2021 CPT Coding Changes: The Importance of Preparing Now

Live Webinar Q&A Session

- **Problem list not reviewed by physician. How would that effect the encounter level?**
    - "Reviewing" a problem list has no relevance on E/M coding level regardless of who does that work. It has to be a problem that is ADDRESSED in the assessment/plan of the note and that by default, must be the provider.
- **What is the AAP/SOAPM doing to head off the inevitable period of insurance holding up claims for "additional documentation" needed?**
    - The Payer Advocacy Advisory Committee of the AAP is planning to use the HIPAA Administrative Rule and encourage pediatricians to file complaints if Payers do not comply with the law as written: which includes "using the CPT codes as defined" (and the use is defined in the description with these changes.) *"To report HIPAA administrative simplification violations, practices can use the CMS ASETT tool to file a complaint: https://asett.cms.gov/ASETT_HomePage - Specifically, if the payer is not using the current CPT codes/descriptors, they would click on the "code set" button to start the complaint."*
- **Forms that need to be completed by a physician like behavioral health forms, and WIC forms - How are they going to be absolved by the encounter since they are not template in the encounter?**
    - That work isn't included in any of the elements of the MDM work. So your choice is to use that time as "clinical work" just document that you "completed WIC form as part of the encounter" and you will mentally/manually have to add that time in your head/note as you see fit. IF you charge for the form, then you cannot count that extra time, as you would already be being paid for this separately.
- **Will OP "flip a switch" on 12/31/2020 to track coding differently? So we would have to override OPs built in coding when completing 2020 charting after 1/1/2021?**
    - OP has every intention of getting this update to our practices sometime by mid-December so you can start to see what this will look like. The legacy coding decision support will still exist on the alternate tab for you to use until January 1st.
- **When do we expect a final rule on the fee schedules?**
    - Traditionally, CMS has done this by mid-November, but with COVID-19 priorities - we cannot be sure.

- **Anyone else having challenges with random denials of 90460 by MCD commercial and private insurance payers? We are having MANY instances of denials of 90460 on claims containing multiple 90460 codes accompanying as many vaccines. Payers are paying one or two of the 90460 codes on a claim, but deny the remaining 90460 codes calling them DUPLICATES or NON-COVERED charges.**
    - So some payers want these codes as multiple units rolled up and some want them as individual line items. If you are having difficulties with a particular payer, reach out to your AAP State Pediatric Council if you have one or file a Hassle Factor form for AAP assistance. https://form.jotform.com/Subspecialty/aapcodinghotline
- **If the provider who takes an after-hours call is not the same provider in our practice who saw the patient in clinic, is that time able to be included in the total time of care?**
    - This answer is in the AAP's living document referred to in the webinar. Their language: "Question: I understand that time is cumulative throughout the day, however, does that also go for multiple providers? For example, a patient sees Dr. A in the office. Time spent was 25 minutes. Later the day the mom calls back to discuss a medication question and another physician in the office explains it as the prescribing physician was not available. The call lasts 7 minutes. Both physicians are pediatricians. Can I add up the time?
    - Answer: Yes, so long as the time is spent on the same day it is cumulative with the same physician and same physicians in the same group practice and the same specialty. How you bill it out (ie, under which physician) is an internal decision and nothing CPT addresses. Each physician should clearly document the total time spent."
- **A big change that will affect pediatricians is that URIs will be considered 99212, if we only recommend symptomatic care. However if we recommend any OTC medicine, that can increased to 99213, correct?**
    - Maybe. If it is a teenager that can read the OTC package instructions that easily apply, it may be harder to justify. If it's an infant and you talk about dosing appropriate for age and weight and provide information (and document that you did) OR you discuss any interaction with other medication or dietary supplements or other underlying conditions (such as ibuprofen may aggravate your GERD), then you are most likely justified in the "risk" level for a 99213 but you will still need to meet one other criteria (Problems addressed or Data reviewed/analyzed).
- **Can APRN's use Time Based Coding? Or is that only for MD's?**
    - Anyone whose clinical work and is considered a provider that can independently bill an E/M visit can use time: NPs, PAs, and physicians.

