Update in Evaluation and Management (E/M) Office Visit Coding for Family PACT Services Webinar Transcript May 05, 2021

Nicole Nguyen:

Okay. Hi everyone. Good afternoon and thank you for joining us today for our webinar titled, "Update in Evaluation and Management Office Visit Coding for Family PACT services." We hope you are all doing well and staying safe. My name is Nicole Nguyen, program manager of the Family Planning program at the California Prevention Training Center. The CAPTC, under contract with the California Department Healthcare Services Office of Family Planning, is sponsoring today's event.

Nicole Nguyen:

So, we're really excited to have you here and before we get started, I just want to go over some really, really quick housekeeping slides. So first, please check your audio and select your desire settings to join either through your computer, audio, or your phone. And if your internet is shaky, we highly recommend that you join through your phone for the best possible sound.

Nicole Nguyen:

And then second, please check that you're able to see the viewer screen with the slides on the left and the go-to webinar control panel on the right. And then, you'll see this orange box with a white arrow in it. This is how you can hide or show your dashboard. If you don't want to see it, or you accidentally clicked it, this is how you can make it appear again. And then, and right under that is the audio tab again, where you can change your audio preference at any time. And then third, please submit all your comments and questions via the questions box.

Nicole Nguyen:

So, today's webinar will be 90 minutes. It will include time at the end for our presenter to answer all your questions. So please send them in throughout the webinar and our speaker will address as many of them as possible. At the end, this webinar will be recorded and respond to any questions not answered today by our presenter will be sent out to participants later, along with the recording and the slide deck, there is also an evaluation at the end. So please fill that out because your feedback is extremely important to us, and that helps guide us in our future content.

Nicole Nguyen:

And then also before I introduce our presenters, I also want to acknowledge that we are really excited to be working with the University of Nevada Reno, School of Medicine to provide CMEs for this event. So, this webinar will qualify for 1.5 CME credits and only available to those who watched the entire webinar live today. Those who watched the recording afterwards will not be

eligible for the credits and the link to access your CME certificate will be included in the follow-up email to those who attended today, along with the recording, the slides and the evaluation.

Nicole Nguyen:

And then also for transparency's sake, we also want to state that all the presenters planners, anyone in a position of power for this content and their partners, do not have any financial relationships or commercial interests relating to the content of this activity.

Nicole Nguyen:

Now, I'd like to introduce our presenters. We are really excited to have Dr. Michael Policar with us today. Dr. Policar serves as the clinical Professor of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco, School of Medicine. From 2005 to 2014, he was the Medical Director of program support and evaluation for the Family PACT program, administered by the California Department of Healthcare Services, Office of Family Planning. And he currently serves as Professor of Obstetrics, Gynecology, and Reproductive Sciences at UCSF. And so, with that, Dr. Policar, I will hand it over to you.

Dr. Michael Policar:

Great, thanks, Nicole. And thank you all for joining us. What I need to do now is to be able to share these slides with you.

Nicole Nguyen:

Yeah. Then do that. I just made you presenter. Okay.

Dr. Michael Policar:

I'm still not seeing that. Hang on, give me a second. I've got, okay. You know, Nicole, I am not getting the screen, which says share slides.

Nicole Nguyen:

All right. Let me try that again. So,

Dr. Michael Policar:

And if not, then you may need to open, may have to go from your screen.

Nicole Nguyen:

Oh, okay. Let me just. [inaudible 00:04:25] and then I'll try this again.

Dr. Michael Policar:

Okay. Yeah. Thank you. Sorry for the short delay, we're getting it worked out.

Nicole Nguyen:

Okay. So, this, I just made you the presenter again. You're able to.

Dr. Michael Policar:

Okay. But the thing is, I'm just, I'm just not getting the, the box that allows me.

Nicole Nguyen:

Oh, okay. So, Hmm.

Nicole Nguyen:

Okay. Let me, that's the case then here, let me there,

Dr. Michael Policar:

I'm going to do is I'm going to turn off my webcam. Okay. Maybe that will make some sort of difference.

Nicole Nguyen:

Okay. Let's see.

Dr. Michael Policar:

I'm sorry. I think you're probably going to need to maybe show it from your side.

Nicole Nguyen:

Okay. So, let me see if I can, can do that. Let me do that.

Dr. Michael Policar:

Sorry. Well, Nicole is working on getting that up. I'll just give you an idea about what we're going to talk about. And, and that is that as most of you know, that AMA and the center for Medicare and Medicaid services last fall announced that they were going to change the way that E/M codes are computed for problem-oriented visits and starting on January 1st, 2021, those went into place and they are in place both for Medi-Cal and for the chairman. So, what I'm going to do today is to tell you about how E/M coding has changed in Medi-Cal family connect and other payers that you work with. Tell you a little bit about some changes in Family PACT policy that have occurred, and then we'll do some, some case types.

Nicole Nguyen:

Okay. Can you see the screen now?

Dr. Michael Policar:

That's great. Okay. So next slide.

Nicole Nguyen:

Okay.

Dr. Michael Policar:

All right. You know, there are our learning objectives. I won't read them for you but given the fact that you're getting continuing education units, we needed to include those. Next slide.

Dr. Michael Policar:

Okay. So, we're going to start with just a quick review of the fundamentals of coding. Next.

Dr. Michael Policar:

So, what are we really trying to do when we talk about the clinicians doing coding and then for your biller to send off a claim to a payer like Medi-Cal or the office of Family Planning. What we're trying to do from the provider end is to prepare a standardized bill for services that are given to a patient for certain ones that we've given to a patient. From the payer side, what they're going to look at is how much do they pay you? And that's based on your Medi-Cal and Family PACT, a rate schedule, which is published and available on the internet. With other payers like Health Net, for example, that may be based on a contractor rate. It's also to evaluate whether or not the services that were provided were medically necessary, whether they're actually a benefit of Family PACT or Medi-Cal. And of course, they have to be supported by documentation. Next slide.

Dr. Michael Policar:

So, I want you to think about coding like you're telling a story. Because what you're doing as a clinician is telling the story to the biller. The biller is then telling the story to the payer. Remember when we were in junior high school, we learned about writing newspaper articles, the what, the, why, the, how, the, where, and in this circumstance, the, what are the services that we performed that's indicated by a CPT code. The drugs or supplies that we provided, that's indicated by what's call a HCPC code. And those are the codes that we use to bill for things like IUD and implant insertion kits. The "why", or the diagnoses at the visit, which ICD-10 diagnosis codes. And sometimes there's a requirement for an additional explanation that's done with a modifier. And those also come from CPT codes. Next.

Dr. Michael Policar:

So, remember to establish medical necessity for every "What" there has to be a matching "Why?". In the example that I give is if, for example, the "what" is a colposcopy. The "why" has to be "how the HPV test in the surgical cytology were abnormal." It's got to be something which matches. And then again, unusual circumstances are explained with the modifier. Next.

Dr. Michael Policar:

Okay. So, remember that for procedures, that those codes from coming from something called the current procedural terminology, the CPT book that's published by the American Medical Association every year. So, the procedures were most likely to bill for IUD or implant placements or removals of, let's say, the genital skin lesion.

Dr. Michael Policar:

Number two is point of care tests. So, things like laboratory tests that we do in our office, like pregnancy tests, microscopy, rapid HIV test, or diagnostic imaging, like an ultrasound has its own assigned CPT codes. We're going to be spending most of our time talking about evaluation and management codes, which are for the cognitive part of an office visit. And the modifier numbers are also contained in the CPT book. Next.

Dr. Michael Policar:

HCPC, which is a series of codes that come from the Center for Medicare and Medicaid services, are for clinic administered and dispensed drugs and devices. Now in the world of healthcare, that's really a lot of things like chemotherapy drugs that are given in infusion centers, but there are also specific HCPC codes for IUD, for implant insertion kits, for birth control pills and patches and rings and other kinds of medications that we dispense in the clinic. Family PACT and Medi-Cal both use a number of HCPC codes. Next.

Dr. Michael Policar:

All right. Now, when we talk about evaluation and management codes, which is going to be the source of most of our discussion today, you remember that there are a variety of what are called series of codes for evaluation and management or cognitive services. The first is a Problem-Oriented Visit. That's when a person has symptoms or complaints. And remember for new patients, those are 99202-5 and then for established patients 99211-5. Next.

