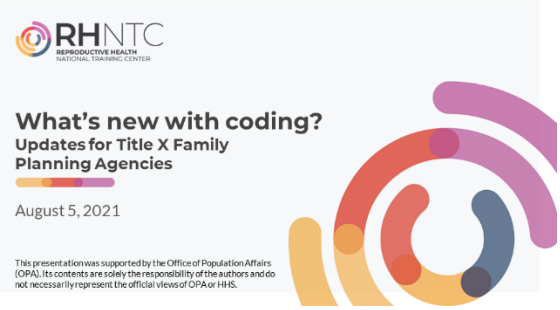
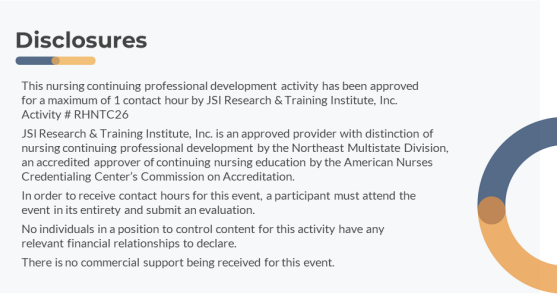
What's New with Coding? Updates for Title X Family Planning Agencies
August 5, 2021
Transcript

Slide 1 - Title



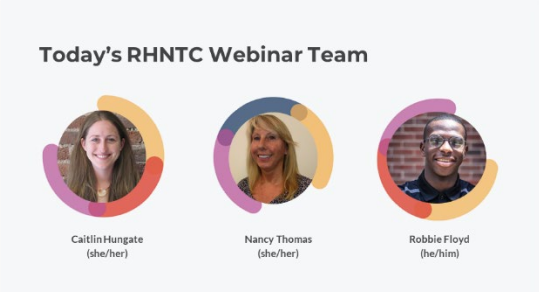
[Caitlin Hungate] Hi everyone, my name is Caitlin Hungate. My pronouns are she and her and I'm from the Reproductive Health National Training Center team and I'm honored to be with you today and welcome you to our webinar on What's New with Coding? Updates for Title X Family Planning Agencies. I have a few announcements before we begin. Everyone on the webinar is muted given the large number of participants and we're so grateful you are with us today. We plan to have time for questions at the end of the webinar. Please feel free to ask your questions using the chat at any time and we'll make sure to ask them to Dr. Policar and Ann at the end of the hour. We encourage you to participate as you're able to do so. There will be opportunities through a Zoom chat as well as the polling that I, that we'll be having throughout the webinar and we welcome your input, your questions and participation in the chat. A recording of today's webinar, will be available as well as the slide deck and transcript on rhntc.org, in the next few days. And last but not least, this presentation was supported by the Office of Population Affairs and...or OPA. Its contents are solely the responsibility of the authors and do not reflect or represent the official views of OPA or HHS. The webinar has been approved for one contact hour for continuing nursing education. To receive contact hours for this event, you must attend the event in its entirety and submit an evaluation.

Slide 2 - Disclosures



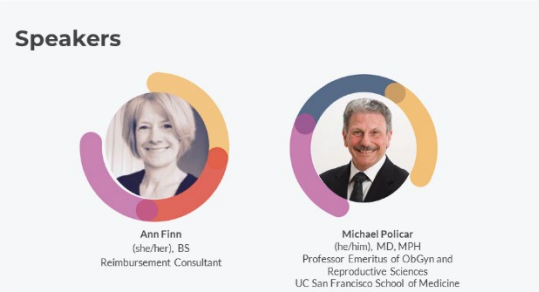
And there are no financial relationships to declare or commercial support for this event. This webinar was supported by the Office of Population Affairs (Grants FPTPA006030, TPSAH000006) and the Office on Women's Health (Grant ASTWH2000-90-01-00). The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Slide 3 - Today's RHNTC Webinar Team



I'd like to briefly introduce our RHNTC webinar team, from the Reproductive Health National Training Center. As I mentioned my name is Caitlin Hungate and my pronouns are she and her, and I'm honored to be with you and I have nine years of Title X experience. My colleague Nancy Thomas, pronouns she and her, is a member of our Title X team as well and has been working behind the scenes to make sure today's webinar runs smoothly and that participants and presenters have the resources they need. And Nancy has title, has over 12 years of Title X experience. And last but not least, Robbie Floyd, pronouns him and he is a member of our Title X team as well, and also will be helping behind the scenes to make sure our webinar runs smoothly. And Robbie has been at, approximately, at JSI for about seven months. And we are joined by Dr. Michael Policar, pronouns he/him, and Ann Finn, pronouns she/her, for this webinar. I'd like to briefly introduce, turn it over to you Dr. Policar and Ann to briefly introduce yourselves.

Slide 4 - Speakers

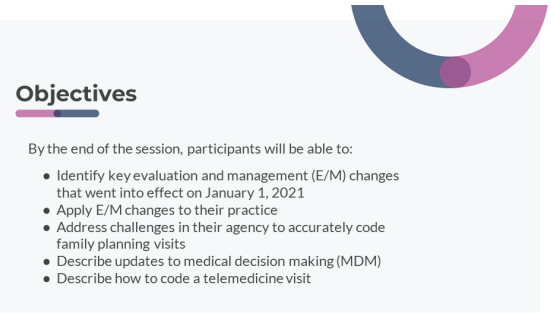


[Dr. Michael Policar] Okay, well I'll go first. I know many of you, I am an emeritus professor of Ob-Gyn at UCSF, and now spend most of my time as a senior medical advisor to the California Office of Family Planning, a family practice program and as clinical fellow of the NFPRHA, the National Family Planning and Reproductive Health Association.

[Ann Finn] Great and hi everyone it's nice to be here with all of you. And for those of you that don't know me, I'm a billing and coding consultant, that's been working in reproductive health for many years I'll leave it at that, a long time. And I really focus on kind of the revenue cycle and all the different parts and, you know from the front desk to the coding and documentation we're going to focus on today, how important that is, and even the backend billing and management aspects of it. And you know what we really like to stress and we're excited to have this opportunity to go over the coding is how important that that coding is to support the work that you do so that you get paid kind of optimally the first time when you're billing services. So welcome to everyone.

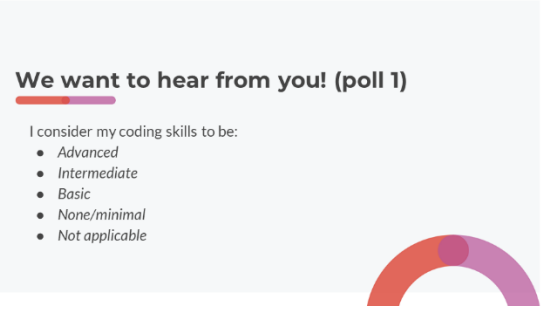
[Caitlin] Thank you Ann and we're so honored to have both Ann and Dr. Policar on today for this webinar.

Slide 5 - Objectives



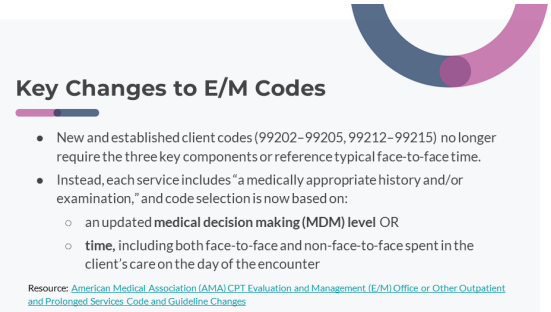
By the end of today's session we hope that you'll be able to identify key evaluation and management or E/M changes that went into effect on January 1st of this year. That you'll be able to apply these E/M changes to your practice, to address challenges in your agency to accurately code family planning visits, to describe updates to medical decision-making or MDM, and last but not least to describe how to code for telemedicine visits.

