Derm Coding Consult

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# Evaluation and management (E/M) coding changes are coming in 2021 – Part 1

Several major E/M guideline revisions will go into effect Jan. 1, 2021, including:

- E/M guideline additions, revisions, and restructuring;
- Deletion of CPT code 99201 and revision of CPT codes 99202 – 99215
- Updates to components for code selection to include:
    - A medically appropriate history and/or physical examination (though required, it is not to be used as part of the code level selection);
    - Medical decision making (MDM); OR<br/> Total time on the date of the encounter.

This article, the first in a series, explains how these changes came to be, how to AADA advocated to prevent changes that would have had a worse impact on dermatology, and how dermatologists can begin preparing for the changes.

**How these changes came to be**

In July 2019, CMS released the Medicare Physician Fee Schedule Proposed Rule which stated that the current E/M coding and documentation requirements were outdated and needed updating.

CMS proposed to make several significant changes to the way office E/M services would be reimbursed, to take effect in 2021. CMS proposed that:

1. There would be one fee for levels 2 through 5 for a new patient and levels 2 to 5 for an established patient;

2. New add-on G codes would be used that were intended to increase payment for care of complex patients; and

3. Payment for the E/M service or the procedure would be reduced by 50% when the E/M is reported with a modifier 25.

This last part of the proposal from 2019, cutting payments when modifier 25 is appropriately included with an E/M service, would have resulted in a reduction in office E/M payments for dermatologists of about 25%, or about 7% of total dermatology payments.

**AADA advocacy**

The AADA engaged in advocacy targeting CMS, HHS, and members of Congress, both alone and as part of coalitions and the overall house of medicine. As a result of the advocacy, CMS agreed to drop its proposal and instead consider a revision of the E/M codes with values developed by the house of medicine. That work was undertaken by the AMA CPT/RUC E/M Workgroup, comprised of representatives of all specialties including the AADA. A key deliberation of the Workgroup centered around whether the new code descriptor language should direct physicians to select the code level based solely on time. Ultimately, the dermatologists involved successfully persuaded the Workgroup to broaden the language to allow for a choice of time or medical decision making. The AADA also participated in the development of values for the newly revised codes through the RVU Update Committee (RUC). The unanimous agreement of all medical specialties to support the new E/M code descriptions and associated RUC recommended values resulted in CMS choosing to accept them in lieu of its original proposal.

**Summary of major E/M revisions for 2021**

E/M levels of service will be based on either the medical decision making (MDM) OR total time spent with the patient on the date of the encounter.

Even though documentation of medically appropriate history and physical examination will still be required, the amount of history or number of elements examined and documented will not factor into the determination of the overall E/M level of service choice. To this end, the AMA has changed the definition of the time element associated with codes 99202-99215 from typical face-to-face time to *total time spent on the day of the encounter, and the amount of time associated with each code.* Total time includes non-face-to-face services and reflects clear time ranges for each code. The next article in this series will provide more guidance on selecting E/M codes based on time.

Overview of major E/M revisions for 2021

| Component(s) for code selection | Office or other outpatient services |
|---|---|
| History & Examination | As medically appropriate;<br>not to be used in final code selection |
| Medical Decision Making (MDM) | May use MDM or total time on the date of the encounter |
| Time | May use MDM or total time on the date of the encounter |

| Component(s) for code selection | Office or other outpatient services |
|---|---|
| **MDM Elements** | • Number and complexity of problems addressed at the encounter<br>• Amount and/or complexity of data to be reviewed and analyzed<br>• Risk of complications and/or morbidity or mortality of patient management |

**Note:** The 2021 E/M changes only apply to the office and other outpatient services (99202 – 99215). There are no changes to Hospital Observation, Hospital Inpatient, Consultation, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, and Home care services. E/M services provided by dermatologists in these settings must continue to be reported using the E/M key components (history, phsycal examination, and MDM).

The revised E/M code changes will go into effect on Jan. 1, 2021. Coding for E/M services will be very different from dermatologists currently code. These changes will require a completely different approach to determining the E/M level of service.

The AADA will continue to release intermittent *Derm Coding Consult* articles and other resources to help derm practices implement the operational, infrastructure, and workflow changes that will allow a seamless transition to the new reporting guidelines. You and your staff can prepare with the AADA’s resources this year.

Part 2 of this article will introduce the changes to the E/M code descriptors, components, and time required for each code selection in 2021 and beyond.

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# Evaluation and management (E/M) coding changes are coming in 2021 – Part 2: What has changed?

**Recognizing the 2021 E/M code descriptor revisions**

Changes to E/M coding will go into effect on Jan. 1, 2021. This article follows up on part one of our series which introduced the reasoning for these coding changes. We will now focus on key changes for each of the E/M service codes and related code descriptors. Understanding these changes is essential to selecting the correct level of E/M service.

Coding guidance for the 2021 E/M service codes has a clear focus on patient care. By reducing the administrative burden of checking boxes for the History and Examination, the new guidelines allow dermatologists to code for E/M services based on the way they think. These changes promote appropriate coding and payer consistency when audits are performed.

