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In this issue

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Billing

For patient notes, copy and paste with care to keep MDM on the level

Set the record straight if your treating practitioners interpreted the guidelines for office E/M visits (**99202-99215**) as permission to use boilerplate or cloning to justify a higher code. Two recent CPT Assistant articles make it clear that cloning and coding based on medical decision-making (MDM) don't mix.

Courtesy updates aren't MDM

You can count a discussion of management or test results with an external physician or other qualified health care professional (QHP) toward MDM. But the discussion must be an "interactive exchange," and it must contribute to the treating practitioner's MDM for the visit, according to the 2022 CPT manual.

A boilerplate statement that the treating practitioner will update the patient's primary care practitioner (PCP) on the patient's care added to every note "does not count toward MDM because no physician work is being performed," according to CPT Assistant, Jan. 2022.

Communicating with a patient's other providers is essential to improving patient care, but canned statements about planned actions can create unnecessary risk when a practitioner forgets to follow through. In this scenario, if the treating practitioner fails to update the patient's PCP it could raise doubts about the accuracy of the entire note.

The doubts will be magnified if the statement is on every note. Because a general statement about updating another provider doesn't contribute to MDM, practitioners should send the update before they add a note about it to the chart.

Create a critical care strategy

Medicare gave its rules for critical care services a major upgrade this year. The changes include new time requirements for critical care services, split/shared services for critical care, and a new modifier for critical care services during the global surgery period. Register for the May 17 webinar, **Critical Care 2022: Make Sure Your Medicare Claims Meet the New Coding and Billing Rules,** to ensure your coding and billing efforts are compliant. Learn more: *https://codingbooks.com/ympda051722*.

Exact copies aren't MDM

Treating practitioners can copy and paste portions of a note from one visit to the next when it is appropriate. But when the visit is coded based on MDM, they should update the note as necessary for each visit, according to CPT Assistant, Feb. 2022.

The question about cloned documentation stated that it is difficult to code based on MDM when the treating practitioner doesn't update the note with information about what did or did not change from one encounter to the next. The questioner asked what the treating practitioner should document to let the coder know what she should count toward MDM.

The reply began with a reminder that the CPT manual does not include documentation guidelines for E/M visits or address cloning, but the article did state that when a treating practitioner copies and pastes a note without "documentation to indicate that the condition was addressed, then this should not count toward MDM."

The article also included following best practices for each visit:

1. Perform the necessary history and examination.
2. Document what is medically appropriate.
3. Indicate any diagnosis or treatment changes.
4. Use the criteria in the levels of MDM table based on each visit's documentation.

The CPT Assistant guidance to be careful when using the copy/paste function and to show what changed at each visit lines up with guidance from CMS and Medicare administrative contractors (MAC). For example, a CMS fact sheet published in 2015 calls for "documentation showing the differences and the needs of the patient for each visit or encounter" and bans the practice of "changing the date on the EHR without reflecting what occurred during the actual visit."

WPS GHA, the MAC covering Iowa, Indiana and four other states in the Midwest, says that copying and pasting can be appropriate, but the medical record "must be specific and complete for that patient for that date of service."

So far CMS has not issued documentation rules for the new E/M guidelines, but that may change after the AMA unveils its new coding guidance for E/M visits in other settings that will go into effect Jan. 1, 2023. Mark your calendar: The AMA is expected to announce those changes early in the summer of 2022 (*PBN 4/11/22*) — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- CPT Assistant, January 2022
- CPT Assistant, February 2022
- CMS Fact Sheet – Electronic Health Records Provider: *www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf*
- WPS GHA – E/M documentation: *https://tinyurl.com/WPSEMdoc*

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Richard Scott, 267-758-2404
Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Julia Kyles, CPC, x6015
Editor
jkyles@decisionhealth.com

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Compliance

Evolving 'equity' push by CMS signals a new front for providers

A flurry of new proposals from HHS and CMS centered around "health equity" suggests that federal agencies may soon require providers to perform equity-related tasks, and experts believe data collection is likely to be the first attainable goal.

