SCAFP Summer Break Away and Annual Assembly

Documenting for Dollars in 2026

Strategies to Prevent Revenue Loss Through
Mastery of the Office Evaluation and Management (E&M) Guidelines

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Objectives

- Know payor tactics used to downcode office encounters
- Realize areas of current OIG E&M audit focuses
- Devise a strategy to combat payer tactics using medical necessity capture while avoiding copy/paste practices
- Understand the make-up of the office E&M encounter and how to use it to get paid

What is "downcoding"

- **Downcoding** occurs when a payer reimburses at a lower E&M level than what was submitted (e.g., paying a 99215 as a 99214). This is a billing and reimbursement issue rather than a clinical one and in early days was aimed at "outliers". Now it may be "trend lines of your peers".
  - Claims data analysis (no actual looking at the encounter needed…) an "algorithmic" audit
  - Actual coding audits still occur based on documentation
- Following the **2021 E/M documentation guideline changes** (which eliminated history and exam requirements in favor of medical decision-making or time-based coding), some payers have been scrutinized for not fully aligning with the AMA/CPT framework. "Denying as a dare" (NU).
- Some providers have been chastised for getting lazier in documenting MDM

What is "downcoding"

- Specific payer down-coding practices vary by region, plan type (commercial, Medicare Advantage, Medicaid managed care), and are subject to frequent policy changes. Covertly done. Many (most…?) involved (Aetna, Cigna, Humana, UHC, others…)
  - "coders on our team"…. 99214→99213 and 99215→99214 due to "lack of medical necessity" …
- Why…? The "level of visit is not supported by the documentation" and the "medical necessity isn't justified".
- Why…? They've found a loophole in contract language that allows them to "validate claims for payment" … and it is early and pushback against this is just starting. ***But, wait…., this is not new…..***

This is not new….aka “*ask Nick Ulmer ~2008*”

- Comprehensive Error Rate Testing (CERT) Report arrived in Laurens
  - I was found to be an outlier with respect to hospital level 3 initial visits (admits)
  - I called our MAC (Palmetto GBA) who denied involvement ….
  - What will happen to me?
  - “If you’re on the curve, then you’d be part of the problem, correct…?”
  - I disagreed, so I met with my Billing Office and had them review my charts
  - *She disagreed with me* and agreed with the CERT Report ….. 🤔
  - I audited my own charts … and came to the *same conclusion* … “thin notes” 😡
  - I corrected my deficiencies and aligned the note (Hx/Ex) w/ my MDM
    - in 2021… *CMS agreed with me* and ***changed the coding rules*** 😇

https://www.medcentral.com/coding-reimbursement/most-billed-e-m-code-was-also-most-error-prone-in-2024

The Feds As Well …

- Office of Inspector General (OIG Work Plan) and Comprehensive Error Report Testing (CERT) – "old news" – 2002 implementation
  - For the 2024-2025 Data Cycle from physician ambulatory claims:
    - 7.66% error rate ($31.7 billion) – FY2024
    - 6.55% error rate ($28.8 billion) – FY2025 (lowest since 2021)
  - Where are the errors?
    - Physician office services are primary driver of improper payments
      - High-level E&M – but 99214 is most billed and most error-prone
      - Split clams (MWV + E&M or E&M + procedures, both using -25 modifier)
  - What is driving the errors?
    - Lacking documentation (51.5%), ***no*** documentation (11.7%) or lacking medical necessity (17.8%)

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OIG Focused Audits

- Medicare Advantage (MA) audit of Independent Health Association (IHA) in 2024, most high-risk diagnosis codes failed validation. Only 17 of 247 sampled enrollee-years were confirmed as supported by medical records, with an estimated $7 million in excess payments (leveling errors).
- Likewise, the data associated with the E&M review yielded numerous examples of "overdocumentation" of diagnoses with the medical conditions. Were noted widely, but some conditions included
  - Acute strokes, MIs, and PE in the office setting
  - Active Breast, Colorectal, and Prostate cancers without treatments
  - Critical care notes did not look "critical" to support the critical care billing
  - Malnutrition in A/P but no supporting documentation to meet malnutrition diagnosis
  - "Active management" was not clear as "listing of conditions" predominated
- Often difficult to see that ***medical necessity*** of care was being delivered