- **Are we only able to bill E/M services based on time in 2021?**
    - The only TWO choices are TIME or MDM.
- **Does the note need to be finalized on same day or just the essential documentation to demonstrate risk? We have evening appointments and sometimes not possible to have all notes finalized same day.**
    - You can do it the next day but you can't count any of the clinical work that is performed after midnight of the day of the visit. Some people may choose to delay if they feel like there may be additional work that will contribute to the E/M level that may happen after they leave the office for the day.
- **What about the time you spend talking to ER or a specialist?**
    - That is not "separately billable" work, so it can count as either time OR increase your level of MDM appropriately. Just make sure you document it.
- **How can they prove you prepped charts the day before and not on the DOS?**
    - If you use an EHR, the audit trail has record of nearly everything you do and when you are logged in to do it. At some point in the future, the payers may begin to requests audit trails as well as notes during an audit.
- **Patient comes in for abscess evaluation and treatment: How would you account for the time in that visit: time assessing the wound, talking with parent and patient, then you do an I&D procedure, then counsel wound care and write the note?**
    - You would use the appropriate CPT code for the procedure and part of the definition of procedures includes preparation of the patient, getting consent and cleaning up afterward. Only the "evaluation of the patient to determine the need for the procedure" would count separately and be included in either MDM or time based code choice. And some payers want you to use a DIFFERENT ICD for the procedure and the E/M, like abscess and cellulitis.
- **Will future templates include a section for historian? (We should be noting that anyways, but sounds like in the future that would be invaluable).**
    - Because not all visits require a template, the independent historian field is on the Visit Info tab of the OP note.
- **When including historian, would the check-in process stating who the patient presents with count? Where the note states at the top, "Accompanied by: Both parents, Mother, father, etc."?**
    - This field really should be filled in by the provider who is doing the visit. The staff will not know if the provider needs to ask a question of the parent/caregiver and who provides the answer. Think of a teen who presents with vaginal complaints and you ask the parent to leave and really don't get any independent history. This is the "provider" work.
- **Are OP staff making changes to templates to make them more user-friendly in conjunction with these changes in guidelines?**

- Take advantage of the Sneak Peek video that was shared with OP Practices earlier this week. This is available on the OP Help Center. More education and support to come. And join the conversation on the Office Manager and Provider listservs!

- **Question about the idea of double dipping. Let's say a newborn comes in for weight check and circumcision. In our experience, we would only get paid for one: either the circumcision OR the weight check visit (which could be 10-15 minutes on its own). Will they now pay for both? Also true for cerumen removal. They come in for ear pain, can't see and spend 15-20 minutes removing cerumen, we have only been paid for either OV OR cerumen removal.**
  - Payer response does not necessarily change after these coding/documentation changes. They are going to get the same CPT codes, it's only in audits where they will have the opportunity to change this. If you have trouble with a weight check and circumcision, that's a great problem to file a Hassle Factor form or work with your Pediatric Council.
  - Cerumen removal is tricky because you are not supposed to use it to 'remove a little wax' to see the eardrum, but if it's really impacted, you could probably use the TIME it takes and NOT report the removal code which may actually be a win in this scenario. Great question for the AAP coding hotline or to first see if it's in the FAQ living document.
- **Can you share how OP will be helping with time tracking? Review of documents and labs?**
  - Take advantage of the Sneak Peek video that was shared with OP Practices earlier this week. This is available on the OP Help Center. More education and support to come. And join the conversation on the Office Manager and Provider listservs!
- **How would you know if a provider finishes a note the day after the appointment?**
  - The audit trail in the EHR can track when work is done and who is logged in doing it.
- **Will there be a webinar which will give specific examples of coding and documentation?**
  - We are looking forward to future webinars on this topic, but in the meantime, the AAP's Coding Newsletter has great examples and their FAQs begins to address some common scenarios.
- **Does the time given to encounters by "extenders" like PAs and NPs count towards the provider's time?**

- If a provider that could bill independently (PA and NP) spends 10 minutes with a patient and then realizes that the patient is complex and the provider comes in and spends 30 minutes, the billing physician can then include the NP's time for a total of 40 minutes, but both should be clearly documented in the record. Same thing would happen if a physician started a visit and then got called out on an emergency and a second physician stepped in OR the patient came back later in the day because of a worsening condition. Document ALL the time a clinician provider spends, and add up to one total E/M coding level. Only ONE E/M per day and only PROVIDER, clinical time.