On April 20, CMS released a strategic action plan, a broad but still developing guide, in which equity would be the "first pillar." Through the action plan, the agency seeks to "close the gaps in health care access, quality and outcomes for underserved populations" and "ensure engagement with and accountability to the communities CMS serves in policy development and the implementation of CMS programs." The plan also calls for the "collection of social needs data" and seeks to "promote broader access to health-related social needs."

While specific details about the action plan remain scant, other recent policy announcements are leading experts to believe that providers may soon have a more direct role in the equity strategy, and it could take the form of reporting requirements, at least for starters.

Age of equity

The term "health equity" has been in use at CMS for years. Since 2018, for example, the Office of Minority Health (OMH) has given awards to organizations that have "demonstrated a strong commitment to health equity." But over the past year, references to health equity have begun cropping up more frequently in regulation, guidance and other CMS documents, including the most recent physician fee schedule rules (*PBN 8/2/21*). In February, CMS changed its Direct Contracting program into the ACO REACH program, which is set to include an unprecedented equity benchmark (*PBN 3/21/22*).

This isn't the agency's only recent equity-related outreach, either:

- The OMH released a "Framework for Health Equity 2022-2032" in April 2022, urging CMS to "build capacity among providers, plans and other organizations to enable stakeholders to meet the needs of the communities they serve."
- On Feb. 2, CMS' Medicare Advantage and Part D Advance Notice requested "input on a potential change to the MA and Part D Star Ratings that would take into account how well each plan advances health equity."
- CMS' hospital inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) proposed rule for 2023 includes three new "equity-focused measures" for hospital inpatient quality reporting, including some that "capture screening and identification of patient-level, health-related social needs — such as food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety."

"So far, CMS has outlined the strategic priorities for addressing health equity in broad brush strokes," says Theresa Hush, CEO of Roji Health Intelligence, a consultancy and data registry in Chicago. In some of these moves "the agency has expressed slightly more detail and references to 'measures' of equity," though these are yet to be defined.

ACOs in front

One area where equity is making inroads is in value-based and accountable care, and not just in the ACO REACH model. Many integrated health care organizations are providing services with social components, and the Center for Medicare and Medicaid Innovation (CMMI) gives awards to interdisciplinary organizations that include social work, behavioral health and other kinds of care. In 2021, for example, CMMI granted $2 million to the Children's Home Society of Florida for outreach that would include "health, social, behavioral health, parental support and after-school activities."

Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa., attended the National Association of Accountable Care Organizations (NAACOS) conference in Baltimore in April and found many ACOs were showing a "focus on health equity that has already begun from an action standpoint."

Among the methods Patrick noted, besides the emphasis on social work and behavioral health support, were "clinics located in more accessible locations, such as [a] strip mall" and "home-based support, with consideration of the digital divide [in telemedicine]."

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Patrick also saw a "focus on life expectancy data to drive patient targeting," which aligns with a consideration of non-medical data that affects longevity, such as poverty and environmental factors.

Equity in QPP, data collection

As the strategic plan eventually filters into rulemaking this year, Patrick anticipates "that when the proposed rule for fee-for-service is published, there will also be mention of proposed changes to the Quality Payment Program [QPP] to begin to incorporate the focus on health equity," probably in measures QPP participants will report.

(Note: The 2022 MIPS Improvement Activities include a Promoting Health Equity subcategory, but with measures such as "Promote Use of Patient-Reported Outcome Tools" and "Comprehensive Eye Exams," the focus is only glancingly related to the broader equity movement.)

Data collection will likely be an early equity touchpoint for providers as CMS works to quantify the equity shortfalls that providers will have to correct. "CMMI is deep in the mix of facilitating the collection and analysis of equity data," Patrick says. "This data is to be overlaid across models to evaluate the inclusion and impact of diverse and underserved populations. The ACO REACH model is the first model to embed equity data; however, it seems to be intended to exemplify the commitment moving forward."

Hush expects to see "the first specific measures coming out of data — or the lack of data — by 2023, and that during 2024 there will be a full fleshed-out set of measures, outcomes and rewards or consequences for organizations." She expects that providers won't be required to report SDOH data, but CMS will "track use of Z-codes and other data sets to examine the collection and use of that data."