The major changes include:

- The level of service can be based on either **medical decision making (MDM) or total time** spent with the patient on the date of the encounter.
- Documentation of medically appropriate history and physical examination will still be required; however, the documentation will not factor into the determination of the overall E/M level of service choice.
- Altering the definition of the time element for codes 99202-99215 from typical face-to-face time to the total time spent on the day of the encounter.
- Specific times associated with each E/M service code are noted in the table below:

**2021 office visit E/M service codes: Time**

| New Patient E/M Code | 2021 Total Time | Established Patient E/M Code | 2021 Total Time |
|---|---|---|---|
| 99201 | Code Deleted | 99211 | Time Component removed |
| 99202 | 15 – 29 minutes | 99212 | 10 – 19 minutes |
| 99203 | 30 – 44 minutes | 99213 | 20 – 29 minutes |
| 99204 | 45 – 59 minutes | 99214 | 30 – 39 minutes |
| 99205 | 60 – 74 minutes | 99215 | 40 – 54 minutes |

Time = Total time on the date of the encounter
(Before face-to-face, during face-to-face, after face-to-face)

**MDM elements**

- Number and complexity of problems addressed during the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

**Time**

- **Total time** is considered both face-to-face and non-face-to-face time personally spent by the physician and/or non-physician clinician on the day of the encounter
    - Includes time spent performing activities that require the physician or non-physician clinician but does not include time in activities normally performed by clinical staff
- Total time may include counseling and/or coordination of care but is no longer the only determining factor for choosing a time-based level of service

There is no ambiguity to the key elements regarding time. Total time uses increments by giving exact time ranges within the code descriptor. The code selection is the total time on the date of the encounter performing services that can include:

- review of tests as dermatologist or non-physician provider prepares to see the patient,
- obtaining and/or reviewing separately obtained history,
- performing a medically necessary appropriate examination and evaluation and counseling and/or educating the patient/family/caregiver.

The AAD has created a downloadable PDF file to help you view the detailed changes to the 2021 E/M service codes.

The AADA will continue to release intermittent *Derm Coding Consult* articles and other resources to help dermatology practices implement the operational, infrastructure, and workflow changes that will allow a seamless transition to the new reporting guidelines. You and your staff can prepare with the AADA's resources this year.

Part 3 of this series will discuss coding examples based on medical decision making and/or time for dermatology specific encounters.

*July 15, 2020 (available online at https://www.aad.org/member/publications/dcc/em-coding-changes-2021-pt-3)*

# Evaluation and management (E/M) coding changes are coming in 2021 – Part 3: Practical applications of the 2021 E/M coding changes

**Selecting the E/M level of service**

Part 3 of the "E/M coding changes are coming in 2021" series will focus on the practical application of the changes to dermatology-specific encounters based on **medical decision making (MDM) or time**. (Review part 1 and part 2.)

On Jan. 1, 2021, E/M coding for office, outpatient, or other ambulatory facility visits will be based on either MDM ***or*** total time spent with the patient on the date of the encounter. At that time, the documentation of a medically appropriate history and physical examination will still be required, but the documentation will not factor into the determination of the overall E/M level of service code choice.

The E/M Office Visit Level of MDM Table (PDF download) serves as a guide to assist in the selection of one of the four levels of medical decision making. There are four types of medical decision making: **Straightforward, Low, Moderate,** and **High** and they are used when reporting an office or other outpatient E/M service code.

The four levels of MDM include three elements of medical decision making, **number and complexity of problems addressed, amount and/or complexity of data reviewed/analyzed,** and the **risk of complications and/or morbidity or mortality of patient management.** Two of the three elements for a level of MDM must be met or exceeded to qualify for each level of service. The combination of these elements determines the E/M level of service reported.

Medical decision making

Medical decision making includes establishing a diagnosis, assessing the status of a condition, and/or selecting a management option. Medical decision making in the office and other outpatient services code set is defined by the three elements below:

| MDM elements | Description |
| --- | --- |
| Number and complexity of problems addressed during the encounter | **Determination of number and complexity of the patient condition as either:**<br>• self-limited or minor<br>• stable, chronic illness<br>• acute uncomplicated illness or injury<br>• undiagnosed new problem with uncertain prognosis<br>• acute illness with systemic symptoms<br>• acute complicated injury<br>• chronic illness with severe exacerbation, progression, or side effects of treatment<br>• acute or chronic illness or injury that poses a threat to life or bodily function |
| Amount and/or complexity of data to be reviewed and analyzed | **Includes reviewing**<br>• Medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.<br>  ◦ Information obtained from multiple sources or interprofessional communications that are not separately reported.<br>  ◦ Interpretation of tests that are not separately reported.<br>  – Ordering a test is included in the category of test result(s). The review of the test result is part of the encounter and not a subsequent encounter.<br>  ◦ Data to be reviewed is divided into three categories:<br>    ▪ Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)<br>    ▪ Independent interpretation of tests.<br>    ▪ Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source |
| Risk of complications, morbidity and/or mortality of patient management | **Includes**<br>• Decisions made during the visit associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).<br>• Possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision to perform surgery includes consideration of alternative options of treatment. |

*Note: None of the medical decision-making level concepts apply to code 99211.*

**Time**

When time is used to select the appropriate level for an E/M office or other outpatient service, it includes time spent *before, during, and after the face-to-face service* performing activities

that require the dermatologist or non-physician clinician but does not include time devoted to activities normally performed by clinical staff.

