a fifth character is needed for stage 3 CKD to specify stage 3a, 3b, or stage 3 unspecified. HBM

Stacy Chaplain, MD, CPC, is a development editor at AAPC. She has worked in medicine for more than 20 years, with an emphasis on education, writing, and editing since 2015. Chaplain received her Bachelor of Arts in biology from the University of Texas at Austin and her Medical Doctorate from the University of Texas Medical Branch in Galveston. She is a member of the Beaverton, Ore., local chapter.

Resources

2021 ICD-10-CM code book

2021 ICD-10-CM Guidelines for Coding and Reporting

By Rachel Dorrell, MA, MS

Respond This Way to a Demand Letter

Reader's question highlights the importance of knowing your options.

Question: Our practice just received a "demand letter" from our Medicare Administrative Contractor (MAC) insisting that we were overpaid. According to a thorough review of our records, we feel that the MAC is mistaken. Do we have any recourse?

- Illinois Subscriber

Answer: Yes, you do. With Medicare overpayments, you have two choices: You can send your MAC a rebuttal or you can appeal the decision, initiating the traditional Part B appeals process.

Appealing an overpayment is similar to appealing a denied claim. You'll need to collect and submit documentation to your MAC proving medical necessity. The standard five levels of Medicare appeals apply and include the following:

Level 1: Redetermination

Level 2: Reconsideration

Level 3: Administrative Law Judge (ALJ) hearing or an Attorney Adjudicator at the Office of Medicare Hearings and Appeals (OMHA) review

Level 4: Medicare Appeals Council Department Appeals Board (DAB) review

Level 5: U.S. Federal District Court review

Reminder: "When requesting a redetermination on an overpayment subject to the 'Limitation on Recoupment' provision, the provider must file the redetermination by day 30 from the demand letter date to prevent recoupment on day 41," notes an MLN Matters fact sheet. "If you file an appeal after Day 30 and by Day 120, your MAC is required to stop recoupment subject to limitation on recoupment when it receives and validates your appeal but will not refund money already recouped," the fact sheet advises.

You may want to opt for a rebuttal in certain cases, but know that a rebuttal doesn't dispute an overpayment like an appeal — and the timeline is much shorter. "A rebuttal permits the provider a vehicle to indicate why the proposed recoupment should not be taken at the designated time," explains Part B MAC Noridian in online guidance.

Sometimes Medicare overpayments can cripple providers financially; the rebuttal offers an avenue to explain these types of circumstances. Plus, the rebuttal statement impacts a MAC's decision on "whether to delay or begin recoupment," Noridian indicates.

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Critical: You only have 15 days from the date you receive the demand letter from your MAC to submit a rebuttal. Plus, your rebuttal statement needs to explain why recoupment should be stopped and offer documentation and evidence to prove your reasoning, CMS online guidance suggests.

Remember, "the rebuttal process is not an appeal and does not change anything regarding the debt owed," Noridian warns. **HBM**

Rachel Dorrell, MA, MS, writes about the Minimum Data Set, practice management, and ICD-10 coding for AAPC, focusing on the issues that keep nursing facility and medical office personnel up at night. She has a Master of Science in narrative medicine from Columbia University and a Master of Arts from York University, in the U.K. She also runs an organic farmstead in the New York Finger Lakes region, focusing on sustainably raising happy, healthy heritage-breed livestock.

This article is reprinted from the *Practice Management 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 Renee Dustman, BS, AAPC MACRA Proficient

Using Regulatory Guidance to Support Audit Findings

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Know where to find the proof you need to support your coding, billing, or auditing.

As a medical auditor, biller, or coder, you can't expect a physician to take kindly to you telling them how they need to document their patient encounters or why they can't code a higher level of service. You're going to need backup in the form of regulatory guidance.

In the HEALTHCON 2021 session "Using Regulatory Guidance to Support Audit Findings," presenter **Pam Brooks, MHA, CPC, COC, AAPC Fellow, PCS**, said, "One of the things that I have found in my work is that physicians and administrators want to know 'why do we have to do this?' Using regulations in terms of finding information is really the best way."

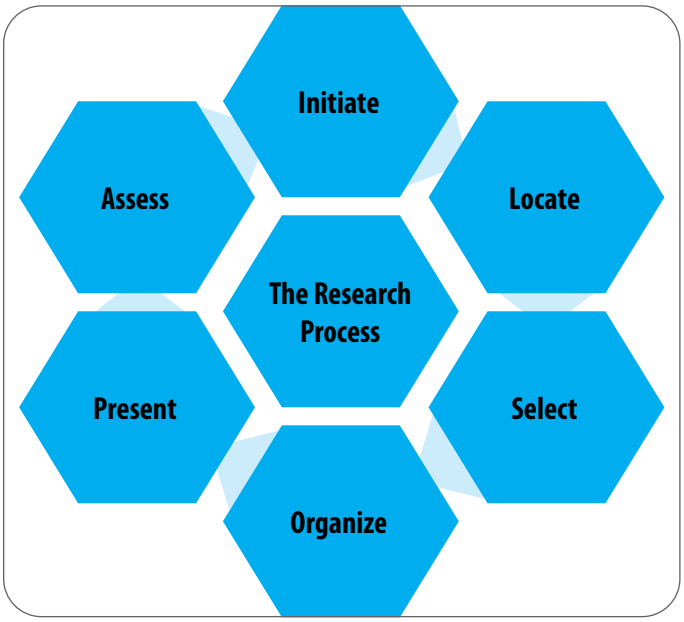
What is regulatory guidance? Brooks, a regulatory billing audit manager for MaineHealth, explains, "According to Law Insider, regulatory guidance refers to all applicable laws, rules, regulations, orders, requirements, guidance, interpretations, directives, and requests from any entity with any regulative authority." All of which you can use to support coding, billing, or audit findings.

In Brooks's session, in-person and remote attendees learned about various regulatory guidance she uses in her work and how she pulls her audit findings and resource information together using the diagram shown in **Figure A** as a guide. This article is a synopsis of that HEALTHCON 2021 session.

The Research Process

Brooks initiates an audit by determining what the scope is and where she might find that regulatory guidance; locating it; selecting the information that's most pertinent to her audit findings; organizing it in a way that makes sense to the people who she's going to report to;

Figure A Brooks' auditing research process



"Make sure those internal policies don't bump up against your audit or compliance audit findings."

and then presenting it to those individuals. She tailors her information to the situation — who she is reporting to and who she is giving those audit findings to.

"If I'm giving audit findings to the coding team," Brooks explained, "I want to have all my ducks in a row, and wear Kevlar®. But if I'm giving that executive summary or audit finding information to the executive leaders, typically they just want to know 'what do we do and how much is it going to cost us?'" In that case, Brooks said, she'll site her regulatory findings but not necessarily share them.

She then assesses what her findings say and how she can use that information to provide a corrective action plan.