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Independent Health Association, Inc. (Contract H3362) Submitted to CMS. June 2024

What is “medical necessity”

- Medical necessity is a fundamental concept in healthcare that ensures patients receive appropriate and effective care based on established clinical guidelines.
- Not something we were specifically taught as it comes about intuitively with application of medical knowledge. It is not “medical decision making” as much as it is appropriate medical need at a time course in the evidence-base treatment pathway of a condition (this is fluid…).
  - A 50-year-old who strained their lower back after a weekend of springtime garden prep without any neurologic or other concerning symptoms, should be given a trial of nonsteroidals, topical ice/heat, and modifications of exercise first before ordering plain films or the MRI of the lower lumbar spine (and a head, neck, thoracic, and lumbar MRI is not “medically necessary”).
- The National Academy of Sciences[1] and other organizations[2] work to develop trustworthy clinical practice guideline standards.
  - Ensures patients get appropriate and effective care that is grounded in best practice evidence

[1]https://www.nationalacademies.org/projects/HCSX-H-08-09-A
[2]https://www.mcg.com/about/data-ethics/

What is “medical necessity”

- This is coming of age now with AI tools to search notes for tangible information. OIG audits (and payors) have found
  - Vague references to “monitoring” and lack of detail to what makes a patient ”unstable” or generic statements about “treatment goals” with difficulty in auditors seeing if goals attained (or what they were)
  - “In my professional medical opinion” … is empty if you cannot explain the “why” in your note (or peer-to-peer phone call).
  - “Copy/paste” is often interpreted as “no new thought work”….and leads to denials
  - Rampant in the hospital space for years (inpatient vs observation) and now the clinical accountability is coming to the outpatient world

This is not going away … technology

- Artificial Intelligence: "revolutionizing" the physician audit space
  - Much more efficient, standardized (human "error" element minimized)
  - …and expansive….100% record review almost instantaneously vs. a subset
  - (Good) Helps meet minimum standards of documentation, can enhance quality capture and reporting, can provide a "gentle nudge" on condition assignment, and recognizes patterns of concern (copy/paste) to alert to avoid such
  - (Not-so-good) If it doesn't "see" linkages in verbiage to support MDM or it sees "note-bloat" where there is confusing/contradictory documentation → if so, then deny. Copy/paste is a sign of "no new thought content" and an avenue to deny/downcode.
- AI learns as it goes ..Words/phrases, linkages, etc.
- But, it is not 100% correct and still needs human intervention

So....what do we do?

Could do nothing and ride this out … "see what happens"

- Stagnation will set into play a definite pay cut … don't know how much
- Stagnation will increase your administrative burden (operating margin shrinks further) as requests will increase in number and scope
- Unsure … but stagnation may trigger a more aggressive response
  - "If we don't fight, they win because it costs nothing to deny…"
- Our job (should we choose to accept it…)

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- Understand the make-up of the office E&M encounter and how to use it to get paid (..and eliminate costly busy-work)

Strategy for Success Based on Audit Findings

- Support appeals/denials by having documentation to support medical necessity to overturn denials and downcoding – esp the 99214 – with "MEAT" in your note. Align MDM with appropriate level of service
- Correctly use the -25 modifier, especially in the context of the Medicare Wellness Visits (all 3) and chronic disease management
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E&M Make-up

- Major overhaul in 2021 (office) and 2023 (facility) to relieve documentation burden
- CMS gave clarification with E&M Services Guide (08.2023), went into effect 01.2024 (referenced again in 09.2024)
  - A chief complaint is still important. This has been removed from the CPT (Commercial) guidelines. A brief "follow-up for HTN" is enough (prefer no "here for recheck")
  - The history and exam is still important – CMS still feels a "medically appropriate history and exam" should be present – provider can decide how much. Care team can help collect, but provider still needs to validate.
  - With time-based, time needs to be documented specifically, but CMS can still look at the documentation to see if it meets "medical necessity". So, even with time, we need to have a good story
- CPT (Commercial) and CMS (Medicare/MA) don't always agree…so check with your Commercial Carriers …. Note updates …