- **Why won't our templates be enough in reference to the independent historian?**
  - This depends on how you use your templates and who documents what information where. If you are using OP, the "coding calculator" will not recognize that work unless it's in the field designated for this purpose but you could put the information anywhere you like, including your plan, and manually override OP's suggested coding level.
- **Can you address the significance of the second historian? Will it really increase MDM points if we document "mom interviewed as well?" We've gotten mixed messages from coders in the past on this topic.**
  - Remember we are headed into untested waters. We have no idea what the auditors will do. Clearly having a mom as an independent historian for a 3 month old is obvious. But not so for a 12 year old. So some folks are advising adding wording like "mother reported no family history of celiac disease or other GI disorders." Having an independent historian IS valid for increasing your Data Review section of the MDM based on the AMA's specifications. Under 99213 "Category 2: Assessment requiring an independent historian(s)"
  - https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- **I'm confused about MDM - how is it determined we "meet" 2 of 3 sections?**
  - Highest level reached in 2 of the 3 categories: Problems Addressed, Data Analyzed/Reviewed and Risk. More upcoming information to address MDM separately.
  - https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- **Does the nurses time spent with the patient count?**
  - No. Billing provider clinical time is the only thing that counts if you are using time.
- **We use 99212 for patients that come in for vaccine only because the doctors are reviewing the patient's chart and making decisions on what vaccines to order. We won't be able to charge that come 2021, correct? Due to time?**

- You are already not following best practice and AAP guidance. Unless the patient has a separately identifiable reason defined by a separate diagnosis and medically necessary reason for the visit, you should only be charging the vaccine product and administration codes and you are at risk for an audit and large take backs.
- https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Private/When-Is-It-Appropriate-to-Report-99211-During-Immunization-Administration.aspx

- **Do you have tips about billing for well child care in medically complex patients? Multiple problems are usually addressed? Medical complexity isn't usually part of well child care codes. Will this change or do we still add modifier 25 and a separate encounter?**
  - There is nothing changing about well visit codes or their RVU value with these changes and your current workflow should not be substantially altered except to document any E/M in addition to the well visit spelling out time or MDM reasons for choosing your E/M code. (For time, be sure to document "in addition to the x minutes spent at the well visit addressing preventive care, spent an additional y minutes addressing the additional problems.)
- **Can you speak to in-office testing as data elements? i.e. Sofia rapid fluA/fluB/covid combination test, would this be three tests/elements?**
  - There is still some granularity to this being worked out. In general, if you can "order it as one test with its own CPT then it "counts as one test". Ordering a CBC and a chem panel (each with its own CPT) gets you 2 tests. But, you do not count the WBC, Hgb, Hct, RDW of each "individual components" of the test. So if there is a combo test that has its own CPT, then that counts as one. If you order a rapid strep and a rapid flu (each its own CPT) that counts as 2 distinct tests.
- **My practice struggles with front desk staff not scheduling enough time for complex patients, well visits and med refills on the same visit but their meds are not working etc. Nursing staff that is efficient or not trained to take any accurate history. You don't address how a practice can start with team building, staff training etc. It's not all on the provider when they're out there on their own.**
  - That sounds like a separate topic for a separate webinar that we might want to address in the future.
- **Any suggestions for adding prompts or statements to templates to help with coding?**
  - This completely depends on the EHR that you are using and understanding where/how you may be assisted in choosing the most appropriate E/M level. Office Practicum's Coding Decision Support will be your best assistant and

putting language in templates will make it easier if you are audited. More to come in subsequent educational materials.

- **How do you foresee "volume" practices handling this workflow?**
    - High volume practices who spend less time with a patient will likely code higher using MDM and I would recommend they become proficient in both understanding what needs to be done and how to document in a way that will stand up to an audit.
- **I'm confused about how this impacts procedure coding (30min taking out a suture on a screaming child). Do we just bill for the procedure?**
    - Suture removal really doesn't have a high value CPT code AND if you put them in, taking them out is part of the initial procedure code. However, if you did not put them in, it is reasonable to use an E/M code, instead of a CPT code and base it on time.
- **Is completing school form/asthma action plan/allergy action plan etc. time counts?**
    - If you do NOT charge separately for those items, and it is a part of the visit, and the provider does it, and it's documented that you "completed and reviewed information on AAP, or needed requirements of school form" then that's part of your clinical work. But, if it's billed or paid for separately by the payer OR the patient, you cannot include it in E/M time.
- **Is there a good Medical Decision Making cheat sheet or Medical Decision Making for Dummies resource anyone knows about to educate providers?**
    - Unfortunately, not yet! The AAP is working on some additional materials. In the meantime the coding newsletter is helpful as is the AMA table.
    - https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- **Will CHADIS surveys give a higher level of coding?**
    - Not if you are using a separate CPT code to bill for those surveys as that time/work/complexity is already included in any CPT code you use for the survey itself. If you are NOT using a separate code, then certainly time can be used. Regarding whether that can be included in "data review and analysis," I would refer this question to the AAP coding hotline for clarity and then please share with the community.
    - https://form.jotform.com/Subspecialty/aapcodinghotline
- **Many times providers review charts the day prior to the visit. How would we include in time?**
    - You cannot include any clinical work that the provider does on the day prior to the visit if you want to use time. Some practices are actually changing their AM start time to allow providers 30 minutes for “pre-patient visit" work.
- **If you order lab work or x-ray or referral, does that contribute E/M level?**