Questionable Places to Look for Guidance

There are lots of places to look for answers to your coding/billing questions or to support your audit findings, but be "wicked" careful, Brooks warned. If you're going to search online, look to reputable sources.

Professional medical organizations, for example, often have a lot of great information with regards to guidance for coders and billers. Their purpose is to support physician practices, however, so be wary of advice on how to enhance payment. Make sure the organization or association cites where they got their information and that it's a reputable source.

Healthcare business forums are also great resources for information, but avoid answers that start out, "Well, in my office, we do it this way …," Brooks cautioned. Ask for their sources and check those sources. It goes without saying (but we'll say it anyway): Make sure those resources are current.

Also consider internal policies, which often exist to streamline processes or create billing edits that allow claims to be processed faster. "Make sure those internal policies don't bump up against your audit or compliance audit findings," Brooks said.

Best Places to Look for Guidance

Have you ever played the telephone game? A bunch of people stand in a circle and one person whispers a message into the ear of the person standing to their right. The next person does the same and this continues until everyone in the circle has heard the message. Usually, by the time the message makes it around the circle, it's completely different. That's what happens with regurgitated information and why it's always best to reference the originating source.

Here are some of Brooks's trusted resources:

Federal Register – The Code of Federal Regulations (CFR) is where you'll find information related to the regulation of U.S. healthcare entities. All Centers for Medicare & Medicaid Services (CMS) rules, transmittals, change requests, and other communications reference back to Title 42 CFR Public Health. (https://ecfr.federalregister.gov)

Chapter 4, Subchapter G: Standards and Certification lays out the conditions of participation (CoP) in the Medicare program.

Chapter 5 talks about the Office of Inspector General (OIG) authorities. "These are the penalties for not doing what the other chapters tell you to do," Brooks said. "And, although I generally don't go into an audit and cite the OIG, it's helpful to have that information should a provider say, 'I don't want to pay back what I owe' or 'I don't want to do this because …'."

"I find that the more egregious the finding is, the more references you might want to provide to support what your recommendations are to the organization or practice."

Watch a part of this session in the digital version of *Healthcare Business Monthly*, available online when logged in to your My AAPC account.

Sometimes information is in more than one location, such as guidance for obtaining consent for surgical services. Brooks explained this exception further in her session.

"I find that the more egregious the finding is, the more references you might want to provide to support what your recommendations are to the organization or practice," Brooks said.

45 CFR talks about administrative data standards, including the standardized use of ICD-10-CM and ICD-1-PCS, as well as CPT® and HCPCS Level II.

False Claims Act – Located at 31 U.S.C. §§ 3729-3733, which you can reference at www.justice.gov/civil/false-claims-act.

Social Security Act, Title XVIII – Health Insurance for the Aged and Disabled. In particular, Section 1848 covers payment for physicians' services and Section 1862 covers exclusions from coverage and Medicare as secondary payer.

Medicare Physician Fee Schedule (MPFS) – This fee schedule includes pricing, relative value units (RVUs), status indicators, and payment policy indicators for services. The MPFS has a lot of information with regards to how practice expense is calculated. "This is some excellent data with regard to practice expense," Brooks said. "One of my favorite files is the supply detailed files." Go to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files and click on the year you are auditing. Download the zip file and extract the files from the compressed folder. Open the PPRRVU worksheet for the appropriate quarter and year, such as PPRRVU21_APR.xls. Here, you'll find information such as a CPT® code's status, bilateral indicator, indication for assistant surgeon, and anything else you may need to know about a particular code in terms of payment under the MPFS.

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CMS manuals – (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs) "I recommend you look at the secondary payer manual, the program integrity manual, the prescription drug manual — there's a lot of information in there," Brooks said. "Based on what kind of audit you're doing, you generally can find what you need to support your findings within the manuals."

State regulations – Sometimes CMS guidance will tell you to check with your state for local policy such as for regulations relating to advance practice registered nursing scope of practice.

National and Local Coverage Determinations – NCDs and LCDs are "the rules of the game," Brooks said. NCDs are published by CMS and LCDs are published by the Medicare Administrative Contractors (MACs). LCDs are typically the same as NCDs but are regional-specific and, in terms of coverage, MACs have the ability to "kind of nudge one way or the other," Brooks said. National and Local Coverage Analyses are also viable resources that serve as "cheat sheets," Brooks said. Search NCDs and LCDs at www.cms.gov/medicare-coverage-database/new-search/search.aspx.

CPT® and the American Medical Association (AMA) – "CPT® is regulatory guidance," Brooks said; "the Code of Federal Regulations tells us it is." Also look to AMA's *CPT® Assistant* (subscription required) and *CPT® Changes* (purchase required).

"Sometimes you see something that might not be best practice and there's nothing really that is being illustrated through regulatory guidance that says 'you can or can't do something.'"

ICD-10-CM – CMS and the World Health Organization maintain the diagnosis codes set and the *ICD-10-CM Official Guidelines for Coding and Reporting*.

***AHA Coding Clinic*® –** This is the American Hospital Association's subscription publication, which provides official ICD-10-CM/PCS coding advice and official guidelines, answers questions on code assignment and sequencing of codes, serves as a reference on regulatory and other requirements for reporting diagnostic and procedural information from medical records, and more.

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National Correct Coding Initiative (NCCI) – "NCCI edits should be part of every audit," Brooks said. You can run it through your encoder, but Brooks recommends that you reference back to all the chapters (www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd).

Note: Something that is statutorily excluded won't have regulatory guidance. Best practice is to query the payer. By the way: The Medical Group Management Association determines "best practices," Brooks said.

"Sometimes you see something that might not be best practice and there's nothing really that is being illustrated through regulatory guidance that says 'you can or can't do something,'" Brooks said. If you choose to give an opinion, make sure to indicate it as such, Brooks advised. A statement such as "audit and compliance recommendations in lieu of regulatory guidance that [company] does [recommendation]."

Where You Can Learn More

Brooks provided several interesting case scenarios and tips for finding supporting regulations throughout her session. She also spent some time talking about defensive audits and how knowing where to find regulations has helped her organization to push back on these third-party audits.

Brooks will present at HEALTHCON 2022 in Washington, D.C. Don't miss it! HBM

Renee Dustman, BS, AAPC MACRA Proficient, is managing editor of Content and Editorial for AAPC and a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

By Brenda Edwards, CPC, CDEO, CPB, CPMA, CPC-I, CEMC, CRC, CPMS, CMRS, CMCS

Clean Up E/M Documentation With SOAP

The old standby still works like a charm to show medical necessity.

The American Medical Association's (AMA's) 2021 Evaluation and Management Services Guidelines (2021 E/M guidelines) are the biggest change in medical coding since the creation of the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services by the Centers for Medicare & Medicaid Services (CMS). There have been many formats for documenting the patient encounter since then. Subjective, objective, assessment, and plan (SOAP) documentation has been a standard for nearly 50 years, and for good reason: SOAP allows clinicians to clearly document patient care and treatment.


