Documentation and Coding of Physi
Service Visits in Palliative Care
Changes for 2023

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Session 2
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Disclaimer

- The final 2021 and 2023 Medicare physician fee schedule rules were published on 12/1/20 and 11/1/22, respectively. We have made every reasonable attempt to represent the new policies for E/M Visits in this presentation.
- Definitions and examples of E/M CPT codes do not include the entirety of the codes' definitions or guidelines. Code selection should be made based on the complete E/M definitions and guidelines, and the supporting clinical documentation.

Agenda

- How we got here
- Revised and deleted E/M codes
- Choosing the level of service based on time
- Choosing the level of service based on MDM

Patient Care Revenue

Palliative Care Physician Services

Amount varies based on coding and volume

Physician Clinical/Professional Services

Hospice Per Diem

Fixed Daily Amount per Patient

Clinical Services
Medical Director Administrative
Pharmacy
DME
Support and Overhead Costs

Historical Palliative Care Billing Codes

- Initial Hospital 99221-99223
- Subsequent Hospital 99231-99233
- Initial Nursing Facility Assessment 99304-99306
- Subsequent Nursing Facility Care 99307-99310
- New Patient Rest Home (Domiciliary/Rest Home/ALF) 99234-99328
- Established Patient Rest Home 99334-99337
- New Patient Home 99341-99345
- Established Patient Home 99347-99350
- New Patient Office 99202-99205
- Established Patient Office 99212-99215
- Prolonged Services
  - 99354-99355 Outpatient Prolonged Services
  - 99356-99357 Inpatient Prolonged Services

Revised in 2021

- New Patient Office 99202-99205
- Prolonged Services
- Established Patient Office 99212-99215

Revised in 2023

Revised

- Initial & Subsequent Hospital
- Initial Nursing Subsequent Facility

Combined

- New/Established Patient Rest Home (Domiciliary/Rest Home/ALF)
- New/Established Patient Home Prolonged Services

How we got here

“Patients Over Paperwork”

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients’ ability to make decisions about their own care.
- Physicians were telling CMS they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- The Administration “listened and is taking action.”
- The changes addressed those problems by proposing to “streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.”

Why Change?

- Stakeholders have said the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. *
- Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record. *
- An incremental approach
  - Starting with outpatient visit codes in 2021
    - Approximately 20% of allowed charges for PFS services are for the E/M visit codes 99201-99215.
  - Moving on to all other E/M visit codes in 2023
    - Approximately 40% of allowed charges for PFS services are for all E/M codes

**CMS Listening Sessions, March 18, 2018 and August 22, 2019*

Evaluation and Management

- CMS, in general, accepted and incorporated the AMA changes and recommendations for E/M visits in 2021 and 2023:
  - E/M documentation will be focused on MDM* or time.
    - Only “clinically appropriate” history and/or exam will be expected
    - Adopted the AMA’s new time ranges and thresholds
    - Effective January 1, 2023 for all E/M codes
  - New “Level of MDM” table to guide appropriate visit code selection
  - New activities that are countable when using time to guide appropriate visit code selecrtion.

* Medical Decision Making

Final 2021 MPFS rule (CMS 1734-F)

- "The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent, reasonable and necessary, and clinically appropriate."

To be clear, from a coding perspective as of 1/1/23, there are no longer any requirements for how many ROS to document, body areas in the exam to document, nor having to document family history for new and initial visits.

Biggest E/M CPT® Changes in Over 20 Years

- Level of service is chosen based on time or medical decision making
  - How time is computed changes dramatically from today
  - Determining medical decision making is more definitive
  - Medically appropriate history and/or physical exam
    - No more counting bullets!
    - Chief Complaint continues to be required

What has and hasn't changed

- All medical necessity requirements remain in place whether choosing the Level of Service based on time or medical decision making.
  - The documented Chief Complaint/Reason for Today's Visit and the narrative History of Present Illness (HPI) will set the stage for determining the complexity of MDM.
- All requirements for modifiers remain in place.
  - Example: Modifier 25 when reporting an E/M visit and ACP at the same encounter
- Previously nebulous terms such as "stable chronic illness," or when a "problem" could be counted in determining MDM are now defined.