Dr. Michael Policar:

There are also preventative medicine services codes that's for a well person visit, like a well woman visit, or a checkup visit, or a periodic health screening visit. Those by the way, are not covered in Family PACT. At least, those codes series are not. Certainly, doing a well woman visit is covered, but they ask if you use it, problem-oriented visit.

Dr. Michael Policar:

Next, there are also preventive medicine counseling codes, 99401-99404, which are based on time. And then, also, are covered are the counseling for behavior change interventions like smoking cessation, substance abuse, and they use that same series of codes.

Dr. Michael Policar:

Now the only one that changed on January 1st of 2021, is the problem-oriented visit E/M codes. So that's really what we're really going to focus on, are the changes in that code series, because they are quite profound. And as I said, they have been adopted by Medi-Cal by Family PACT and by a variety of other payers as well. Next.

Dr. Michael Policar:

Okay. So, just a quick reminder about the way that you used to assign an E/M code for a patient visit. You had a choice of what were called the three key components, which is history, physical and medical decision making. Or you could build on time if at least 50% of the face-to-face time in the visit was spent on counseling or coordination of care. And in the family planning world, for the most part of a typical family planning visit, we were billing on the basis of time. Because in family planning visits, with the exception of a IUDS or implants, most of that visit is nowadays spent in counseling and not very much in physical assessment. So historically, we have built most of family planning visits based on time. Most of STD visits, particularly when a physical exam was involved on a basis of the three key components of history, physical medical decision-making.

Dr. Michael Policar:

So, the important point here is that this approach that we've been doing for decades is now gone. It's been replaced. Next slide.

Dr. Michael Policar:

And it's been replaced with these new rules for E/M coding that began on January 1st of this year. Now, the reason that that happened was that AMA was petitioned to change how we select E/M codes for a number of purposes.

Dr. Michael Policar:

Number one, that coding was felt to be a huge administrative burden on clinicians. They wanted to make that easier. Number two, to reduce the need for audits for either over coding or under coding. They wanted to reduce the need for what they call, "note bloat", which means entries into an electronic medical record, which were way more complicated than they needed to be to support coding we wanted to simplify that. And then they wanted to align the CPT or particularly the E/M coding set with the way that the Center for Medicare and Medicaid services wants visits documented. And that applies both to Medicare and Medicaid services. Of course, that's Medi-Cal in California. So, you know, kind of the overall idea is that they wanted to make coding easier. Next.

Dr. Michael Policar:

And to quote them directly "the changes are "Centered around how clinicians think and take care of patients. They're not only mandatory standards that encouraged a lot of copy and paste

and checking boxes." Because what a lot of people had been doing with their electronic medical record from one visit to the next is a lot of cutting and pasting and trying to get coding credit in that way. And they're now they're trying to simplify it.

Dr. Michael Policar:

So, what are the specific things that happened on January 1st? Well, one of the E/M codes, 99201, which was for a new patient with a very straightforward visit, has been deleted. So, that code is gone. Number two is 99202-99215 were revised. Next.

Dr. Michael Policar:

So, in the revision, we will select a problem-oriented E/M code based either on total time, and that has a new definition or medical decision-making, which also has a new definition. So the point is, is that we'll choose one or the other, and remember in the old system, like history, physical, medical, decision-making, you got basically points for how much of a history you took and how much of an exam you did. Nowadays, that's gone. So, do whatever's clinically necessary for history and physical examination, but it's not factored into coding.

Dr. Michael Policar:

So, first let's start with the way that we calculate total time. Okay. And the first thing they did was to change the time intervals associated with each code, for either a new patient or an established patient. Next, is it removed that 50% threshold of counseling. And now whether you spend most of the visit on, let's say physical assessment, or most of the visit on counseling or some combination of the two, you can use total time. Doesn't matter what percent. Number three is the fact that time was redefined from face-to-face time with your clinician and the patient now to total time, which is spent on the day of the encounter. And we have very specific criteria for how you compute total time. They also tell you how to do time when more than one provider is as involved in the care of the patient. Next.

Dr. Michael Policar:

Okay. So, the first thing is, is that the time intervals have changed. So over on the left, you see the time intervals spring E/M visit for a new patient 99202-99205.

Dr. Michael Policar:

And I want you to note that in purple for the 99205 to 99215, even though those are part of the E/M coding system, that those are not Family PACT eligible. So, Family PACT benefits only go through a 99204 for new patients and 99214 for established patients. So, these are the new timeframes for E/M visits. Next.

Dr. Michael Policar:

Now, the other thing which is very different is what you get credit for in terms of time. Remember in the old system, it was only face-to-face time. In the new system, what goes into

the computation of time is the time it takes for you to prepare it, to see the patient. In other words, looking at a prior note, looking at a note from another clinic that the patient went to looking at test results from the last visit. Next is reviewing a history that might've been taken by another clinician, or maybe a medical assistant in your office Next.

Dr. Michael Policar:

Then of course, to perform what is a medically appropriate exam or evaluation. Next.

Dr. Michael Policar:

Counsel, the patient, and educate her or him and a family member, if they're present, or a caregiver if they're there. Next, is to document that clinical information in the health record. So, the time it takes for you to type your note into the EMR is included in time to independently interpret test results. What that means basically is that if, for example, your patient had a pelvic ultrasound done in the radiology unit, and you can see those images and you are trying to interpret those images beyond what the radiologist did. Then you can get credit for that time as well.

Dr. Michael Policar:

And then the last bullet is care coordination. That's not separately reported and billed for. So basically, from the time that you start looking at the patient's chart until the time that you finished typing your note, all that time, you get in this new system. So that's total time.

Dr. Michael Policar:

The other way of billing an E/M code is based on medical decision-making selection. And this has changed significantly as well. So, the way that it used to be is that medical decision making was based on the number of diagnoses, the amount or complexity of added that you had to review. Number three, the risk of complications of treating the patient. Next.

Dr. Michael Policar:

So, this is what it has been modified to. So, the blended element of medical decision making is the number and complexity of problems that we address. Second, is the amount and complexity of data reviewed and analyzed. And the third is the risk of complications of morbidity or even mortality of patient management. So, there's been a little fine tuning of each of those three elements.

Dr. Michael Policar:

Now let's talk about medical decision-making in more detail. So, the first has to do with the number of problems. And what you'll do is come up with a score in this first of three elements in terms of how complex was medical decision-making. So minimal if the patient came in just for a minor problem. Low is if the patient came in for an acute uncomplicated illness or injury. Moderate, as all five of those bullet points, but the one we're most likely to deal with is an

undiagnosed new problem that has an uncertain diagnosis. And then high is when there are either very severe problems or, you know, an exacerbation that something that was previously existing. Next slide.

Dr. Michael Policar:

The next slide is important because it gives you some examples about the number of problems in the family planning context. Next.

Dr. Michael Policar:

Okay, so we're looking at a number of problems. Things that would be minimal score would be a refill of a birth control method, a pre pregnancy visit, an STI counseling visit. Next, our low level of the number of problems. That might be a healthy patient who comes in for contraception, a patient with a new complaint of the vaginal discharge. The hormonal contraceptive user, like a pill, patch, or ring user, who now has a complaint of unscheduled bleeding. Next, is the moderate level for the number of problems and that might be a person who comes in with recurrent vaginitis, who now has a new episode, or an acute pelvic pain you have to work up. Or a new complaint of a breast mass, or a new complaint of pelvic pain that is diagnosed as being PID or pelvic inflammatory disease.

Dr. Michael Policar:

And then what's considered to be a high number of problems are things that are life threatening, like an ectopic pregnancy, a hemorrhage from an ovarian cyst, a deep vein thrombosis in a person who uses combined hormonal contraceptives. So, this table correlates with the one that I showed you in the previous slide, in terms of those examples in family planning or STD care, that would be minimal, low, moderate, or high in the column of the prompts. Next.

Dr. Michael Policar:

So, the next thing we were looking at is how much data had to be reviewed. Then, this comes from the A/D table and it basically says, if we have to look at no other data, no test results, or we didn't order any tests, that's considered to be minimal. On the other hand, if we review test results, we get a point for unique tests. And for each unit unique tests that we order, we get points for that. It has to be at least two of ordering a test, reviewing a test result, or looking at a prior note from an external source, which means from a clinician in a different clinic.

