

OSMA Coding and Documentation Q&A

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Agenda and Introduction

- A review of the key changes for 2024
- A detailed review of the new G0136 Assessment for SDoH
- A detailed review of the new G2211 Complexity Coding
- A discussion of take backs and down coding
- Q&A

- The OSMA is committed to ongoing support and education of physicians and staff. This program today is presented to support this mission. If there are questions after the program please contact the presenter at dezucker@sbcglobal.net or OSMA at info@osma.org.

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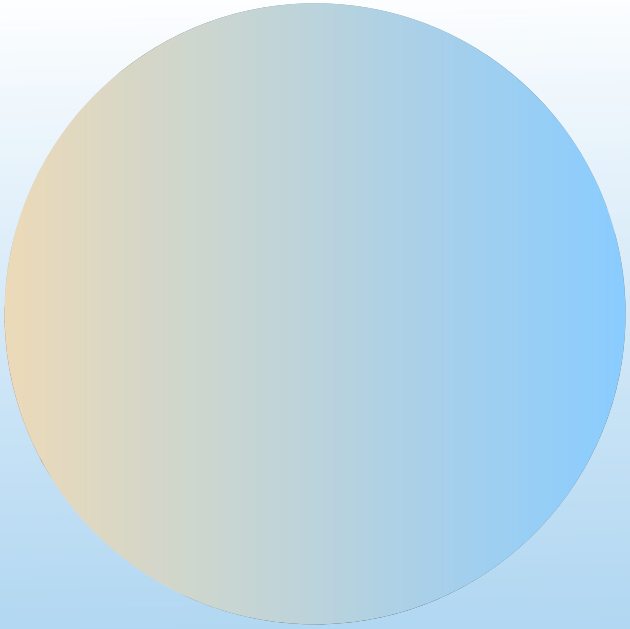
A review of telehealth

- Telehealth will continue beyond the PHE and the use by your practice is based on patient need and your ability to provide quality care.
- Moving forward – only secure technology should be used.
- If coding E/M one must have audio and video
- The documentation for telehealth requires:
  - Method of Telehealth (Doxy)
  - Informed consent with identified risk/benefit
  - Visit information at the level to code correctly



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More on telehealth

- In cases where there is a mental health or SUD diagnoses one should also identify where the patient is in case emergency intervention is needed
- If there are other individuals involved with the visit - family, friends, support people VNA, etc. they should be identified in the note
- If the visit is a timed visit then the specific time involved in care reflected in the note (for E/M this would include time before, during and after the contact
- Remember all care requires a specific diagnoses and reason for care
- Make sure you are using HIPAA-compliant video communication products (by Aug. 10 as required by CMS
- CMS Medicare Learning Network Fact Sheet on Telehealth Services

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A few other things to remember…

- Shared visits between an APN/PA and a physician must have better documentation in 2024 and this concept only applies to a hospital or nursing home (not office).
- Medical decision making should be the driver for a level of care unless time of the encounter for the date of care is clearly documented and there is a summary of the care provided.
- Letting the insurance program know you are coding a service on time is as easy as putting a comment in the comment section "Total time today in clinical activities of…."

G0136 – Social Determinants of Health Assessment

How will this process work?

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Who and how…

- The new services identified in this program require a physician, APN or PA have an initial assessment where the care, services and needs are identified for some of these services.
- The assessment of SDoH can be performed at a visit, AWE by support staff.
- The new services can be performed by support staff but will be required to meet education, training and proficiency as identified by CMS.
- Specific services may be provided by both primary care and specialty practices as long as the service meets the coding and care definition and is documented as part of the assessment and plan.
- Many of these new services will require written treatment plan.

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The services

- All of the services are coded and billed under the ordering or planning provider of care (MD, DO, APN, PA).
- Some services can be provided without the patient present
- Some services are supportive in nature – over the phone, chat, internet, etc.
- Some services are not part of telehealth (so review the list carefully).
- All services require informed consent.
- The documentation to support the care billed may be time based, acuity based and/or support based so creation of templates to meet these needs within your EMR is essential,

What the G0136 says….

- Administration of a standardized, evidence –based social determinants of health risk assessment too, 5 to 15 minutes.
- The assessment is performed to identify social determinants of health (SDOH) that limit the ability to diagnose or treat problems. The SDOH may include issues from income, education, language, access to health and other psychosocial factors.
- This assessment can be provided at the same time as an E/M visit or an annual wellness visit. It can be provided every six months and can be provided via telehealth. The service can be provided by support staff under the incident to guidelines.

What would the documentation look like?