Revised and Deleted E/M codes

E/M Code and Guideline Changes

- E/M introductory guidelines change dramatically
  - Imperative to have the 2023 CPT® code book
- Hospital Inpatient/Observation Care Services
  - Combined into one code set
    - 99221-99223, 99231-99239
  - Hospital Observation Care codes deleted
    - 99217-99220
- Consultation codes and guidelines revised
  - 99242-99245, 99252-99255

E/M Code and Guideline Changes

- Revision to Nursing Facility codes and guidelines
  - 99304-99310
  - Annual assessment (CPT® 99318) deleted
- Home or Residence Services
  - Now includes private home, ALF, etc.
  - 99341, 99342, 99344, 99345 and 99347-99350
  - Guidelines revised
  - Domiciliary, Rest Home, ALF (routine care at a hospice house) codes deleted
    - 99324-99328, 99334-99337 all deleted

Let’s look at coding based only on Time…

Time: Countable Activities

Physician/other qualified health care professional time includes the following activities, **when performed on the date of the OV:** [emphasis added]

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
  - But only on the date of the visit
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Qualifying Time

- The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional.
- If the physician's or other qualified health care professional's* time is spent in the supervision of other clinical staff who perform the face-to-face services of the encounter, only reportable in the office/clinic
  - 99211

**Qualified Health Care Professional: a clinical provider who is allowed to report an E/M code; typically includes MD, DO, DPM, ARNP, PA, CNS, CRNA, CNM*

Documenting Time Spent

- It is reasonable to require documentation of the actual activities and the total amount of time spent.
- We do not recommend use of an all-encompassing macro that memorializes activities that may be counted towards time whether all of them were actually performed.
- Consider which of the following examples might be more easily accepted by Medicare or any other third party payer.

Documenting Time Spent

Was it the patient? Family? Who the heck is "other?"

"Total of [24] minutes spent preparing for the obtaining the patient's history; performing an exam; providing education to the patient/family/other; ordering prescriptions, tests or procedures; and documenting in the EMR."

Vs.

"Total visit time [24] minutes. Reviewed prior visit and patient intake form. Obtain history and perform exam. Discuss with patient and order diagnostic tests. Complete note in the EMR."

AAFP FAQs on Time

How should total time be documented?

The physician or QHP's documentation needs to justify the time spent for the visit. Use your documentation to justify t he medical necessity for the level of service that is being billed. Do not document a time range (even though the CPT® code description identifies a time range for each E/M code). Document the actual time spent precise

NOTE: Medicare requires that the time threshold be met or exceeded.

Palliative Care inpatient consultation of 58 minutes could be coded 99253

99253 - 45 min.

99254 – 60 min.

AAFP FAQs on Time

If I am leveling the visit based on total time, do I still need to document an assessment and plan (A/P)?

Yes, an A/P should always be documented for each visit. The A/P may provide additional information that will allow your visit to be leveled if the time statement does not have enough information. if the A/P is not documented and the total time is ambiguous or missing, the visit may be unbillable. If you document both MDM and total time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.

AAFP FAQs on Time

If I am leveling the visit based on total time and have also provided additional time-based services (e.g., advance care planning, tobacco cessation counseling, etc.) how do I document time for those services?

Make sure to document time separately for each of those services in order to bill for them separately. The time for each service must be carved out of the total time. Example (for billing 99213-25 and 99406): A total of 25 minutes was spent on this visit, with 20 minutes spent reviewing previous notes, counseling the patient on DM and HTN, ordering tests, refilling meds, and documenting the findings in the note. An additional 5 minutes was spent on tobacco cessation counseling, discussing the importance of quitting, options for medications and a quit plan.

