Winds of Change: Whirlwind or gentle breeze?

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Disclosure

- I have no relationships with proprietary entities related to the content of this activity.

- Persons involved in the planning of this activity have reported no relevant financial relationships with any commercial interest.

Educational Objectives

Following the conclusion of this activity, participants will be able to:

- Describe the changes to the Current Procedural Terminology (CPT) 2023 Codebook and how they apply to your practice
- Identify pitfalls in computer charting and documentation that increase legal risk

Coding and Billing Mantra

- Services must be medically necessary and reasonable
- Diagnoses must be coded to the highest level of specificity
- Documentation must support the level of services coded and billed

2023 Consolidated Appropriations Act

- 2.08% decrease in the Conversion Factor
- RVU is multiplied by a dollar conversion factor (cf) to become a payment schedule
- This change will result in an overall decrease in physician reimbursement

2023 Consolidated Appropriations Act

- Increase in NIH budget
- Increase in Maternal and Child Health Block Grant
- Increase in WIC spending for fruit and vegetables and adds additional 6.2 million participants
- Additions to Child School Nutrition Programs – summer programs, breakfast programs, and school kitchen equipment grants

2023 Consolidated Appropriations Act

- Increased funding for CDC, particularly in public health infrastructure and safe motherhood and infant health

Current Procedural Terminology (CPT)

- E/M, critical care or time-based
- Some are bundled
- Some are global (by days, hours or comprehensive service)

Evaluation and Management Codes (E/M)

- Medically appropriate history
- Medically appropriate physical exam
- Level of medical decision making (number and complexity of problems addressed, amount and complexity of data analyzed, risk of complications and/or morbidity or mortality)

Evaluation and Management Codes (E/M)

- Address each category that supports MDM
- The documented details of the H & P do not determine the code
- Interpretation of tests is important; don't just copy and paste results in medical record
- Be sure to state the risk associated with management and treatment

Code Deletions for 2023

- 99217: Observation Care Discharge. Use 99238 or 99239
- 99218-20: Initial Observation Care. Use 99221-23
- 99224-26: Subsequent Observation Care. Use 99231-33
- 99241: Outpatient Consult Code. Use 99242-45
- 99251: Inpatient Consult Code. Use 99252-55

Adjusted Inpatient E/M Codes

Codes	Previous Times (mins)	Updated Times (mins))
99221	30	40
99222	50	55
99223	70	75
99231	15	25
99232	25	35
99233	35	50

Adjusted Office or Outpatient Consultation Time Revisions

Codes	Typical time (mins)	Time threshold (mins)
99242	30	20
99243	40	30
99244	60	40
99245	80	55

Inpatient or Observation Consultations Time Revisions 2023

Codes	Typical Time (min)	Time (mins)
99252	40	35
99253	55	45
99254	80	60
99255	110	80

Emergency Department Services

- Revisions to E/M 99281-85
- 99281 no longer requires MDM or presence of QHP
- 99282-99285 solely based on MDM
- Time is not a criterion for ED code selection
- 99282: straightforward 99283 Low complexity
- 99284 Moderate Complexity 99285 High Complexity

Evaluation and Management Codes (E/M)

- Because some inpatient E/M encounters require significant time, a new inpatient/observation E/M code has been introduced, 99418

- This code can be used when the total time required exceeds the highest level of service (with or without direct patient contact). Use in addition to regular E/M codes (99223, 99233 or 99255 for in patient consult)

- Billed in 15 minute increments, used only if E/M is billed using time and the time performed is on the day of service

Evaluation and Management Codes (E/M)

- Outpatient prolonged E/M time code is 99417
- Same rules apply; when primary service level E/M time is exceeded. In 15 minute increments
- Can also be used with outpatient consultation codes

Evaluation and Management Codes (E/M)

- Updated time based code for prolonged clinical staff services in the outpatient setting
- 99415, first hour; 99416, each additional 30 minutes
- This code can be used if you provide services in your office by your staff under your supervision, such as rehydration, nebulizer therapy, observation after vaccines, etc
- The time has to be face to face with patient and/or family/caregivers by clinical staff under direct supervision of the physician or QHP
- The time starts at 30 minutes beyond the typical clinical staff time (table in CPT manual)

Evaluation and Management Codes (E/M)

- There are codes for interprofessional telephone/internet/EHR E/M consultation codes
- Provided without face-to-face encounter
- May require software interfaces, insurance approvals, etc so check with your hospital systems, employer
- Don’t work for free if you can get paid

Time-Based Coding

- 4 types of encounters can be based on time
  - E/M services that include counseling or coordination of care
  - Prolonged services
  - Hospital discharge
  - Critical care services

Time-Based Codes: What counts for time?

- Documenting in EHR or other health record
- Reviewing patient chart, labs, tests or procedures
- Obtaining and/or reviewing a separately obtained history
- Exam
- Speaking with consultants as well as pt/family
- Must be on same floor as patient
- Reviewing from office or another floor doesn't count
- Care coordination if not accounted for elsewhere

- Outpatient time has different rules

Time-Based Codes
What doesn't count?