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New Isn't Always Improved

Templated information has become the standard for documenting the patient encounter in electronic health records (EHRs) as a result of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act and the push for EHR interoperability. Templated information holds both good and perhaps not so good qualities, however, such as copy/paste, carry forward, and cookie-cutter documentation.

This lackluster documentation won't hold up with the new E/M guidelines. According to the 2021 E/M guidelines, "Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. … The extent of history and physical examination is not an element in selection of the level of office or other outpatient codes."

Gone are the days of counting bullets and elements of history of present illness (HPI), review of systems (ROS), past medical, family, and social history (PFSH), and exam, at least for this category of codes. Documentation should now include what the provider feels is relevant and will help to support medical necessity of the encounter. Providers may find reverting back to SOAP to document 2021 office and other outpatient E/M services (CPT® 99202-99215) more helpful in their quest to show medical necessity for services rendered.

Case in Point

Let's compare documentation of an encounter to that of a book:

- The chief complaint is the title of today's encounter.
- The history sets the stage for the encounter.
- The exam expands upon today's story.
- The assessment summarizes what our story brought to light.
- The plan closes the story.

A deeper look at SOAP may assist providers in how to document the encounter (story).

Subjective

This element describes the patient's statements about their symptoms and current condition(s). The elements of HPI work very well for this:

Location – Where the condition is located.

Duration – How long the condition has been occurring.

Severity – The severity of the problem on a scale of 1 to 10.

Quality – Description of condition such as aching, burning, radiating pain.

Context – Circumstances when the issue was first noticed; how the problem has manifested since onset.

Modifying factors – Things that have been tried and have an impact on the condition.

Timing – The status of the problem (constant, comes and goes).

Associated signs/symptoms – Other conditions that may be occurring alongside the presenting problem.

Example:

Mrs. Smith presents today with a two-week history of left knee pain. She indicates that she has been told she has bone-on-bone osteoarthritis. She has tried cortisone injections in the past without relief. She presents to our clinic today as a new patient inquiring about other treatment options. She does share that she had been climbing stairs more frequently while she was visiting family and that her knee has become swollen and painful.

The HPI adds rich details that can help to support medical necessity. The other elements of history, such as ROS and PFSH, can be documented at the provider's discretion.

Objective

This section contains information that is measurable and quantitative. Information in this section includes:

- Vital signs
- Physical examination findings
- Laboratory data
- Imaging results
- Other diagnostic data
- Review of other pertinent documentation

Vital signs recorded for today's visit: BP 120/76, height 5'6", weight 125 pounds, pulse 72 bpm. Upon examination, Mrs. Smith's mobility is evaluated on left vs. right leg. The range of motion on the left leg is diminished in comparison to that on the right side. She does not have decreased sensation or pulses in either lower extremity. Her left knee is visibly swollen and painful. I have reviewed her previous X-rays from last year that she had sent to us and there is obvious decrease in the joint space on the left knee. We will get X-rays today to compare to those.

This objective information is specific to the presenting problem and includes only elements the provider deems necessary.

Assessment

The assessment is a compilation of information from subjective and objective that is used to arrive at a diagnosis. Elements that may be included in the assessment are:

Problem – A list of problem(s) in order of importance (diagnosis).

Differential diagnosis – The possible problems from most to least likely, including the thought process behind them. This should include other possible diagnoses.

After reviewing and comparing the X-rays of the left knee, it is apparent that the joint space is bone-on-bone. We have discussed the possible options for treatment of osteoarthritis in the left knee that include another cortisone injection, gel injection, PRP injection, and surgical intervention.

This assessment includes information on possible treatment options. It could also include any contraindications specific to this patient, as well as any discussion.

Plan

Any good book has a conclusion and that is what the plan tells in this story. The plan can include:

- Testing that will be performed along with the rationale and next steps if the testing is positive or negative.
- Therapy needed, including medications. Documentation of changes in dosage of existing medications.
- The frequency the patient is to be seen in follow-up. This sometimes is a hint at the severity of the problem; a patient not returning for a year likely has a less complex condition than one who is seen frequently. This could indicate the condition is stable.

> *"The HPI adds rich details that can help to support medical necessity. The other elements of history, such as ROS and PFSH, can be documented at the provider's discretion."*

After reviewing the different treatment options, Mrs. Smith would like to pursue the gel injection, considering the limited relief of the last couple steroid injections. I have explained that insurance may not cover this, so we would like to verify benefits before proceeding. We should be able to determine her coverage in the next week. In the meantime, we have prescribed Meloxicam 7.5 mg once a day and have counseled her not to take additional ibuprofen with it. She may take acetaminophen to supplement for the joint pain. We will contact her after we have verified coverage and set up the injection appointment.

This plan gives us a closure to the story: *A new prescription was given for the presenting problem and the patient will return soon for an injection.*

Ensure Quality Outcomes

SOAP documentation can aid in telling an accurate story of the patient's encounter. It is important to remember that medical documentation serves multiple purposes in addition to an accurate accounting of the patient's health, including legal protection and reimbursement. The SOAP format aids in organizing a patient's information into a succinct and thorough note that ultimately promotes quality of care. HBM

Brenda Edwards, CPC, CDEO, CPB, CPMA, CPC-I, CEMC, CRC, CPMS, CMRS, CMCS, is director of auditing for Crossroads Health Resources. She has over 30 years' experience in chart auditing, coding and billing, education, consulting, practice management, and compliance. Edwards shares her expertise, writing for *Healthcare Business Monthly*, as well as other national publications, such as the American Academy of Family Physicians (AAFP) and BC Advantage. Edwards helps students obtain their coding credentials through the AAPC Professional Medical Coding Curriculum, and she is an AAPC ICD-10-CM/PCS training expert. She currently serves on the board of directors for AMBA and served on the AAPC Chapter Association Board of Directors from 2010 to 2014 and held office as chair. She has been involved in the Hardship Fund for AAPC since its inception. Edwards is a mentor and co-founder of the Northeast Kansas chapter and has served in many officer roles.

Resources

Vivek Podder; Valerie Lew; Sassan Ghassemzadeh, "SOAP Notes," Last update: Sept. 3, 2020. https://www.ncbi.nlm.nih.gov/books/NBK482263

AMA, 2021 Evaluation and Management Guidelines, page 4, History and/or Examination, updated 3/9/2021. https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

By Monica Wright, MHA, CPC, CPMA, CPCO

Evaluate Your OT and PT Coding

These services may seem alike, but differences in requirements can make or break your code assignment.


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Physical therapy (PT) and occupational therapy (OT) evaluations are similar, but like the two disciplines themselves, there are some distinct differences. Both include four components that must be performed and documented to meet the requirements for a particular level of service. But where they part ways is the actual component requirements. Medical coders must understand these differences for proper coding of these services.