Slide 6 - We want to hear from you! (poll 1)



And before I turn it over to Ann to go in changes to the key E/M changes that went into effect, we want to hear from you. And so a Zoom poll will pop up momentarily and please take a moment to answer where you consider your skills to be if you're advanced, intermediate, basic, none, or minimal, or if it's not applicable to your coding skills. And if you're unable to use the Zoom poll, please feel free to use chat and answer your responses. So we'll give you a couple more seconds. 5, 4, 3, 2, 1. Thank you all for voting. So it's a mix today which is wonderful. So there's about 4% of you that are advanced, 36 intermediate, 42 basic, 14 that it's none or minimal, and then five of you or 5% excuse me that are not applicable. So it's great to know that we've got a variety of people on the line with various coding skills. So Anne I'm going to turn it over to you.

Slide 7 - Key Changes to E/M Codes

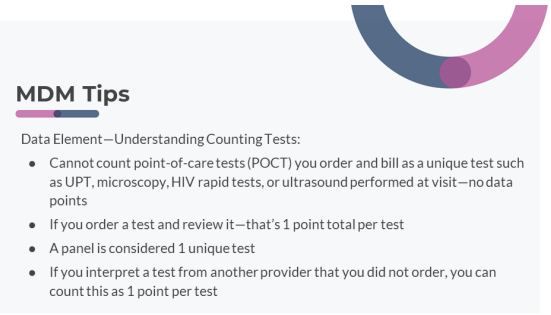


[Ann] Okay thanks Caitlin. So, we're going to talk about evaluation and management codes today. As we know prior to 2021, evaluation and management or E/M codes and we're going to talk about problem-oriented visits, they were based on the three key components of history, a physical exam, a medical decision-making, or time. But it was limited to only if greater than 50% of the face-to-face time was spent counseling. And it really didn't reflect that the work and the time that the provider spent with the patient was accurately captured. So there's been a lot of work, and there's been new guidelines and hopefully all of you are familiar, with the changes that came out in January of 2021, this January 1st. And, you know we all, these are new guidelines, it takes a while to get used to them, so we're going to, you know go through some of the changes and, you know we just encourage you if there's any questions and to familiarize yourself with the changes. So let's look at a couple of key changes. First off the old 1995 and '97 guidelines that we used to refer to, those are now outdated. So you shouldn't be using those guidelines anymore. We can put them to rest in an old folder in the garbage. And now as of January 1st, CPT code 99201 that's for a new patient, that code has been deleted and it's no longer applicable for billing. So if you bill that code, it's still in your system then you're going to face it denial. So you want to make sure that that code has been cleaned up and that you're using, you know the current relevant codes. 99202-99215 are all still valid, but the descriptors have been changed a little bit and the guidelines updated. So we'll be talking about those today. And then we also have the components for the E/M selection. So instead of those three key components, it's now focused on medical decision-making, or time and the, you know the great thing is that time has been updated to include all of the clinician's time on the date of the encounter that they spend with the patient, in face-to-face and non face-to-face activities. Which we'll discuss but that really raises the level of time that you can include and may, you know raise the code that you're able to bill, and then ultimately the reimbursement, because we're capturing all of the time and energy that you're putting into that visit. It's also worth, you know noting and we'll talk a little bit about some of the preventive visits that those codes, the preventative codes, the 993 codes, those did not change as of January 1st. So we're focusing only on the 992 codes on those changes. Okay, so let's look at the medical decision-making or MDM method now.

Slide 8 - Updated Elements of MDM

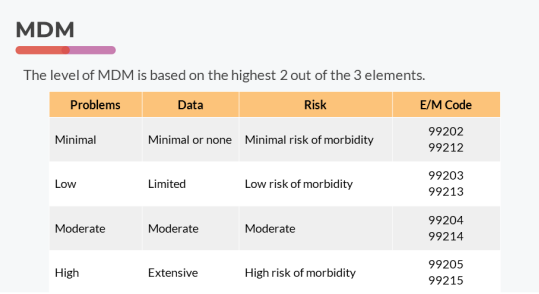
So there, just like in the past, there's still three elements but there's been some little updates and tweaks to each one of these elements that are important to get familiar with. So the three elements are still the number and complexity of problems addressed. So really focusing on what's being addressed today. Not so much the number of diagnosis like in the past, but what are the problems that are presented today. The amount and complexity of data to be reviewed and analyzed, and the risk of complications to the client. So let's look at a quick example. There would be a healthy, new, healthy client who schedules an appointment wanting contraception to avoid getting pregnant. She is screened for chlamydia and gonorrhea so samples are sent to the lab. She's also administered a pregnancy test which is negative. She decides to start an oral contraception, and she's given a prescription. Let's look at the first element, the number and complexity of problems being addressed in this case, the clinician would be addressing the need for contraception, right? To avoid pregnancy. So that correlates on the MDM chart to one acute uncomplicated or single problem. So that would be a low level of problems. Of course, if the client presented from multiple issues that were being addressed, or more, you know she had a lot of complex, you know comorbidities that would impact the level of the problem being addressed. Okay the second element would be data, so in the example of here was that she had chlamydia and gonorrhea, so we would use those two tests and have a limited level of data. Obviously the more testing, the more resources that are used to make the decision on the plan of care for the patient, the higher that level of data would be. And then our third element is the risk element or the risk of complications or morbidity to the client, right? On treatment. So if we think about this is what the presenting the physician or the nurse practitioner or PA uses to make the decision. But if, you know there's a number of elements, but most common in family planning is if they have an oral, over-the-counter drug or a contraceptive prescription given that's typically a low level of risk, and once we get to a prescription level of a contraceptive or drug where at moderate. So once we hit that bullet we can kind of use it. So that's kind of commonly used in family planning visits. It's the risk component is about what's going on with the patient. We can also look at like some social determinants, you know and there's some other factors that we'll touch on in the charts, you know that would increase some of the risk or some of the data that's being used. But there's not as common in family planning. Okay, so let's look at the next slide.

Slide 9 - MDM Tips



So a couple of things, when we started doing these slides and updates and we updated the modules we got a little bit tripped up Dr. Policar and I and we're working on them and then, we're kind of like wait, let's look a little closer at this. So it's important this that as you read the guidelines and make sure that all of your staff kind of understand some of these nuances, one being that if you have point-of-care tests so those are those in-house tests that happen the urine pregnancy tests, the HIV rapid test microscopy, or an ultrasound it's in-house. You separately report those with the CPT codes so you don't count those as data. If you order a test and review it it's counted as one point per test. So in the beginning I kind of thought like one, read to me like one to order and one to review but it's one point per test, right? So if you order a chlamydia and a gonorrhea test that would be two points, right? One for each test. If we order a panel like a CBC, that's considered one unique test so you would get 1.4. Now a good question came up that, well, what if you do chlamydia and gonorrhea as a combo, is that considered one or two? Those are each unique tests that are looking for two different diseases, so those are counted as, you know two points. And then finally if you do interpret a test for another provider, that you did not order you can count this as one point per test. Okay, so an example would be like a patient who has had tests done with their primary care, and then those tests are sent over to you to help, you know inform you of your decision of care.