Dr. Michael Policar:

Now, the next level of the data element is moderate. And for that, you have to have any combination of three of reviewing external notes, ordering tests, or reviewing test results. Next.

Dr. Michael Policar:

So, some examples of this in family planning are that if you had a patient encounter, no test ordered, there were no results reviewed. There was no review of external records then that would be called a minimal level.

Dr. Michael Policar:

A limited, in the data element, is if you reviewed a note from a provider in, let's say the primary care clinic, or in the pediatrics clinic. Or it would be a review of each unique test result ordered by external provider. Or it would be unique tests that you ordered today that you are not billing for in your clinic. So, an example of that would be, you get a vaginal sample for gonorrhea and chlamydia, or you send off a CBC or hemoglobin A1C. All of those, you get credit for each individual one. Or an additional history, which has been required from a partner, a parent, a guardian, or a caregiver.

Dr. Michael Policar:

Now, for the moderate level of the data element, it has to be any three of limited categories. So, in other words, at least 3 of unique tests that you've ordered, unique tests that you've reviewed, or the notes that you've reviewed from a provider in a different specialty. Next.

Dr. Michael Policar:

So, the, oh, just before I get to the third one, which is the risk, there are some new ones, but really important ports. When you point, rather, when you look at the medical decision-making data element. Number one is that if you code and bill for a point of care test, that is to say a pregnancy test, microscopy, an HIV tests that you do in your office, you can't count that as they're ordering it or reviewing a test result because you're billing separately for it. You can't get credit twice. So, number two, is that if you order a test like a chlamydia and a gonorrhea, it includes the review of that result. You only get one. Ordering the test and reviewing the test results, whether you result review that result today or next week. Next.

Dr. Michael Policar:

Next, is that review of test results basically can be counted only for tests that you didn't order. It has to be a test result that someone else ordered. And lastly, that unique test has its own CPT code. A panel counts as one unique test. So, for example, a CBC, a complete blood count, for example, is a combination or a hematocrit, the hemoglobin, platelets. But you don't get credit for that. It is three different tests.

PART 1 OF 4 ENDS [00:27:04]

Dr. Michael Policar:

But you don't get credit for that. It's three different tests. It's a CBC, it has its own unique CPT code, and therefore you can only count that as one test that you ordered or if you review the result of it, somebody else ordered.

Dr. Michael Policar:

All right. The third column, when we think of medical decision making, is the risk of complications. And we have minimal, which is basically no risk. Low, which is a low risk of complications from diagnostic testing and treatment. And then moderate. And the important thing about moderate is whenever you prescribe a drug, then that is considered to be a moderate level of the risk of complications. Okay, next.

Dr. Michael Policar:

So, some examples of that in family planning are, if you see a patient there's no diagnostic study ordered or no treatment, that's minimal. Low would be a point-of-care test done, dispensing condoms and spermicides, treatment of, let's say, menstrual cramps with an over the counter NSAID. And then moderate is prescription of any contraceptive that is a prescription contraceptive, pill, patch, ring, an IUD and so on, or a prescription of any antibiotic. Also, at the moderate level of risk are discussion and consent about an IUD or an implant or an endometrial biopsy or colposcopy, discussion, and consent for a laparoscopic tubal ligation, for example, or extraction of a translocated IUD. Next.

Dr. Michael Policar:

Okay, now you've done your calculations about... In the first column, what was the number of problems? In the second column is what was the amount or complexity of data that had to be reviewed? The third is the risk of complications or morbidity. So, what you do is you score in each column and you can take the highest two out of three. So, let's say, for example, it's a low number of problems, a moderate amount of data that has to be reviewed, and a moderate risk of complications or morbidity. The highest of two out of three would make that moderate level of medical decision-making. For a new patient that's going to be a 99204. For an established patient, that's going to be a 99214. Next. Next slide.

Dr. Michael Policar:

Okay. And here's just another way of a sort of quick summary of all of this. For a new patient we have codes, E/M codes between 99202 and 99205. And basically, what's in yellow is the level of medical decision making. What's in gray is the number of minutes. And the same for established patients. The only one we haven't really talked about so far is the 99211 which is an RN visit without a clinician being involved. That one hasn't changed. All right, next slide.

Dr. Michael Policar:

Okay. So enough about the background of these changes. What we'll do is to take our case studies in just a minute. But before that, I want to tell you about the changes in Family PACT E/M policy. These were published in February 2021, so a couple of months ago. And the most important policy for you to look at among Family PACT policies is the one called office visits evaluation and management, and education and counseling or E/C visits. So, go to the FamilyPACT.org website, go to the provider section, go to the PPBI section, and you can actually look at the original policy.

Dr. Michael Policar:

So, what this policy says is that Family PACT has adopted these changes that I just explained. Next. And what they also did, very importantly, is they deleted the old policy that had to do with an evaluation and management visit that involved both the clinician and the counselor.

Dr. Michael Policar:

So, what I mean by that is what Family PACT used to cover, and this policy is 15 years old, basically. It said that if a health educator saw a patient first, let's say for 10 minutes, and a clinician then saw the patient for 15 minutes, that you could bill that visit as a 25-minute visit. You could add up the clinician time and the counselor time and use that to compute the face-to-face time for an E/M visit. That is now gone. It has been replaced with... Next.

Dr. Michael Policar:

When you indicate an E/M code for an office visit, you can only use clinician total time based on the definitions I've just said. And in addition to that, you can build an education and counseling code for services given by a provider that's billed separately with a code that comes from the series called individual preventive medicine counseling, and that's based on face-to-face time. So, 99401 with a U6 modifier if your health educator or counselor spends up to 15 minutes with the patient. A 99402-U6 for a time between 16 and 30 minutes, and the 99403-U6 for a counselor or health educator time that is 31 to 45 minutes. Now that's in addition to the E/M code for the clinician. So basically, instead of adding them up the way we used to, these are now billed separately, but you can bill both if both were done.

Dr. Michael Policar:

All right. Well, let's put this into real life now and let's do some case studies. Next. All right. And for all of the case studies, I'm going to use what's called the Coding Framework. For any patient encounter, you need to ask yourself whether or not there were any of six different categories of services done, and if so, indicate what the code is. So was there a procedure, and which would be indicated by a CPT code. So, an IUD insertion, an implant removal, a colposcopy, an endometrial biopsy, a vulvar biopsy are all procedures which are billed by CPT code.

Dr. Michael Policar:

Next is, did your clinic or practice dispense any drugs or supplies? That's going to be indicated by what's called an NDC code, National Drug Code, maybe with or without a HCPC code and that's something which is in the Family PACT policies as well. So that's how you bill for an IUD insertion kit, for an implant insertion kit, for condoms, spermicides, any other clinic-dispensed medication.

Dr. Michael Policar:

Next is you can bill for certain point-of-care, meaning done in your office, laboratory test or imaging test. Okay? So, in the case of onsite laboratories, it would be a pregnancy test or a microscopy of a vaginal discharge. Or in some cases in Family PACT, much more in Medi-Cal, it would be billing for an office ultrasound like an abdominal ultrasound or a vaginal ultrasound.

Dr. Michael Policar:

Number four is what's the level of the E/M code, and in Family PACT that's for problem-oriented visits. Number five, is are there any modifiers? The modifiers we're most likely to use are 25... We're going to talk about that a lot in just a minute. 51 is when you do more than one procedure on the same day, like taking out an expired implant is one procedure, putting in a new implant at the same day is a second procedure, and the second procedure has a 51 modifier or a 95 modifier, and that's done for telemedicine visits.

Dr. Michael Policar:

And then lastly, number six is what's your diagnosis code? Most of those are going to be Z-codes, a few of them are going to be N-codes. And so, you're going to see this kind of table for each of our four case studies. Next.

Dr. Michael Policar:

Okay, so our first case study is Janae. She's 24-year-old established patients, patient rather, who comes in because she has concerns about whether she acquired a sexually transmitted infection and she wants to be tested. Now during Janae's visit, it also came up about what method of contraception is she using, what would she like to do, what are her reproductive intentions? And that is to say, would she like to get pregnant anytime soon. And her answer was, "Yes, I really wanted to be protected, and no, I'm not planning on getting pregnant any time soon." Her decision was she wanted a three-year levonorgestrel IUD.