While the encounter may be dominated by counseling and/or coordination of care, it is no longer a requirement for determining the level of service based on time. For services provided by clinical staff under direct supervision of the dermatologist or non-physician clinician, report 99211.

**Practical applications of the 2021 E/M coding changes**

Q1. A 35-year-old new female patient presents to the office for treatment of persistent inflammatory acne, predominately on her lower cheeks and jawline. She has previously taken courses of oral antibiotics without long-term improvement and is on a combined oral contraceptive pill and has no plans for future pregnancies. She is otherwise healthy and only takes a daily multivitamin. After taking a relevant history and performing an appropriate physical exam, you make the decision to initiate treatment with spironolactone. Using medical decision making as the coding criteria, what is the appropriate level of service for this encounter?

A1. Based on the 2021 E/M coding guidelines, to meet requirements for a 99203 the encounter must meet or exceed two of the three elements for the selected E/M code. In this encounter, the medical decision making is considered "low" because the patient presents with one chronic illness — acne vulgaris. According to CPT, a chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care is considered a problem at the Moderate level. The treatment course has a moderate risk of morbidity due to prescription drug management. There is no additional data for the dermatologist to review. Because encounter meets the complexity required for moderate, the appropriate level of service code is 99204.

Q2. Based on time, what is the correct coding for a new patient office visit where the total face-to-face time with the patient plus the time spent reviewing records prior to the encounter and then coordinating care post encounter total 23 minutes?

A2. The encounter is appropriately reported with 99202 – total time spent 15 – 29 minutes.

Q3. Based on time, what is the appropriate E/M level for a visit for an established patient encounter who presents for follow-up of a clearing patch of localized contact dermatitis? The total time spent taking care of the patient was 10 minutes.

A3. The encounter is appropriately reported with 99212 – total time spent 10 – 19 minutes

Q4. Using MDM, what is the appropriate E/M level service code for an established patient encounter for a 16-year old male with previously stable acne who today presents with an exacerbation of severe nodulocystic acne requiring care coordination and initiation of isotretinoin therapy? The dermatologist provided patient education, informed consent was obtained, and laboratory testing was ordered prior to initiating treatment.

A4. Based on the new E/M coding guidelines, one must meet or exceed two out of the three elements for the selected E/M code. In this encounter, the patient presents with one chronic illness with exacerbation for which the dermatologist prescribes medication, orders and will review laboratory testing. The chronic illness with exacerbation meets the moderate level for number of problems addressed, the laboratory test is ordered and will be reviewed by the dermatologist which supports the requirement for low complexity of data to be reviewed and analyzed, while the treatment course has a moderate risk of morbidity due to prescription drug management. Therefore, the correct code is 99214.

*August 5, 2020 (available online at [https://www.aad.org/member/publications/dcc/streamlining-claim-denial-process](https://www.aad.org/member/publications/dcc/streamlining-claim-denial-process))*

# Streamlining the claim denial process in your practice

Claim denials are a reality for every dermatology practice. It is wise to be proactive and understand what you need to do when you receive a claim denial. Streamlining your claim denial process requires understanding the meaning behind each denial on the explanation of benefits (EOB) and the appropriate action you need to take.

A majority of private payers and the Medicare Administrative Contractors (MACs) use the **American National Standard Institute (ANSI)** codes to identify a post-initial adjudication adjustment.

Within the ANSI codes, there are 2 distinct code sets that help understand why a claim was denied. They are the **Claim Adjustment Reason Codes (CARCs)** and the **Remittance Advice Remark Codes (RARCs).**

The **CARCs** explain the reason a claim or service line was adjudicated differently than billed. If there is no adjustment to a claim line, no adjustment reason code is listed.

The **RARCs** provide additional explanation for an adjustment already described by a CARC or convey information about the adjudication process.

The chart below shows the most frequent CARCs and RARCs, as seen on dermatology claim EOBs, and the appropriate actions you can take to remedy the claim denial.