This could be a further stimulus to long-promised new tech standards for health care, particularly in terms of interoperability (*PBN 1/18/21*). Rafal Walkiewicz, founder of insurance navigator Hella Health in New York City, believes this level of data collection will require it. "They need standardized frameworks to provide data and then the means to provide it," Walkiewicz says. "Tech can help capture and organize the data needed while protecting the privacy of patients."

Amanda Simmons, executive vice president at Integrated Health Partners, a subsidiary of Health Care Partners of California (HCP) of Southern California in San Diego, agrees. "The data gap in equity/social determinants is wide and will need to be addressed before initiatives take place," she says. "EHRs are not built to accommodate SDOH datasets and usage; therefore, vendors will need to be engaged as well. Additional data tools for SDOH datasets are emerging, such as Unite Us and Aunt Bertha, but there is no funding for such investments."

Peter Manoogian, principal with consultancy ZS health care in Boston, would like to see "more hard objectives or quantifiable goals due to meet by certain dates" to stir provider involvement.

"There are very tangible [solutions] a system could implement to address equity," Manoogian says. "For example, average wait time for a non-English-speaking patient to get a support person at the provider, with a mandate to get from X to Y to serve a multilingual population — the kind of obvious, doable changes within an existing workflow that break down some of the obvious care barriers." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "CMS Outlines Strategy to Advance Health Equity, Challenges Industry Leaders to Address Systemic Inequities," April 20, 2022: *www.cms.gov/newsroom/press-releases/cms-outlines-strategy-advance-health-equity-challenges-industry-leaders-address-systemic-inequities*
- CMMI, "Health Care Innovation Awards Round Two: Project Profile, Children's Home Society of Florida," May 4, 2021: *https://innovation.cms.gov/innovation-models/participant/health-care-innovation-awards-round-two/childrens-home-society-of-florida*
- CMS Office of Minority Health, "Framework for Health Equity 2022-2032": *www.cms.gov/files/document/cms-framework-health-equity.pdf*

Rulemaking

Watch federal 'network adequacy' standards for ACA plans

On April 28, CMS released the 2023 Notice of Benefits and Payment Parameters Final Rule, which issued new provisions for health plans operating on the federally-facilitated marketplace (FFM). The rule may serve to buoy access to physician providers, but in

(continued on p. 6)

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Benchmark of the week

Hospital code use took double-digit hit in 2020, but denials stayed light

Like many other services, hospital inpatient and observation numbers took a hit in the first pandemic year of 2020. But providers performed better in getting their claims accepted than before.

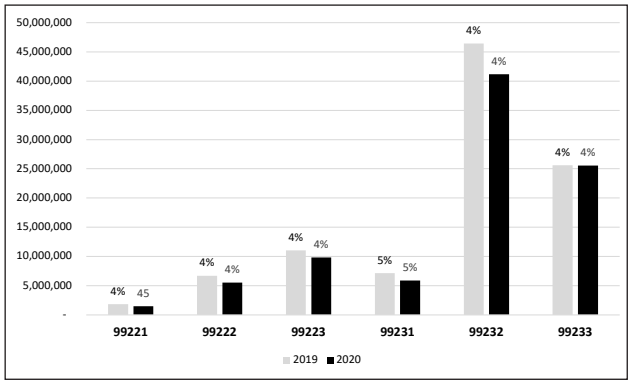
The Medicare claims data for 2020, the first year of the COVID-19 public health emergency (PHE), has revealed stark utilization drops in most areas. New and established office visit E/M codes dropped 22% and 21%, respectively (*PBN blog 11/23/21*). Some of the slack was picked up by phone E/M services, which were more generously allowed as a COVID-19 flexibility by CMS (*PBN 1/17/22*, *1/24/22*). But most of the top preventive services, transitional care management, behavioral health codes and other services tanked in 2020 (*PBN 1/31/22*, *3/14/22*, *4/4/22*).

The first year of the PHE was also bad for hospital E/M codes for initial (**99221**-**99223**) and subsequent (**99231**-**99233**) inpatient care, observation visits (**99218**-**99220**, **99224**-**99226**, **99234**-**99236**) and discharge services (**99238**-**99239**). In the previous six years (2014-2019), these codes had shown mixed results, with some codes rising considerably, like 99220 (Initial observation care, high complexity), which jumped 31%, and others like 99232 (Subsequent hospital care, moderate complexity) slightly declining (*PBN 5/17/21*). But as you can see from the charts below, the PHE changed all that: Every code declined, including 99220, which fell 22%, from 1.7 million claims in 2019 to 1.3 million claims in 2020. Overall use of the hospital codes contained in this analysis fell 10%, from 110.6 million claims to 99.2 million claims.

