Questions and Answers from Open Door Forum: Physicians-December 9, 2020

1. I'm seeking clarification on the required documentation by a physician, a teaching physician when working with students. In our case, it's medical students, but students of any sort. In the final rule it says as long as they review and verify. And then in parentheses it does say that they basically sign and date it. Is that all that is required by the teaching physician is just that they sign and date the student documentation? Or do they need to do an attestation similar to what is required for working with residents?
    a. The billing professional physician, right, would be reviewing, signing and verifying the information that was included in the medical record by students, other members of the medical staff. I think that's separate from the attestation that you mentioned. I'm not as familiar with that. So I don't know if they are in conflict. But I think our clarification holds up for purposes of billing Medicare. That's what would be required.
        i. Simply a date and a signature for billing Medicare?
            1. Yes, verifying and dating.
2. If the inclusion in the medical record by the therapy student is to be signed and dated by the billing therapist, we just wanted to clarify that this is for any therapy documentation that would normally be entered into the medical record. And then a follow on question would be are the students signing those entries themselves and then it being co-signed by the billing therapist or, after they have reviewed it, or is the student creating the record but the billing therapist is the only one signing it?
    a. So I think the same principle applies, right, where the therapy student is entering information to the medical record. Again, they're not the ones billing. We're really relying on the billing therapist, practitioner, physician, to verify and sign off on the information that's been included in the medical record, given that it's subject to medical review, to the extent that that is necessary. But for purposes of billing Medicare, we expect that that billing practitioner is signing off on that information. And then your second question, I'm blanking, so if you wouldn't mind just repeating, just a bit of it. For your second question, I think we leave that up to the workflow that, you know, the practice, institution, whatever, may have established. We're just looking for ultimately, the billing practitioner. So, you know, if the student is just entering the information, creating the record versus signing off on what they created, that's not what we're looking for, versus the billing practitioner that would be submitting that claim or billing Medicare, having verified and signed off on the documentation. I think the best way to say this is that as far as teaching physician presence goes, we would expect a full documentation in the medical record to state how the teaching physician was present during the particular encounter. So if the teaching physician was virtually present through let's say an office visit, we would expect that information to be found in the record. I think agency policy generally has been that doesn't matter to us who on the medical team is doing the documentation, but that at the end of the day the billing practitioner whether that's a teaching physician or someone else, does need to be able to verify all the information that is in the medical record and to sign off and date on all of that. So it doesn't necessarily matter to us who actually is making the notations in the medical record. Just as long as the billing practitioner is overseeing that process and can

sign off on it. And specifically, if the teaching physician is virtually present, that there is a documentation in the medical record that reflects that as well.

3. A lot of facilities are trying to start using this and to me it just keep changing. And, you know, I'd like somewhere some type of clear explanation of what is available and how it's to be done and who can bill it. I mean I don't know about anybody else, but I'm very confused.
    a. I might add is that if you've got coders that you're working with they will be familiar with the CPT manual which contains most of what is in there as far as CPT coding. And that's the AMA that owns that. So go to them for CPT coding.
4. I'm inquiring about the screening for potential opioid use disorder that's part of the IPP and annual wellness visit. I'm wondering, if somebody is not taking opioids, if you can see that in the annual wellness visit, do we still have to screen them? And when you say screen, do we have to have a specific tool that we use to screen? Does it have to be for everybody even if they're not on opioids? And what are we looking at that this documentation needs to show us?
    a. Unfortunately, the final rule went out a bit late this year. And we missed some of our opportunities for the routine updates of the annual wellness visit and initial preventive physical exam educational materials. So we are in process of updating those now and we will - and, you know, thank you for your question here on the phone today, because as we work on those we will try to include language that answers that question. If you have that question I'm sure many others do as well. And we will try to make that more specific. What I can say is that for these two wellness visits the general guidance that has been given over the past years and that hasn't changed today, is that you would have to demonstrate in the record, that each of the services were furnished. And if they weren't furnished then, that would just need to be documented too. So it would need to touch upon that each one of these requirements as part of each of these visits, has been touched upon during the visit. Or if it hasn't, why? To answer your question about screening tools, Medicare has not required that a tool be used to satisfy the screening requirement. So again, that leaves - we left that purposely to the discretion of the practitioner to do what is appropriate for their particular patient. There is more a discussion on that in the preamble of the physician fee schedule. Off the top of my head I don't have a page number for you out of the hundreds of pages that were published. But I do believe - but the upcoming educational materials should be able to make these things more clear to practitioners and to stakeholders.
5. The first one is about the behavioral health 99441 through 99443. And the question is since COVID I know those services are now available to audio only. So the question I have is can those be billed using the E/M codes 99213 through 99215 based on time? I see that in the final rule they've updated the RBUs for that. And have crosswalked these codes to the E/M codes. And so can you use E/M codes in lieu of the 99441 through 99443 on that?
    a. So right now the policy is that we do pay separately during the public health emergency for the 99441 through 99443 which are audio only phone evaluation and management services. Now it is true that you can now choose a level for the office outpatient E/M visits based on time. However, those codes still in terms of when they're furnished via telehealth, they are not able to furnished via audio only communication technology. And you would need to continue to use the 99441 through 99443 in instances where you're using audio only communication technology.
        i. So based on what the rule says, when you see it cross walking what does that really mean? What is it that you're trying to convey? I'm not understanding why you would publish that, that you're cross walking it. Can you explain that?