Physical Therapy Evaluation Guidelines

PT evaluations focus on standardized measurements, use clinical presentation as a measure of complexity, and focus on activity limitations, participation restrictions, and body functions.

History components include personal factors such as sex, age, coping style, social background, education, and profession and comorbidities such as other medical conditions that directly impact the plan of care. This can include the overall behavior pattern, character, and other factors that influence how disability is experienced by the individual.

Examination components include body structures and functions (classified by body systems) which are broken down as follows:

- Body regions: head, neck, back, upper extremity, lower extremity, trunk
- Body systems: musculoskeletal, neuromuscular, cardiovascular, pulmonary, integumentary

The American Physical Therapy Association (APTA) provides a detailed breakdown of assessments for each body system.

Examination also includes activity limitations, such as reported difficulty in performing any task, or activity and participation restrictions such as reported issues that limit interaction in work or social events. When considering the elements included in the PT evaluation, the number of body structures should be based on the degree or extent of the examination. For example, the examination may involve an entire

"CMS has indicated it will review code usage to determine payment stratification, so it is very important that the level of complexity billed matches the documentation."

limb, a joint, or a specific area of the spine. It is the therapist's responsibility to define and document the specific structure(s) examined.

As shown in **Table A,** clinical decision making includes clinical presentation or severity of the patient's condition. Low complexity includes a stable or uncomplicated clinical presentation; moderate complexity requires changing characteristics; and high complexity includes unstable or unpredictable clinical presentation. Determination of complexity is made using standardized assessment tools or measurable functional outcomes.

Although typical time is listed for the evaluation codes, unlike office and outpatient evaluation and management (E/M) services, time cannot be used as a factor in determining the level of service. A plan of care must also be completed.

Occupational Therapy Evaluation Guidelines

OT evaluations require occupational profile/history, performance deficits, and clinical decision making. Development of a plan of care is also required. To bill an evaluation code, you must meet the requirements of all four components of the code.

An occupational profile is required for every evaluation and is adapted directly from the Occupational Therapy Practice Framework. It is the starting point to determine what treatment is needed. An occupational profile should include the patient's occupational history, concerns, reasons for referral, and the patient's goals. History includes reviews of related medical conditions and previous therapy history.

The three levels of the occupational profile and history components are broken down into brief, expanded, and extensive:

- Brief looks at the presenting problem alone.
- Expanded and extensive also consider related physical, cognitive, and psychosocial performance and therapy history.
- Extensive differs from expanded in the amount of information documented and the number, length, and severity of comorbidities.

The second component, performance deficits, has caused some confusion regarding whether the assessment should be occupations or performance skills where there are challenges. The American Occupational Therapy Association (AOTA) states that performance defi-

Table A: Breakdown of CPT® codes and components that determine complexity level

Evaluation Code	History	Examination of Body Systems	Clinical Decision Making
Low Complexity 97161	History with no personal factors or comorbidities that impact the plan of care	Examination of body systems addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions	Clinical presentation with stable and/or uncomplicated characteristics and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome
Moderate Complexity 97162	History with 1-2 personal factors or comorbidities that impact the plan of care	Examination of body systems addressing 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions	Clinical presentation with changing characteristics and clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome
High Complexity 97163	History with 3 or more personal factors or comorbidities that impact the plan of care	Examination of body systems addressing 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions	Clinical presentation with unstable and/or unpredictable characteristics and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome

cits should be considered occupations. A complete list of occupations can be found in the Occupational Therapy Practice Framework.

This process does not discount performance skills deficits; rather, the skills should be outlined in terms of the occupation that is affected. Keep in mind, this process is being performed as a means of determining what occupations will be addressed in the plan of care, so everything should be reviewed using that context. A low complexity evaluation examines 1-3 deficits, moderate 3-5 deficits, and high 5 or more deficits.

Clinical decision making is generally the hardest component for practitioners to grasp because there is a subjective component to it. It requires use of clinical judgment in determining whether the complexity is low, moderate, or high. That judgment must be justified in the documentation.

As shown in **Table B**, low complexity generally is an analysis of a problem-focused assessment with limited treatment options and no comorbidities. Moderate complexity includes analysis of a detailed assessment with several treatment options and possibly comorbidities.

Table B: Breakdown of CPT® codes and components that determine complexity level

Evaluation Code	Occupational Profile/Medical and Therapy History	Patient Assessment	Clinical Decision Making
Low Complexity 97165	Brief history relating to presenting problem	1-3 performance deficits relating to physical, cognitive, psychosocial limitations/restrictions	Low complexity, limited amount of treatment options, no assessment modification, no comorbidities
Moderate Complexity 97166	Expanded review of therapy/medical records Additional review of physical, cognitive, psychosocial performance	3-5 performance deficits relating to physical, cognitive, psychosocial limitations/restrictions	Moderate analytical complexity, detailed assessments, minimal to moderate modification of assessments, may have comorbidities
High Complexity 97167	Extensive review of physical, cognitive, psychosocial performance	5 or more performance deficits relating to physical, cognitive, and psychosocial limitations/restrictions	High analytic complexity, comprehensive assessments, multiple treatment options, significant modifications of assessment

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"It is the therapist's responsibility to define and document the specific structure(s) examined."

Some modification of tasks may be required to complete the evaluation. High complexity includes analysis of a comprehensive assessment with multiple treatment options and comorbidities affecting performance. Significant modification of tasks is required to complete the evaluation. Modification refers to any assistance the occupational therapist must provide to the patient to complete the evaluation. This can include verbal cues or physical assistance.

Don't Forget the Plan of Care

Every PT and OT evaluation requires a plan of care. Without a plan of care, an evaluation cannot be billed. Evaluations are face-to-face services. Even if it takes multiple days to complete, an evaluation can only be billed once. Bill the evaluation on the date it is completed.

PT and OT evaluations are untimed codes. Even though the descriptions include typical time, unlike office and outpatient E/M billing, there is not a circumstance where time can be used to determine level of service. Interventions can be billed on the same day of the evaluation provided the plan of care is completed prior to the intervention. The intervention must be based on the plan of care. It cannot be billed if it is used to complete the evaluation.

Medicare continues to reimburse all three levels of evaluation codes at the same rate. The Centers for Medicare & Medicaid Services (CMS) has indicated it will review code usage to determine payment stratification, so it is very important that the level of complexity billed matches the documentation.

The requirements for a reevaluation include an assessment of changes in patient functional or medical status; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. The requirements go on to specify that a formal reevaluation is only performed when there is a documented change in functional status or a significant change to the plan of care is required. Without meeting these requirements, a progress note may still be required, but a reevaluation cannot be billed.

For additional questions, please reach out to AOTA at regulatory@aota.org or APTA at advocacy@apta.org. HBM

Monica Wright, MHA, CPC, CPMA, CPCO, has over 20 years' experience in medical coding, billing, and practice management. She serves as manager, Coding and Payment Policy, for the American Occupational Therapy Association (AOTA). Wright is a member of the Annapolis, Md., local chapter.