- Identification of the specific assessment tool(s) used.
- In cases where there are no findings the ICD 10 coding would be based on the condition the patient presented with for the visit.
- In cases where there was a positive SDoH then the specific ICD 10 coding would be appended to the visit as additional ICD 10 codes.
- The person providing the assessment should identify the approximate time of the assessment and under whose direction it was performed (to meet the incident to rules).

Within the providers note…

- Within the providers documentation they should reference within the Assessment and Plan portion of the note:
  - The SDOH performed - which then “drops” the G0136 code for billing
    - If no issues are identified, identified no issues identified in this assessment
    - If issues are identified they provider would list the issues and the action taken (referred to social services, community outreach or provided a list of resources.

Samples documentation..

- M presented today for follow up of HTN and diabetes, and per Dr. Jones the SDoH assessment was performed using the AAPP assessment tool and the Health Leads tool. The assessment with M tool approximately 9 minutes with the information provided to Dr. Jones, no positive issues were identified.

- Q presented today for follow up of COPD and hospital care, and per APN Wilson the SDoH assessment was performed using the Kaiser and CMS tools were used to assessment the patient for approximately 10 minutes with the information provided to the provider. Issues identified were transportation concerns, living alone and financial issues.

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The claim form for both examples:

- M would have the following coded:
  - 9921x I10, E11.9
  - G0136 I10, E11.9 (no modifier should be needed)

- Q would have the following coded:
  - 9921x J44.9
  - G0136 Z59.82(transportation), Z60.2 (lives alone) and Z59.87 (financial

Diagnoses Coding for Social Determinants of Health

- These diagnoses support a positive assessment and higher levels of E/M services based on care provided.
- As you think about all of the changes in health care today - tracking, quality improvement initiatives, early intervention and even coding moderate complexity care (in all locations) SDOH are critical… to be documented and the appropriate Z code

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The Z Code that is appended for SDoH -

These codes that are common for the psycho social determinants of health are in the following families of ICD 10 codes…

- Z59 series with home setting
- Z60 series with social environment
- Z61 series with upbringing issues
- Z63 problems with support group and family circumstances
- Z65 problems related to legal and related issues
- Z91 compliance issues

G2211 – Visit Complexity

G2211 is an add on code to identify visit complexity

- Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
- One cannot add this code when providing a procedure (example knee injection or biopsy) when using modifier -25.
- It can be used by all specialties that provide longitudinal services – not acute care or one time services
- The nature of this service is continuity, consistency over time, longitudinal care.
- Expected use initially 38% of the patients, over time up to 54%

More on G2211

- E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. In response to comments, we also made further refinements to the HCPCS code descriptor to clarify that the code applies to a serious condition rather than any single condition.
- No specific documentation requirements identified but this would be supported within the assessment and plan process that reflects continuity, complexity and care needs in both the narrative and diagnoses (ICD 10 coding).

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Documentation may say something like this in the assessment

- A/P for problem 1) new diagnoses of ABC requires additional support, referrals and follow up making this a complex visit with follow up XYZ
- A/P HTN is in poor control, additional work up, will call with home BP's and see the nurse in 2 weeks after med change, close follow up needed, complex in nature.
- Assessment for chronic issue of COPD, multiple medications, concerns about compliance, SDoH assessed positive for support needs, close follow up and complex due to long term risks, O2 use and compliance.

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How this might be documented…

- Within the assessment and plan will reflect…
  - The chronic or acute problem and how this complexity is impacting the management and care of the patient
  - Requires that care is ongoing (not episodic) with this in mind there should be a follow up care plan
  - Any secondary issues that are impacting this process should be identified and ICD 10 coded specific to the encounter and care – not just from the EMR problem list
  - If others are involved in this complex process making sure they are referenced as part of the assessment and plan (home health, VNA, other providers, community agencies, etc.)

Complexity coding

- Is an add on code and could not be coded alone or with transitional care coding.
- This add-on code represents the additional time and resources associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a serious or complex condition for a new or established patient. The relationship between the provider and the patient must be ongoing to provide consistency and continuity for the patient's acute or chronic health conditions over a long period of time. Medical condition managed by the single provider may span a broad spectrum of diagnoses and organ systems. The provider's continued responsibility for the patient's health care needs increases the complexity of the evaluation and management service.

Take Backs

At the time you accept the patient…

- Importance of patient verification of coverage and validate that the insurance information is accurate and complete.

- The registration process making sure the patient understands that if they provide you inaccurate information that they are responsible.

- Keeping a copy of the verification within the patient billing record – scanned, email or other method to use as proof of coverage should the insurance program question this at a later date.

When take backs happen…

- Timing – Ohio rule 3901-8-11 identifies a 2 year window from the date of claim payment. The only exception to this rule is fraud by the provider.
- The provider has the right to appeal this decision
- Insurance programs have 46 days from the date of a claim submission (if clean) to pay the claim.