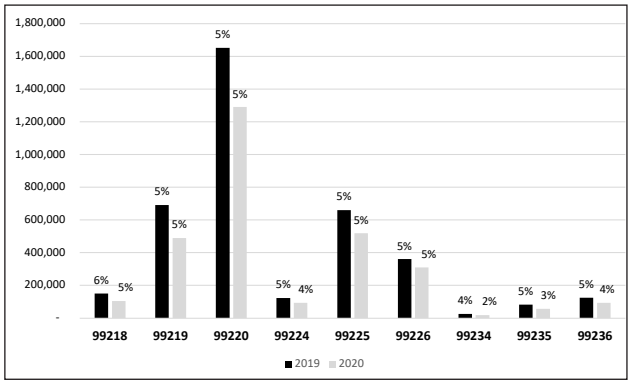
The good news was that denial rates, historically low, changed hardly at all, and in the cases of same-day admission and discharge codes 99234 and 99235, they fell two points, leaving them at 2% and 3% rates, respectively.

The specialty/code combinations that accounted for the most claims in 2020 were internal medicine and 99232, with 11.1 million claims; internal medicine and 99233 with 8.1 million claims; and nephrology and 99232 with 3.5 million claims. Internal medicine practitioners were leaders overall in the use of these codes, accounting for 28.4 million out of the 99.2 million claims, or 28.6%. — *Roy Edroso* (*redroso@decisionhealth.com*)

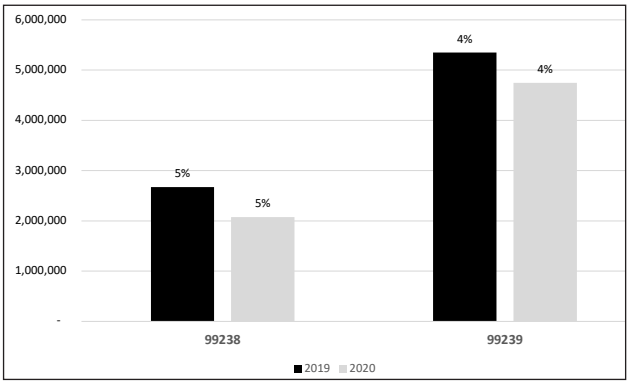
Inpatient hospital E/M code use, 2019-2020 with denial rates



Observation hospital E/M code use, 2019-2020, with denial rates



Dicharge services code use, 2019-2020, with denial rates



Source: Part B News *analysis of 2019-2020 Medicare claims data*

(continued from p. 4)

the longer term it could also have implications on your patient intake policies.

The rule requires health plans on the FFM "to ensure that certain classes of providers are available within required time and distance parameters," according to CMS. One example the agency offers: It will require plans' provider networks to include a primary care provider who is accessible within 10 minutes and five miles for enrollees living in large metro areas.

The rule also sets a requirement — this one doesn't kick in until 2024 — that health plans serve as a watchdog to ensure that physician practices meet "minimum appointment wait time standards." In 2024, for example, primary care and OB/GYN provider groups will be required to see enrollees within 15 business days of a requested appointment date. HHS plans to review other specialties and potentially add them to the wait time standard.

The agency specifically mentions emergency medicine, outpatient clinical behavioral health, pediatric primary care and urgent care as specialties it will be reviewing ahead of the 2024 start date. HHS also will review the same specialties for physical distance between provider and patient.

Among other updates contained in the final rule, CMS seeks to "simplify the consumer shopping experience" with rules that would standardize plan options for enrollees, which could lead to expanded coverage during the next open enrollment period, which begins Nov. 1. — *Richard Scott* (*rscott@decisionhealth.com*) ■

RESOURCES

- HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet: *www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet*
- Final rule: *www.cms.gov/files/document/cms-9911-f-patient-protection-final-rule.pdf*

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for your. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Coding

Unpack CPT coding for implant and foreign body removals

When coding for removal or insertion, it's imperative to understand the difference between a foreign body and an implant, and coders must be familiar with new CPT definitions for implants and foreign bodies that went into effect Jan. 1.