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| 1 | PR | Deductible amount | The patient is financially liable for the unpaid amount. | N/A |
| 2 | PR | Co-insurance amount | The patient is financially liable for the unpaid amount. | N/A |
| 3 | PR | Co-payment amount | The patient is financially liable | N/A |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
| --- | --- | --- | --- | --- |
| | | | for the unpaid amount. | |
| 4 | N519 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | Review the modifier usage and correct the claim. | Submit a corrected claim with an appropriate modifier. |
| 5 | OA | The procedure code is inconsistent with the place of service. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review and resubmit correct CPT code and/or POS. |
| 6 | OA | The procedure/revenue code is inconsistent with the patient's age. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review the medical record and resubmit corrected claim. |
| 7 | OA | The procedure/revenue code is inconsistent with the patient's gender. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review the medical record and resubmit corrected claim. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| 9 | OA | The diagnosis code is inconsistent with the patient's age. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review the medical record and resubmit corrected claim. |
| 10 | OA | The diagnosis code is inconsistent with the patient's gender. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review the medical record and resubmit corrected claim. |
| 11 | OA | The diagnosis code is inconsistent with the procedure. | Other Adjustment (no financial liability)<br>Service not covered — patient not liable for the unpaid amount. | Review the medical record and resubmit corrected claim. |
| 16 | MA13<br>MA27<br>N264<br>N276<br>N382 | Claim/service lacks information or has submission/billing error(s).<br>Missing/incomplete /invalid ordering provider primary identifier.<br>Missing/incomplete /invalid other payer | Review claim for missing information or submission error. | Submit a corrected claim. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| | | purchased service provider identifier. | | |
| 18 | N522 | Duplicate claim/service | The claim was previously submitted and adjudicated. | No action is required. |
| 45 | CO | Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. | Practice fee schedule exceeds payer fee schedule<br>Contractual Obligation, Provider is financially liable for the unpaid amount | Adjust the balance of the claim line. |
| 50 | M127<br>N115<br>N130<br>N180 | Non-covered because service has not been deemed a medical necessity by the payer.<br>Documentation requested was not received or was not received timely.<br>Item billed may require a specific diagnosis or modifier code based on related Local Coverage Determination (LCD). | Service does not meet the medical necessity requirements. | After the physician reviews the medical record documentation for medical necessity, submit a request for Redetermination/Appeal. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| 55<br>56 | OA | Procedure/treatment/drug deemed experimental/investigational by the payer. | Other Adjustment (no financial liability<br>Service not covered — patient not liable for the unpaid amount. | Adjust the balance of the claim line. |
| 58 | | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. | Service not approved/valued to be performed in the place of service reported on the claim. The claim will not be paid. | Review coverage criteria, correct with appropriate code and resubmit corrected claim. |
| 59 | | Claim processed based on multiple procedure rules. | Review NCCI guidelines. | Resubmit corrected claim with appropriate modifier(s). |
| 96 | N245 | Non-covered charge(s) | Service is statutorily excluded. | The patient is financially liable for the unpaid amount. |
| 97 | M15<br>N390 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.<br>Separately billed services/tests have been bundled as they are considered | Review the National Correct Code Initiative Edits (NCCI). | Resubmit corrected claim with appropriate modifier(s) to indicate service was performed independently of other services on the same DOS. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
| --- | --- | --- | --- | --- |
| | | components of the same procedure. Separate payment is not allowed. | | |
| 100 | | Payment made to patient/insured/responsible party. | N/A | Bill patient for the unpaid amount. |
| 107 | | Related or qualifying claim/service not identified on this claim. | The claim is missing primary procedure information. | Resubmit corrected claim with the primary procedure listed. |
| 109 | N130 | Claim/service not covered by this payer. | Review patient plan information. | Submit the claim to the correct payer. |
| 144 | N807 | Incentive adjustment<br>Payment adjustment<br>based on the Merit-based Incentive<br>Payment System.<br>(MIPS) | Positive MIPS Payment<br>Adjustments | N/A |
| 140 | | Patient/insured health identification number and name do not match. | Check patient insurance card for the correct identification number. | Resubmit claim with corrected insurance identification information. |
| 150 | OA | Payer deems the information submitted does not | Other Adjustment (no financial liability) | After the physician reviews the medical record documentation for |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| | | support this level of service. | Service not covered — patient not liable for the unpaid amount. | medical necessity, submit a request for Redetermination/Appeal. |
| 151 | N115<br>N362 | Payment adjusted because the payer deems the information submitted exceeds this many/frequency of service. | Review the MUEs allowed for the procedure and adjust the quantity or code(s). | Correct the claim with the appropriate number of units. Report excess units on a separate line of the claim form. |
| 155 | OA | The patient refused the service/procedure | Other Adjustment (no financial liability)<br>Service not covered – patient not liable for the unpaid amount. | After the physician reviews the medical record documentation for proof of service, submit a request for redetermination/appeal. |
| 163 | | Attachment/other documentation references on the claim were not received. | Review encounter medical record documentation for medical necessity and completeness | After the physician reviews the medical record documentation for medical necessity, submit a request for redetermination/appeal. |
| 167 | | Diagnosis(es) is not covered. | Review coverage criteria exclusions to confirm diagnosis coverage. | Ensure ABN was completed and on file, resubmit the claim with an appropriate |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| | | | | modifier for re-adjudication.<br>Private payer exclusion, the patient is responsible for unpaid service. |
| 181 | | Procedure code was invalid on the date of service. | Review Dermatology Coding and Billing Manual | Correct CPT code and resubmit corrected claim. |
| 183 | | The referring provider is not eligible to refer the service billed. | | Contact the referring provider for valid billing privilege criteria. |
| 184 | | The prescribing/ordering provider is not eligible to prescribe/order the service billed. | Review ordering provider billing privilege criteria | Update provider enrollment status in PECOS to avoid future claim denials. |
| 189 | | NOS or Unlisted procedure code billed when there is a specific procedure code the service. | Review Dermatology Coding and Billing Manualfor more specific procedure code | Resubmit corrected claim. |
| 193 | | The original payment decision is being maintained. This claim was processed properly the first time. | | Review documentation, proceed with the appeals process. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| 197 | | Payment adjusted for the absence of recertification/authorization. | Pre-authorization not obtained for service rendered. | Contact payer or primary care provider to obtain pre-authorization. |
| 236 | | Procedure/modifier combination is not compatible with another procedure/modifier provided on the same day. | Review NCCI Edit guidelines. | Correct modifier use and resubmit corrected claim. |
| 237 | N807 | Incentive adjustment Payment adjustment based on the Merit-based Incentive Payment System (MIPS). | Negative MIPS Payment Adjustments | N/A |
| 252 | | An attachment/other documentation is required to adjudicate this claim/service. | Review missing information to support claim submission. | Submit missing information to the payer. |
| 253 | | Sequestration reduction (Mandatory Payment Reduction of 2%) | N/A | N/A |
| OA | | Other Adjustment (no financial liability | Service not covered — | Adjust the balance of the claim line. |

| Claim Adjustment Reason Codes (CARCs) | Remittance Advice Remark Codes (RARCs) | Description | Explanation | Resolution |
|---|---|---|---|---|
| | | | patient not liable for the unpaid amount. | |