1. So - yes, so generally speaking, when we talk about cross walking, it has to do with how the service is valued. And so I think what you're pointing out is that we did say that during the public health emergency, we would pay for the audio only E/M at the same payment rate as we would pay for the established patient level two through four office visit.
    a. So you cannot use the 99212 through 99214 in lieu of the 99441 through 443?
        i. That is correct.
            1. So we have prenatal visits that since COVID, we've had patients come in and not come in - not come in really, and do prenatal antepartum visits through telehealth. My question is we have two codes for telehealth for antepartum rather, the 59425 and 26 based on the number of visits. Can telehealth visits be used as the number of visits?
                a. Yes. So I think you're referring to - these are codes that have a certain number of office visits that are kind of built into the structure of the code. Yes. So those absolutely can be done using telehealth.
                    i. Okay. Just for the 59425 it's 426, so I know that they have a lot of patients who exceed that and they can go into the next set of codes, the 59426 if it's greater than 7. So you're saying that if any of those antepartum visits go beyond that I can go into the next set of codes?
                    ii. Yes. So these are - because these visits are not actually reported separately, we have no way to even know whether or not, even under normal circumstances, they're furnished like in person or if they're furnished remotely. So while there are certain aspects of these codes that will require, I do believe that right now they're not on the telehealth system. I mean that would be because you believe that there's still some components that have to be in person. But those follow up

visits that are built into the code, can absolutely be done as telehealth.

6. So if an individual healthcare system who belongs to a network can access the EMR from other members of that same network, are they considered external organizations? Because we both are actually using - well actually we're different networks, but we're both using the same like EMR record because they both can access the EPIC. Would this be considered external notes or would it be considered internal notes?
    a. That's a tricky one. It's got a lot of nuance to it. But ultimately someone's going to be billing for a service, right, that is furnished using information in those notes?
        i. Those other entities are contributing to the care or could be considered members of a medical team that are contributing to the services being furnished to the beneficiary for which the claim would be submitted.
            1. Yes. So - and that's why they're both using the same EPIC - they're both using the same notes because they can read each other's notes in the EPIC system. So to me that would seem like it's external organizations but I'm not sure. That's why I'm asking. So yes, they would both - different entities would be billing different yes.
7. I have a specific question related to the non-face to face prolonged services for the new outpatient code set. It does indicate that CMS will no longer be reimbursing for the 99358 and 359 associated with an outpatient E/M visit. And I just wanted clarification because we have codes that do require that there's an established previous visit or a new visit occurring for these non-face to face prolonged services. And there's no timeframe. So these, at times, you know, occur 30 days after a visit. And I just wanted to get a clarification if the E/M services or the non-face to face services related to any outpatient E/M visit that they're no longer payable. These would only be payable in relation to inpatient services.
    a. That's correct. The reason we are not paying 99358 and 9 in association with the office visits anymore, which means that there's not a mechanism to report work done on another day. There's a new prolonged code for face to face and non-face to face time the day of the visit as you know. It was a CPT code. We're doing a G code for now. We've been working hard to align with CPT on this. But we're not yet in the same space. And I don't - I think we said in the rule that in concept, we're not opposed to paying for work on a separate day, but we think there should be a unique code that identified time specific to an office outpatient visit. And the 99358 and 9 code as you're saying, is not. And since it's - can be reported on any other day, when we see that in the claims really have no way of knowing what the base visit was. If the patient had more than one visit, let's say they had an admission and then outpatient follow up, in that month we also see a 99358 in the record, we don't know whether the prolonged time is for the inpatient visit or the outpatient visit. And especially now that time can be used to select visit level and really drive payment in a new way, we'd like to be able to know for certain how much time is done for a given visit. So for now we're not using the 99358 and 9. That could change in the future if CPT revises the framework or if we could consider revising our G code. But that's where things stand for right now.
8. I just have a question about the time component for the (E/M) services 99202 through 99215. In the rule, in the final rule on page 210, it was stating that you were going to go with the actual times which are different than what CMS - different than what the AMA has documented in the CPT book, which is a range. Are you - is that a change? Are you following the AMA guidance on the time for these codes?
    a. So for level selection, we wrote that the level selection continued to use the CPT code descriptor. What the table on page 210, I am scrolling there right now, discusses, is how

we use time to calculate a payment rate. So when you're using time for level selection, continue to use what is outlined in the CPT book.