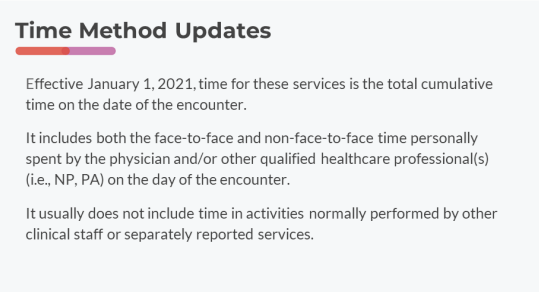
Slide 10 - MDM



Okay, well those are our golden nuggets, little helpful hints that'll help you. So here's our MDM chart now and you know I really, the more that I've used the new guidelines, the more that I like them, they're, it's much more straight forward, it's easy to use, you'll see by, we have developed a really nice handout with medical decision-making that is applicable to family planning situations so that you can figure these out, but it's very straightforward. So we're going to look and figure out what are the highest two or the three elements just like in the past, we pick the highest two out of the three. So our patient visits that we just, in our scenario, we had a healthy patient who presented for contraception, and she was counseled to redetermine that was a single problem or a low level of problems, right? So we have low. Then we move over to the data, she was screened for chlamydia and gonorrhea, and she was

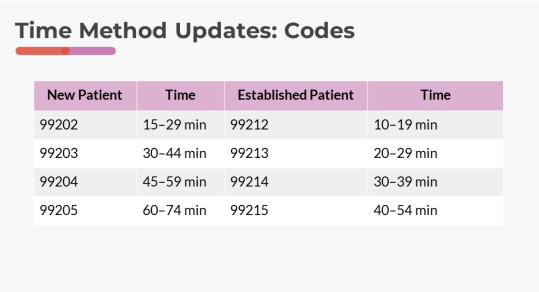
administered a point-of-care pregnancy test, but we know we don't count that pregnancy test since we separately report it. So we have two and that would be a limited number of data. Once you get up to like three send-out tests you move up to moderate. Finally the patient had oral contraception pills, which are prescription level, so we know right there that we are at moderate level of risk, we've met that level. So we have limited like low problem and limited data and a moderate risk so the highest two, equals 99203 or 99213. And they're the same, whether it's an established patient or a new patient. And remember that established patient is someone who's been to the practice within the last three years. So, it's a little more straightforward than the past. So we can use MDM, and of course we want to look at both, you know the MDM and we also want to use time and we want to see which one gets us to the highest level of code and then we're going to pick that code. So let's look at time next. Move to the next slide, thank you.

Slide 11 - Time Method Updates



Okay so, we can now use time. So remember we said in the past you could only use face-to-face time and it was rated at 50%, so remember we can kind of put that aside, it's the total time that the clinician spends with the patient on the date in the encounter. And that's a really big change. So it's important that your clinician and the clinical staff get used to that and document all of their time that they're spending with a patient. So let's go to the, oh, one other thing is that it doesn't, it does not typically include activities. Like I always get this question, you know what about the time that they spend with the, you know, checking in at the front desk? Or what about when the nurse is doing a pregnancy test? That time doesn't count. It's still the clinician's time, her time. Unless your payer has some separate, you know guidance where they allow nursing time in, but that would be payer specific. And so, you know we always say Dr. Policar and I that you should be checking with your payers for any specific guidance.

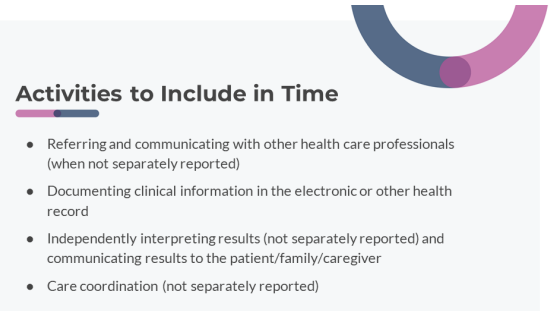
Slide 12 - Time Method Updates: Codes



Okay let's look at the time now for our patient. So remember we should said that our clinician spent 30 minutes, right? With our patient. That was total doing all of the activities on that date. So we look at the

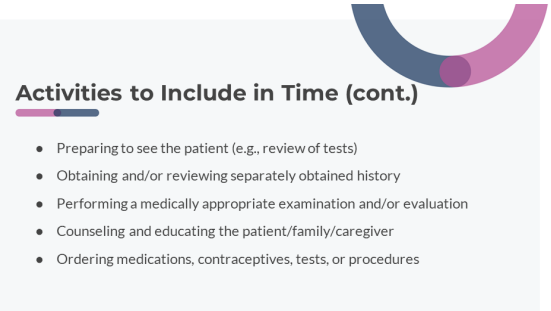
time chart and this is a great, you know having this time chart available is really helpful as well. So if it's a new patient and we looked at 30 minutes, we see the interval here 30 to 44 minutes it would be a 99203. If it was an established patient however, we do move up to 99214 for the 30 minutes. And sometimes I get the questions like, can we really code a level 4 or like a level 5? And you can see by these times and think about all the time that you spend on the date of the encounter, and we'll look at the activities that can be included, how you can get to 30 minutes until we do want to be able to, you know, we want to be able to code and bill for these, and so it's very important that the time that you spend is documented.

Slide 13 - Activities to Include in Time



Okay, let's look at the next slide and say what can we include? So this is where this is a big change and we really want to make sure the clinicians are familiar with this. But now we can include activities such as preparing to see the patient. So before I go into the exam room, when I'm looking over their tests, or the chart note from before, that time can be included. If you're getting, you know obtaining a history, reviewing the history, right? Doing a, obviously an exam or an evaluation, all the time that we spend counseling you know with reproductive health we spend a lot of time on counseling and risk reduction and educating the patient or their family on methods and safe practices. So we want to make sure that we capture all of that time. Ordering their medications and contraceptives,

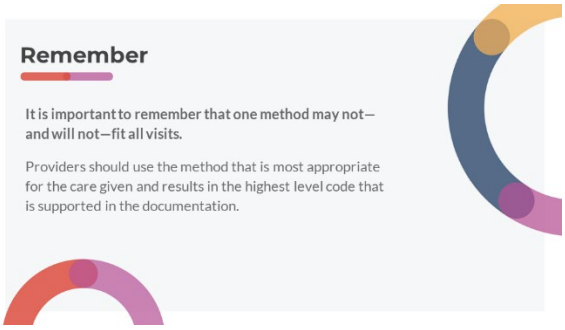
Slide 14 - Activities to Include in Time (cont.)



and if we go to the next slide there's a few more that we can include. So we also can include when we refer and communicate with other healthcare professionals. And the key words here with, and you notice that I said it with the lab testing and also with time, is where we don't count things that were separately reporting with another CPT code. So as long as this is something that's included in the E/M code that you're providing then you can count that time. Also the documentation that happens in the EHR and in medical record. So as long as it's on that date of the encounter, so there's incentive for providers to be doing it on the date of the encounter so they can count that time. If they do it the next

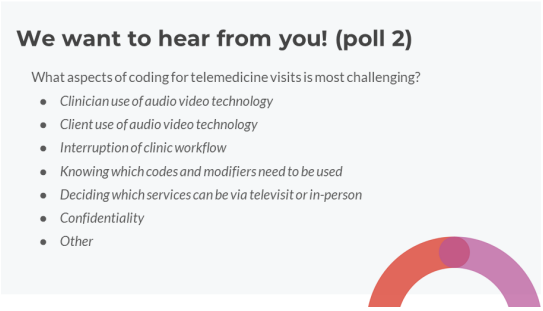
day or the next week, it's not able to be counted. Separately, independently interpreting results again, ones that weren't separately reported, but where you're going over test results and coordinating care. So there's a lot of different activity, right? That can be included. What's a couple of things that can't be included? And this is one that I see where people are not clear in the documentation. Don't count the time that you spent on other services, other separately reported services. So a good example is when we do same day LARC and we have a counseling visit, and then we do a implant or an IUD insertion, right? Sometimes I know that people are counting even all of that time. That LARC insertion is reported with its own CPT code so we want to make sure that we clearly don't over count that time. We don't want to include the time with front desk staff and nursing staff, and like I said, if it's on a different date service, different than the date of the encounter like they're doing their chart notes on a different date then you can't count it. But all of the services on the day of the encounter can be included.