Dr. Michael Policar:

So, an office pregnancy test was done. That was negative. A point-of-care, HIV 1+2 antibody test was done. Like an [inaudible 00:35:44] quick test, and which is a Family PACT benefit. That was negative. And a vaginal sample of whatever vaginal fluid there was, was sent to the lab for a gonorrhea and chlamydia nucleic acid amplification test. So, she had the IUD placed easily.

The clinician decided to do a quick pelvic ultrasound with a vaginal probe, just to check the placement. It was fine.

Dr. Michael Policar:

It was important that you look at time frames, because the face-to-face time with Janae was 18 minutes, but the total time, which was the time it took for the clinician to look at her old records, look at her old laboratory test results, to take care of Janae and write the note afterwards, type the note into the EMR, was 26 minutes. But importantly, the time it took to put in the IUD can't be counted, otherwise that would be billing twice.

Dr. Michael Policar:

Now, when you bill a CPT code for a procedure like her IUD placement, that code includes a brief history checking about medications or allergies; administration of local anesthesia, for example, if she needed a paracervical block, which Janae did; doing the procedure itself; and then watching her for a few minutes afterwards. Next. So, in those visits, we only bill the CPT code, but not an E/M code. If the counseling that was given to the patient was solely in the context of the procedure, and we really didn't do anything, we just did counseling about the procedure, we did the procedure code. Next.

Dr. Michael Policar:

Okay, so... And this is advice which comes from ACOG from their Quick Coding Guide. If a patient comes in and says, "I want an IUD. I want an implant." And that's all you discuss, but then you did the placement, you cannot bill on it on an evaluation and management code for that. On the other hand, if the patient came in and said, "I don't have any idea what I want." You spent a half hour talking with her about what are your reproductive intentions, what are you looking for in a method of contraception, you do shared decision-making counseling. And after that she decides she wants an implant or an IUD, then you can bill both for the counsel and the CPT code for the procedure.

Dr. Michael Policar:

Then the third point is, if she's seen for another reason, and during that same visit you do a procedure, you can bill both for the E/M services and for the procedure. Okay. That's what's called a turnaround visit. And that's exactly what Janae had. The turnaround is, she came in because she wanted to be checked for sexually transmitted infections. The turnaround that Janae was, that she ended up getting services for contraception and also got a Skyla placement. And you can bill for both those things. So now what we'll come to is how are you going to bill for Janae's visit in Family PACT. Next.

Dr. Michael Policar:

All right. So, we're going to be reporting both an E/M because she got STD services, she also got contraceptive counseling, and a procedure. And for the part about all of the counseling that we

had, we're either going to use medical decision making or total time. But again, if we use them, we cannot count the time for that IUD insertion itself. Next.

Dr. Michael Policar:

And then we have to put a 25 modifier onto the E/M code, which says that the counseling that we did about contraception and STDs was separate from the procedure of inserting the IUD. That 25 modifier is really important, not only for Family PACT and Medi-Cal, but it's important with your other payers as well. It says two different things were done. Two distinct services on the same date of service. Next.

Dr. Michael Policar:

Okay. So, we're going to code this visit on the basis of time. Remember... Next. There we go. Remember that Janae is an established patient. We spent 26 minutes reviewing her old records, providing her counseling, typing the note into the EMR. That was 26 minutes for an established patient. That's a 99213. By the way, I mentioned that it's not 18 because it was only 18 minutes of face-to-face time. We get to count the preliminary time plus the time it takes to type the note, and that's why it's 26 minutes. So, the computation of total time is 99213 for an established patient. Next.

Dr. Michael Policar:

So next what we're going to do is to... Next slide. Is to compute the level of the medical decision making for Janae's visit. Remember, first we compute the number of problems, then we compute the amount of data, then we compute risk. Next. Okay. So, what did Janae receive when it comes to that first element of medical decision making? She had one acute, uncomplicated illness or injury. So that level is considered to be low. Next. Okay, so one acute, uncomplicated illness is low. So, we'll do the score for that column. Next.

Dr. Michael Policar:

So, the next is the amount and complexity of data. Then here's where we get into the [inaudible 00:41:10]. So, the pregnancy test and the point of care HIV 1+2 test, we're going to bill for separately so we can't treat those as tests that were ordered. But samples were sent for gonorrhea and chlamydia, and so we get two points, one for the gonorrhea, one for the chlamydia, for those tests that we ordered. And so that is a limited level of data reviewed. Next.

Dr. Michael Policar:

So, the next thing we have to... Go ahead, next. There we go. So, the next is what is the level of risk? And because of the fact that putting in an IUD is a prescription method, that is counted as moderate risk of complications. Next. So now we have three different scores. Let's run them into this table. So, number of problems was low. The amount of data we reviewed was limited. She had a moderate risk of morbidity, so we take the best of two out of three. And she's an established patient, so that's a 99213 based on medical history. Next.

Dr. Michael Policar:

So, to sum it up for Janae, basically the procedure that we did was a 58300, which was to insert her IUD. That's the what. The why is an ICD-10 code of Z30.430. Next is of course we have to bill for the insertion kit itself because your clinic is going to be reimbursed anywhere between $400 and $900 for the cost of the kit, for the Skyla. So that's of J7301. Next is the laboratory tests that we did for Janae, which is an 81025, which is a urine pregnancy test, and 86703, which was for her point of care HIV test. And then the E/M code is a 99213 with a 25 modifier.

Dr. Michael Policar:

Want you just to notice what the corresponding ICD-10 code is, which is other family planning advice. Because remember when we gave her lots of family planning advice before she made the decision to have this done. Next. Okay. So, remember that the codes in purple are not required by Family PACT, but they might be by other payers. In other words, when your biller fills out the claim for the urine pregnancy test and the HIV, she's going to put in those CPT codes, but she doesn't need to put in diagnosis codes. And again, that 25 modifier says that we did two separate things at Janae's visit. One was all of her counseling about STDs and about contraception, and the other one was the insertion of the IUD itself. Next.

Dr. Michael Policar:

Let's take our second case. This is Wendy. Wendy's a 17-year- old new client who's seen for STI screening after learning that her boyfriend was diagnosed with genital warts. She has no symptoms; she's using oral contraception... Oral contraceptives as a birth control method. On physical exam, a look at her vulva and peritoneal area, she had normal skin, she didn't have any warts herself. But because of her concern about STD exposure, she had a gonorrhea and chlamydia sent from a vaginal sample. Syphilis and HIV tests were drawn, and they were picked up by a laboratory. And the total time for the clinician from the very beginning of the visit until the time that the note was typed was 26 minutes. Afterwards, she met with a health educator for 10 minutes to discuss STI prevention and safer sex. So, two components of the visit, one with the clinician, one with the health educator.

Dr. Michael Policar:

So, we'll start with the medical decision-making. So, the medical decision-making in this case was low. The data was moderate and four different tests were ordered, and that is gonorrhea, chlamydia, syphilis, HIV. None of those were point-of-care tests and therefore we get four points for that, which makes it a moderate amount of data. And then the risk of the testing that she had was minimal, and so we're going to check that box. So again, we take the highest of the two out of three, and the highest of two out of three is low. Next.

Dr. Michael Policar:

Okay. So, MDM level is low. She's a new patient, so that's a 99203. Next. Okay, so how are we going to bill this? Wendy did not have a procedure. She did not get any drugs or supplies. She

didn't have any point of care tests. Remember, we sent off four different laboratory tests. The E/M code is a 99203, okay? And the reason for that is total time is a 99202, a new patient, rather, who had a 26-minute visit. Next. But remember, the 99203 is chosen because that was the level of medical decision making. All right? And this is really important. We can choose the higher of the two. So, if you go by time, it's 99202. If you go by medical decision-making, it was 99203. And you can use the higher of the two, and that's why we're going to bill the 99203 in this case.

Dr. Michael Policar:

The ICD-10 diagnoses are Z20.2, which is contact with or exposure to STD. Remember the reason that Wendy came in was because her boyfriend had genital warts. We're also going to use a secondary diagnosis, which is Z30.41, surveillance of an oral contraceptive user. And remember that is necessary in a Family PACT visit where we always have to indicate what method of contraception a person is using at any Family PACT visit. But it can either be the primary diagnosis or the secondary diagnosis.