**Frequently asked questions**

Q1. Why are there two different types of denial codes on the EOB? What do they mean?

A1. Claim Adjustment Reason Codes (CARCs) explain why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code. The Remittance Advice Remark Codes (RARCs) provide additional information for an adjustment already described by a CARC or to convey information about remittance processing.

Q2. We have a denied claim for CPT code 21552 done in the office, the payer's denial code is 58 — *treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.* We've tried to appeal but have been unsuccessful, is there anything we can do to get this overturned?

A2. Denial code 58 is a denial that indicates that procedure code 21552 is a service routinely performed and valued for the facility setting and not in the office setting. Typically this denial cannot be overturned. To prevent this, obtain pre-authorization or pre-determination from the patient's insurance plan before the service is provided.

Q3. We constantly receive claims with reduced payment and denial code CO45 — *Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.* Can we balance bill the patient so we can collect the total fee in our fee schedule?

A3. Denial code CO 45 indicates that the service charges exceed the contracted fee schedule with the payer and should be written-off.

*August 14, 2020 (available online at https://www.aad.org/member/publications/dcc/mips-overpayment-notification)*

# Watch out for MIPS 2019 overpayment and recoupment notification

Dermatology practices may soon receive notification of over- or underpayment from their Medicare Administrative Contractors (MACs) due to an error in claims payment. The error arose from provisions in the Bipartisan Budget Act of 2018 that made several changes to the Merit-based Incentive Payment System (MIPS), including no longer calculating the cost of Part B drugs in the low volume threshold.

If a practice was over- or underpaid, it will receive a notification letter from its MAC requesting recoupment or outlining a forthcoming positive adjustment. The letter will outline the reason for overpayment, recoupment request, and your rights to appeal. If you receive a notification, review your MIPS 2017 performance score (payment adjustment applied in 2019), read the letter carefully to understand what is being requested, and contact your MAC with any questions. For more information about overpayments, review this Medicare Overpayment Factsheet.

*August 19, 2020 (available online at https://www.aad.org/member/publications/dcc/mfs-includes-telehealth-em)*

# Proposed Medicare fee schedule includes telehealth, E/M coding updates

The proposed Medicare fee schedule for 2021, released Aug. 3, 2020, includes important proposals related to telehealth and evaluation and management (E/M) coding.

## Telehealth

Telehealth is of particular interest in the proposed rule this year given the many telehealth waivers put in place earlier in the year due to the Public Health Emergency (PHE). The waivers have allowed services to be provided with less restrictions and from areas that were normally not considered appropriate. Dermatologists have also benefitted as they have been able to deliver timely care with less communication restrictions to their most vulnerable and in-need patients. The 2021 proposed rule establishes the intent to continue paying telehealth codes as currently outlined through the end of the calendar year in which the PHE ends or Dec. 31, 2021.

The proposed rule also calls for the addition of several Healthcare Common Procedural Coding System (HCPCS) codes to the list of telehealth codes currently approved by Medicare on a Category 1 code basis and has also called for the temporary addition of several others as Category 3 codes. The addition of the select Category 1 codes is proposed because the services are similar to services already on Medicare's approved list of telehealth codes.

Some of the proposed Category 1 and Category 3 codes relevant to dermatology are detailed below:

| Proposed Permanent Category 1 codes | Proposed Temporary Category 3 codes |
|---|---|
| Domiciliary, Rest Home, or Custodial Care services HCPCS Code 99334 and 99335 | Domiciliary, Rest Home, or Custodial Care services, Established patients HCPCS Codes 99336 and 99337; |
| Home Visits HCPCS Codes 99347 and 99348 | ED Visits HCPCS Codes 99281, 99282, and 99283; |
| Prolonged Services HCPCS Code 99XXX | Home Visits, Established Patient HCPCS Codes 99349 and 99350 |

The proposed temporary Category 3 code list contains codes that have been included in the list of approved codes during the PHE declared in early March. Under the proposed rule, these proposed temporary codes would remain on the approved Medicare telehealth services list through the end of the year in which the PHE ends.

Interestingly, CMS has called for the removal of the telephone CPT codes, 99441-99443, that have been of extreme help to both patients and dermatologists during the PHE. As this is a proposed rule and open to public comment, CMS has asked for comment on whether a new code similar to the virtual check-in with a longer unit of time and higher reimbursement values should be created to be reported for audio-only. The AADA's comment letter to CMS on the proposed rule will be emphatic in stating that the audio-only codes should continue to be reimbursed. The Academy further supports the review and creation of an additional longer time unit audio-only code, similar to the virtual "check-in."