CMS 09.2024; MLN006764

What we know from audit findings…

- CMS is not the only one actively auditing medical records (office-based E&M, AWV, etc.)
- Post pandemic and preliminary findings show some records having difficulty in showing the documentation to show the medical necessity
- Take Home:
  - “Think in Ink” → brief organized thoughts are enough (and needed)
  - Avoid copy/paste as using such does not show “new thought work” and will usually not support medical necessity
- MDM is the driver of charges (address pertinent parts of Hx and Ex)

1. *Lacking documentation*
2. *Medical Necessity not aligned to visit charge*

CMS 09.2024; MLN006764

The E&M Make-up: Time or MDM Documentation

- Designed to simplify code selection and decrease documentation burden. Bill based on **total time** OR **Medical Decision Making** (**MDM**)
- **Total time** is for the calendar day and is focused on the time the billing provider delivers care
  - Review chart, talk to family, discuss with consultants, review labs, time with patient, time in chart completion, etc.

Evaluation and Management Office Coding (MDM Based on 2 of 3 Components)

E/M LEVEL, MDM, {time} (99201 deleted, 99211 N/A	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or doc. reviewed counts)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99202 {15} 99212 {10} Straightfwd MDM	MINIMAL • One self-limited or minor prob.	Minimal but usually none	Minimal risk of morbidity from additional diagnostic testing/treatment.
99203 {30} 99213 {20} Low MDM	LOW • 2 or more self-limited or minor prob. *OR* • 1 chronic stable illness *OR* • 1 acute, uncomplicated illness/injury *OR* • 1 stable, acute illness	**(Must Meet 1 of 2 Categories)** Category 1: Tests and documents (any 2) 1. Review of prior external note(s) from EACH unique source 2. Review results of EACH unique test 3. Order of EACH unique test *OR* Category 2: Assessment requiring an independent historian	Low risk for undergoing additional testing/treatment Consider: OTC drugs, non-contrast imaging, PT/OT, skin bx, minor surgery
99204 {45} 99214 {30} Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury	**(Must Meet 1 of 3 Categories: Moderate)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. *OR* Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) *OR* Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed)	Moderate risk of morbidity from additional tests/treatment Consider: • Rx mgmt., • Decision regarding minor surgery w/ patient or procedure risk factors • Decision regarding elective major surgery w/o risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 {60} 99215 {40} High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily function	**(Must Meet 2 of 3 Categories: High)**	High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care (admit/escalate), Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog, IV controlled substance use

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- CMS states that a simple notation of total time is needed, but medical decision-making needs to match the time…so a note like this may not survive the audit

Here for depression check. Moods stable. Resting well. Managing stress at home. I spent 39 min caring for this patient.

May have some trouble with the 99214 … "thin"

A/P (1) Depression, controlled. Stay on meds.

39 min → 99214

The E&M Make-up: MDM

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A/P (1) Depression, controlled. Stay on meds.

39 min → 99214

Consider ….

Here for reck on Depression. PHQ2/9 was 10 now down to 3 since adding Buproprion to the Sertraline 4wks ago. Still with some sleep issues, but better. Energy and appetite is good. No further weight loss. Wants to start getting more active at church and get out since it's getting warmer. Fully supportive. Stay on meds and reck in 4 weeks or sooner as needed.
39 min → 99214.

The E&M Make-up: Time or MDM Documentation

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The E&M Make-up: MDM

- *Here for BP check. Getting an ingrown nail. I spent 39 min caring for this patient.*

  A/P
  (1) Ingrown toenail: Soaks, Cephalexin, call for concerns
  (2) HTN – stable. Stay on meds.