Dr. Michael Policar:

Now, remember that the clinician spent 26 minutes with Wendy, but the counselor spent additional time with Wendy. So, in addition to the E/M code, we can also bill an E&C code of 99401 with a U6 modifier. And the reason for that is contact with exposure to an STI. And so, you see this important change in Family PACT of billing both for the clinician effort, in this case with medical decision making, the 99203, and the counselor or health educator effort, which is the 99401 with a U6 modifier. And that's the new Family PACT benefit.

Dr. Michael Policar:

All right, next is a male visit. So, Sam is a 20-year-old new client who's seen because he has general warts. In fact, he might even be Wendy's partner. So, on physical exam of his penis and his scrotum, he had seven or eight small genital warts. A urine sample was obtained for gonorrhea and chlamydia. Blood samples were drawn for syphilis and HIV and were sent to the lab. His genital warts were treated in the office with the application of trichloroacetic acid. And in addition, he was dispensed 30 condoms.

Dr. Michael Policar:

He was scheduled for a follow-up visit in a week to see if he needed another treatment with trichloroacetic acid. He was counseled by the clinician regarding his STD risk. And the total time, excluding the time for treating his genital warts, was 24 minutes. From the time that his chart was open to the time that the note was written was 24 minutes. And remember, the treatment of his warts with the TCA is the procedure. That's why we are going to bill for that. We can't count the time of actually applying the TCA.

Dr. Michael Policar:

So, in any visit that has this cognitive component, we're going to compute both medical decision-making and total time. So, for medical decision making, the number of problems is low. The amount of data is moderate because he had four tests ordered. The risk of complications with the TCA application is low. So, we take the best of two out of three, which makes this a low medical decision making. And Sam is a new patient and therefore computing medical decision-making the E/M code is 99203. Next

Dr. Michael Policar:

Okay. So how are we going to bill Sam's visit? Well, the first is 54054, and that's for treating his warts. And by the way, that CPT code is defined as destruction of lesion on the penis, simple, which means that there were 14 warts or less and it was done with a chemical, it was done with [inaudible 00:50:03], it's done with trichloroacetic acid, 80%. Then we use that CPT code. And that code, by the way, is a Family PACT benefit. The reason we did that was because of a diagnosis of A63.0, which is condyloma accuminata.

Dr. Michael Policar:

Now there's another procedure there, which is 99000. And that is if you draw a blood sample and you have to pay to have that sample sent to a laboratory, then you can actually bill for reimbursement of the cost of having it sent to the laboratory. That is a Family PACT and Medi-Cal benefit. Now, if the laboratory comes and picks up the sample and you don't have to pay them for the transport, then you can't bill the 99000. But on the other hand, let's say, for example, you're sending a laboratory sample to Texas and you've got to pay for the postage, then you can bill the 99000 CPT code as a Family PACT benefit.

Dr. Michael Policar:

The next thing we did for Sam was to give him 30 condoms. And so, the HCPC code for that is A as in apple, 4267. There were no point of care laboratory tests done for Sam. The E/M code, which was all of the history and counseling and so on that he received is a 99203. And the reason for that is because it's the higher of medical decision making and total time. Total time for a new patient, but the amount of time we spent with Sam is a 99202. Medical decision-making, as I just explained in the prior slide, is a 99203. We can use the higher of the two.

Dr. Michael Policar:

And then lastly, when we bill the 99203, it has to have a 25 modifier because we did a procedure, which was treating his warts. And we did the office visit, taking all of his history and so forth, on the same date of service. And that's how we're going to bill for Sam. Next.

Dr. Michael Policar:

Okay. Our next patient is Betty. We have two more patients, but we'll finish this up in the next 10 minutes. So, Betty is a 41-year-old established client who's seen for a well-woman visit. She

doesn't have any complaints. She's currently using oral contraceptives. She wants to continue. But you notice, let's say when you're getting an HPV test, that she has a vaginal discharge and you have a look at that under the microscope. She has lots of clue cells and the pH is 5.5. And she's diagnosed with bacterial vaginosis, which by the way, is asymptomatic BV, so she's given the option of being treated for bacterial vaginosis or not and she wants to be treated.

Dr. Michael Policar:

So, she was dispensed oral metronidazole and counseled about how you got BV, how's it going to be treated, and so on. So, the face-to-face time with Betty was 32 minutes, 20 minutes was for her well-woman visit, 12 minutes was for the evaluation of her bacterial vaginosis. And the total time from the time we opened up her medical record until the time we typed the note into the chart is 39 minutes. And, good. Remember she didn't have any procedure.

Dr. Michael Policar:

So for Betty, the total time is 39 minutes for her well-woman visit, for the bacterial vaginosis diagnosis, to tell her about treatment, to counsel her about how she got bacterial vaginosis, and the time it took for you to chart. So that being the case, based on time for 39 minutes of established patient, that's a 99214 based on time. Next.

Dr. Michael Policar:

But whenever we calculate time, we also calculate medical decision making because we have a choice of the two. For medical decisions making, the number of problems is low. The amount of data that we reviewed was none. The risk of complications is moderate because we gave her a prescription for metronidazole. And the highest of two out of three... Next.

PART 2 OF 4 ENDS [00:54:04]

Dr. Michael Policar:

... prescription for metronidazole. And the highest of two out of three, next, was that she has a medical decision making of low. She isn't an established patient. So that's a 99213. Next.

Dr. Michael Policar:

So, this is a summary of how we're going to bill Betty's visit. There were no procedures. She was out of birth control pills. So, she was dispensed 13 cycles of pills, and HCPC code for that is S4993. And you get paid for all 13 cycles of drugs. okay. She was also dispensed metronidazole 500 milligrams twice a day for seven days to treat her bacterial vaginosis. And so, you can bill Family PACT for that. The reason for giving her 13 cycles of pills was a Z30.41, which is surveillance of an OC user. The reason for giving her metronidazole was N76.0.

Dr. Michael Policar:

And the reason that that's the code for acute vaginitis, is that it's also used for bacterial vaginosis. BV does not have its own unique diagnosis code, so we use N76.0 for bacterial vaginosis. Next is she did have a point of care lab, which was her microscopy to diagnose the clue cells, and Family PACT, that is Q as in queen 0111 wet mount.

Dr. Michael Policar:

And then for the E/M code, basically, on the basis of time, it's a 99214. Remember it was 39 minutes. On the basis of medical decision making, it's a 99213. And therefore, we're going to build the higher of the two, which is a 99214. And remember that the diagnosis for Betty has to be, number one, the fact that we have to mention her birth control method, which is surveillance of an OC user. And then number two, if you ... and that's why she came in by the way. And number two was we happened to find that she had BV and that's why the N76.0 for acute vaginitis is a secondary diagnosis. Okay, next.

Dr. Michael Policar:

So, we have one last patient before I take your questions. And this is Meri. Meri is a 30-year-old established client who's been using DMPA, Depo-Provera, every 13 weeks for the last two years. She called for an appointment two weeks before her next injection was due, but because of the pandemic, she was hesitant to come in. So instead, Meri had an audio video telehealth visit. And during that telehealth visit, there was a 15-minute discussion with a clinician about her alternatives to coming in for a Depo-Provera shot. What she decided to do instead was to try self-injection of DMPA SubQ. Next.

Dr. Michael Policar:

So, one unit of Depo sub Q was E-prescribed. She picked that up at a pharmacy. What are some of the alternatives that Meri could have had to Depo-Provera, and how are we going to code this visit? Next.

Dr. Michael Policar:

So, remember that Family PACT does cover a variety of telemedicine codes. This is a summary of all the telemedicine codes that Family PACT covers. Okay. And just to very quickly review them for you, a G2010 is a HCPCS code of what's called a virtual check-in. That's when a patient takes a photo of a skin lesion and sends that to you for evaluation about this, do you need to come in or not for this particular skin lesion. You can bill Family PACT or Medi-Cal for that.

Dr. Michael Policar:

Next is a HCPCS code of G2012. That's a telephonic visit with the patient to decide whether or not she needs to come in. That's called a virtual check-in visit. It can be done by a staff. Doesn't need to be done by a clinician. And that's when there's a 10-minute conversation, do I need to

come in or not? And then you can bill this code, which has just come up since last month during the pandemic.

