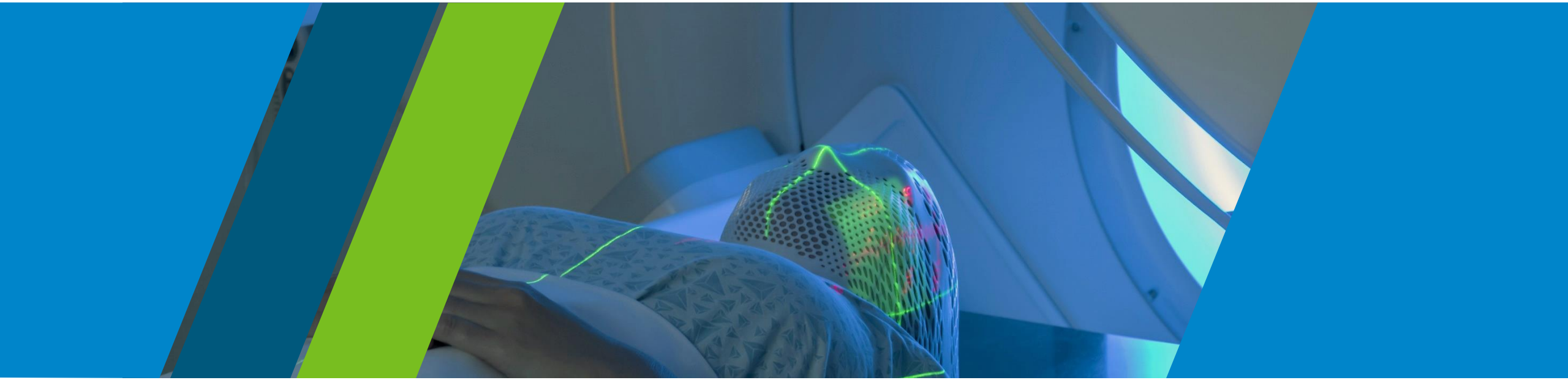
REVENUE CYCLE CODING STRATEGIES®



Best and Worst of Oncology Billing, Including NP Billing

Notices

When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.

The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

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REVENUE CYCLE CODING STRATEGIES®

Presenter

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Executive Director, Oncology Client Services

Revenue Cycle Coding Strategies

REVENUE CYCLE CODING STRATEGIES®

One can make a case either way and even both ways at once

Objectives

1. Review areas of change in the billing for services in the oncology setting
2. Understand positive and negative impacts to those changes
3. Identify potential risks and rewards for the practice
4. Discuss areas for internal review and oversight to ensure billing compliance

Key Topics

Public Health Emergency

Evaluation and Management

Nurse Practitioners

Hierarchical Condition Categories (HCC) Coding

Public Health Emergency

Current PHE declaration effective through October 13, 2022

Best

- Supervision flexibilities
- Increased telemedicine regardless of setting
- Audio-only visits
- Increased options for new patient visits

> Over the course of the PHE, we have learned a great deal from health care providers, facilities, insurers, and other stakeholders' experience and use of the waivers and flexibilities. In many cases, these have proven to be especially useful during the initial challenges of the pandemic. In fact, we determined that some of these measures should remain in place even after the end of the PHE to promote innovation, maintain or improve quality, advance health equity, and expand access to care.

-Health and Human Services (HHS)

> Conversely, we have also identified certain flexibilities that, while useful during the initial response to COVID-19, are no longer needed in the current stage of the pandemic.
>
> *-HHS*

Public Health Emergency

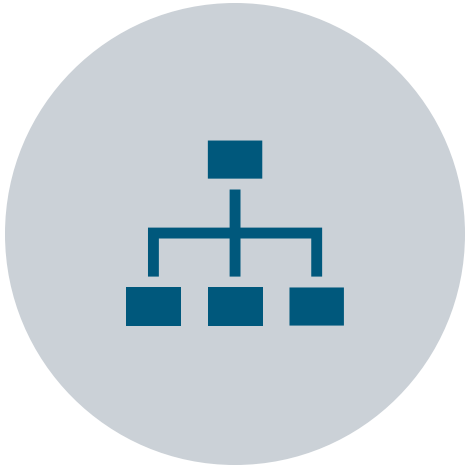
Worst

- PHE will come to an end
- Many of the flexibilities are temporary
- Timelines for change vary by waiver
- Oversight will be required to lessen compliance risks