  39 min = 99214

Denied due to insufficient documentation to support MDM. Approve 99213. …..consider

Time-based vs. MDM billing…consider this

- Painful L great toe for 5d. No injury, except hiking last weekend with g-kids. Redness 2d ago, some puffiness on medial nail edge yesterday. Getting worse. BP 132/77 today which matches home. Needs to stay on Lisinopril, needs refill. Toe is swollen and distal ½ is red and medial edge is starting to get puffy/ingrown. No drainage. Tender to touch. Start Cephalexin, soaks, and if not improving in 4d, call back.
- *A/P (1) Ingrown toenail: Soaks, Cephalexin, call for concerns (2) HTN – stable. Stay on med*
  - 12 minutes → 99213 for time-based or 99214 for re: MDM for a chronic condition and an acute illness

What in the note helped? Need to see **m**edical **e**valuation and **a**ctive **t**reatment ("MEAT"). Focused pertinent exam. A/P to show active treatment.

There was an assessment of context of condition (no injury), duration of condition (5d), causation (hiking), and severity (redness → swelling progression w/o drainage.). The second condition (HTN) was assessed w a BP ("stable") and noted use of a prescription medication.

What to say every time to show "MEAT"….?
How long have you had the condition? How bad is it? What are you doing about it? Anything else?

Time-based vs. MDM billing…consider this

- Painful L great toe for 5d. No injury, except hiking last weekend with g-kids. Redness 2d ago, some puffiness on medial nail edge yesterday. Getting worse. BP 132/77 today which matches home. Needs to stay on Lisinopril, needs refill. Toe is swollen and distal ½ is red and medial edge is starting to get puffy/ingrown. No drainage. Tender to touch. Start Cephalexin, soaks, and if not improving in 4d, call back.
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What in the note helped? Need to see **m**edical **e**valuation and **a**ctive **t**reatment ("MEAT"). Focused pertinent exam. A/P to show active treatment. MDM still only shows "self-limited" and not moderate MDM

There was an assessment of context of condition (no injury), duration of condition (5d), causation (hiking), and severity (redness → swelling progression w/o drainage.). The second condition (HTN) was assessed w a BP ("stable") and noted use of a prescription medication.

What to say every time to show "MEAT"….?
How long have you had the condition? How bad is it? What are you doing about it? Anything else?

E&M Application: Two Chronic Problems

- 68 yo F for reck hypertension and for Depression. PHQ is 3, last month it was 10. Started Fluoxetine. Thinks it may be a little better from a mood standpoint. No homicidal/suicidal ideation. Compliant on meds. BP ck at home is in line with this today. No edema. Counseling is doing OK, but just started w one session last week.
- No distress. HR77, Resp 11. 131/76. Numbers at home mirror this.
- HTN: BP at goal. Stay on Lisinopril. Labs q6mo (next visit: CMET, CBC, UA)
- Mild Depression. Improved. Cautiously optimistic. Reck in 4wk. Get feedback from counselor prior to next ov.

Respiratory Illness with fever and wheezing

- 51-year-old with a history of reactive airways. Develops a frontal headache, body aches and has a productive cough. No n/v/rash. Nonsmoker. No one else at home is ill.
- 108/66, T101.5 oral, resp rate 12, no distress. Scant wheeze. No access. Muscle use. MMM. Supple. Small cervical adenopathy. Alert, but appears to feel bad.
- Lab: COVID (neg), **Flu A (POS),** CBC wnl. CXR read by me showed NAD.
- Influenza. Start Oseltamivir, Rx for albuterol MDI, anti-tussive OTC. Dring plenty of fluids and if things are not improving in 48 hours at least call.

What is the E&M level for this visit?