Slide 15 - Remember



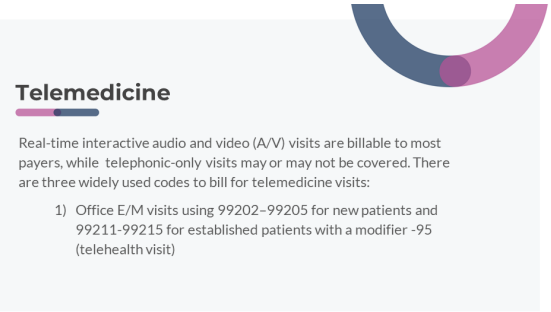
Okay, so let's look at, this time and to wrap up, because we're giving you a very brief, we have a lot of information today, so we're just very briefly kind of hitting the high notes of this, but remember you can use either method, right? For the visit based on the documentation. It's so important, it's documented in the medical record and in the chart. You can use either MDM or time and you can pick the highest code and bill the optimal code to receive, you know, the optimal reimbursement. Some of the payers, many payers reimburse you on the level of codes billed, right? So sometimes some of you with an FQHC might get a inclusive rate, but most payers are billing on that level that's billed. So if we under code we're leaving revenue on the table and if we over code, we really risk getting into situations having to give back money which is no fun to any of you. Again, so those are kind of the highlights of the changes. Remember these other problem focus codes, not the preventive codes, they stay the same and we can bill using either method, and we want to pick the highest level of code for the visit that's applicable. Okay, thanks. I'm going to hand it over back to Caitlin.

Slide 16 - We want to hear from you! (poll 2)



[Caitlin] Thanks Ann and thank you for providing a brief update on the key changes that went into effect in January 1st. So we want to hear from you again and before we go into a conversation around telemedicine if you could contribute in the Zoom poll of what aspects of coding for telemedicine visits is most challenging to you? And feel free to select any of the others and if you select other use the chat we want to hear from you, what is difficult? The clinician use of audio/video technology, client use of audio/video technology, interruption of clinic workflow, knowing which codes and modifiers need to be used, deciding which services can be via tele or in person, confidentiality, or, and if you selected other please feel free to use the chat. So, we'll give you about 10 more seconds to weigh in on the poll. 5, 4, 3, 2, 1, thank you. And we'll see the results momentarily. Okay so it's a mix which is great. But the majority of you indicated at 47% knowing which codes and modifiers need to be used.

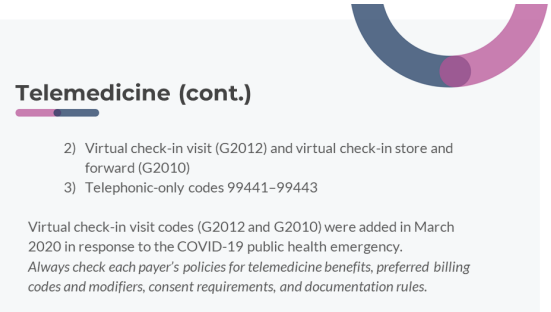
Slide 17 - Telemedicine



So I'm going to turn it back over to Dr. Policar to dig into some of that and hopefully you'll have some clarity on knowing which codes to use. So Dr. Policar.

[Dr. Policar] Okay, thank you Caitlin. One of the things that I really want to emphasize that Ann was mentioning, she brought it up a couple of times but I'll do it yet again, is that given the choice of using either medical decision-making or total time, remember that in the past in family planning visits, most of the time, in most circumstances, in most visits, we use time because it's led to a higher E/M code, when using history, physical, medical decision-making. Nowadays for family planning visits, you will notice that it's probably going to be somewhere around an equal split between using total time or medical decision-making. However in every single visit you need to make that determination of using total time or medical decision-making each time you see a patient because you can never predict in advance exactly how that computation was going to come out. So there's not an overall rule in the way that we used to think of the fact that you mostly did it, mostly billed through time. All right, well let's talk a little bit about telemedicine and I think of this as happening in three different phases. The first phase is that the center for Medicare and Medicaid services, which basically writes most of the national policy, both for state Medicaid programs and the national Medicare program, actually paid for telemedicine visits before the pandemic. And they define the telemedicine visit as a real-time interactive audio and video visit, that would be billed using one of our standard E/M codes. And because of the fact that there're telemedicine in the past that was mostly based on time. In addition, you would not only use a standard E/M code, but you also had to use a 95 modifier with the E/M code to be able to show that it was a telemedicine visit. At that time before the pandemic, telephonic visits were not covered by most payers. Things have changed a little bit now and we'll talk more about that in the next slide, but at least in the formal definition of a telemedicine visit, it required an audio/video interaction.

Slide 18 - Telemedicine (cont.)



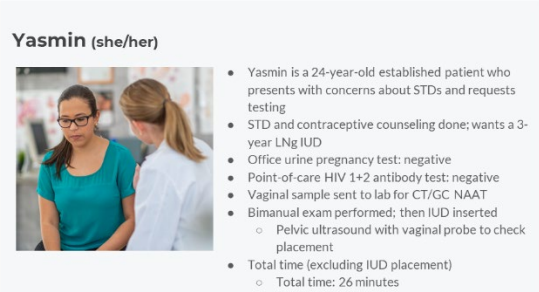
Next slide. The next phase is that with the onset of the pandemic in March of 2020 CMS added a number of additional codes that were available for telemedicine. So one is called a virtual check-in visit. It's billed with a HCPC code of G2012, and that basically is a telephonic visit between a patient and a clinic, doesn't necessarily have to be a clinician, a clinic or a medical office, where that is usually a short 5 or 10-minute interaction to decide whether or not the patient needs a bigger telemedicine visit or actually needs to come in in person. The second type of telemedicine visit was also added in March of 2020, which is called a virtual check-in store and forward. And that, what that refers to is basically a photograph so that a patient could let's say take a picture of a skin lesion for example, send that to the clinic so a clinician would be able to have a look at that skin, look at the photo of the skin lesion and decide whether or not a patient should come in or whether this could be handled through a virtual visit. And the code for that is G2010. For most payers, the amount of payment was somewhere between $15 or $20 for those visits. Now the third phase happened last summer. And that is that state Medicaid programs and CMS started hearing from clinicians about the fact that there are lots of patients who don't have the ability to be able to do an audio/video visit. Some clinics didn't have that capability, there are some patients who don't have smartphones or access to a computer, there are some people who wanted to have a telephonic visit rather than an A/V visit because of confidentiality. Some people lived in areas where there wasn't very good internet service. So, what many payers did including most state Medicaid programs, starting last summer, was temporarily they also cover telephone-only visits that does not require the capability of having a video component. And in that circumstance, what they recommended was using a standard E/M code based either on total time or medical decision-making, again with the 95 modifier. But as this slide implies, it's so important for someone in your office periodically to check what the policies are of your various payers, about telephonic-only visits. Specifically whether or not they're covered, number two, what special rules are about the use of telephonic-only visits, and then also remember the fact that for many payers, that option of telephonic-only visits will go away, will be sunsetted once the public health emergency is over. And of course that's going to vary by payer and none of us know when the public health emergency is going to be past the point where we really need to be able to cover the telephonic visits as well. I also want you to notice numbers three on the slide where it says telephonic code 99411-99443. Those are CPT codes, E/M codes really for telephone-only interactions between a clinician and a patient. And these were available even before the pandemic, but most payers don't cover them. Some commercial payers do, the large majority of state Medicaid programs and state family planning programs do not use those codes. But if you have the patient with private insurance there's some possibility that the payer would want those codes for a telephone-only visit, rather than a standard E/M code with a 95 modifier. So that's basically the three categories of what we have available. And as I said after the public health emergency is over, each payer

is going to make a decision about whether or not they will cover all of these possibilities or whether they'll retrench and go back to where we were before the pandemic. Next slide.

Slide 19 - Case Studies in Coding for Family Planning Visits

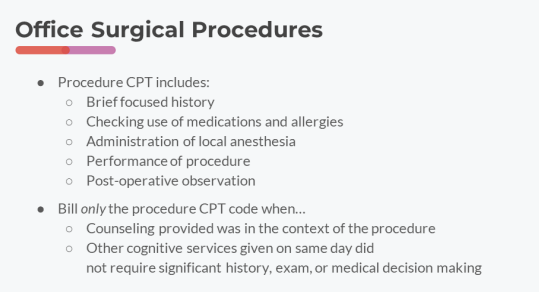
Okay, so after that introductory material, let's now do three cases. I'm going to do the first and the third and then Ann is going to do the one in the middle. Next slide.