CMS has also called for the extension of a provision made during the PHE regarding direct clinician supervision to include instances in which a supervising physician or practitioner oversees other clinicians via interactive audio/video real-time communications technologies. According to the proposed rule, this provision would remain in place through Dec. 31, 2021.

The 2021 proposed rule also notes that telehealth rules do not apply when a physician delivers a service in the same location as the beneficiary. For example, if the physician providing the service is in the same institutional setting as the patient, but due to exposure risks, is using telecommunications technology to provide the service, the visit would be classified as in-person and not as a telehealth visit.

**Evaluation and management services**

E/M visit codes are by far the most heavily used codes across all specialties. They accounted for about 15% of all dermatology Medicare Part B expenditures in 2018, according to Medicare Part B Utilization Data.

As detailed in a previous article series in *Derm Coding Consult,* many changes to evaluation and management (E/M) coding are set to take effect on Jan. 1, 2021. Those changes include:

- Deletion of CPT code 99201.
- Revision of CPT codes 99202 – 99215.
- The use of medical decision making (MDM); OR total time (including face to face time and non-face to face time) spent with the patient on the date of the encounter.
- CMS has proposed increased Relative Value Units (RVUs) for these services which will in turn increment payments for these services.

In addition to the anticipated changes, CMS is proposing:

- A refinement to clarify the times for which prolonged office/outpatient E/M visits can be reported and is proposing to revise the times used for rate setting for this code set.
- Finalization of separate payment for a new prolonged visit add-on CPT code 99XXX, listed separately in addition to CPT codes 99205, 99215 for office or other outpatient E/M extended visits when the visit is based on time and only after the total time of the highest-level service has been exceeded in increments of 15 mins.

Please note that these are only proposals made by CMS and they may change when the final rule is released in early November. CMS has noted that the release of the final rule may come 30 days later than usual in light of the PHE.

For additional and up to date telehealth and E/M updates and resources, please visit the Academy's Practice Management Center.

*Sept. 4, 2020 (available online at https://www.aad.org/member/publications/dcc/cms-claim-review-audits)*

# CMS resumes medical claim review audits

The Centers for Medicare and Medicaid Services (CMS) has announced that it will be restarting claim audit reviews conducted by the Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Supplemental Medical Review Contractors (SMRCs). Claim audit reviews had been suspended in March 2020 due to the COVID-19 Public Health Emergency (PHE).

In a revised COVID-19 Provider Burden Relief Frequently Asked Question (FAQ) document posted July 7, CMS announced that service-specific medical audits would resume on Aug. 3, 2020 regardless of the status of the PHE and would include pre-payment Medicare reviews under the Targeted Probe and Educate (TPE) program, along with post-payment reviews by SMRCs and RACs.

Given that many dermatology practices are still closed due to the PHE, some practices will have difficulty responding in a timely manner to these audit requests. CMS has stated that if selected for review, a practice that is unable to meet response requirements should discuss with the contractor any COVID-19-related hardships that may affect the timeliness of their response.

**What is a Targeted Probe and Educate program?**

The TPE is a review process utilized by the MACs when providers are selected for a medical review audit. The TPE includes up to three rounds of a prepayment or post-payment probe review with education. After each round of review, the MAC will provide "one on one" education directly to the provider. This targeted education is what makes this type of audit different. Like all audits, a mailed letter is sent to providers requesting an audit of 20 to 40 medical records. The MACs are limited to a 40 chart request and a service-specific review based on data analysis procedures. The local MAC personnel provide the instructions after the first and second reviews on next steps for the provider.

There are currently no dermatology-specific TPE audit activities listed on individual MAC websites. However, this could change at any time.

**What is a Medicare fee-for-service service-specific post-payment medical review?**

A Medicare fee-for-service (FFS) audit is a post-payment review of claims and medical documentation for a claim that has already been processed and adjudicated. CMS's goal is to reduce payment errors by identifying and addressing billing errors in the areas of coding, documentation, and reimbursement. In cases where high errors and high coding utilization are identified through data analysis, the MAC will initiate a post-payment review.

If your practice is identified and contacted under either of the pre- or post-payment Medicare reviews, an Additional Documentation Request (ADR) letter is sent to the practice from your

local MAC requesting medical record documentation associated with claims selected for the post-payment review.

At this time, there are no active dermatology service-specific FFS pre- or post-payment medical review activities listed on individual MAC websites. However, CMS may add items to the list at any time.

*Sept. 10, 2020 (available online at [https://www.aad.org/member/publications/dcc/new-code-99072-for-covid-19-ppe](https://www.aad.org/member/publications/dcc/new-code-99072-for-covid-19-ppe))*

# AMA announces new CPT code 99072 for COVID-19 PPE

During the special COVID-related Panel Meeting held on Sept. 8, 2020, the American Medical Association (AMA) approved and published a new CPT code under special services, procedures and reports for immediate use.

*CPT code 99072 - Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease*

The code was created as a new practice expense code specifically for use during a declared Public Health Emergency (PHE) as defined by law due to respiratory-transmitted infectious disease. The code is intended to capture the rising costs of safely providing patients with access to high-quality care during in-person interactions with health care professionals.