Strategy for Success Based on Audit Findings

- Support appeals/denials by having documentation to support medical necessity to overturn denials and downcoding – esp the 99214 – with "MEAT" in your note. Align MDM with appropriate level of service
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G2211

G2211: Visit Complexity Code

- As of 01/2024 and set for providers who primarily use E&M (vs surgical)
  - 99211-99215, 99202-99205
- CMS feels there is a "cognitive load" at baseline as part of this "focal point" role which merits this add-on code for the person with the longitudinal clinical "relationship"
- Includes both the "new" and "established" encounters ("provider-patient relationship") CAN have G2211 applied …. Need to document and note follow-up plan
- Effective 01.2025, CMS will allow G2211 to be billed with -25 in the context of a Medicare Part B Preventive Service (usually done in conjunction with the E&M). Transmittal 13015.

G2211 in the Home/Residence Setting

- Beginning Jan 1, 2026 CMS expanded G2211 to include home/residence E/M codes (99341-99350)
- Released in the Medicare Physician Fee Schedule Final Rule CY 2026
  - "This ensures we achieve our E/M visit complexity add-on policy, which aims to pay for previously unaccounted resources inherent in the complexity of all longitudinal primary care visits."
  - "We believe that building trust in the longitudinal practitioner-patent relationship may be particularly significant in the context of home and residence E/M visits."

MM14315 - Medicare Physician Fee Schedule Final Rule Summary: CY 2026

Is a -25 modifier needed ….? Is G2211 OK in **2026**…?

- Electrocardiogram: No -25, so OK to use E&M and G2211
- Ultrasound: Joint (shoulder, knee, hip): No -25, needed, so OK with E&M & G2211 (if US only)
- Radiography: No -25 needed, so add on to ov and G2211 is OK
- Ambulatory Continuous Glucose Monitoring (95249) – ok for G2211(stand-alone, no -25)
- Audiometry (92557): no -25, G2211 is OK to add G2211 to visit
- Advance Care Planning (99497, 99498): no -25 since preventive, G2211 is OK
- 99406 and 99407 (Tobacco Cessation Counseling): no -25 w/ E&M, G2211 OK as preventive
- Annual Alcohol misuse screening (G0442) … YES , is prevention
- Annual Depression screening (G0444) … YES , is prevention
- High-intensity behavioral counseling to prevent sexually transmitted infection (G0445) … YES , is prevention
- Annual, face-to-face intensive behavioral therapy for cardiovascular disease (G0446) … YES , is prevention
- Face-to-face behavioral counseling for obesity (G0447)… YES , is prevention
- Injection code for preventive immunizations *allows G2211**

-25 Needed, so *no G2211 allowed* in these cases

- Joint injection (for steroid) needs 96372, and add-on procedures (office procedure – shave, etc.) both need -25 so no G2211 allowed
- Med admin. (96372): Yes, -25 needed if E&M added, so G2211 **NOT** allowed
- Spirometry, inhalation treatment, or other pulmonary function services (94010-94799) needs a -25, so no G2211 allowed
- Osteopathic manipulative therapy (98925-98929) needs -25, thus no G2211
- 99495/99496 (Transitional Care Mgmt) visits – G2211 is NOT allowed unless a preventive service is also delivered.

-25 is needed when....

- A Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- Use when service is
  - Above and beyond another service that is provided on the same date/provider
- Two common scenarios for -25 use
  - Preventive Service (wellness visit) and then a problem is addressed
  - Problem-focused visit is performed and a need for a procedure comes up

*www.cms.gov/files/document/2025nccimedicarepolicymanualcompletepdf.pdf

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IPPE/Initial or Subsequent AWV and E&M together

- Performing any of the three Medicare Wellness Visits requires the focus to be on wellness and prevention and the documentation needs to follow.
  - Updating the medical record, and performing several health maintenance screenings (depression, falls risk, dementia screens, etc.) is the focus
- AWV is not for chronic disease management and if such comes up ("Can you fill my simvastatin…?") the patient should be informed that this condition's management should be addressed in a chronic disease follow-up setting. Physicians feel this type of "sorry, cannot help you" is inefficient and not conducive to good patient care, so most combine the wellness visits with chronic condition management.