Return to Normal

- **Permanent Changes**
  - New rules codified to make certain flexibilities permanent (mental / behavioral health)
- **Phased Out**
  - Allow for extension of the flexibilities for transition period after PHE ends
- **Cease Immediately**
  - Ends with the PHE declaration

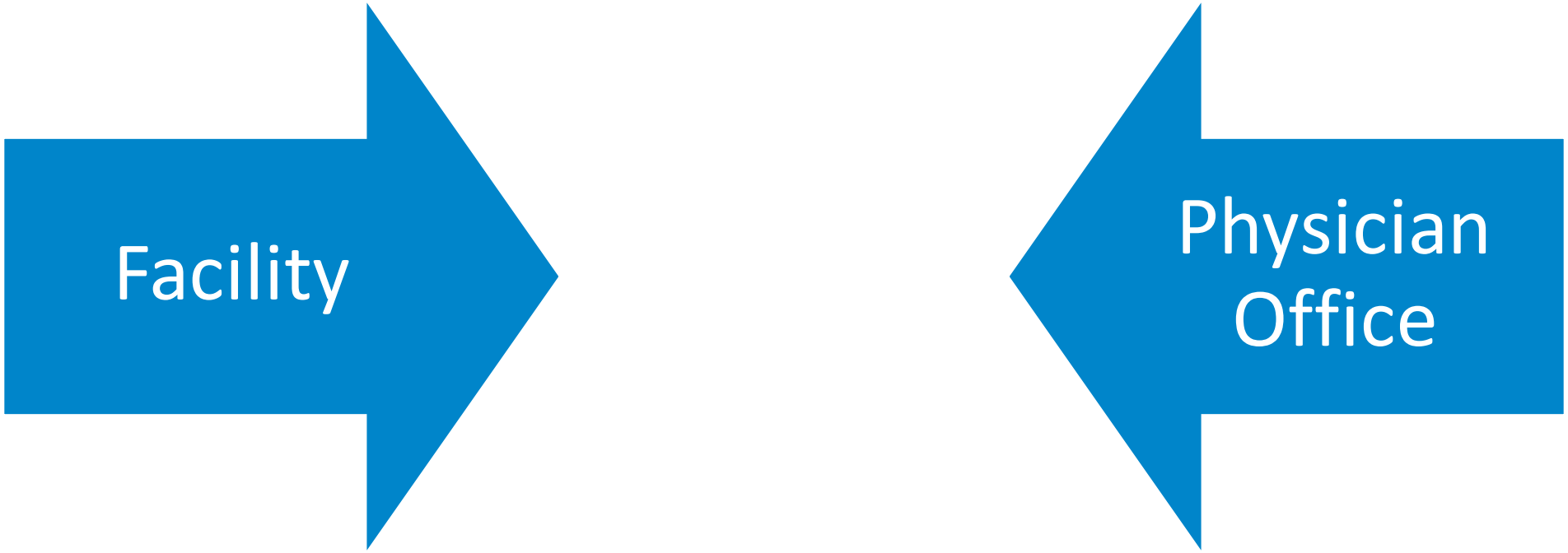
Key Flexibilities in Oncology



SUPERVISION

TELEHEALTH

Supervision



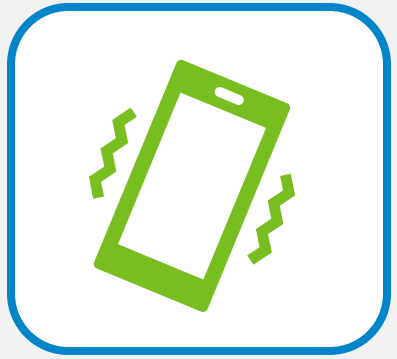
General Supervision

Direct Supervision

Facility Setting

General Supervision

“procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure”



Physician Office

Direct Supervision

Supervising provider to be in the same office suite, but not in same room

Immediately available

Must be able to furnish assistance and direction

Supervision Flexibilities

- Definition of direct supervision adjusted to include “virtual presence”
- Allowed supervision of clinical staff through real-time audio and video technology
- Set to return to pre-PHE rules at the end of the calendar year that the PHE ends

Potential rule changes may be seen in future years based on future rule making and policy changes