Technically, a foreign body is something that is stuck inside the body but isn't supposed to be there, such as a splinter or bullet. An implant is something that is secured deep within body tissue, such as a cochlear ear implant, breast implant, embryo or long-term prosthetic device.

The 2022 CPT Manual defines an implant as an object that is intentionally placed by a physician or other qualified health care professional (QHP) for any purpose (i.e., diagnostic or therapeutic). The updated manual defines a foreign body as an object that is unintentionally placed. Previously, the terms "intentionally placed" and "unintentionally placed" were not used.

The 2022 CPT Manual also describes instances where an implant would be considered a foreign body. According to the manual, an implant might be described as a foreign body if it has moved or migrated from its original position, is functionally broken or damaged, or not operating as intended. In addition, an implant may be considered a foreign body if its presence is causing the patient harm, such as causing headaches, pain or allergic reactions.

Double check provider documentation

Carefully review provider documentation when selecting CPT codes for foreign body and implant removals. If any aspect of the documentation is unclear, query the physician to ensure the most appropriate CPT code is reported. The provider may be asked to specify if the removed object was a "foreign body" or an "implant."

Consider the following example: A patient has chosen to have an intrauterine device (IUD) placed as a therapeutic device due to menorrhagia. The IUD is intentionally placed at the fundus of the uterus. The patient then decides to have the IUD removed as she would like to get pregnant. The coder would report the

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removal of an IUD using CPT code **58301** (Removal of an IUD).

Consider the same scenario but with new details. Suppose the ultrasound images show that the IUD migrated from the uterine fundus to the myometrium, resulting in a partial perforation. The physician then decides to remove the IUD via hysteroscopy. A hysteroscopic removal of the foreign body (IUD) would be reported using CPT code **58562** (Hysteroscopy, surgical; with removal of impacted foreign body).

The IUD is now considered a foreign body, as it migrated into the myometrium from its original position in the fundus. It would be inappropriate to assign code 58301 for the removal of an IUD, as the IUD is no longer serving its intended purpose.

If a foreign body is not removed and remains in the body, it can cause inflammation, infection or an allergic reaction. If that happens, the foreign body must be removed. If a foreign body is located in the subcutaneous skin, a simple removal procedure is usually all that is required; however, if the foreign body is located in a fatty layer, then a deep removal is required.

If the physician documents that the procedure is complicated and the foreign body is near an organ or bone, or that it may interfere with normal body function, then the coder should report a CPT code for a complex/complicated removal. If the provider does not document the complexity of the procedure, then a query is warranted.

In contrast: Simple vs. complex removals

In the CPT code set, removals can be described as simple, deep or complicated. CPT codes usually include foreign body extractions in descriptors for major or complex procedures. However, CPT has designated some surgical removal codes that are separately reportable.

The following are CPT codes used to report simple and complex foreign body removals:

- **10120** (Incision and removal of foreign body, subcutaneous tissues; simple).
- **10121** (… ; complicated).
- **11010** (Debridement including removal of foreign material associated with open fractures and/or dislocations; skin and subcutaneous tissues).
- **11011** (… ; skin, subcutaneous tissue, muscle fascia, and muscle).
- **11012** (… ; skin, subcutaneous tissue, muscle fascia, muscle, and bone).
- **20520** (Removal of foreign body in muscle or tendon sheath; simple).
- **20525** (… ; deep or complicated).

The following CPT codes are used to report implant removals:

- **20670** (Removal of implant; superficial [e.g., buried wire, pin, or rod], separate procedure removal hardware).
- **20680** (… ; deep [e.g., buried wire, pin, screw, metal band, nail, rod, or plate], removal of hardware).
- **24160** (Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components).
- **24164** (… ; radial head).
- **26320** (Removal of implant from finger or hand).

When coding for a wound exploration for a foreign body, if the provider needs to enlarge the incision site to fully examine and explore the wound, only report the foreign body removal. It would be inappropriate to code for a wound repair.

Consider a case study

Consider the following case study for removal of bilateral ruptured breast implants.