Wellness and Chronic Disease

- The two visits (best practice) should be documented SEPARATELY with the chronic condition having a disease specific history, a focused exam, and well fleshed out A/P.
- The pertinent wellness requirements (depression/dementia screens, falls risk, etc.) should be clearly seen in the note.
- This is a perfect example of *significant, separately identifiable Evaluation and Management Services* and as such, a -25 should be used. It should be placed on the E&M (not the preventive service) code indicating to the the payor "pay me for both"
- The chronic condition billing should be driven by the medical decision making of the chronic condition (without discount)

Depression Screening: Medicare Covered Service

- Of those > 65 years of age, 1 in 6 suffers from depression, and those with co-morbid conditions increase the # closer to 25% in that group
- 75% of older adults who committed suicide saw their PCP in the prior month – 39% saw the PCP the prior week – of their suicide
- **G0444**: Annual Depression Screening, 15 minutes (50% threshold). Telehealth with PHE.
- No mandated screening tool.
- Screening with PHQ-2/-9 would not break 7½ min threshold (so maybe only consider if screen abnormal and treatment discussion ensues)
  - Document time carefully

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- Correctly use the -25 modifier, especially in the context of the Medicare Wellness Visits (all 3) and chronic disease management
- Compliantly document the interaction of physicians and APPs in team-based care

Physician Services: "Incident to" Care

"Incident to" care

- Services furnished as an integral, though incidental, part of the personal professional service by the physician in a non-facility setting. Done under direct (on site) supervision
- Bill for services provided by NPP as though the physician performed service
  - Private payers may have differing rules
- Part of normal course of treatment when the physician/practitioner has personally performed an initial service and remains actively involved in course of treatment – f/u care
  - New problems, New patient workflow decision needed (or no 100%)
- The provider who is directly supervising the service is who bills for the incident to care visit
- Medicare reimburses the provider 100% MPFS for "incident to" care, 85% for NPP-delivered care (non incident to). FQHC/RHCs get a flat facility rate for care delivery

What is supervising?

- Direct Supervision
  - Physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed.
    - “Yell” (per NU)
    - Not in the same room
  - Physician must have subsequent services of a frequency that reflects his or her continuing active participation in and management of the course of treatment (treatment that he/she initiated).
    - No set mandate. “every other”…..AWV/CPX…..but some participation is needed ongoing
  - Documentation to support

Documentation and Incident To

- The progress note must substantiate the service performed and be signed by the person performing it.
- When the physician is involved with a particular service, his or her contribution to the care must be documented. This will assist in substantiating his or her continued involvement in the patient's care.
- The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainly of the situation.
- All documentation should support the level of care provided.
  - If site of service is office setting (POS 11), then E/M guidelines are to be followed

Documentation To Set Up "Incident to" Process

- The Plan of Care
  - Need to clearly define the disease(s) that are being managed with a patient. Having a plan of care on ALL of the conditions will allow the NPP use this as a "roadmap" or treatment care plan. Do so at EACH encounter to show the medical necessity for your involvement in the patient's care
  - Not "incident to" new probs or diagnostic tests performed separate from physician involvement (FTF)
- Consider:
  - Listing the diagnoses and assess stability. Set a goal, Give direction.
    - HTN: Start Lisinopril 10mg qhs. Dietary measures and focus on lifestyle modifications and weight mgmt. Goal to get BMI below 30 in 3 months. F/U with NPP in 3 wks. Check Chem7 then. Titrate up Lisinopril with HCTZ next visit if needed. Goal < 140/90. See me 2 weeks thereafter.

The "Incident To" Clinical Scenario

- The Plan of Care is pre-set, so condition(s) have been seen by the physician already. Care in outpatient private office (POS 11).
- So:
  - New patient visits can NEVER be incident to (all new problems)
  - Cannot be furnished in a hospital setting (ED, hospital inpatient or outpatient departments, nursing facility, home visit)
  - Cannot be used in established patients on new problems and physician not intimately involved with plan of care (no signature, FTF). Protocol?
  - With these situations, use NPP NPI to bill (and get the 85% rate)

Document the Clinical Scenario

- Identify that the service is medically necessary, that the physician is supervising, available, and any clinical interaction that is provided
- Record needs to support interaction
- Best Practice (per me) for "Incident to":
  - NPP documents that "Dr. Ulmer on-site and available today".
  - Physician provides co-signature of all "Incident to" encounters
    - "I have reviewed and agree with management plan"
- If this is my NPP and I am off, my partner (if on record as a supervising physician) can serve as being available – Incident To is OK to bill (100%)
- Can other staff use "incident to"?