Telehealth Flexibilities

- Telehealth available regardless of setting
- Patient not required to be at “originating site”
- Use of smartphones and other audio/video technologies
- Expanded allowable telehealth services
  - Audio-only encounters by utilization of telephone evaluation and management services
  - Virtual check ins and e-visits for new patient visits
  - Treatment management visits (CPT® 77427) for radiation oncology

Consolidated Appropriations Act of 2022

- Extends certain telehealth flexibilities for Medicare patient for 151 days after the official end of the PHE

Key Provisions

- Telehealth provided at home
- Expanded telehealth practitioners
- Audio-only telehealth
- Delayed in-person requirement for mental health services
- Extension for FQHCs and RHCs as distant sites

Increased Scrutiny

Office of the Inspector General (OIG) conducting studies to assess appropriateness of the use of telehealth during the PHE

Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks

In response to the COVID-19 pandemic, CMS implemented a number of waivers and flexibilities that allowed Medicare beneficiaries to access a wider range of telehealth services without having to travel to a health care facility. This review will be based on Medicare Parts B and C data and will identify program integrity risks associated with Medicare telehealth services during the pandemic. We will analyze providers' billing patterns for telehealth services. We will also describe key characteristics of providers that may pose a program integrity risk to the Medicare program.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
October 2020	Centers for Medicare and Medicaid Services	Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks	Office of Evaluation and Inspections	OEI-02-20-00720	2022

Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency

Telehealth is playing an important role during the public health emergency (PHE), and CMS is exploring how telehealth services can be expanded beyond the PHE to provide care for Medicare beneficiaries. Because of telehealth's changing role, we will conduct a series of audits of Medicare Part B telehealth services in two phases. Phase one audits will focus on making an early assessment of whether services such as evaluation and management, opioid use disorder, end-stage renal disease, and psychotherapy (Work Plan number W-00-21-35801) meet Medicare requirements. Phase two audits will include additional audits of Medicare Part B telehealth services related to distant and originating site locations, virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits to determine whether Medicare requirements are met.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
Revised	Centers for Medicare and Medicaid Services	Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency	Office of Audit Services	W-00-21-35862	2022

Resources

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

Unless otherwise noted, the waivers will terminate at the end of the COVID-19 public health emergency (PHE).

Look for additional finalized policy changes in 2023 MPFS Final Rule

Evaluation and Management

Best

Coding changes more reflective of current provider practice patterns

Choice in scoring methodology to best fit encounter

Evaluation and Management

Worst

- Coding continues to be open to interpretation
- Inconsistent coding principles for different visit types
- Inconsistent coding for prolonged services

E/M Categories

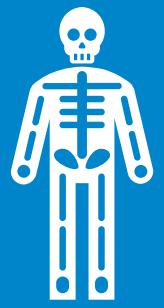
Hospital Visits & Consultations

1995 or 1997 guidelines

Outpatient Office Visits

2021 guidelines

Inpatients and Consultations



History

- *History of Present Illness (HPI)*
- *Review of Systems (ROS)*
- *Past Medical, Family, Social History (PFSH)*

Examination

- *Body area or organ system*
- *Bulleted items*

Medical Decision Making

- *Diagnosis or treatment options*
- *Amount or complexity of data reviewed*
- *Risk of complications, morbidity or mortality*

Time may be used for when coordination or counseling dominate visit

Coding By Time

Time can be a key factor in coding E/M services in cases where counseling and coordination of care dominates the visit

- Total length of time of the face-to-face encounter must be documented
- Record must also state that more than 50% of time was spent in counseling and/or coordination of care
- Record should describe the counseling and/or the activities performed to coordinate care

Outpatient Office Visits

MEDICAL DECISION MAKING

TIME

The extent of history and physical examination is not an element in selection of office or outpatient visits.