By Lee Fifield, BS

The Evolution of Fraud Liability

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Nothing stays the same, including the way the feds interpret the law.

The False Claims Act (FCA) has become the government's fraud enforcement vehicle of choice, and the changes to the FCA under the Fraud Enforcement Recovery Act of 2009 (FERA) and the Affordable Care Act (ACA) have enhanced the Department of Justice's (DOJ's) enforcement authority, according to AAPC National Advisory Board President and Legal Advisory Board member **Michael D. Miscoe, JD, CPC, CPCO, CPMA, CASCC, CCPC, CUC, CEMA, AAPC Fellow**.

In February, AAPC teamed up with the American Health Law Association (AHLA) to deliver a two-day virtual conference focused solely on healthcare compliance. The conference covered a range of topics from coding to law. In the session "FCA, FERA, ACA: Understanding the Evolution of Fraud Liability," Miscoe explained what the current fraud standard is, how voluntary disclosure is not so voluntary anymore, how to identify and handle overpayments, and the knowledge and mechanisms organizations should have in place to mitigate fraudulent intent.

Fraud Is Big Business

In 2019, 146 non-qui tam cases (cases brought directly by the DOJ) and 636 qui tam cases (cases where an individual who meets certain requirements can file a false claims act case in the name of the government) were filed. The DOJ has recovered more than $64 billion since the launch of FERA in 1997 and more than $2.2 billion from FCA cases in fiscal year 2020 alone.

"FCA prosecutions are probably the only money-making gig the government has," Miscoe said. While the stats vary, cases return four to seven dollars for every dollar spent on fraud enforcement.

Potential penalties of $5,000-$22,000 can incentivize physician offices and hospitals to settle their cases quickly. "When you're looking at $22,000 per claim form in penalties plus treble damages, it doesn't take an enormous amount of conduct; a hundred-thousand-dollar case could end up with millions in damages and penalties," said Miscoe. That kind of threat provides an extremely strong incentive for people on the adverse side of a false claims act case to settle.

FERA Changes

In 2009, FERA authorized substantial new funding to the DOJ for investigating and prosecuting fraud offenses, including significant changes to existing federal fraud laws. FERA resulted in the following changes:

- Clarified the applicability of the FCA to claims that are either directly or indirectly paid with government money
- Codified the materiality requirement
- Expanded the definition of "claim"
- Expanded conspiracy liability
- Added procedural amendments that strengthen DOJ authority
- Expanded FCA liability for retention of overpayments
- Modified the retaliation provision applicable to qui tam relators

"Mistakes and negligence are not fraud. The lowest required intent standard to justify a false claim is reckless disregard."

The objective standard of materiality was recognized by the majority of the U.S. Court of Appeals. A misrepresentation is material where it is "capable of influencing" or "has the natural tendency to influence the government's payment decision." Liability exists even where the government was not actually influenced and didn't even pay the claim.

Before FERA, conspiracy liability was limited to only one liability prong of the FCA — an agreement or common purpose associated with getting the claim paid. Post-FERA, you can have conspiracy liability with any prong of the FCA. Any agreement or common purpose to violate any of the FCA liability provisions is enough to meet conspiracy liability.

FERA extended liability for retaliation against employees only to include retaliation against contractors and agents, as well.

Intent Is Everything

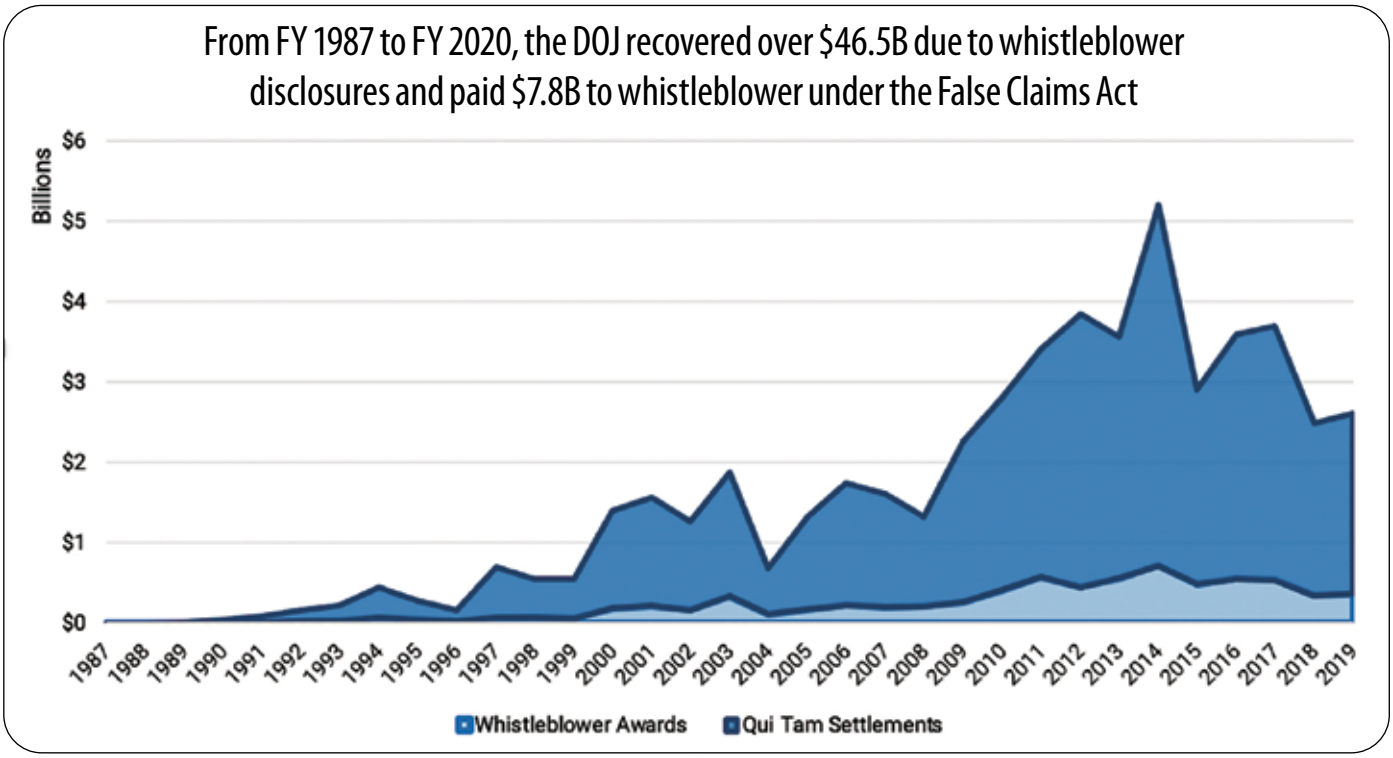
To violate the FCA you have to have a legally false claim, as well as knowledge of the falsity. Actual damage need not be shown except for purposes of calculating damages. There is an intent requirement under the FCA.