Document the Clinical Scenario – Non-provider Staff

- Staff under your direct supervision can perform services on your behalf and bill for medically appropriate services under your name/number, but only 99211 is allowed
  - PharmD, MSW, LPN, etc.
- Non-providers cannot bill Medicare, so the only option would be to bill "99211"

EXAMPLE:

66-year-old with HTN comes in for reck. BP at home 144/99 (confirmed x 2 at pharmacy) and in office today is 155/92. Increase ACEI. F/U 2 wks with nurse, bring in BPs from home. Check BMET that day. F/U PCP 4wks.

F/U 2 wks later for **nurse/lab visit**: BP 139/88 and #s at home much better. BMET drawn. F/U Ulmer in 2wks. No change med. No FTF visit on follow-up, but patient is scheduled to see PCP in 2wks..

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***99211** would be the charge for that encounter, plus charge for lab appointment.*

Split/Shared Services

- A split/shared E/M visit is defined by Medicare Part B payment policy *as a medically necessary encounter with a patient where the physician and a qualified NPP of the same group each personally perform portions of an E&M visit on the same patient and on the same date of service.*
- The billing goes to who documents/performs the Medical Decision Making or >50% of the total time of the encounter
- A split/shared service: NOT allowed in office (POS - 11), but is
  - Hospital Inpatient (POS 21), Hospital Outpatient (POS 19, 22), ED (POS 23)
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf
  - When critical care services can be shared and in nursing homes (as of 01/2022)
- Add – **FS Modifier** to claim with Split/Shared billing performed

Split/Shared Services

- When billing split/shared using MDM, it is based on the three components of MDM
  - **Diagnoses** Assessed
  - **Data** considered
  - **Risk** of the evaluation/management decisions in the encounter
- The billing provider is the one who performs the *substantive portion* of the visit – based on MDM, that could mean that the physician is virtual/remote but able to review labs, notes, images, communicate with family/clinical team, etc. – and have the service billed under their number and not the NPP at the bedside. Much variability here.

Evaluation and Management Office Coding (MDM Based on 2 of 3 Components)

E/M LEVEL, MDM, {time} (99201 deleted, 99211 N/A	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or doc. reviewed counts)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99202 {15} 99212 {10} Straightfwd MDM	MINIMAL • One self-limited or minor prob.	Minimal but usually none	Minimal risk of morbidity from additional diagnostic testing/treatment.
99203 {30} 99213 {20} Low MDM	LOW • 2 or more self-limited or minor prob. *OR* • 1 chronic stable illness *OR* • 1 acute, uncomplicated illness/injury *OR* • 1 stable, acute illness	**(Must Meet 1 of 2 Categories)** Category 1: Tests and documents (any 2) 1. Review of prior external note(s) from EACH unique source 2. Review results of EACH unique test 3. Order of EACH unique test *OR* Category 2: Assessment requiring an independent historian	Low risk for undergoing additional testing/treatment Consider: OTC drugs, non-contrast imaging, PT/OT, skin bx, minor surgery
99204 {45} 99214 {30} Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury	**(Must Meet 1 of 3 Categories: Moderate)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. *OR* Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) *OR* Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed) **(Must Meet 2 of 3 Categories: High)**	Moderate risk of morbidity from additional tests/treatment Consider: • Rx mgmt., • Discussion regarding minor surgery w/ patient or procedure risk factors • Discussion regarding elective major surgery w/o risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 {60} 99215 {40} High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily function		High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care (admit/escalate), Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog, IV controlled substance use

Thanks for allowing me to present!

- Any questions …..

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