Dr. Michael Policar:

Next, you can bill a 99451 if you do an email consult with a specialist about a patient's particular problem. And then most importantly are the telehealth visit codes, which are standard E/M codes, the way that I've just described them to you. But they have to have a 95 modifier. So, for a new client, having a telehealth visit, you'd get anywhere between a 99202 through 204 with a 95 modifier. And for an established client, anywhere between a 99212 and 99214 with a 95 modifier.

Dr. Michael Policar:

Now, I know many of you have tuned in for my prior webinars that I've done on billing for telehealth visits and Family PACT. Remember for the last 10 years, they have paid for audio/video telehealth visits, but since June of 2020, three or four months into the pandemic, they have also been covering telephonic telehealth visits. So, if, for example, you don't maybe capability in your clinic, or a patient doesn't have a computer, doesn't have a smartphone, and can only do a telephone call and cannot do an audio/video telehealth visit. Then for the time being, Family PACT will let you bill for those using standard E/M codes, based on either total time or medical decision-making. But it has to have a 95 modifier to explain the fact that this was either an audio video telemedicine visit, or it was a telephonic telemedicine visit. Next slide.

Dr. Michael Policar:

Okay. And this is just basically an algorithm that tells you the same thing. Were there video or pictures? The answer is yes. Was it real time? The answer is yes. Then you use an E/M code with a 95-telemedicine modifier. If it wasn't real time, in other words, the image was evaluated later, then you would use a G2010. Next question. If there was no video, was this phone call to determine the need for a visit? If the answer is yes, then you use G2012. If they answered a no, is the client on the phone? Is this visit a telephonic visit? If the answer to that is yes, bill a telehealth visit using a standard E/M code with a 95 modifier. Next.

Dr. Michael Policar:

Okay. Now remember what Meri was interested in is, I don't want to come into the clinic for my Depo-Provera shot. So, what her alternatives are, is she can either come in-person, get an IM injection in clinic. She can come in-person, literally get a curbside injection in her car. If that's something that your clinic is doing. Many clinics, by the way, are still doing this, giving curbside Depo injections. Next is she can switch to self-injected Depo SubQ, which is what Meri decided. And then finally, we would advise her that she had the option of switching to what's called a bridge method. She can use progestin-only pills. She can use a pill patch or ring. She can use a barrier method instead of Depo if she wants to come into the clinic for a visit. But in her case, she chose to give it a try, to give herself a self-injection of Depo SubQ. Next slide.

Dr. Michael Policar:

Okay. So how are we going to bill for Meri's visit? Number one, there was no procedure. Number two, we don't bill for the Depo SubQ injector. The reason for that is that Depo SubQ is not a Family PACT benefit for either administration in a clinic or dispensing by a clinic. Got to be picked up at a pharmacy. And remember, in Meri's case, what happened was is that an E-prescription was sent to a pharmacy. She went to the pharmacy and she picked up that injector for her Depo SubQ. And so, the pharmacy is going to bill or Family PACT and not your clinic.

Dr. Michael Policar:

There was no point of care lab because remember this was a telemedicine visit, and the E/M code would be a 99213 for an established client, duration of her visit was between 20 and 29 minutes. The reason for that was surveillance of an injectable contraceptive, which is DMPA, and the modifier that has to be attached to the 99213 is a 95, indicating that this was a telemedicine visit. Next slide.

Dr. Michael Policar:

So, what I want to do in the last slide ... oh, sorry. There are just a couple of more twists on Meri, and then I'll take your questions. So, Meri was able to do her self-injection of Depo, but 12 weeks later she called the clinic and said, "That was kind of uncomfortable. I wasn't very confident about that. I want to switch back to Depo IM at the clinic." So, when she was seen, she complained that she's had continuous light spotting over the last two weeks. She discussed that with a clinician, but she wants to continue using Depo. She did have an office pregnancy test that was negative, and she had a Depo IM injection given by a medical assistant. And the total time of that visit was 24 minutes in the clinic, face-to-face.

Dr. Michael Policar:

All right. So, there are two ways to bill for a Depo injection. Next. So, an IM injection, which is given by a medical assistant, and RN, or a clinician after a very short history update. That is, how are you doing? I'm doing fine. I want my Depo shot. That one is billed as a 99211. Next. If on the other hand, the patient needs a clinician visit related to her Depo and it's a Depo related or another problem, then we can use a standard E/M code between 99212 or 99214, based on either medical decision making or time.

Dr. Michael Policar:

Now remember, in Meri's case, she was complaining about her spotting. She needed to see a clinician. So, in this circumstance, we're going to bill an E/M code based either on the basis of time or medical decision making for Meri's Depo injection visit, because there was a problem associated with her Depo, which was her bleeding. And so that's going to require two different ICD10 codes. One ICD 10 code is Z30.42, which is for surveillance of her Depo. The other end is secondary diagnosis code for her complaint, which was N92.1, which is excessive or frequent menstruation within the regular cycle. So next slide.

Dr. Michael Policar:

So, this explains the billing for Meri's visit when she was seen face-to-face. So, there was no procedure. And by the way, some payers actually cover 96372, which is for an office injection. So, Health Net, or even Medi-Cal might cover that, Family PACT does not. For drugs or supply, for the Depo IM shot she had in the office, that's J3490 with a U, the number eight, modifier. And then to treat her bleeding, she was given generic estradiol, that's 5,000 to help her a bleeding issue.

Dr. Michael Policar:

She did have point of care lab, which was a urine pregnancy test. And given how long that visit took, it's reasonable to use a 99213 for the time of that office visit for an established patient. The primary diagnosis is Z30.42, which is surveillance of a patient who's using Depo-Provera. And then the secondary diagnosis N92.1, which is her irregular bleeding. And there is no modifier since there was new procedure. Next slide.

Dr. Michael Policar:

Okay. So that's it. I just want to very quickly mention a couple of reference that are really important for this. So, when it comes to all of the changes in E/M services that I just explained, again, remember they were produced by a combination of the American Medical Association and the Center for Medicare and Medicaid Services. If you click on the top link, you will get about a 50-page document that explains all of this in great detail.

Dr. Michael Policar:

The next link is to a medical decision-making chart, which is just a two-page version of all the charts I showed you about how to compute the medical decision-making level. Next. There are some additional resources here about the detail of these modifications in 2021 E/M codes. Next. Even more. Next slide. I promise there are only two or three left. Okay.

Dr. Michael Policar:

So, this one I threw in just because you might not have been in the webinar that I did last summer that had to do with billing for telehealth services and Family PACT. And this is the link to the specific Family PACT email blast and policy that has to do with billing for both A/ and telephonic telemedicine visits in Family PACT. And this, by the way, is still in enforced right now. So, you can see the link up there in blue. And if you want to know all the details about how to bill for a telephonic visit in Family PACT, this is where you'll get it. Next slide.

Dr. Michael Policar:

Okay. And basically, what that particular policy and letter will say is how telephonic visits can be considered telehealth visits during the public health emergency. The relevant parts of that letter are, for Family PACT, are between page seven and page nine. And I know many of you tuned in today work in federally qualified health centers. There are other parts of this guidance

from that account that explains how to bill for telemedicine visits and telephonic visits in FQHC. Next.

Nicole Nguyen:

That was it.

Dr. Michael Policar:

Well, that is it. Okay. I am done. I am going to try to see if I can actually bring up the question box after all my other problems here.

Nicole Nguyen:

Okay. Let me open this up and see. Sorry about that.

Dr. Michael Policar:

Okay. And I-

Nicole Nguyen:

Sorry. As I was advancing your slides ... but let's see.

Dr. Michael Policar:

Okay. Well, here I'll-

Nicole Nguyen:

I have a question. So, one of the questions was from Ida. Can you go over same sex relationships that are not reproducing? Will Family PACT services be covered?

Dr. Michael Policar:

Yes. So, what the current rule is in Family PACT is that, for eligibility, it has to be a female who is capable of becoming pregnant or a male who is ... and here, I'm talking about body parts, basically. A female with a cervix and a uterus and ovaries who is capable of becoming pregnant, or, and of course that could be a person who identifies as a man, but still has female ... a transgender person who still has female organs who is capable of becoming pregnant. Or it has to be a male who's capable of causing pregnancy. Okay.