Slide 20 - Yasmin (she/her)



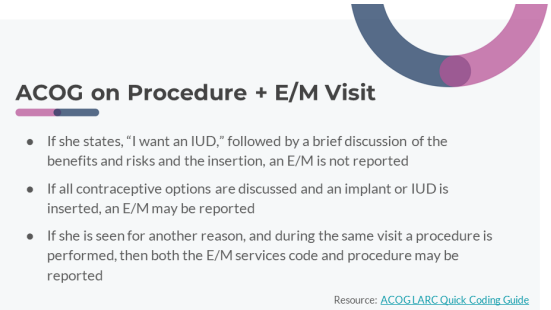
Okay, so our patient is Yasmin. She's a 24-year-old established patient who presents concerns about sexually transmitted infections and wants to be tested for STIs. STI and contraceptive counseling was done, and by the end of that she stated that she wanted to have a three-year levonorgestrel IUD placed at the time of that visit. A urine pregnancy test was done because she had a sort of unsure history regarding her last menstrual period, that pregnancy test was negative, she also had a point-of-care HIV one and two antibody test, given her concerns about sexually transmitted infections that was also negative. A vaginal sample was sent to the lab for a chlamydia and gonorrhea Nucleic Acid Amplification Test. Subsequently a bimanual pelvic exam was performed. The Skyla IUD was easily inserted, the clinician decided to do a pelvic ultrasound with a vaginal probe, just to check and make sure it was in the right place. And the total time of the visit, the preliminary part, the discussion with her about STDs and contraception, and the time it took to chart at the very end of her visit was a total time of 26 minutes. Then again to reemphasize what Ann said, that that does exclude the time of the IUD placement itself because that's going to be billed separately with its own CPT code. Next slide.

Slide 21 - Office Surgical Procedures



So just a quick reminder about how office procedures work. The procedure CPT code is actually a bundle of services which includes taking a brief focus history, checking for the use of medications and allergies, administration of local anesthesia if it's necessary, performance of the procedure itself and then a very short postoperative observation of a few minutes after an IUD or an implant insertion of let's say an endometrial biopsy or colposcopy. And when we do those office procedures, most often we bill only the procedure CPT code. So if a person comes in solely for the purpose of a procedure, best example of that might be a colposcopy. And that's the only thing we do is the colposcopy, we don't talk about other things, then you don't bill an E/M code, you only bill a CPT code. The other circumstances when a person comes in for a procedure, and we talk about other things that are fairly minor, they don't require a significant history exam or medical decision patient, decision-making. patient might have let's say a rash or discoloration of their skin or some other thing that we can very quickly deal with. Then we don't bill an E/M for that as well. We solely bill for the procedure itself. Next slide.

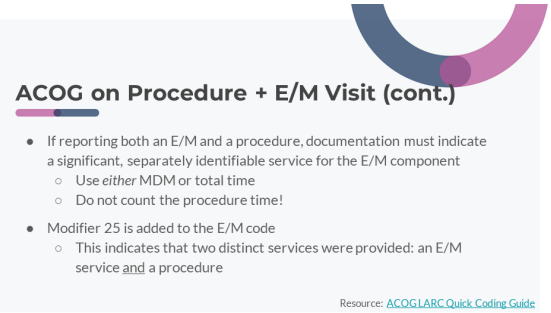
Slide 22 - ACOG on Procedure + E/M Visit



Now, ACOG and its LARC quick coding guide actually gives us some very helpful information about when we can bill the CPT code for a procedure, and an E/M cognitive visit on the same date of service. So if a patient says, I want an IUD, followed by a brief discussion about the benefits, risks, and then we go through the whole consent process, we only bill the CPT and we do not bill an E/M. On the other hand, if the patient comes in, we have a long discussion about what are her reproductive intentions. We go through the whole process of discussing the available contraceptive methods with her through a process of shared decision-making, and then make a decision let's say to place an IUD or an implant. Then you can bill for both. Because you're billing the E/M code for all of the counseling that you did upfront, and then you're billing the CPT code for the procedure itself, of the IUD or the implant placement. And then third if the person is seen for another reason, and then during that same visit, a procedure is performed you can do both. And our patient Yasmin is a perfect example of that. She came in because she was worried about sexually transmitted infections. And then the discussion morphed in the direction of her

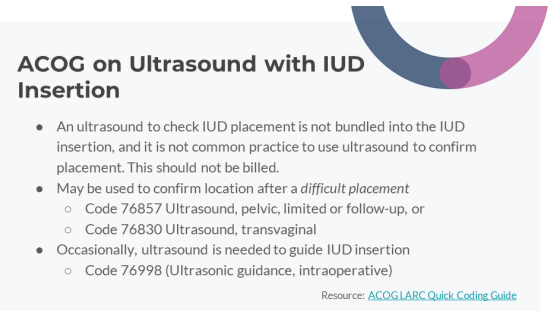
contraceptive needs and then it turned into an office procedure to be able to insert her three-year IUD. That's often referred to as a turnaround visit because the visit itself, the subject of the visit, or the main reason for the visit turned around from starting as an STD visit, and then ultimately became a contraceptive visit, including an IUD insertion. Next slide.

Slide 23 - ACOG on Procedure + E/M Visit (cont.)



Okay so, when we do both the procedure and an E/M at the same time, our documentation has to include the fact that these were really two different things. One was the contraceptive counseling and one was the procedure itself, and when we think about the counseling part, STDs, contraception, or both, we can either use medical decision-making or total time, but again we don't count the time of the procedure. And very importantly in this circumstance when you bill an E/M code and a CPT code on the same date of service, you have to use a modifier 25, which is attached to the E/M code. And you'll see how we'll bill Yasmin visit in just a moment. But the point is is if that 25 modifier is attached to the E/M code, to say that what we talked about in that time period was different than the consent for the procedure and the procedure itself. Next slide.

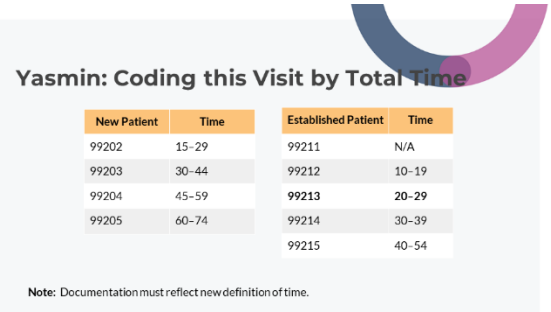
Slide 24 - ACOG on Ultrasound with IUD Insertion



Now you'll also note that in this visit an ultrasound was done just because the clinician wanted to check and make sure that the IUD was exactly in the right place and not too low within the endometrial cavity. And again ACOG reminds us that an ultrasound to check for IUD placement as a standard routine intervention is really not considered to be part of the standard of care where that should be done for every IUD insertion, and therefore they say that routinely that should not be billed. But it can be billed in certain circumstances. So if we want to confirm the location after a particularly difficult placement, patient was moving a lot, there was some amount of cervical stenosis, we weren't exactly sure whether the IUD was in the right place for a particular placement, in that circumstance we can bill for an office ultrasound in order to make sure that it's in the right place, as long as there was a specific clinical indication to do that. And then in some cases we actually use the ultrasound machine real-time to watch

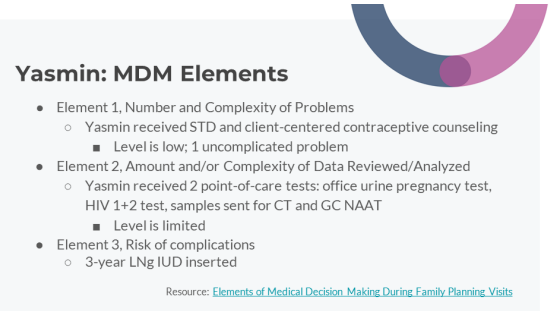
where the instruments are going and to make sure that the IUD is in the right place, that also can be billed separately with code 76998 which is for interoperative or real-time ultrasound. Just don't do it routinely. Next slide.