The code accounts for additional supplies, materials, and clinical staff time required for patient symptom checks over the phone and upon arrival, donning and removing PPE, and increased sanitation measures to prevent the spread of communicable disease.

This new code is designed to capture the following practice expense factors by clinical staff to provide the service safely such as:

- Time over what is included in the primary service of clinical staff time (registered nurse [RN]/licensed practical nurse [LPN]/medical technical assistant [MTA]) to conduct a pre-visit phone call to screen the patient (symptom check), provide instructions on social distancing during the visit, check patients for symptoms upon arrival, apply and remove PPE, and perform additional cleaning of the examination/procedure/imaging rooms, equipment, and supplies
- Three surgical masks
- Cleaning supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers

Code 99072 is to be reported only once per in-person patient encounter per National Provider Identifier (NPI), regardless of the number of services rendered at that encounter.

In the instance in which the noted clinical staff activities are performed by a physician or other qualified health care professional (e.g., in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met; however, the time spent should not be counted in any other time-based visit or service reported during the same encounter.

Currently, there is no information on payer reimbursement for the new CPT code 99072. The AADA is advocating to ensure appropriate reimbursement is assigned for this code. An update will be provided to announce any information related to reimbursement from the Centers for Medicare and Medicaid Services (CMS) and private payers as soon as it is obtained. Alternatively, you can also check with each of your private payers to determine their reimbursement for this specific code.

**Q1. Code 99072 is stated as being applicable "during a PHE." What information should be documented to verify that the service reported with CPT code 99072 was provided during a PHE?**

**A1.** The code can only be reported when a PHE declared by law is in effect. No other documentation is required.

**Q2. What type of patient encounters or services should code 99072 be reported for?**

**A2.** Given that code 99072 may only be reported during a PHE, one would not report this code in conjunction with an evaluation and management (E/M) service or procedure when a PHE is not in effect.

Code 99072 can be reported with an in-person patient encounter for an office visit or other non-facility service, in which the implemented guidelines related to mitigating the transmission of the respiratory disease for which the PHE was declared are required. Use of this code is not dependent on a specific patient diagnosis.

**Q3. What documentation is required to report code 99072?**

**A3.** Code 99072 is reported justifiably only when health and safety conditions applicable to a PHE require the type of supplies and additional clinical staff time explained in the code descriptor.

Documentation requirements may vary among third-party payers and insurers; therefore, they should be contacted to determine their specifications.

*Sept. 17, 2020 (available online at [https://www.aad.org/member/publications/dcc/em-service-code-utilization](https://www.aad.org/member/publications/dcc/em-service-code-utilization))*

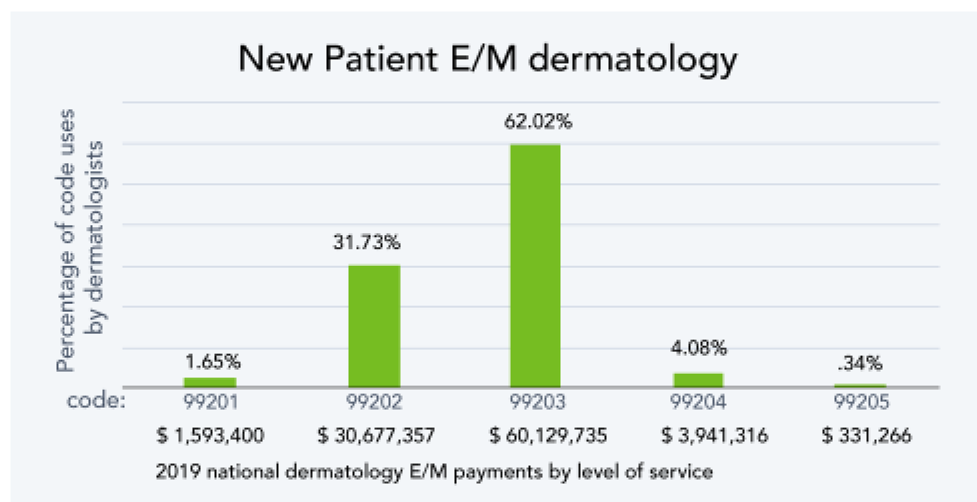
# Dermatology evaluation and management (E/M) service code utilization

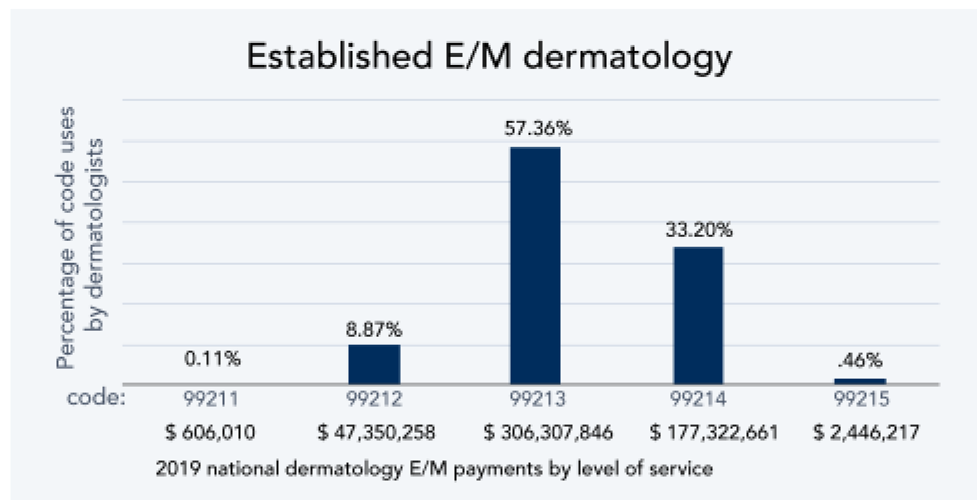
As part of its advocacy and educational efforts with the upcoming 2021 E/M coding changes, the AAD encourages dermatology practices to take a moment to understand their E/M code utilization.