What is the reason for the “take back”

- Validate the take back reason with the insurance plan.
- Notify the patient the same or next day if this appears to be a valid reason – and if the patient provides secondary insurance then submit the claim to this coverage with the “take back” notification.
- Identify to the patient, that if the service ends up to not be covered by the initial insurance or the information provided they are ultimately responsible as they did not provide you accurate and complete information at the time of care.

Down Coding

Down-coding of E/M services…

- The primary reason insurance programs down-code E/M services is that the diagnoses coding provided on the claim form did not meet their algorithm for the level of care coded.
- As you have a service down coded – review the following
  - Was it a time based service – if yes, then was the time documented and did you identify this on the claim form (line 19 loop that says “total time in clinical care today was… minutes)
  - For services down coded by MDM (medical decision making) did the note meet this level of acuity?

Medical decision making…

- In the MDM model…
  - Were the diagnoses codes identified on the claim specifically addressed in the visit with an assessment and plan (or just carried over from visit to visit to visit)
  - Were these codes specific?
  - If there was prescription medication management as part of the care provided was this adequately documented? Was lab monitoring involved and coded Z51.81
  - Was the medication high risk with potential side effects and a black box warning that would support Z79.899
  - Was there a SDoH impacting care and addressed at this visit and coded?

The E/M problem levels

- Minimal problem (nursing level of care) – nurse type visit
- Self limited or minor problem – something that will go away without your intervention
- Stable, chronic illness (something at least 12 months in duration) (asthma, DM, COPD, Depression)
- Acute, uncomplicated illness/injury (strep throat, sprained ankle)
- Acute uncomplicated illness or injury requiring hospital inpatient or observation level of care
- Stable, acute illness (resolving gastritis)
- Chronic illness w/exacerbation, progression, side effects (poorly controlled..)
- Undiagnosed new problem with uncertain diagnoses – that can cause major medical issues
- Acute illness with systemic symptoms (COVID, RSV)
- Acute complicated injury
- Chronic illness w/severe exacerbation, progression or side effects of treatment elevating care plan
- Acute or chronic illness or injury that poses threat to life or body function

Down coding often…

- The problem coded with the ICD 10 code does not support the problem level of the 99204/99214 or 99205/99215 as coded.
- Is done because the problem level was not specific in the note – acute versus chronic, controlled or uncontrolled, exacerbation …
- The data that you are using to support the level of acuity is not detailed in terms of the assessment and plan and what this means to long term outcomes.
- The treatment plan does not have the details of risk, functional status or management concerns.

All E/M Services are based on:

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How do we document Acuity of Care

- The process of identify the acuity of patient care is not just about the number and specificity of the diagnoses but what this means to patient care, treatment, long term needs and outcomes in health
- The documentation goes beyond this history and exam to identify
  - Status of the condition
  - Risk of the condition and treatment
  - Overall plan of care for the condition and the patient as a whole

Medical Decision Making and the assessment

- Diagnosis
  - Status (acute, chronic, better, worse, deteriorating, episodic)
  - Is this diagnoses “forever” and what does it mean for long and short term functional issues (asthma, CHF, COPD, diabetes) and care needs
  - Any secondary issues that impact care (SDOH, chronic other conditions)
- Data reviewed and used in care (all kinds of information used in care)
- Overall risk of treatment – medications, surgery, testing
- Prognosis, care needs and plan

Time as the factor in coding of care

- When time is the driver of care for office/outpatient E/M services this time will include:
  - Pre-visit preparing to see and care for the patient – review of records, calls, reports
  - Time face-to-face with the patient
  - Time throughout the day of the visit involved in direct patient care (orders, discussion, review, etc.)
  - Unique documentation (ISP, care plans, goals/objectives, etc.)
  - Specific time range for each level of care will be identified
  - Additional coding will be available for prolonged care that can only be added to the highest level of E/M codes – 99205 for new patients and 99215 for established patients

Determining the correct Prolonged care code to use…

None face to face on a non patient care day	99358 Prolonged evaluation and management service before and/or after direct patient care; first hour + 99359 each additional 30 minutes (List separately in addition to code for prolonged service)	At minimum 31 minutes of activity and would include review of documentation, contact with patient/family or others. Not to be confused with telephone or telehealth services
Additional time on a date of care outpatient/office or patient home/residence setting	99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	(Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483 (Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416) (Do not report 99417 for any time unit less than 15 minutes)
Additional time on a date of care for a facility- based service	99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)	(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310) (Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359)◀ (Do not report 99418 for any time unit less than 15 minutes)

Ask me anything!

What questions do you have?

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