The three levels of intent are:

- Mistake
- Negligence
- Reckless disregard

Mistakes and negligence are not fraud. The lowest required intent standard to justify a false claim is reckless disregard, which, according to Miscoe, "is something more than a mistake, more than negligence, but something less than actual knowledge." Getting a rule wrong can happen, especially when a rule is complex or ambiguous. There can also be good faith disagreements on issues such as commonly occur when evaluating the level of service (evaluation and management).

In *Wang v. FMC Corp* (9th Cir. 1992), it was decided that recklessness is required to violate the FCA. Because of this, fraud does not exist in very many cases, let alone in every case simply because there is an error leading to an overpayment. On the other side of the



Source: www.whistleblowers.org

"If any person in the organization knows of anything that might have caused an overpayment, an investigation must be conducted."

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coin, as established in *U.S. v. Mackby*, it is a provider's duty to be familiar with payment rules; however, "If there is a bona fide objective error that led to an overpayment," said Miscoe, "the provider has a duty to refund that money, and, if they don't, what may not have been fraudulent to begin with could become fraudulent" due to the failure to return the government's money.

The FCA does not punish honest mistakes or incorrect claims submitted through negligence. This includes entities that have a compliance plan in place. *U.S. ex rel Heffner v. Hackensack University Medical Center* (3rd Cir. 2007) ruled that no reckless disregard of the billing rules existed where the billing department had a compliance plan in effect, but the plan did not catch the error. Stated another way, a compliance plan does not have to absolutely ensure that no mistakes are made. Just because a mistake occurred despite formal compliance efforts, that does not mean the provider recklessly disregarded the billing rules and is subject to FCA liability. Mere failure of a billing system or a compliance plan to catch an error does not establish reckless disregard. It is important to note, however, that where the overpayment was caused by a failure to follow the requirements of the compliance plan, a court's conclusion might differ greatly.

Be Cautious With Compliance Plans

If you have a compliance plan, implement and follow it in good faith, Miscoe advises. Constantly re-evaluate your efforts and revise them to address changing requirements. If you don't have a formal compliance plan, a compliance program should be implemented where you document what you're doing relative to internal auditing and training. Hiring consultants to assist with compliance is another positive step you can take to show you are trying to follow the rules.

"Audit programs, efforts to get clarification on rules, setting up internal policies as to how you're going to deal with the ambiguities — these are all positive things that you can do to demonstrate what I like to call good citizenship and mitigate or minimize any potential False Claims Act liability," said Miscoe. "Such conduct is likely to convince the government that any conduct resulting in an error and overpayment is the product of nothing more than a mistake or negligence, thereby rendering it unactionable under the FCA."

The Evolution of Voluntary Disclosure

Another way of mitigating intent is to voluntarily disclose errors resulting in inappropriate payments after identifying a problem. Voluntary disclosure used to be truly voluntary but is now required by law. To avoid FCA liability, however, the disclosure cannot be in response to an investigation.

Based on changes under FERA and the ACA, "I call it the mandatory voluntary disclosure rule," joked Miscoe. The revised rules have put a lot of burden on the provider. If any person in the organization knows of anything that might have caused an overpayment, an investigation must be conducted. For that reason, practices must encourage people who have compliance concerns to bring them forward. Once it's known by any person, the clock starts ticking, which can lead to unfortunate consequences if the situation is ignored. Because of this requirement, practices should avoid dismissing concerns, even if the concerns are not founded in the end.

"Make sure you have a mechanism in place to identify overpayments so you can return them promptly. Be aware of state FCA requirements, as well."

ACA Time Requirement for Voluntary Disclosures

The ACA significantly increased resources that the government has and was willing to dedicate to identify fraud, waste, and abuse, which makes it more likely that errant conduct will be identified. It also added to the fraud enforcement recovery act provisions relative to voluntary disclosures by creating a 60-day refund clock for overpayments. With FERA, you had an obligation, but there was no time requirement to it. Unrefunded overpayments are considered false claims by lack of action, and violation of the Anti-kickback Statute was made an explicit basis for FCA liability. A violation of the Statute is automatically an FCA violation.

Reverse False Claims

The reverse false claim provision essentially addresses passive conduct. "With the reverse false claims, the way it works is, if you know or should know that you have money that doesn't belong to you, and you avoid giving it back to the government, that's what triggers the liability," said Miscoe. An FCA violation traditionally required an affirmative act; either an express or implied false certification. You had to do something to violate the FCA. Under the Reverse False Claims Act, purely passive conduct — knowing that you have money that doesn't belong to you, or you should have known and you didn't do anything about it — is also now grounds to trigger liability.

"Knowing" (or knowingly) is defined by the FCA as:

- Having actual knowledge of the information,
- acting in deliberate ignorance of the truth or falsity of the information, and
- acting in reckless disregard of the truth or falsity of the information.

Deliberate ignorance is purposely trying to avoid learning about false claims, Miscoe explained. To meet reckless disregard, it's about perception based on the facts of the case. The conduct of the provider will be the deciding factor between negligence and reckless disregard.

"Obligation," previously undefined, was defined under FERA as "[A]n established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the **retention of any overpayment**."

Some offices take an equity approach when looking at payments. If they receive a double payment for one service but don't get paid for another service, oftentimes offices call that a wash. Such an approach will trigger liability under the FCA. Under the voluntary disclosure and refund rule, you must return the overpayment of the double paid claim and appeal the lack of payment for the unpaid claim.

Make sure you have a mechanism in place to identify overpayments so you can return them promptly. Be aware of state FCA requirements, as well. A number of states have enacted a model of the FCA with false claims provisions of their own. They model them so they can get a share in any Medicaid recoveries.

What to Do When You Identify an Overpayment

When you have identified actual overpayments, you must identify:

- What caused the overpayment
- How it was discovered
- The means used to identify the entirety of the overpayment

"Under the requirement that a claim be 'legally false' and submitted with requisite intent to establish an FCA violation, physicians need to ensure that the clinical information and other documentation support the diagnosis and medical treatment decisions made, and also be consistent with the standards of medical care."

You must explain all of this information to the Medicare Administrative Contractor (MAC) in your disclosure. Remember that once an actual overpayment is identified, the ACA amendments to the FCA and implementing regulations requires disclosure and repayment within 60 days. The lookback period for disclosure of overpayments is six years. While circumstances associated with the error may not require you to go back that far, when they do, you must disclose and refund any errors causing an overpayment over the prior six-year period.

Medical Necessity and Recent Case Law

Miscoe referenced case law throughout and ended his presentation by citing recent cases concerning medical necessity fraud.