- Waiting for test results
- Waiting for changes in patient's condition
- Discussions with trainees or medical students not in direct face-to-face contact
- Test results or other information reviewed not on the date of the patient visit

Time-Based Discharge Codes

- 2 codes: one for 30 minutes or less, one for greater than 30 minutes
- Includes: examination, discharge instructions, prescriptions, follow up planning
- Must be done by you
- Must be done on day of discharge

Discharge Summary Time Documentation

- I spent 60 minutes on discharge of this patient which included examining the patient, speaking with parents, answering questions, writing the discharge summary and follow up care planning

2023 Hospital inpatient/observation E/M

Initial		
CPT	MDM	Time
99221	Low	At least 40 min
99222	Moderate	At least 55 min
99223	High	At least 75 min
When reach 90 min, add +99418 (prolonged service, ea 15 min)		
Subsequent		
CPT	MDM	Time
99231	Low	At least 25 min
99232	Moderate	At least 35 min
99233	High	At least 50 min
When reach 65 min, add +99418 (prolonged service, ea 15 min)		

2023 Inpatient consultations

CPT	MDM	Time
99252	Straightforward	At least 35 min
99253	Low	At least 45 min
99254	Moderate	At least 60 min
99255	High	At least 80 min
If exceed 95 min, add +99418 (ea 15 min of prolonged inpatient/observation time)		

Medical decision-making: 2023 E/M

Level of MDM (based on 2 of 3 elements)	Number and complexity of problems addressed at the encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Limited	Low risk of morbidity from additional diagnostic testing or treatment
Low	Low	Limited	Low risk of morbidity from…..
Moderate	Moderate	Moderate	Moderate risk of morbidity from……
High	High	Extensive	High risk of morbidity from ……

Role of history and exam: 2023 E/M

- E/M codes that have levels of services include a medically appropriate history and/or PE, when performed
  - The extent of history and physical examination is not an element in selection of the level of these E/M service codes.
- The nature and extent of the history and/or PE are determined by the treating physician or other qualified health care professional reporting the service
- The care team may collect information, and the patient or caregiver may supply information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other QHP

Using Time to code inpatient or consult E/M

- Total time on date of encounter—separate from any other billed services
- Examples of activities included in Time:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)

Critical Care Services

- Defined as direct delivery by a physician(s) medical care for a critically ill or injured patient such that there is a high probability of imminent or life threatening deterioration in the patient's condition.
  - Code 99291 (first 30-74 minutes)
  - Code 99292 (each additional 30 minutes)
  - does not have to be continuous time spent, can be aggregate time b/w different physicians in the same group
  - Documentation

Critical Care (cont'd)

Key Point: Critical Care is determined by the level of care being provided and not by the location of the patient

Physicians of the same specialty within the same group bill and are paid as though they are a single physician.

Critical Care Codes

- 24 hour “global” codes
- Some services are bundled
- Attached to the calendar day, not actual 24 hours

What is the purpose of Documentation/notes?

1) Chronologic record of care a patient has received

2) Communication between providers (stakeholders)

3) Statistical/ Public Health Data collection

4) To Get Paid☺

Documentation

- In the paper chart world, legibility was a huge problem
- Paper chart was physical and maintained in the hospital or clinic
- Extraneous information was not included; only pertinent information was recorded via SOAP note format

Electronic Documentation Benefits

- More accessible
- More legible
- Available remotely to all stakeholders, regardless of location
- Synthesizes structured data elements found elsewhere in the record

Electronic Documentation Pitfalls

- Overwhelming amounts of textural and tabular data
- Hard stops, required fields and forced fields
- Pop ups
- The above have been linked to physician burnout

Electronic Documentation Pitfalls

- Functions that were created to alleviate some of those burdens (copy forward, templates, drop downs, scripts) can lead to increased length and decreased clarity “note bloat”

Repetition

- **Imaging**
- Imaging Results:
- (4/30) US Abd: Moderate volume simple ascites, no intraperitoneal free air
- XR Abd: dilated bowel with air fluid levels
- (5/1) XR Abd: Abnormal bowel gas patter w/gas-filled dilated bowel loop and pneumatosis along left flank.
- XR Abd, PM: Similar abnormal bowel gas pattern with bubbly lucencies suspicious for pneumatosis, less likely enteric contents. No pneumoperitoneum
- (5/3) XR Abd, 0025: Similar abnormal bowel gas pattern with scattered relatively fixed gaseous distention of the intestinal tract. No definite pneumatosis.
- XR Abd, 0610: Slightly decreased aeration of the intestinal tract with an otherwise relatively fixed bowel gas pattern.