Slide 25 - Yasmin: Coding this Visit by Total Time



Okay, and remind me which, I'm trying to, I'm just trying to notice exactly which slide we're on here, but okay. So how are we going to bill this particular visit then? If we bill it by total time, remember that it was 26 minutes and Yasmin is a established patient, so this is going to be a 99213, for, with the STD and contraceptive counseling time. Next slide.

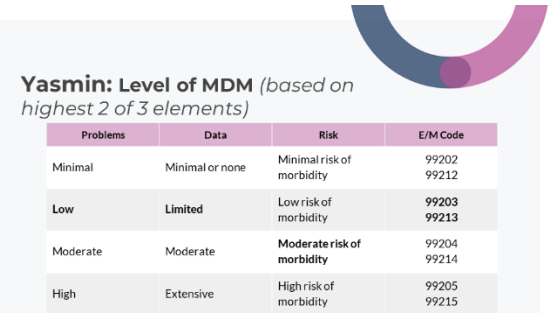
Slide 26 - Yasmin: MDM Elements



All right, now we're going to switch over to medical decision-making, all right? And here Robbie is going to help us to actually have a look at a job aid that we produced, it is on the website [Elements of Medical Decision Making During Family Planning Visits Job Aid (https://rhntc.org/resources/elements-medical-decision-making-during-family-planning-visits-job-aid)], which helps you to decide how to come up with the level of the three different elements. You know, when you make your medical decision-making a determination and this is specifically in a family planning context. So remember that the first element is the number and complexity of problems addressed. Yeah continue to, there you go. So in that first column, hold it right there, she basically fit into the category of having a low number in complexity of problems because she had one acute uncomplicated illness or injury, in other words a single uncomplicated problem, and so the level of the first element for medical decision-making is low. Now scroll down some more and next we're going to get to depth so keep going. Okay moderate and high, all right, now we're to element 2 which is the amount and complexity of data reviewed and analyzed. And remember the two tests that we ordered were gonorrhea and chlamydia, okay? So go down a little bit further, okay great, right there, and because of the fact that we ordered two tests that's considered to be limited in the level of depth. Scroll down a little bit more in our job aid, and now we're going to get to risk. And because of the fact that, let's see, that's still element 2 keep going a little further. And by the

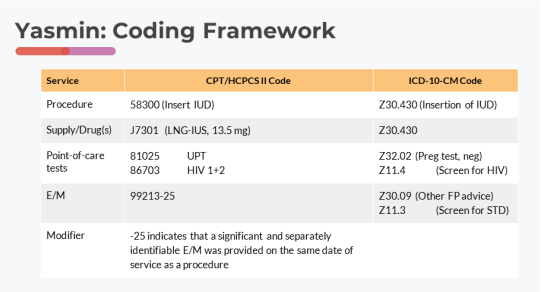
way, this is going to be, hold it right there, this is going to be available to you with these correlations between the different levels of MDM and the different types of family planning visits. Go down a little bit further Robbie to moderate risk and give, yes great, and given the fact that the three-year IUD is medicated, it's a prescription product, therefore it fits into the moderate risk of morbidity from the procedure. Okay and so now we can remove the job aid, and we're going to go back and talk about how to code Yasmin's interaction.

Slide 27 - Yasmin: Level of MDM (based on highest 2 of 3 elements)



So Robbie go ahead, oh there we go, okay. So what we just talked about with MDM, is that she has a low level of problems, she has had a limited amount of data because it was two tests and a moderate risk of morbidity based on the fact that this is a prescription product and therefore we're going to code the best at of two out of three, which makes it a 99213, given the fact that she's an established patient. Next slide.

Slide 28 - Yasmin: Coding Framework

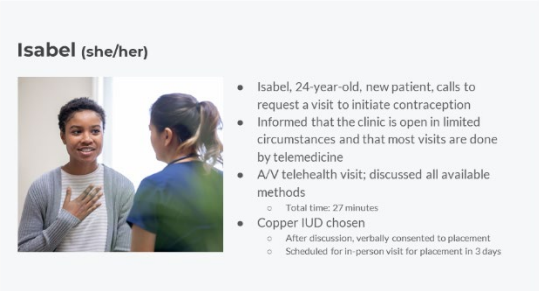


Okay and so this is the full billing for Yasmin's visit. So, and we call this the coding framework because whenever you're coming up with the codes for a particular interaction, we always think about five different things. Number one, did you do a procedure? Number two, are there any billable supplies or drugs? Third is did you do any point-of-care test or imaging studies? Number four, is what's the E/M code? And number five is there a modifier? So if a procedure is a 58300, which is placing the IUD, the reason why is Z30.430 which is the ICD-10 code after this interaction. Next is the J code, the HCPC code for the Mirena insertion kit. And it's critically important to make sure that that goes on your encounter form, where you check that off with a superbill, because that's a lot of reimbursement for that placement kit. Next are point-of-care tests, we can bill for the urine pregnancy test in the point-of-care HIV one and two test. Next is the E/M code, and remember the Yasmin's case, whether we computed by total time or whether we computed by medical decision-making, it came out to be a 99213. If they were different, we would use the higher of the two. But given the fact that they're the same, we're going to

use 99213 and the 25 modifier is on there because of the fact that we did counseling, that was separate from the procedure on the same day of date of service. Now, the ICD-10 codes for the counseling are Z30.09 which is for family planning advice and Z11.3 which was the screening that we did for a sexually transmitted infection, next. Okay, so that's Yasmin. And I'm going to hand the microphone back over to Ann for Gabrielle.

[Ann] Okay, well don't turn off your microphone because we're going to skip over, we're going to, since you have all these slides and we're just being cognizant of time for questions, we're going to move through this and go to Isabel's.

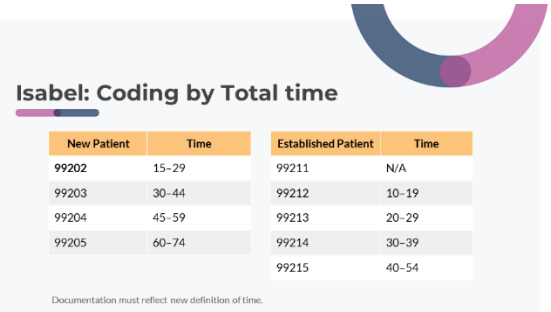
Slide 29 - Isabelle, she/her



But I just want to make, point out a couple of things while we're getting to Isabel is one, I do, I love this new job aid with all the family planning and really want to encourage you to share that with your clinical staff, because it has great examples that are applicable to family planning and common visits that we see. And just one of the takeaways from Gabrielle's visit is you can review the slides, is again that when we have a problem visit with a preventative visit capturing the time that's spent on the problem visit and you know, and coding and capturing both the preventive code and the problem-focused code and using that modifier 25, it's so important that we use a modifier in order to be paid appropriately and capturing kind of the optimal code for what happens. And again, it goes back to really making sure that our clinicians are clearly documenting the services that are happening in the visit. So let's now, I'm going to hand it back over to Dr. Policar to do Isabel 'cause I thought this was a good example of kind of a hybrid with telehealth in person. So back to you.

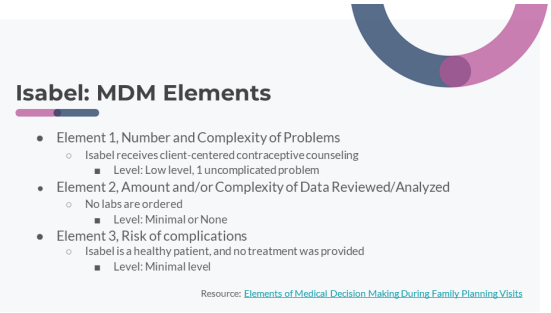
[Dr. Policar] And I'll make this, we'll make this quick so you can get your questions in. So Isabel is 24, she's a new patient, and she calls to request a visit to initiate contraception. She was informed that the clinic is open in limited circumstances, and that most visits are done by telemedicine. So she had an audio/video telehealth visit, all available methods were discussed, the total time of that conversation was 27 minutes and she decided that she wanted to have a copper IUD placed. And so she was scheduled for an in-person visit three days later, next slide.