U.S. v. AseraCare (11th Cir. 2019)

This case established that objective falsity must be proven in order to violate the FCA. Where there is only a reasonable disagreement or difference of opinion between medical experts as to the medical necessity of services ordered or rendered, with no other evidence to prove falsity of the assessment, objective falsity is not proven. A reasonable difference of opinion among physicians reviewing medical documentation after the fact is not sufficient on its own to suggest that those judgments — or any claims based on them — are false under the FCA. A properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong. Although the U.S. Court of Appeals sent the case back for additional consideration by the trial court, the foregoing analysis and holding provides hope for a reasonable approach to allegations of medical necessity fraud asserted by the federal government and the whistleblowers.

Subjective assessment about medical judgments by two different auditors is not objective falsity. This theory can extend easily into the coding realm where you have code selection and reimbursement rules that are open to differing interpretations.

U.S. ex rel. Druding v. Care Alternatives (3rd Cir. 2020)

In a ruling contrary to AseraCare, the district court held that physicians are required to make certain that their clinical judgment can be supported by clinical information and other documentation that provides the basis for any treatment certification and recommendations (hospice care, in this case) even though making a medical prognosis is not an exact science. The district court held that a "mere difference of opinion" is insufficient to show the FCA falsity is at odds with the meaning of "false" under the FCA. On appeal, the circuit court reversed the holding that objective falsity improperly

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conflates the elements of falsity and intent. On Feb. 22, 2021, the U.S. Supreme Court denied a petition to review the court's decision.

How This Affects Providers

Under the requirement that a claim be "legally false" and submitted with requisite intent to establish an FCA violation, physicians need to ensure that their clinical information and other documentation not only support their diagnosis and medical treatment decisions but are also consistent with the standards of medical care. FCA liability is not premised on factual falsity alone, but a certification is false simply if the service or procedure was knowingly not reasonable and necessary under the clinical circumstances and standards of care. The bright-line rule that a physician's clinical judgment cannot ever be false was rejected. An understanding of the varying facts in AseraCare and Druding will help you understand the apparent divergence in these opinions.

The bottom line is that medical opinions are not insulated from fraud scrutiny; however, well-justified medical opinions and decisions likely are. Medical judgment can be the basis for fraud liability when the basis for that judgment is either not honestly held or significantly diverges from the standard of care. A good faith medical opinion is not punishable under the FCA, but it is clear that a physician who saw one thing on a test and consciously wrote down another, then used that misinformation to perform and bill unnecessary services and procedures, will likely face FCA liability. "I think we'd all agree that purposely misreading a diagnostic study to justify performance and coverage of a procedure is not a legitimately held medical opinion," said Miscoe.

Whether a physician was acting in good faith or committing fraud is a question for the jury. Physicians must be vigilant to understand coverage rules and document findings honestly. The objective is to treat the patient appropriately and honestly report the services performed and the reasons for them so that an accurate coverage determination can be made; even if that determination is that the service is not covered. Documenting falsely for purposes of obtaining coverage where it is not appropriate will always be problematic. **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 more than 15 years.

Resources

https://media.ca11.uscourts.gov/opinions/pub/files/201613004.pdf

http://www2.ca3.uscourts.gov/opinarch/183298p.pdf

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By Judy A. Wilson, CPC, COC, CPCO, CPPM, CDEO, CPB, CANPC, CPC-P, AAPC Approved Instructor

Teach Professionalism in Your CPPM® Curriculum

Conduct yourself with integrity and kindness to inspire greatness in those around you.


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AAPC is committed to providing quality curriculum that enables Certified Physician Practice Managers (CPPM®s) to lead others. Some requirements of a good practice manager are harder to teach than others, however. Professionalism, for example, requires several innate qualities such as personal and work ethics, passion, and a positive attitude.

As an AAPC instructor, you should first and foremost be professional, and then, over time, you will become a good leader. Let's explore some teaching and learning concepts and techniques that, when applied by personal example, will increase your teaching abilities and benefit students and new coders/billers alike.

Lead by Example

To impart what we know (our knowledge of coding and billing) more effectively, we must first demonstrate that we care. This can be done by connecting with other employees, students, or instructors.

Realize you cannot always do things your way; you must follow policies and guidelines, even if you do not think they are right. You can always get involved to help change what you believe is wrong, but you cannot do that if you do not respect those who set these policies and understand why they set them.

Part of being a good leader is hearing what others have to say. I cannot stress enough how important it is to listen and not just talk. When others are speaking, listen and maintain eye contact. You can find out so much when you just listen; you would be amazed at the difference it can make.

A Positive Attitude Goes a Long Way

Having a positive attitude is also essential for a practice manager. Always show appreciation for your employer and employees and be enthused about your job. Performing random acts of kindness will only make your day better. It is much easier to be kind and professional. Help others to feel that way too.

Be Passionate and Never Stop Learning

Think of all the role models you have been around. I would bet that they all have several things in common, including a passion for what they do and a craving to learn and do more.

Having a skilled professional workforce starts with understanding and remembering key coding and billing concepts, producing quality work, and striving to strengthen professionalism. I invite you to strengthen your professionalism by reinforcing personal and work ethics and a positive attitude.

Only after you integrate all these components of professionalism into your role as a CPPM® instructor, will your goal of mentoring a skilled professional workforce be realized. HBM

Judy A. Wilson, CPC, COC, CPCO, CPPM, CDEO, CPB, CANPC, CPC-P, AAPC Approved Instructor, is AAPC's CPPM® Advisory Board chair and has been doing medical coding/billing for well over 38 years. Wilson was the business administrator for Anesthesia Specialists, a group of eleven cardiac anesthesiologists who practice at Sentara Heart Hospital for over 26 years. Wilson is now self-employed doing education training and teaches online courses for AAPC. She has had the honor of serving on the Board of Directors of the AAPC-Chapter Association from 2010-2014 and served again from 2015-2017. She was the Chair of the Hardship Fund and had the honor of announcing it at the AAPC National Conference in Las Vegas in 2012. Wilson is the chair of the AAPC CPPM Advisory Committee and has had the pleasure of presenting at several AAPC regional and national conferences, the Decision Health Symposium, and at the AMBA conference. She has presented at AAPC chapter meetings all across the United States and has written multiple articles including ones for HCPRO/Just Coding, AAPC's *Healthcare Business Monthly*, and given several webinars.

By Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, CEMA, AAPC Fellow

How Do You Define Professionalism?

Take actions to add value to your AAPC credentials.

It is my belief that the value of our credentials is directly related to how we are perceived by the entities that seek to employ coding, billing, compliance, auditing, and practice management employees. Our voluntary adoption and adherence to professional standards are what sets us apart from non-credentialed individuals who have developed a similar degree of technical competence on their own.

The term "professionalism" relates to how we, as AAPC members, are perceived. There are many drivers of such a perception. These include technical competence, our individual and collective level of conformance to our Code of Ethics, and the image we portray based on how we dress and engage in written and verbal communication.