Outpatient Office MDM Scoring

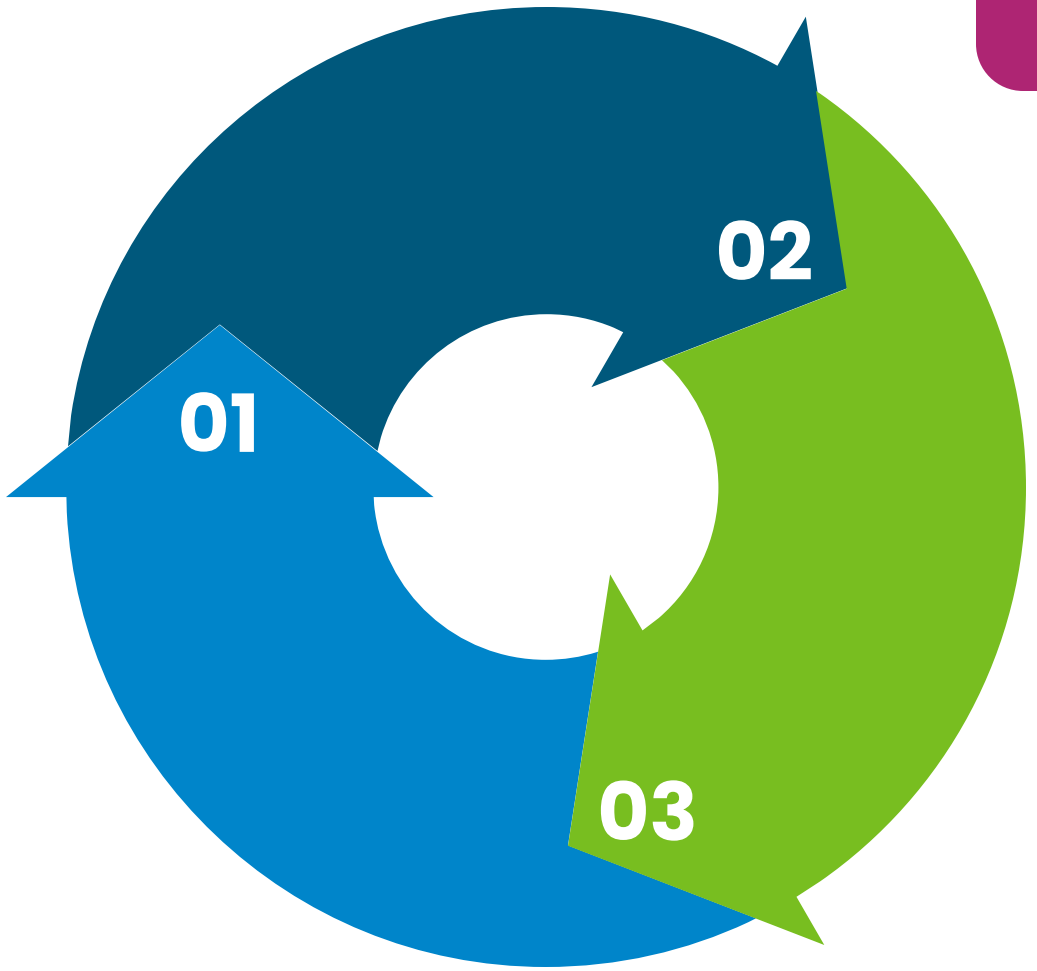
Level of Medical Decision Making is based on 2 out of 3 Element Levels

Data

Minimal or None, Limited, Moderate, Extensive

Problem(s)

Minimal, Low, Moderate, High



Risk

Minimal, Low, Moderate, High

Outpatient Office Total Time

New Patient Visits

New Patient E/M Code	Total Time (2021)
99201	Code deleted
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Established Patient Visits

New Patient E/M Code	Total Time (2021)
99211	Time component removed
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Total Time

TIME INCLUDES TOTAL TIME ON DATE OF THE ENCOUNTER

FACE-TO-FACE AND NON-FACE-TO-FACE TIME BY PHYSICIAN OR OTHER QUALIFIED HEALTH PROVIDER

DOES NOT INCLUDE TIME FOR ACTIVITIES NORMALLY PERFORMED BY CLINICAL STAFF

Potential E/M Problems

- Change in practice patterns regarding history and physical examination
  - May result in lower level visits due to 95/97 criteria
  - Potential scenario for over coding
- Application of incorrect time-based coding criteria
  - Date of encounter versus face-to-face time
  - Counseling and coordination of care requirements

Prolonged Service (AMA)

99417

Prolonged office or other outpatient evaluation and management service(s) beyond the total time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes

Compliance Risk

CMS feared double dipping for prolonged service code (99417)

CMS example: CPT® 99215 (40-54 minutes)