Preoperative diagnoses:

1. Acquired absence of left and right breast, status post mastectomy for breast cancer.
2. Ruptured gel subpectoral implants.

Postoperative diagnoses:

1. Acquired absence of left and right breast, status post mastectomy for breast cancer.
2. Ruptured gel subpectoral implants.

Operation performed: Left and right total capsulectomy with en bloc implant removal of ruptured gel implants.

Surgeon: John Doe, M.D.

Assistant: Jane Doe, PA-C.

Anesthesia: General.

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Blood loss: Less than 100 mL.

Complications: None.

Specimen: None.

Description of operation: The patient was taken to the operating room and under general anesthesia had undergone bilateral mastectomy and sentinel node biopsy. The inferior lateral edge of the capsule was identified, and dissection then proceeded deep to the pectoralis muscle, creating a submuscular flap, elevating muscle tissue up off the entire anterior capsular surface. The outer edge of the capsule was then elevated up off the chest wall, removing the entire capsule with gel implant inside of it intact on both sides.

There were multiple small areas of bleb-type extensions outside of the capsular wall, where it had thinned out and gel was probably about to leak through. These were removed completely. Both fields were then irrigated with bacitracin antibiotic solution. Hemostasis was obtained with cautery, both along the skin flaps as well as the muscle surface.

Skin closure was completed with buried 3-0 Vicryl suture in the subcutaneous and deep dermis with running 4-0 PDS mid dermal subcuticular repair. Site was closed with buried PDS suture. Drains were aspirated dry and then 10 mL of 0.25% Marcaine with epinephrine was injected on each side through the drain tubing. Bulb was placed on but not yet suctioned. Benzoin and Steri-Strips were applied to the incision. Gauze dressing, tapes and surgical bra were applied.

The patient tolerated the procedure well with no apparent complications. The patient was extubated in the operating room and transferred to recovery in satisfactory condition postoperatively.

CPT coding:

- **19371-50** (Bilateral periprosthetic capsulectomy, breast).

ICD-10-CM coding:

- **T85.43X**- (Breakdown [mechanical] of breast prosthesis and implant).
- **Z85.3** (Personal history of malignant neoplasm of breast).
- **Z90.13** (Acquired absence of bilateral breasts and nipples). — *Sarah Gould, CPC* (*pbnfeedback@decisionhealth.com*) ■

Ask Part B News

No time limit on incident-to billing if problems are unchanged

***Question**: I read your recent article about incident-to billing. One of my practitioners has a question I am unable to answer. Is there a time limit on what is considered a new problem? For example, if a patient is not treated for a particular problem in over a year, is it now considered a new problem? Please advise.*

Answer: You are correct that focusing on a new problem is key to incident-to billing, because you should not report incident to if a patient presents with something that's novel and necessitates a change in the plan of care (*PBN 3/14/22*). As far as a time limit, however, experts tell *Part B News* that there is no hard-and-fast rule governing time constraints.

"It depends on the 'onset' and need for a new plan of care," says Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC emeritus, president of Enos Medical Coding in Warwick, R.I. "If it's simply a recheck of a problem that has not changed at all, it's established."

Example: If a patient who suffers from arthritis comes in for the first time in a year, your qualified health professionals (QHP) can see the patient and bill under the physician's national provider identifier (NPI) to gain full fee schedule allowances. But if something has changed in the patient's condition, even if the diagnosis remains the same, then your QHPs will be barred from billing incident to.

"If something has occurred that needs to be evaluated, that would probably be a 'new problem' even if the patient has had that problem in the past," Enos says.

The new problem would require a fresh check-in with the physician. "There could have been treatment previously but the problem exists or is exacerbated and a new treatment plan must be developed," shares Maxine Lewis, CMM, CPC, CPC-I, CPMA, CS-P, president of Medical Coding Reimbursement Management in Cincinnati.

How your practice is structured also plays into the billing protocol. For example, same-specialty groups are considered to be "one entity" under Medicare rules, Lewis notes, and if a provider has addressed a patient's problem in the past, the patient is considered established when seen by other providers in the practice — as long as nothing has changed.

"It isn't time specific, but rather, a new scenario," Enos says. — *Richard Scott* (*rscott@decisionhealth.com*) ■

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