E/M Coding Guidelines for Medical Decision Making

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Using the 3 Elements

- Three elements of Medical Decision Making (MDM)
  - 2:3 Elements of MDM must be met or exceeded to qualify for a given level of service.
- Concrete definitions and their impact on code selection
- Understanding new terms in determining complexity, e.g.
  - Problems Addressed
  - Each unique test
  - Stable chronic illness

Some MDM Definitions

- ***Problem:*** A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
- ***Problem addressed:*** A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Some MDM Definitions

- ***Stable, chronic illness:*** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia. [emphasis added]

Element #1. Number and Complexity of Problems Addressed

- Multiple new or established conditions may be addressed at the same time and may affect medical decision making.
- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
- Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Element #2. Amount and/or Complexity of Data to be Reviewed and Analyzed

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- ***External:*** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
- ***External physician or other qualified healthcare professional:*** An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty.

Element #3: Risk of Complications and/or Morbidity and Mortality of Patient Management

- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as ‘high’, ‘medium’, ‘low’, or ‘minimal’ risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities).
- For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Element #3. Risk of Complications and/or Morbidity and Mortality of Patient Management

- ***Independent historian(s):*** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met. [emphasis added]

Medical Decision Making

- Four types of medical decision making are recognized:
  1. straightforward,
  2. low,
  3. moderate, and
  4. high.

Remember 2:3 Elements must be met or exceded.
Since hospice & palliative care rarely order tests (Element #2)
Let's look at the other 2 Elements.

Element #1:
Number/Complexity of Problems Addressed

- **Low Complexity**
  - 2+ self-limited or minor problems
  - 1 stable chronic illness
  - 1 stable acute illness

- **Moderate Complexity**
  - 1+ Chronic illness w/ exacerbation, progression, or side effects of treatment
  - 2+ Stable chronic illnesses
  - 1 Undiagnosed new problem w/ uncertain prognosis
  - 1 Acute illness w/ systemic symptoms
  - 1 Acute complicated injury

- **High Complexity**
  - 1+ Chronic illnesses w/ severe exacerbation, progression, or side effects of treatment
  - 1 Acute or chronic illness or injury that poses a threat to life or bodily function

Element #3: *Risk of Patient Management*

- **Low Complexity**
  - Low risk of morbidity from additional diagnostic testing or treatment.

No examples regarding OTCs.
Prior, OTCs were low risk/99213

- **Moderate Complexity**
  - Prescription drug management
  - Decision-minor surgery w/identified pt or procedure risk factors
  - Decision-elective major surgery w/o identified risk factors
  - Dx or treatment impacted by SDoH

- **Level 5**
  - Drug therapy requiring intensive monitoring for toxicity
  - Decision-elective major surgery w/patient or procedure risk factors
  - Decision-emergency major surgery
  - Decision regarding hospitalization or escalation of hospital level of care
  - DNR or de-escalate care due to poor prognosis

Telephone Visits

Telephone Visits – During the PHE

- 99441 – 5-10 min
- 99442 – 11-20 min
- 99443 – 21-30 min

- Cannot bill these within 7 days of a past in-person visit or if an in-person visit takes place in the next 24 hours…

Wrap Up and Final Thoughts

Practical Documentation Considerations

- Point & Click HPI versus a descriptive narrative
- Capture the doctor's thought process
  - "Think in ink"
  - Hospice patient at the end of life and decision is made to begin withdrawing treatments
- How to define 'at goal' for chronic conditions

Practical Considerations

- How to eliminate deleted E/M codes from being a choice
  - While preserving the codes historically
- For Part B billing, Home is POS 12 and ALF is POS 13
  - Combo code set now (Home or Residence)
  - How to capture the place of service for billing.
- Education and Training throughout your organization.

Billable Services & Combining Codes


Questions?

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