Slide 30 - Isabel: Coding by Total time



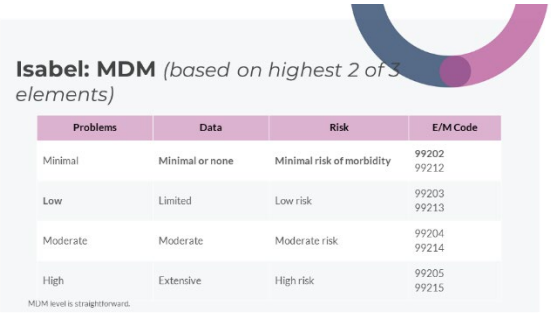
Okay, so based on the amount of time of Isabel's visit, it was 27 minutes and she is a new patient. So when we code by total time, that would be a 99202 which fits into that time benefit. Next slide.

Slide 31 - Isabel: MDM Elements



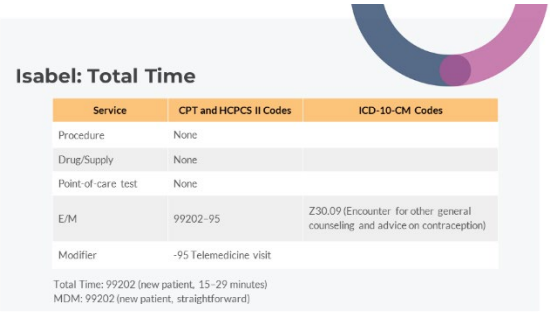
Okay, so the, what we always do is to always check again what the level would be with medical decision-making and Robbie in this case I'm just going to go through each of the elements, we don't need to bring the job aid back up again. But number one about the number and complexity of her problems, was that she had one uncomplicated problem, so that's a low level, element 2 was being amount of data reviewed and in this particular case there were no laboratory test ordered for this telemedicine visit, and so it is the lowest level of minimal or no data review. And for element 3, the risk of complications is again, the lowest levels of minimal level because we didn't provide any treatment for her. Next slide.

Slide 32 - Isabel: MDM (based on highest 2 of 3 elements)



So when we drop that into the medical decision-making table, it's a low level of problems, a minimal level of data, a minimal level of risk. So the best of two out of three is the lowest level of E/M code and because she's a new patient for the telemedicine visit, that's going to be a 99202. Next slide.

Slide 33 - Isabel: Total Time

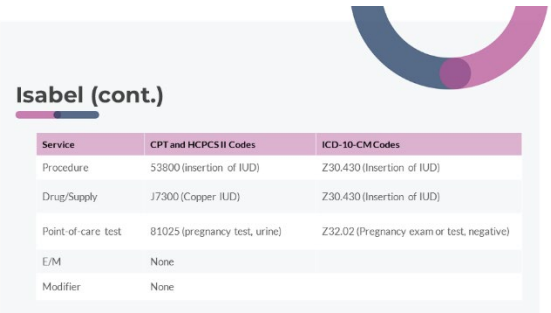


So how would we bill for Isabel's telemedicine visit? No procedures, no supplies, no point-of-care test, both ways of computing in visit 99202, it's a telemedicine visit so it has a 95 modifier and the ICD-10 code for the visit is Z30.09 which is counseling and advice on contraception, next.

Slide 34 - Isabel: seen in-person 3 days later

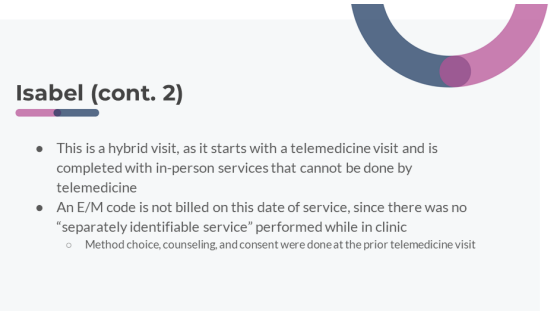
Okay, so Isabel comes back three days later for her copper IUD procedure. A urinary pregnancy test was done, again because of a confusing menstrual history, the copper IUD was placed without difficulty and the total time was 15 minutes, next. So the way that we're going to bill the in-person visit, is a 58300 for the insertion of her IUD. The next is the HCPC code for the Paragard insertion kit, which is J7300. Next is the point-of-care pregnancy test that she had done in the office. And the reason for that is Z32.02 which is a pregnancy exam or pregnancy test which was negative. And given the fact that all of her counseling was done at the time of the initial telemedicine visit, in this particular case there is no E/M billing and there's no modifier. Because when she came back to the clinic for the in-person visit to have the IUD placed, that was just the 10 or 15 minutes to get the IUD done with no additional problem that was addressed. Next slide.

Slide 35 - Isabel (cont.)



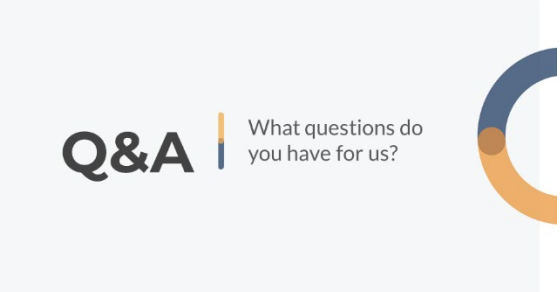
So this is what's referred to as a hybrid visit because it started with the telemedicine visit and then was completed with in-person services that obviously we can't do like telemedicine when you're going to do a procedure. And an E&M code wasn't billed on this date of service because there wasn't anything that was separately identifiable service performed in the clinic on the day of her IUD placement. Next slide.

Slide 36 - Isabel (cont. 2)



Okay, so that is Isabel, we went through that fairly quickly, but now we still have about 12 minutes or maybe a little bit more to be able to answer your question. So Caitlin back to you.

Slide 37 - Q&A



[Caitlin] Yeah, thanks so much Ann and Dr. Policar and apologies for us running short on time and skipping the second case, but we wanted to make sure that we get through as many of your questions as possible. So without further ado, the first question is what if a clinician does not have a nurse and is taking care of the patient from taking the blood pressure, to the history update, to counseling, et cetera. How does that clinician count that time? Or does that clinician count that time?

[Ann] So I'll jump in on this one. So if the nurse is doing part of the service with the E/M codes, unless your payer has a specific policy that includes nurse visit into the E/M service, you only count that time that is for, with the clinician for an E/M service. The only billable code for a nurse as of 99211. But if a nurse practitioner or a physician is doing the main services, they would focus on the time that they spend with the client and the time they've spent with the nurses, like additional support time.

[Caitlin] Okay and sorry for the confusion. What if they do not have a nurse and the clinician-

[Ann] Oh I'm sorry.

[Caitlin] Is doing all of those services?

[Ann] So then you would count all the time sorry about that.

[Caitlin] No worries.

[Ann] That's a good question because all of the time that the clinicians, or if you're nurse practitioner, or PA, a physician it is all of your face-to-face and non face-to-face time that is spent with that patient on the date of the encounter. So then you can include it into the E/M code. So document what you do, you know being clear too, like sometimes in the chart notes it's not clear who did what, so just making sure that your chart note tells the story, you know to the payer and you know, when somebody comes in and looks at it that it's very clear that you did all those services then you can count it.

[Caitlin] Great, Dr. Policar did you have anything else to add?

[Dr. Policar] No I agree.

[Caitlin] Okay, here's another question. When using time, how does the clinician bill for interpretation of send out lab results, when this is not on the date of encounter? Is it a separate bill or how are they to be reimbursed for that time?

[Dr. Policar] So when you're checking laboratory test results oftentimes that's done while the patient is checking in, you're getting ready to go into that room to see the patient and you're taking the time to go into your electronic medical record and check laboratory tests and the answer is, you can count the time to do that. So as Ann pointed out, it's not only the face-to-face time that you spend with the patient, it's the time that the clinician takes getting ready for that visit, that might be looking at a prior note in your clinic, it might be looking at a prior note in the primary care provider or another specialty, certainly would include looking on a computer for laboratory results, then you go on and see the patient you count that time, and then once a patient leaves and you're typing your notes into your EMR you count that time as well.