Dr. Michael Policar:

It doesn't necessarily mean that they're in a relationship where they can actually cause pregnancy and will become pregnant, but they have to have that capability. So, if it's a person who, let's say it's a female who's had a hysterectomy or a tubal ligation, currently she's not eligible for Family PACT. If it's a male who's had a successful vasectomy, then he's not eligible for Family PACT. But other than that, it simply has to be a male who is capable of causing

pregnancy or a female who is capable of becoming pregnant. And they would be eligible for Family PACT. There are actually a few bills which were presented in California, which would change those rules, but they have not been passed in the [inaudible 01:10:55]. So, we'll see what happens in the future.

Nicole Nguyen:

Okay. So, then I'll just go over it. I'll just read them out. So, in general, are you able to bill a problem-oriented visit along with a preventative medicine service visit?

Dr. Michael Policar:

Yeah. Hang on just one second. I am trying to bring this up so I can ... I heard you read it, but when I ... So, in general, are you able to ... I can't read the whole thing. So, can you read it to me again? I'm sorry. In general, are you able to bill a problem-oriented along with a preventative visit?

Nicole Nguyen:

Yes.

Dr. Michael Policar:

Okay. So, the answer to that is it all depends on whether you're talking about Family PACT or whether you're talking about other payers. So, with Family PACT, they do not cover the code series that has to do with preventive medicine visits. So, when you see a patient, like one of the patients we had in our case studies was a person who came in for ... a woman actually, but she ended up having her bacterial vaginosis managed. And in that circumstance, you would take all the time combined, which was 39 minutes, and bill that with [inaudible 01:12:11] E/M code.

Dr. Michael Policar:

Now, if it were a different payer, let's say it was Health Net, for example. In that circumstance, you would use one of the preventive medicine visit codes. And those by the way, are based on the patient's age and whether or not she's new or established. And then if you did something beyond preventive medicine visit, a well woman visit, then you could also bill an E/M code. And it has to have a 25-modifier associated with that. So that's how you would do that with commercial payers, but with Family PACT, because they don't cover the preventive medicine codes, you'd add up everything that goes in the well woman visit and in the evaluation for vaginitis and total up the time or use medical decision making.

Dr. Michael Policar:

So, I can see the next one that comes from Candice. Can individual counseling codes and E/M office codes be billed together? And the answer in Family PACT for that is absolutely yes, but the other part of Candice's question is, we're billing together but receiving denials from Medi-Cal for the office visit. So, I'm not sure of the definitive Medi-Cal answer to this, but I don't think

that that's acceptable in Medi-Cal. Okay. This idea about billing for the individual counseling versus what the clinician does with an E/M code. So basically, an E/C plus an E/M in the same visit, that is very unique to Family PACT. Okay. Medi-Cal I'm 98% sure does not do it that way. And in Medi-Cal it has to be based on medical decision making or the time spent with a clinician. So, remember that E/C, education, and counseling, is unique to Family PACT and is not part of Medi-Cal.

Dr. Michael Policar:

So, the next question from Shannon is, if you order STI testing on all your patients, which, by the way, should never be happening, Shannon. But if you are, gonorrhea, chlamydia, RPR, which is for syphilis and HIV, that counts for four points, would that automatically make the visit moderate? Okay. So, two things here. Number one, you should never be doing all four of those for all your patients. That should be done strictly on a basis of the person's risk factors. Gonorrhea and chlamydia, I agree. Annually, routinely for people that are 24 or under, but for gonorrhea and chlamydia in people 25 and older, as well as syphilis and HIV, it's strictly based on risk factors and never automatic.

Dr. Michael Policar:

Number two is no, that does not make the visit moderate. It only makes the column of data moderate. Because remember, in medical decision making you've got three different elements. You've got the number of diagnoses is in the first column. The second column is the amount of data. The third column is what's the risk. So, if you had a patient where you had to order those four tests, gonorrhea, chlamydia, syphilis, HIV, okay. In that middle column that has to do with data, you would get four points for that. And that would make it moderate in the data column. Okay. But remember that in medical decision making, you only get the best of two out of three. So, you also have to take into account what's in the number of diagnoses first column, what's in the risk in the third column, and that's how you compute clinical decision-making okay.

Dr. Michael Policar:

Next is, when you refer to complexity that's high for a DVT, would that only be for an acute DVT or for follow-up after? I'm definitely referring to an acute DVT. Basically, in that column that has to do with the number of diagnoses, and I'm just looking at it in front of me just to make absolutely sure, but for the number and complexity of problems, the very first column, okay. The only things that are considered to be high are basically life-threatening.

Dr. Michael Policar:

And so the examples that I gave are an ectopic pregnancy that you've diagnosed in clinic, a person who has a [inaudible 01:16:24] because they've ruptured an ovarian cyst, a person who has tenderness in her calves and is having difficulty bleeding. And you're going to refer her to an emergency room to evaluate and determine a deep vein thrombosis. All of those count as being the highest level of number and complexity of problems addressed. Okay. If it was a

follow-up after a DVT, that would be counted as a, probably more like a moderate, which is a follow-up visit for a prior problem.

Dr. Michael Policar:

Okay. Next is multiple site testing for gonorrhea and chlamydia. And I can't read that entirely, Nicole. So, it says, can either site-

Nicole Nguyen:

Oh. For multiple site testing for gonorrhea and chlamydia, can each site be a unique test?

Dr. Michael Policar:

And the answer is yes, but that ... Oh, I see what you're saying. Let me think about that for a minute. So, we're talking about in that middle column of data for number of tests ordered. So, remember we talked about four tests being gonorrhea, chlamydia, syphilis, HIV. And so, what Pamela is asking is, what if I sent one circle for gonorrhea in the throat, one sample for gonorrhea from the vagina, and one sample for gonorrhea from the rectum? I don't know the specific answer for that, but I'm going to give you the conservative answer, which is, I would only count that as one point for screening for gonorrhea. Of course, if you do gonorrhea, chlamydia, HIV, syphilis, you're going to get four points, but just because you did gonorrhea and chlamydia separately from the throat and the rectum, the reality is it that that has the same CPT code.

Dr. Michael Policar:

And what the rules say is that in either ordering tests or reviewing tests, it's based on the CPT code, different CPT of different tests. And because you've done three different sites, but they all have the same CPT code, I would only count those once.

Dr. Michael Policar:

Okay. Next question from Misty is, can Family PACT services be done during a telephonic visit during the public health emergency if it's a reasonable visit, or should all Family PACT visits be done face-to-face? No. And Misty, I would say majority of Family PACT providers are actually doing some of both. They are doing some visits by telemedicine; they're doing other visits face-to-face. Of course, as things loosen up, what's happening is that more and more visits, particularly for people who've been hesitant to come in, they're being done in-person, face-to-face in clinic. But there's still a heck of a lot of telemedicine visits happening either with A/V or with telephone only.

Dr. Michael Policar:

And some patients, by the way, given the opportunity of doing telephonic visits, absolutely love that. Because it's better confidentiality for one. Number two is the fact that they don't have to

get on the bus or in a car or drive 40 miles to go to a clinic visit. So, people are just ... Very many clients are just really into the idea of telephonic visits, and it's for all those reasons.

Dr. Michael Policar:

So, the reality is that, for the time being, Family PACT is continuing to cover telephonic visits. There are some specific rules about what you have to document for telephonic visits, and those documentation rules are in that policy that I showed you at the very end of the webinar, that you need to go to that, look on page seven or eight, and it will tell you what the very specific rules are for telephonic visits. But you can continue to do those for Family PACT patients until you're told not to.

Dr. Michael Policar:

So, the point is, is that those are still in place. They will probably be in place for months or longer. And we'll wait until the OFP tells us that we can't bill for telephonic visits anymore. But you can either do telephonic visits. You can do A/V telemedicine visits, or you can do face-to-face visits.

Dr. Michael Policar:

Okay. So next question from Sanji is ... Again, I can't read all of that. So, you're going to have to help me. If someone comes in for a pap only, for cervical cancer screening only, would you only use a procedure code ... Read to me what the rest of that says, Nicole.