Knowledge and Expertise

The most important driver as to whether we are perceived as professionals is our collective level of technical competence. While AAPC offers members a wide variety of low- or no-cost educational offerings that will help each of you to advance your level of technical skill, each of us has to put in the work and continually expand our level of knowledge and expertise. We demonstrate our technical competence through the quality of our work product.

Code of Ethics

Adherence to the AAPC Code of Ethics also sets us apart. Conforming conduct to the mandates of the Code of Ethics (Integrity, Respect, Commitment, Competence, Fairness, and Responsibility) makes us very different from our non-member/non-certified peers. Living up to the Code of Ethics assures confidence that members will conduct themselves professionally while delivering a high-quality work product.

"Regardless of our individual or collective level of technical competence, getting the chance to demonstrate our level of technical expertise often turns on whether we are perceived as professionals."

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Image and Representation

Regardless of our individual or collective level of technical competence, getting the chance to demonstrate our level of technical expertise often turns on whether we are perceived as professionals. There is an old adage that in business, dress for the job you want, not the job you have. The image you portray often has more to do with whether you are taken seriously than the expertise you possess.

We must also consider the image we portray both as individuals and as an organization based on how we communicate. Effective writing permits you to convey concerns as well as ideas and solutions that can result in change. A poorly articulated argument has little chance of being understood or adopted. Unhinged attacks only

demonstrate that you have already lost the argument. Be cognizant of how you communicate on social media, as well. Rants on social media reflect poorly on the individual as well as the organization. I would encourage all that when posting to an AAPC related social media site about a concern or problem, take a breath before writing. It is okay to address problems as long as you do so constructively and propose a solution.

Showing Our Value

AAPC has done an excellent job of promoting the value of our credentials. We can support that value proposition by elevating our level of technical competence while at the same time conducting ourselves professionally at all times in person and on social media. The more professionally we are perceived as an organization, the more value our credentials will have. **HBM**

Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, CEMA, AAPC Fellow, has over 25 years of experience in healthcare coding and over 20 years as a compliance expert, forensic coding expert, and consultant. He has provided expert analysis and testimony on a wide range of coding and compliance issues in civil and criminal cases and his law practice concentrates exclusively on representation of healthcare providers in post-payment audits as well as with responding to HIPAA OCR issues. He has an extensive national speaking background and has been published in numerous national publications on a variety of coding, compliance, and health law topics. Miscoe is the 2019-2021 National Advisory Board president.

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By Lee Fifield, BS

Advice From a CCVTC™

AAPC member **Lena Holbrook, CPC, CDEO, CPMA, CCVTC, CEMC**, has worked in healthcare for 15 years and currently works for a revenue cycle management company. AAPC asked Holbrook about her experience with earning the Certified Cardiovascular and Thoracic Surgery Coder (CCVTC™) credential and how it has helped her career.

What led you to obtain the CCVTC™ credential?
I was working as a coder in a cardiovascular and thoracic clinic and loved the work, so I decided to sit for the CCVTC™ exam.

Do you have any tips for individuals preparing for the CCVTC™ exam?
The AAPC practice exams are very helpful. Make sure to refresh your knowledge in anatomy and terminology as well.

How has the CCVTC™ credential helped you in your job/career?
The CCVTC™ certification has opened many doors during my career. I have worked in several different roles including practice manager, supervisor for physician coding, manager of physician coding, and director of physician coding.

Who in the revenue integrity business do you think would most benefit from the CCVTC™ credential?
A revenue integrity analyst, specialist, and/or auditor.

What resources do you use most to earn your continuing education units (CEUs)?
I use AAPC webinars, quizzes, and ZHealth Publishing webinars for my CEUs. **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 more than 15 years.

"The CCVTC™ certification has opened many doors during my career."

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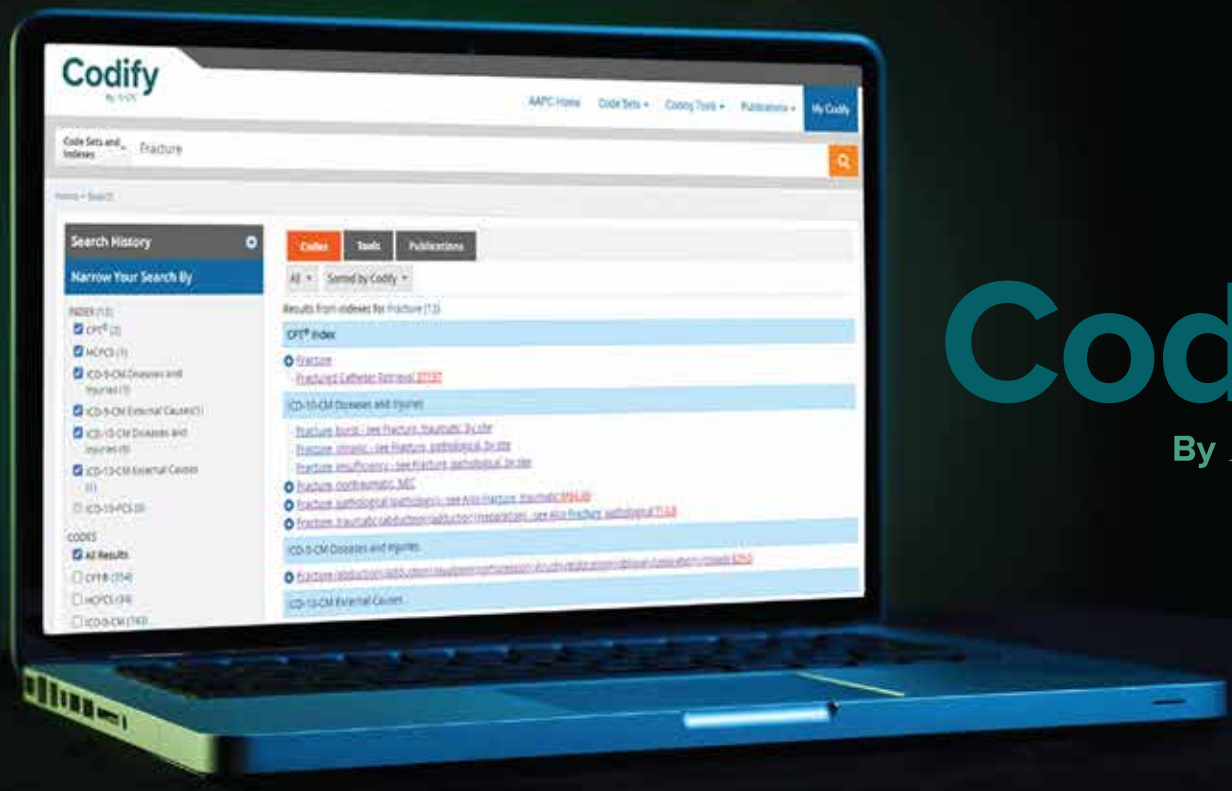

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