[Ann] And if the patient is, if you're looking at the lab results like a couple of days later when it comes back from the lab, that time would not, and it's just that you're reviewing the findings at that point, the results, that would not count because it's not on the date of the encounter or on a follow-up, right? So then that time doesn't really count towards the E/M code. Just to be clear if you're just looking at the results that come back, you know maybe preparing to make a phone call or something. But if it's on the date of an encounter, like Dr. Policar said include it.

[Dr. Policar] Yeah, thanks for adding that, that's really important.

[Caitlin] Yup, thank you so much. Okay another question for you. There's a lot of questions around point-of-care tests so this one's specifically around GC/CT. So if it is, if chlamydia and gonorrhea screening is collected from multiple sites, are each counted as a point-of-care test? Does it make a difference also, if a clinician is collecting the sample versus the patient collecting the sample?

[Dr. Policar] So the answer is, is that if it's, if the samples are being taken from the throat, from the vagina, from the anus, the answer is that it's basically the same test and so you don't get credit basically for three chlamydia tests and three gonorrhea tests. You basically get credit for one chlamydia test and one gonorrhea test. Now if you were sampling for different organisms, that might be a different story. But because you're sampling for the same organisms at three different sites, you get credit for each of chlamydia and gonorrhea. And then the other part of the question is what if somebody else actually takes the sample and the answer is you still get credit for that, it really doesn't matter who takes the

sample, the point is that it was the clinician who made the decision to order the test in the first place. And that's what you're getting credit for basically, it's not the physical act of taking the sample, it's for making the decision that the test was necessary in the first place. And that's when you get credit in that data column.

[Ann] And in that case if you're using time, you know because of collecting the specimen like Dr. Policar is saying is really part of the E/M service it's not part of the lab test itself that CPT code. Then you know, again, counting all of the time that you spend is important 'cause it adds up more than we realize or are used to reporting in the past.

[Dr. Policar] You're right Ann and then it's a perfect example of why we're going to calculate it both ways. We're going to do it with time we're going to do it with medical decision-making. And bill for the higher of the two.

[Caitlin] That's great, and I think we have time for one more question, although there's lots of questions coming in, so I'm sorry if we can't get to everything. Another participant asks, what if, what should we bill if the patient is seen by two different nurse practitioners on the same day for different services? For example, one NP is not trained to perform a transnational ultrasound for an IUD placement so it is performed by another nurse practitioner.

[Dr. Policar] Well, as far as I'm concerned that's pretty simple because of the fact that the cognitive part of the visit maybe even putting in the IUD, is going to be billed as with the 58300 for an IUD insertion, and then on a separate line, you're going to bill for the office ultrasound, really doesn't matter who did that. Whether it was the first clinician, whether it's a different nurse practitioner or whether it's an ultrasound technician that you happen to have in your office, the point is is that, you know you're billing for that office procedure of the ultrasound and it doesn't matter if it's the same clinician or a different clinician. It's going to be the code for the ultrasound.

[Ann] But the other thing is in the AMA guidelines about the E/M changes, there is a section that you could refer to about shared visits where there's two practitioners like a doctor and a nurse practitioner, two doctors, that aren't doing the same, that are both participating in the medical, the E/M service doing different tasks. So there is some guidance and I, you know want to just recommend looking through those to see if that's applicable in your practice when you have that type of a scenario. Because you are able to capture kind of both of those times and add them together.

[Caitlin] Exactly.

[Dr. Policar] Absolutely, so like a good example of that is let's say, you as a nurse practitioner are seeing a patient who has a rash, you spend maybe 10 minutes with her, you can't figure out what it is, but another nurse practitioner in your office who is really good at figuring out rashes, then you can bring that person in. Now, if the two of you are in the room at the same time, okay? Then basically that, all that credit for time goes to the first nurse practitioner. But basically if the first nurse practitioner leaves the room and then the second nurse practitioner spends an extra 15 minutes, you basically add all that up. And not two separate claims but one claim with the time of both nurse practitioners.

[Caitlin] Thank you, Dr. Policar and Ann. And we just have a few minutes left and I want to make sure that we hop over to the resources. We have been working busy with with Dr. Policar and Ann on a suite of resources we've completely revamped the coding and the reproductive health care environment e-

learning module, so please do review and take that e-learning module and we have five new job aids to support you in your work around coding. The first two, the ICD-10 codes and the commonly used CPT and HCPCS code are both customizable. So they, so you can tailor to your setting. I want to turn over a Dr. Policar and Ann, is there anything else you want to say about the resources that we've been working on to support the folks on the line and the network?

[Dr. Policar] You know, just the recommendation that you go to the website, have a look at them and download them. They are highly tailored to circumstances in family planning. You know, and so much of what you find that, you know of good quality on the internet particularly from the American Medical Association and ACOG and CMS and other places, are somewhat generic. On the other hand this is really focused on family planning and designed in such a way that this information is at your fingertips and you will find it to be very, very helpful for you.

[Caitlin] Exactly, thank you. And I should, all of these resources are free and the e-learning module does allow you for continuing nursing education credits. And that last resource on the slide from NFPRHA is a wonderful e-learning, self-paced module on telehealth coding and billing. So it's another wonderful resource available as Dr. Policar mentioned tailored to family planning settings. So thank you so much for your time. Here are ways that you can engage the RHNTC, we look forward to hearing from you and thank you all for joining us today. Our hour went by very quickly. I hope you'll join me in thanking Dr. Policar and Ann, and to Robbie and Nancy who have helped behind the scenes make this webinar run smoothly. As a reminder, in the coming days materials from today's session, so the recording, the slides and a transcript will be available. If you have additional questions for us on this topic, which I'm sure you do, please do email us at rhntc@jsi.com. Please don't hesitate, we're happy to answer your questions after the webinar. And our final ask is if you can please complete an evaluation for today's session. As a reminder if you are wanting to receive CME, contact hours for this event you must submit an evaluation. And the link will appear when you leave the webinar and it will also be emailed to you after the webinar. And we really appreciate receiving your feedback and use it to inform future sessions. Thank you again for joining us and this concludes our webinar.

[Dr. Policar] Bye.

Slide 38 - Resources

Coding in the Reproductive Health Care Environment: The Fundamentals of Coding eLearning (Module 1) (https://rhntc.org/resources/coding-reproductive-health-care-environment-fundamentals-coding-elearning-module-1)

ICD-10 Codes for Family Planning Services Job Aid (https://rhntc.org/resources/icd-10-codes-family-planning-services-job-aid)

Commonly Used CPT and HCPCS Codes in Reproductive Health Care Job Aid (https://rhntc.org/resources/commonly-used-cpt-and-hcpcs-codes-reproductive-health-care-job-aid)

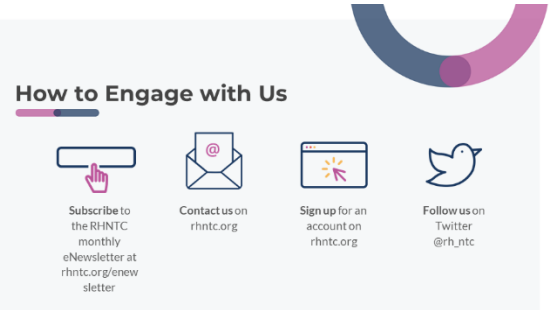
Elements of Medical Decision Making During Family Planning Visits Job Aid (https://rhntc.org/resources/elements-medical-decision-making-during-family-planning-visits-job-aid)

Evaluation and Management Codes Job Aid (https://rhntc.org/resources/evaluation-and-management-codes-job-aid)

Coding for Telemedicine Visits Job Aid (https://rhntc.org/resources/coding-telemedicine-visits-job-aid)

Telehealth coding and billing eLearning from NFPRHA (https://www.nationalfamilyplanning.org/telehealth-billing--coding?)

Slide 39 - How to Engage with Us



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