- Reviewing or ordering any tests increases complexity. I do not believe simply referring a patient to an outside specialist increases complexity in and of itself, but any reviewing of data in order to make that decision does. This would be a good question for the coding hotline: https://form.jotform.com/Subspecialty/aapcodinghotline.

- **Will we be coding based on time OR MDM or do you have to satisfy both types of criteria?**
  - No. It is ***either*** Time ***or*** MDM
- **Problem list should all be reviewed at well visit?**
  - An inherent part of every well visit (and its corresponding CPT code) should be a comprehensive review of problem list, history, medication list, allergies, etc.
- **Can you just document reviewed?**
  - If I'm understanding this question correctly, any text that you document in your note emphasizes to auditors what exactly you did. So documenting "reviewed ER record from 10/1/20 and prior report from Allergist on 6/6/20" tells the auditor exactly what you did.
- **If nurses document history or meds and you note reviewed and accurate does that not count as provider time?**
  - If you are using time to choose your E/M level, reviewing the work that your practice team did is valid clinical time spent.
- **The first video demonstrated some possible modifications to the templates (time vs MDM pages for example). Will there be a sample database we could play with before all that goes live?**
  - Unfortunately, there is no way for Office Practicum to allow all of our users in a sandbox. Please contact me directly or ask the question on the OP Provider listerv so we can assist you in this work.
- **Will providers be able to access this recording even if they did not register for the webinar?**
  - Absolutely! Share this link with anyone you wish: https://www.officepracticum.com/portfolio_page/2021-coding-changes-prepare-now
- **Our front office fills out the visit info with the person bringing the patient to the appt. Do I need to also record in a separate section of my note an independent historian?**
  - If you are an Office Practicum client, then the clinician should document who the independent historian is if you actually need to ask them anything. If you want the calculator to automatically give you credit for this, then using the appropriate field is how to get credit for it. Alternatively, documenting

somewhere in the note that "mom provided information that there is no family hx of x" is what is considered best practice.

- **What kind of coding change will there be for 90460 or 90461?**
    - There is no coding change for these codes, just increased RVUs as described in the webinar and available in the AAP News article resource.
- **How do providers "keep time"?**
    - There are multiple ways to do that. Some providers are using a tool similar to what lawyers use, some are keeping their own "approximate times" manually. Office Practicum users will have tracking done based on where they are inside the EHR and will be presented with a summary to edit/adjust as needed.
- **Is there a need to have OP templates re-configured for the change?**
    - There are several updates that will make this work easier. They are described in the Sneak Peek video and more to come. Also great questions to ask on the listservs.
- **Do we not need to a certain number of history and review of systems elements anymore?**
    - No. Effective 1/1/21 HPI, ROS and exam elements are irrelevant except as needed for clinical reasons and medial legal reasons. Many providers are planning to get rid of "note bloat" in their templates starting in January.
- **If the provider finished the office visit during the office hours, but later called the patient after hours to discuss the lab results or returns their call to address any of their concerns, can that time be included in the coding for that visit?**
    - Yes. Any time the provider spends on the same calendar day as the visit, that is related to clinical care aspects of the visit, and can be counted in the time for that visit.
- **We archive the chart 24 hours after the visit is that Okay?**
    - Your workflow for finalizing or archiving notes/charts should not necessarily need to change. Every practice should just consider the workflow for how to potentially adjust coding levels that were chosen based on time to adjust the E/M level if time was spent after the end of the day (should be the minority of visits, but practice should have a workflow outlined.)
- **We already have a payer down coding our claims that started this month.**
    - Some national payers are doing "pre-audit" downcoding and this is a growing concern at the AAP. Please fill out a Hassle Factor Form.
    - https://www.aap.org/en-us/my-aap/Pages/Hassle-Factor-Form-for-Private-Payer.aspx