The AAD coding team has reviewed Medicare's [2019 national E/M code utilization data](#) (PDF download) (previously known as "BESS Data") for claims submitted by all specialties. The data includes information on how dermatology compares to other specialties nationally in Medicare E/M service codes utilization.

This information can be used as a benchmark to compare your individual practice utilization of E/M service codes to the national Medicare utilization data. This comparison will assist you in determining whether your E/M coding practices make you an outlier when compared to the Medicare national utilization pattern of other dermatologists nationwide.

**Note:** The information provided does not reflect an individual practice's utilization pattern of E/M service codes (bell curve) either statewide or among peers in your county or city. To determine your practice's state, county, or city coding utilization pattern, coding data can be requested from the individual payers you are contracted with and analyzed for comparison to the Medicare utilization data listed below.






Medicare paid $590,334,997 in CY 2018 for dermatologic E/M claims compared to $630,706,066 in CY 2019. This represents a 6.8% increase in dermatology Medicare expenditures for these service from 2018 to 2019.

**Dermatology payments compared to all specialties**

According to the data, dermatology received a total of $96,673,074 for all new patient E/M codes representing 2.58% of the national Medicare expenditure for all specialties. The data shows that for all established patient E/M codes, dermatology received a total of $534,032,992 representing 0.45% of the national Medicare expenditure for all specialties.

**Reporting an E/M service with a procedure?**

Some private payers have not reimbursed for E/M services when reported either

- on the same day as a minor procedure; or
- previously paid E/M service within 60 days of another encounter with the same or similar diagnosis.

The American Medical Association's Current Procedural Terminology (AMA CPT)<sup>TM</sup> coding guidance indicates that a significant and separately identifiable E/M service can appropriately be reported by appending modifier 25 to the E/M service code when reported on the same date as a minor procedure. The guidance further indicates that a different diagnosis code is not required for the E/M to be reported. Likewise, modifier 57 is appended to an E/M service code to indicate the encounter resulted in the initial decision to perform the surgery with a 90-day global period.

When it is appropriate to report a significant and separately identifiable E/M service, dermatologists are encouraged to exercise due diligence with medical record documentation to ensure the record supports a separate E/M service that is above and beyond that which is included in the procedure performed. The Academy continues to advocate to payers for the proper usage of modifier 25 and to appropriately reimburse dermatologists rather than go through costly claim denial appeals.

**Minor procedures**

Minor procedures are those procedures that carry a 0 or 10-day global surgical period. Excision (114xx, 116xx) and destruction (17xxx) codes are examples of minor procedures.

These procedures typically include a low (minimal) E/M service component which can hinder the reporting of a separate E/M service code on the same date as the procedure.

*The 2019 National Correct Coding Initiative (NCCI)* manual states: "The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. …If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is 'new' to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure."

The following are best practices to consider when reporting an E/M service on the same date as the minor procedure:

- The documentation for both the E/M and the surgery must be succinct in describing the services provided.
- Once all the documentation related to the minor procedure, e.g. history of the lesion, examination of the site, and decision to perform the surgery, is accounted for, the remaining documentation must support the E/M level of service reported.

It is also good practice to check with your individual private payers for specific modifier 25 billing rules as they may be different from CMS guidelines.

**Frequently asked questions**

Q1. What does "significant and separately identifiable" mean when determining whether to report an E/M service with a dermatological procedure?

A1. "Significant and separately identifiable" is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service reported on the same day as the procedure.

Q2. A Medicare beneficiary is sent by their primary care provider to the Mohs surgeon for consultation with a biopsy confirmed basal cell carcinoma (BCC) on the nose. The Mohs surgeon evaluates the new patient with a medically appropriate history and physical examination, determines Mohs surgery as the treatment plan, and proceeds with the surgery on the same day. The defect is repaired with a complex linear closure. Is it appropriate to report 9920X/25 with 17311, 1315x?

A2. According to November 2006 *AMA CPT Assistant:* Evaluation and Management (E/M) services provided on the same date of service as Mohs micrographic surgery may be reported if a significant separately identifiable service is performed and documented. A separately identifiable service may include an initial evaluation of a new patient, an initial consultation, or other E/M service, or it may include the decision to perform surgery.

**Q3.** A patient presents with a skin lesion on the forehead that requires a tangential skin biopsy. The physician notices a minor discoloration of the skin on the nose and advises the patient to avoid sun exposure and performs the biopsy. Does this support reporting an E/M code and the biopsy?

**A3.** No, according to comments from a CMS Contractor Medical Director, "by-the-way items brought to the provider's attention by the patient are not a significant component of the E/M service and should not be considered."