55 minutes

69-83 minutes

Prolonged Service (CMS)

G2212

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

New Patient Visits	
Medicare & Other Government Payers	
60-74 minutes	99205 x 1
75-88 minutes	99205 x 1
89-103 minutes	99205 x 1 and G2212 x 1
104-118 minutes	99205 x 1 and G2212 x 2
119 or more	99205 x 1 and G2212 x 3 (1 unit for each additional 15 minutes)
Commercial Payers	
60-74 minutes	99205 x 1
75-89 minutes	99205 x 1 and 99417 x 1
90-104 minutes	99205 x 1 and 99417 x 2
105 or more minutes	99205 x 1 and 99417 x 3 (1 unit for each additional 15 minutes)

99417 and G2212 are not interchangeable; therefore, validation of coding and units is necessary

Established Patient Visits	
Medicare & Other Government Payers	
40-54 minutes	99215 x 1
55-68 minutes	99215 x 1
69-83 minutes	99215 x 1 and G2212 x 1
84-98 minutes	99215 x 1 and G2212 x 2
99 minutes or more	99215 x 1 and G2212 x 3 (1 unit for each additional 15 minutes)
Commercial Payers	
40-54 minutes	99215 x 1
55-69 minutes	99215 x 1 and 99417 x 1
70-84 minutes	99215 x 1 and 99417 x 2
85 or more minutes	99215 x 1 and 99417 x 3 (1 unit for each additional 15 minutes)

Nurse Practitioners

Best

Increased autonomy allowing for additional flexibility when billing to Medicare

Bill independently or part of professional group

Nurse Practitioners

Worst

- Scope of practice varies by state
- Billing guidelines can be confusing
- Potential risk for compliance concerns
- Reduced reimbursement

Scope of Practice

https://www.aanp.org/advocacy/state/state-practice-environment

- **FULL**: NPs can prescribe, diagnose, and treat patients without physician oversight. Nurse practitioners who operate in full-practice states are also allowed to establish and operate their own independent practices.
  - 22 states including Washington DC

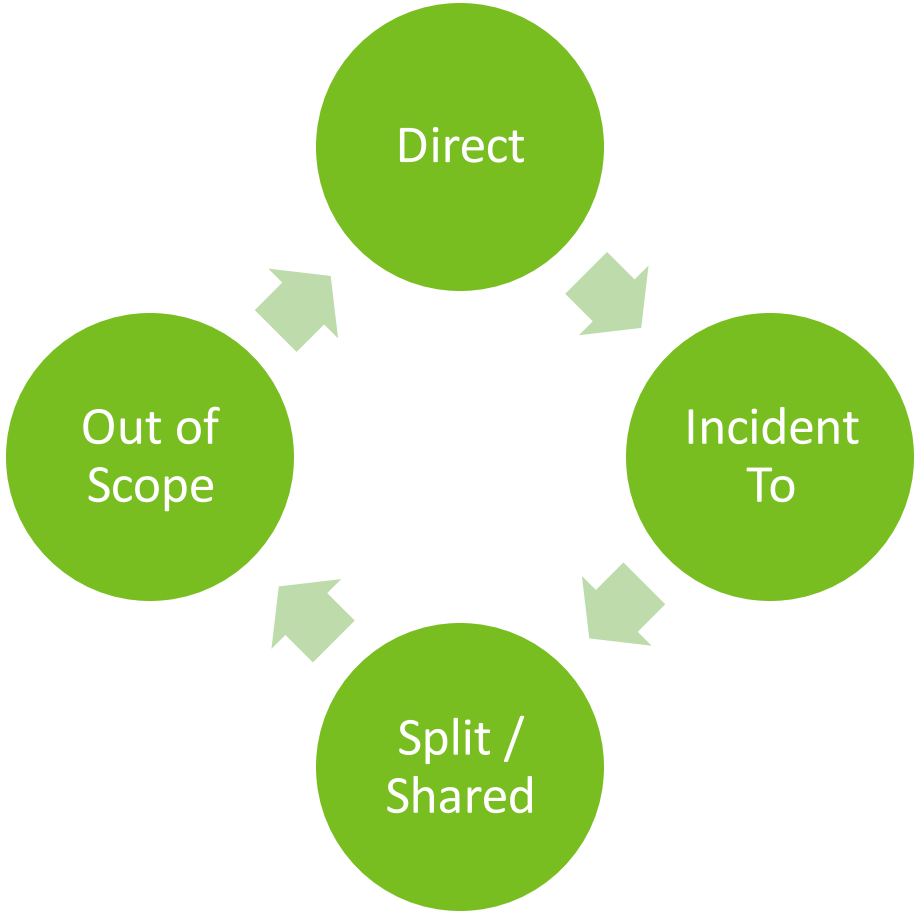
- **REDUCED:** NPs can diagnose and treat patients but need physician oversight to prescribe medications.
  - 16 states