Nicole Nguyen:

Yes. Would you only use the procedure code and not use an E/M code?

Dr. Michael Policar:

No. The answer is there is no procedure code for you for a pap. When you ...

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Dr. Michael Policar:

... procedure code, for you, for a PAP. When a patient comes in for cervical cancer screening, whether that's done with cervical cytology or HPV, or it could [inaudible 01:21:11] with both, taking that sample is built into the E/M code for the visit. Okay? You can't bill for that for the obtaining of the specimen. And then when it comes to running the cytology or running the HPV test, you're not doing that, the laboratory is doing that. So, the laboratory is going to go for the running of the test. And for the obtaining of the test, that's integrated into your CPT code. So, patient comes in for a well woman visit, she's due for her cervical cancer screening, you get a sample for an HPV plus a cytology, okay? That visit takes only 25 minutes altogether. You're going to bill the E/M code for that 25-minute visit either on a total time, based on that, or

based on medical decision making. Okay? But even though you took those samples, you don't bill for those at all. And the laboratory is going to bill for having done them.

Dr. Michael Policar:

All right, another question from Shannon it is, "How should time spent be supported in the medical record?" Great question, Shannon. And that is that obviously you need to put what the total time is. So at a very minimum, if you spend 38 minutes with the patient, from the beginning to the middle to the end and at the time you were finished writing your note, then you would say, "Time of visit: 38 minutes." Personally, I don't think you have to do much more than that. Okay? In other words, you don't need to say, "25 minutes," or, "38 minutes reviewing laboratory results, getting a history from my MA, typing the note in." You don't have to say that. But what you do have to say is, "Total time for this visit was 38 minutes." Okay? You can't just bill a 99214 because it was a 38-minute visit, you've got to say somewhere in the note that it was the 38-minute visit.

Dr. Michael Policar:

And on the other hand, if you decide to bill your E/M code based on medical decision-making you should put that in your note as well. So, you should say, "99214 based on medical decision-making," or, "99214 based on total time of 58 minutes." And that would be plenty.

Dr. Michael Policar:

Okay. Let's see. Valerie. You're going to have to read that one to me, Nicole.

Nicole Nguyen:

Okay. "The new patient presents for STI testing, no symptoms, doesn't need a clinician face-to-face. Is 99211 billable?"

Dr. Michael Policar:

Yes. Yeah. It all depends on who does that, but the assumption is that the patient had an interaction either with a registered nurse or a medical assistant. Okay? And by the way, I don't want to have to discuss all the medical implications of that. I think that's a terrible idea personally, which is to have a non-clinician making decisions about which STI tests are necessary. I think a clinician needs to be doing that. But if the way things work in your clinic is that if a person discloses that she has certain risk factors for example, and then there's a standing order that the person gets certain STI tests but her only interaction is with an RN or an MA, then you would use a 99211 in that case.

Nicole Nguyen:

Okay. [crosstalk 01:24:43].

Dr. Michael Policar:

We have a question from Veronica. I know we're running out of time, but Veronica's question is really important. And I can read part of it, it says, "Who can we consider as a health educator? Can an MA provide these?" Oh, there it is. "Can an MA provide these services?"

Dr. Michael Policar:

All right. So, here's something critically important if you're going to be using E/C codes. In the Family PACT policy that I made mentioned called office visits, evaluation and management, education, and counseling visits. Okay? On page six of that policy there are very specific guidelines about who is considered to be a counselor. I know I use the term health educator, the term that [Family PACT 01:25:28] uses is counselor. Might be a health educator, might be a counselor, it might be a person who has gone through training as a family planning worker. I know that Essential Access actually has a training course for family planning workers. It could be any of those things, but Family PACT has very specific policies about this.

Dr. Michael Policar:

I'm not going to read the whole thing, but it says that, "Providers may choose non-clinician counselors in the process of client education and counseling. These services are subject to supervision by healthcare professionals who themselves are qualified to provide educational [inaudible 01:26:04] and services." And so, then it goes through a number of paragraphs about who can be considered as a counselor, how they have to be supervised and how they have to be trained. So, if you're going to be using the E/C code, you really have to be familiar with page six of this Family PACT policy.

Dr. Michael Policar:

Okay, let's see. I'm going to do this one really quickly from Kelly. "If you have your own lab that processes your gonorrhea, chlamydia, can we count that toward the E/M code on the day that we ordered?" Yeah. Let me think about that. So, you answered it yourself, the gonorrhea and chlamydia are not a point of care test. It's being done by a lab. And yeah, I know that you have an affiliated lab it's going through that test, I know it's particularly true in some of the Planned Parenthoods in Northern California. No, that that's not a point of care testing. You're running in your office, that you're going to bill as being done during the office visit. And therefore, you can count that as toward the E/M codes.

Dr. Michael Policar:

Next is a question from Marisol, "During the training we were told that for new patients we always have to start with a family planning method ICD 10 as your primary diagnosis, but in your second example you had an [inaudible 01:27:27]." Okay Marisol, I'm really glad you picked that up because I was being inconsistent. So up until about two or three years ago what's called the primary diagnosis code, the first code which is listed on the claim, had to be the family planning method. And then anything else was considered to be the secondary diagnosis.

Dr. Michael Policar:

And then two or three years ago Family PACT changed to be consistent with national standards. And what they said is that the main reason for the visit, what you spend most of your time doing, would be the primary diagnosis code, and the anything else is going to be the secondary diagnosis code. So, if a person comes in and they're... I'm going to give you a different example. Their main problem is they have burning on urination. And you diagnose that she has a bladder infection. By the way, she's saying the NuvaRing has her method of contraception.

Dr. Michael Policar:

Your primary diagnosis in that circumstance is going to be the ICD10 code for cystitis, for a bladder infection. Your secondary diagnosis is going to be the fact that she's using the ring as her method of contraception. Okay? So, it's got to be there, but it can either be the primary diagnosis or the secondary diagnosis. Okay? That's the way of doing it. So, Family PACT does require that family planning diagnosis, but it can either be the primary or the secondary diagnosis.

Dr. Michael Policar:

Okay, so this will probably need the last one because we're running out of time. "If another provider ordered and reviewed a test from a previous visit, could that test result be considered for review in another visit if the visit is with another provider within the same health center?" The answer to that is yes. So, let's say for example, you're seeing a patient for birth control pills, and she's a type two diabetic. She's also seen over in the primary care clinic, and her primary care doctor or nurse practitioner ordered a hemoglobin A1C three months ago, and that provider not only ordered the hemoglobin A1C, but also looked at the results.

Dr. Michael Policar:

The point is that wasn't in your clinic. And when you review her test results and see that her hemoglobin A1C was six percent, okay? You get credit for reviewing that. Because you didn't order that test, that's the first time you've seen that test result, but that test result is relevant to this clinic visit. And therefore, in the column you get credit for having reviewed that hemoglobin A1C result. Okay? Basically, the only thing you don't get credit for is what you ordered yourself. So, ordered and reviewed yourself. So, in other words, if you are the hemoglobin A1C you would get credit, just one point, ordering it and the result. But let's say somebody else in your clinic ordered the hemoglobin A1C three months ago and now you're reviewing that A1C for the first time? Then you get credit for reviewing it because you didn't order it.

Nicole Nguyen:

Okay. So now we are right at 1:30. Thank you so much, Dr. Policar, for answering all those questions. And again, we repeat for those that we didn't get to, we will compile these questions and send out afterwards with the answers. And again, we do have the slides, the recording, and

the certificate, the link to that to get your CME certificate in the follow-up email that will come out in a few days once we get all this compiled up. But yes, thank you so much for all of you for attending today. Thank you, Dr. Policar for the amazing webinar and for being patient with us for our little technical difficulties today. But yeah but thank you everyone for attending and I wish you a wonderful rest of your week.

Dr. Michael Policar:

Okay, my compliments to you for being able to very quickly switch over to managing the slides.

Nicole Nguyen:

Yes. We prepare as much as we can, and then always at the very last minute it happens, and things come up. So, thank you for being patient with us. So, thank you all, and have a wonderful rest of your week.

Dr. Michael Policar:

Okay. Bye.

Nicole Nguyen:

Bye.

Dr. Michael Policar:

Yes.

Dr. Michael Policar:

(Silence).

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