- **In the history section, there is a pertinent button [which I never use]. If we use that and have standard words would that be a better way to document in a quick way that we addressed a problem?**
    - Just acknowledging that the problem is pertinent is not enough. You need to address its implications for this particular visit and that you "did something" to address it. Examples might include: "Addressed asthma with parent and reviewed asthma action plan and family has adequate supply of medications" or "discussed with parent implications of developmental delay and ability to administer medications successfully. Parent will reach out if has difficulties and will adjust plan of care appropriately."
- **Does this mean we can bill 99212 for our phone calls at night to our on call doctor?**
    - "No. The non-direct care codes have not changed. Time for a phone call after the hours can be added to the coding level related to an in-person visit that occurred the same day and increase the time which may or may not increase the E/M CPT level. And remember that phone calls have their own CPT codes and cannot be used if the patient was seen for a visit related to an E/M service within the previous 7 days nor can they lead to an appointment within the next 24 hours or soonest available.
- **How would you bill if you see a patient via telemed on Monday and they come on Tuesday for lab tests?**
    - If that Tuesday is for labs only, and those labs have their own CPT code, you would simply charge for the CPT codes related to that work. If this does not answer your question, we recommend sending more specifics to the coding hotline: https://form.jotform.com/Subspecialty/aapcodinghotline
- **Does the after-hours call have to be documented as an addendum on the note or as a message in order to be added to the total time?**
    - If you are adding an additional message or other communication to the total time of a visit which you are choosing the E/M level based on time, there should be some notation made in the note for the visit or an addendum that refers to the time spent (not necessarily the message itself) with reference to the updated information. For example: spent additional 10 minutes speaking with mother related to the visit which occurred 10/22/20 (see message recorded for details.)
- **Do completion of forms by provider for the patients count in the visit time?**
    - If you do NOT charge separately for those items, and it is a part of the visit, and the provider does it, and it's documented that you "completed and reviewed information for needed requirements of school form" then that's part of your clinical work. But, if it's billed or paid for separately by the payer OR the patient, you cannot include it in E/M time.

- **Can we have who is the historian added as a drop down in the history?**
    - If the person who asked this question is an OP client, please refer to the Sneak Peek video for how Office Practicum is approaching the independent historian.
- **On the Pediatric Superbill the 99211 is still listed as Clinical staff, I was under the impression that code was going away completely.**
    - 99201 is being deleted in January of 2021.
- **Will MDM and billing impact the worlds of Managed Medicaid and CHP?**
    - These changes apply to ALL payers, as they are changes at the CPT definition level. You are using the same codes you always did (except for 99201 which will be removed in January). It's just how you choose the level and how you need to document your visit justifying the E/M level you chose.
- **Do the comments on the coding screen become part of the note?**
    - OP is currently discussing options for this but currently will show up in your audit note (to be used in payer audits) but not necessarily in your office visit note.
- **If work must be done on the same date of visit, should we have patients return on separate day to discuss test results etc. if there will be a lengthy discussion/questions/counseling with/by patient?**
    - There are all kinds of implications to bringing patients back to discuss results of tests. Remember if you use MDM, you get credit for ordering or reviewing those tests. However, if it will significantly change plan of care (for example a celiac test is positive, or the patient has an elevated HgbA1c), this may be a perfect fit for a telehealth visit or an in person visit. (Families may have financial responsibility for some of these costs which may impact how you decide to handle these individual patient scenarios.) The 2021 coding changes should not substantially alter your workflow for circumstances such as these.
- **What happens if OP is out for an unseen reason? Sometimes that happens for a few minutes or longer. How should we document?**
    - That is addressed partially in the Sneak Peek video but a more granular presentation focused on Time will be forthcoming.
- **So that I make sure I understand, is a provider able to complete his/her note the next day so that he/she makes sure everything was charted correctly?**
    - Absolutely. However, the time you spend completing the note that next day cannot be calculated in the "total clinical time" IF you are choosing an E/M level based on time. (Has no impact if choosing a code based on MDM.)
- **Is training available for the providers?**

- Please direct this question to your OP Account Manager. OP has not yet considered how to best address requests such as this one.

- **Do you think you will coding mostly on time or MDM?**
  - I think I will personally use whichever fits the scenario best. In general, I'm a fast documenter and fast talker, so likely will default to MDM the majority of the time. However, for those prolonged visits, if time gets me a higher E/M code, then I will use time.
- **I am now retired but note significant changes in OP and all for the better.**
  - Thank you so much! OP takes our practice feedback seriously and we truly believe that as a community of pediatricians solving similar problems that we are indeed #BetterTogether