- **RESTRICTED:** NPs need physician oversight to prescribe, diagnose, and treat patients.
  - 11 states including Virginia

Oncology Billing

Billing Options

- Under their NPI as rendering provider
  - Direct
- Under the physician's NPI
  - Incident To
  - Split/Shared
- Not billable
  - Service not within their scope of practice



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“”

Incident to services or supplies are those provided as an integral, although incidental, part of the physician’s personal professional services during diagnosis and treatment.

-CMS

Requirements

- Integral part of the patient's normal treatment when the physician or other listed practitioner personally performed an initial service and remains active in that treatment course.
- Commonly provided without charge or included in the physician's or other listed practitioner's bill.
- Expense to the physician or other listed practitioner.
- Commonly provided in the physician's or other listed practitioner's office or clinic.
- Physician or other listed practitioner provides direct supervision for the procedure.

NPs and PAs providing Medicare patient care must enroll in the Medicare Program whether billing services under their National Provider Identifier (NPI) or the supervising physician's NPI.

Incident To Reminders

- Physician office or non-facility setting only
- Not applicable in the facility setting (hospital), including inpatient visits
- Must follow established plan of care
- Physician must see patient periodically
- Reimbursed at normal fee for service rate if performed incident to a physician
- Reimbursed at 85% of fee for service rate if performed incident to another NP

If Incident To guidelines not met, visit would be billed under the NPI of the Nurse Practitioner

Plan of Care

- Incident to billing is not supported for:
  - New patients
  - Established patient with new or worsening problem

- What happens when patient presents for a routine visit with a new or worsening problem?
  - Best practice is to ask the physician to take over care for the encounter to establish new or revised plan of care

Documentation

May be co-signed by the supervising physician

-State regulations require certain % of documentation to be reviewed

Clear statement of Direct Supervision for service

Split/Shared

- Shared evaluation and management service between billing provider and non-physician practitioner in the same group
- Documentation for each individual is combined to define the level of service
- Available in facility or non-facility setting
- In non-facility setting, incident to requirements still apply
- Billed under provider providing the substantive portion of the visit based on supporting documentation
  - Time
  - Medical Decision Making

What Is Substantive Portion?

Method 1

Provider who performed greater than 50 percent of the time of the visit

Method 2

Provider who performed either the history, or the exam, or the medical decision-making (MDM) portion of the note, in its entirety

In 2023, Method 1 will be the only option

Method 2 (2022 Only)

CMS instructs:

"…if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed."

History and physical examination no longer utilized to select level of service; therefore, instructions create confusion determining the substantive portion

New Modifier

Effective January 1, 2022

Utilized to indicate split / shared visit was performed on the billed charge

Utilized regardless of billing provider

Hierarchical Conditions Category (HCC) Coding

Best

Consistent with shift to value-based payment models

Accounts for patient complexity and risk

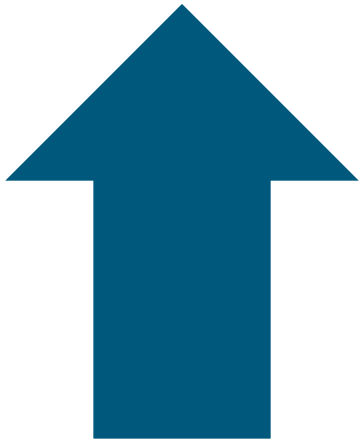
Hierarchical Conditions Category (HCC) Coding

Worst

- Increased use by Medicare Advantage and commercial payers to lower levels of service
- Requires improved coding and documentation
- Down coding may go unnoticed

What Is HCC Coding?