Repetitive data, uncertain value

Vital signs:

Patient Vitals for the past 24 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2	Weight			
05/02/21 0700	—	—	—	162	40	98 %	—			
05/02/21 0600	—	—	—	165	40	97 %	—			
05/02/21 0500	—	—	—	166	40	96 %	—			
05/02/21 0415	—	—	—	170	40	93 %	—			
05/02/21 0400	**(!) 73/31**	98.5 °F (36.9 °C)		Axillary	166	40	95 %	—		
05/02/21 0300	—	—	—	169	40	94 %	—			
05/02/21 0219	—	—	—	170	40	94 %	—			
05/02/21 0200	—	—	—	167	40	95 %	—			
05/02/21 0100	**(!) 67/32**	—	—	167	40	94 %	—			
05/02/21 0000	—	98.6 °F (37 °C)	Axillary	178	40	91 %	**(!) 1.045 kg (2 lb 4.9 oz)**			
05/01/21 2303	—	—	—	180	46	95 %	—			
05/01/21 2300	**(!) 72/32**	—	—	180	40	94 %	—			
05/01/21 2200	—	—	—	179	40	95 %	—			
05/01/21 2100	—	—	—	180	40	99 %	—			
05/01/21 2009	—	—	—	189	55	95 %	—			
05/01/21 2000	**(!) 72/32**	98.7 °F (37.1 °C)		Axillary	188	60	92 %	—		
05/01/21 1922	—	—	—	178	**(!) 70**	99 %	—			
05/01/21 1900	—	—	—	175	**(!) 89**	99 %	—			
05/01/21 1800	—	—	—	183	**(!) 63**	93 %	—			
05/01/21 1755	—	—	—	183	50	92 %	—			

Copy, no editing

- **Nutrition**

- Source of Nutrition: d10w with lytes (KCL and NaAcetate) at 120 mL/k/day at 100 mL/kg/day

Copy forward: did you examine this baby?

Abdomen: round but soft, without masses, organomegaly or tenderness; bowel sounds normal, UVC present and secured to abdomen
GU: normal preterm female features
Skin: warm, dry, no rash, no lesions
Lines: PIV Clean/dry/intact

Active LDAs:
Lines, Drains, and Airways
PIV Line

Improving Electronic Documentation

- Use of narratives or free text
- Careful editing of any copy forwarded text (especially if you are not the original author)
- Daily progress note limited to pertinent information (limited historical information, previous tests, etc)
- Modified SOAP note

Modified SOAP note

- Proposed by AAP Council on Clinical Information Technology
- S = succinct
- O= original (no copy forward)
- A=accurate
- P=problem based

Dictation Programs

- Speech training times have been vastly reduced (speech recognition)
- Speech accuracy is approximately 99%
- Encrypted and HIPPA compliant
- Designed to allow spoken data to drop directly in EHR fields and forms

Dictation Programs

- Time saving
- Fewer Clicks
- Microphone needed (cell phone can be used)
- Many programs; interface with EHRs

Legal Protection/Malpractice Considerations

- Extended liability in Pediatrics (18 years)
- The medical record is the only record of care you have provided to a patient
- Narrative documentation is very important. Unless totally obvious, a narrative on your thought process and why a certain test or course of care was chosen should be included

Protection from Malpractice/Liability

- Have lengthy discussions about risk/benefit, possible side effects, alternatives and document well, especially when parents refuse recommended treatment

- "Informed vs Refusal" of consent

- Document all discussions with families including their specific questions and responses

Problematic Charting-Just don't do these

- Always: nothing is always true or certain in charting or patient status
- Never: see always
- Good: as compared to what? Use descriptors, instead of "normal for age" consider " consistent with appropriate growth and development for age"
- Inappropriate or colloquial abbreviations. Use only those recognized as official abbreviations. Just because it makes sense to you, or it is common in your hospital, it does not mean it makes sense to others (the person giving the deposition)
- Incorrect time recording. You are responsible for documenting time to the minute of occurrences, especially untoward or unexpected ones. Make sure your time matches all other's (RN, RT documentation all matches up)

Problematic Charting-Just don't do these

- Be specific with measurements. Don't say "ETT in good placement". Instead, document tip placement anatomically via CXR, auscultation with equal breath sounds, good chest rise.

- Never blame someone in the chart for an error. That is a check for the plaintiff. Describe the event/error accurately without judgement.

- Don't say "will continue to monitor". Instead, consider "will remain on continuous HR, BP and spO2 monitoring".

- Asphyxia. Instead, record blood gas, lactate, heart rate tracings, exam. However, if it is an infant on total body cooling, the proper diagnosis is hypoxic ischemic encephalopathy. That is the only indication for TBC. Please make sure the baby meets all criteria and document the Sarnat score and be specific about the biochemical criteria.

How to Improve your Charting

- Be very specific; don't use words like "reassuring" or "good"
- Use simple, accurate wording that reflects only the facts of the situation or plan
- Narratives regarding your thought process on the condition of the patient and why you chose a certain course of therapy will help your lawyer
- Keep the family informed the best you can; don't postpone communicating. Document your conversation.

Questions?