- Coding system used to patient's estimated costs to the system to determine Risk Adjustment Factor (RAF)
  - Diagnosis, Age, Gender…
- Resources target most medically needy patients
- Patients billed with same code will be paid differently based on risk score



Higher RAF = Higher Reimbursement

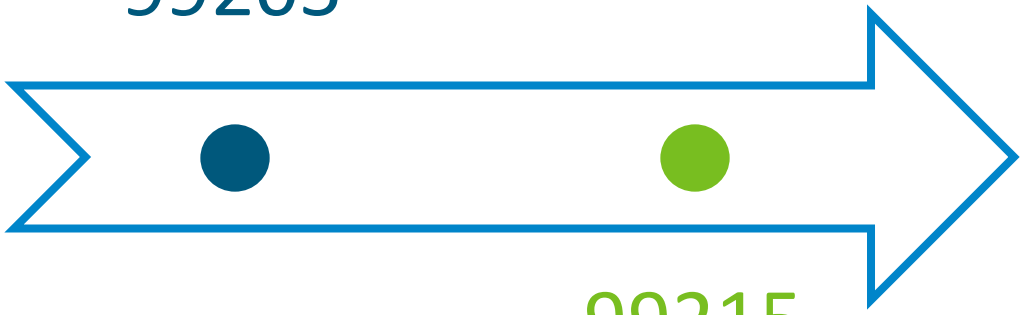
Lower RAF = Lower Reimbursement

Example

Patient seen for new breast cancer diagnosis (C50.412). An established visit is performed prior to treatment to assess patient toxicities from treatment.

Billed to Payer

99205



99215

Reimbursement

99205

99213

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Coding Is Key

- Informational coding regarding patient treatment and status
- Coding for signs, symptoms, and conditions treated
- Coding for conditions managed
- Coding for comorbidities affecting care of patient
- Coding for adverse effects

Encounters for Therapy

Encounters for Therapeutic Services

- Z51.0 Encounter for antineoplastic radiation therapy
- Z51.11 Encounter for antineoplastic chemotherapy
- Z51.12 Encounter for antineoplastic immunotherapy

Treatment Related Anemia

If the encounter is to manage the anemia, code the anemia first, followed by the cancer

D64.81 – Anemia due to antineoplastic chemotherapy

D61.1 – Drug-induced aplastic anemia

D61.2 – Aplastic anemia due to other external agents (radiation therapy)

For chemo-related anemia, also assign an adverse effect code (T45.1X5-)

For radiotherapy-related anemia, also assign code Y84.2

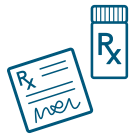
Example

A patient who is on carboplatin for cancer of the left ovary is seen for management of chemotherapy-induced anemia.

- **D64.81** Anemia due to antineoplastic chemotherapy
- **T45.1X5A** Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter
- **C56.2** Malignant neoplasm of left ovary

Note: *Because this patient's anemia is chemotherapy-induced rather than neoplasm-induced, and the focus of the encounter was to treat the anemia, sequence the anemia first.*

Long Term Drug Therapy



Indicate patient is receiving long-term drug therapy

Non-oncologic drugs, i.e. insulin, Coumadin

Cancer drugs, i.e. tamoxifen

2 Assign a code from Z79 as a secondary diagnosis

Long Term Drug Therapy Codes

Code	Definition
Z79.810	Long term (current) use of selective estrogen receptor modulators (SERMs) Raloxifene (Evista) Tamoxifen (Nolvadex) Toremifene (Fareston)
Z79.811	Long term (current) use of aromatase inhibitors Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara)
Z79.818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels Estrogen receptor downregulators Fulvestrant (Faslodex) Gonadotropin-releasing hormone (GnRH) agonist Goserelin acetate (Zoladex) Leuprolide acetate (Lupron) Megestrol acetate (Megace)

Example

A patient has infiltrating ductal carcinoma of the upper outer quadrant of the left breast that is estrogen receptor positive. The patient is taking tamoxifen as an anti-estrogen therapy.

- **C50.412** Malignant neoplasm of upper-outer quadrant of left female breast
- **Z17.0** Estrogen receptor positive status [ER+]
- **Z79.810** Long term (current) use of selective estrogen receptor modulators (SERMs)

Reminder

Attention to payments is recommended, as decreased reimbursement may go unnoticed

Payer may allow for appeal with supporting documentation

Questions

Thank you for attending!