Anesthesia & Pain
Coder's Pink Sheet
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In this issue

New coding guidance

Uniform LCDs limit facet blocks, push RFA to the forefront

Train staff on the update to paravertebral facet joint nerve blocks and radiofrequency ablations (RFA). Medicare administrative contractors (MAC) teamed up to create a uniform policy that includes new rules for diagnostic blocks, restrictions on therapeutic injections, and frequency limits. New companion articles contain more updates to the way you will report these high-utilization services.

The changes have been in the works for several months and include the new frequency limits contained in the proposed update (*APCPS 12/2020*). The new Local Coverage Determinations (LCD) are titled Facet Joint Interventions for Pain Management and cover blocks and RFA (**64490-64495** and **64633-64636**). The LCDs for six MACs have an April 25 effective date. The effective date for CGS Administrators is May 2 (*see chart, p. 3*).

Analysis by *APCPS* revealed there may be significant differences between the new LCD and your current LCD. This article will provide an overview of the update and upcoming issues *APCPS* will delve into details.

Alert staff now

Give relevant staff, including schedulers, an overview of the changes as soon as possible and provide additional training based on their roles. See this month's TipSheet for the notice one practice sent to its staff. The notice was shared by Mary Klumpstra, ACS-PM, billing administrator, Javery Pain Institute, Grand Rapids, Mich.

Frequency limits

There must be an interval of at least two weeks between the initial and follow up diagnostic block unless there's a clinical reason for an exception. "Clinical circumstances that necessitate an exception to the two-week duration may be considered on an individual basis and must be clearly documented in the medical record," the LCDs state.

Create a protocol for informing schedulers when a patient qualifies for a shorter interval between sessions and make sure treating providers understand that convenience or patient

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request is not sufficient reasons to shorten the period between diagnostic blocks.

The new frequency limits for diagnostic blocks, therapeutic injections and RFA in a rolling 12 month period are as follows:

- Diagnostic: Maximum of four per spinal region.
- Therapeutic (when medically necessary): Maximum of four per spinal region.
- RFA: Maximum of two per spinal region.

Default to RFA

Therapeutic blocks are the exception under the new policies. In most cases when diagnostic blocks establish facet-mediated pain, the next step will be RFA, notes Devona Slater, president, Auditing for Compliance & Education, Leawood, Kan.

"Therapeutic intraarticular facet injections are not covered unless there is justification in the medical documentation on why radiofrequency ablation RFA cannot be performed," the new LCDs explain and give the examples of a patient who has established spinal pseudarthrosis, or an implanted electrical device.

A therapeutic injection in conjunction with a synovial cyst aspiration will be covered when the following two conditions are met:

1. Compression or displacement of the corresponding nerve root by a facet joint synovial cyst has been confirmed by an advanced diagnostic imaging study.
2. There is documentation of clinical and physical symptoms related to a synovial facet cyst.

Articles offer coding help

Each new LCD has a companion article titled Billing and Coding: Facet Joint Interventions for Pain Management. That's where you'll find additional guidance, including the list of covered diagnosis and procedure codes and the new rule for coding diagnostic blocks.

A link to the companion article is in the Related Local Coverage Documents section at the end of each LCD. Tip: Use the Section Navigation box at the beginning of the LCD to get to that or any other section of the LCD in a couple of clicks.

Modifier KX and diagnostic blocks

The restriction on therapeutic blocks will introduce a new coding wrinkle: Practices must report diagnostic injections with modifier **KX** (Requirements specified in the medical policy have been met). And the use of the modifier on more than two claims may trigger denials or documentation requests.

According to the new articles, the modifier "should be appended to the line for all diagnostic injections. In most cases the KX modifier will only be used for the two initial diagnostic injections. If the initial diagnostic injections do not produce a positive response as defined by the policy and are not indicative of identification of the pain generator, and it is necessary to perform additional diagnostic injections, at a different level, append the KX modifier to the line. Aberrant use of the KX modifier may trigger focused medical review."

The requirement isn't a surprise, says Judi Blaszczyk, RN, CPC, ACS-PM, ICDCT-CM, medical compliance auditor with Auditing for Compliance & Education. Medicare needs a way to distinguish diagnostic and therapeutic blocks now that it wants providers to use RFA. However, the new requirement could be problematic if doctors don't indicate the reason for the block, Blaszczyk predicts. "Especially for remote coders that don't have access to the entire medical record."

The modifier also raises a compliance risk. "By adding the KX it is like saying 'I promise I abided by the rules in your LCD.' So if an audit is done and they haven't complied, they made a false statement," Blaszczyk warns.

"There has been such a focus on levels and utilization within a twelve-month period that I think they are trying to be able to automate some of the differences by adding the modifier so as not to count those against any therapeutic blocks," Slater adds.

A typical billing pattern will be two diagnostics with the new modifier KX, followed by either two RFAs or four therapeutic blocks if patient is not an RFA candidate in the 12 month rolling period, Slater says.

Third level blocks not covered

Be prepared to appeal a denial if you report a third-level paravertebral facet joint nerve block. "Codes 64492 and 64495 will only be covered upon appeal if sufficient documentation of medical necessity is present," the articles state. Most MACs had already

effectively blocked coverage by restricting the number of levels that could be performed during one session, Slater notes. However, the codes have been added to a new list of non-covered codes, including paravertebral facet joint blocks performed with ultrasound. This indicates all MACs have updated their claims processing systems to block the claims as they come in.

Diagnosis codes revamped

Last but not least, review the list of ICD-10-CM codes that support medical necessity. The articles list 20 diagnosis codes, which will double the number of covered codes for some MACs (*see chart, this page*).

You'll find new guidance that states facet cyst rupture procedures are only covered in association with code **M71.30** (Other bursal cyst, unspecified site) or **M71.38** (Other bursal cyst, other site).

Take note as well of what's not on in the updated list. Diagnosis code **M62.830** (Muscle spasm of back) has been removed along with guidance to only report it with facet syndrome.

Watch your remittance advices

MACs aren't perfect and errors on their end could snarl claims. For example, if a MAC fails to add the new diagnosis codes to its claims processing system, practices may see improper diagnosis-related denials. Monitor your remittance advices and check denials against the new LCD and article. If you need to dispute a denial, be sure to include the relevant section from the LCD or article.
— *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Facet joint interventions for pain management LCD list

The following chart contains the local coverage determination (LCD) number and effective date for the new LCDs (*see story, p. 1*). Links to the companion articles: Billing and Coding: Facet Joint Interventions for Pain Management, are at the end of the LCD.

MAC	LCD#	Effective date
CGS Administrators	L38773	May 2
First Coast Service Options	L33930	April 25
National Government Services	L35936	April 25
Noridian	L38801	April 25
Noridian	L38803	April 25
Novitas	L34892	April 25
Palmetto GBA	L38765	April 25
WPS	L38841	April 25

Covered ICD-10-CM codes for facet joint interventions

The following codes are included in the new local coverage article Billing and Coding: Facet Joint Interventions for Pain Management (*see story, p. 1*).

Code	Descriptor
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M71.30	Other bursal cyst, unspecified site
M71.38	Other bursal cyst, other site

Source: Billing and Coding: Facet Joint Interventions for Pain Management

E/M 2021

Appropriate sources, independent historians contribute to MDM

Remember to track your clinician's dialogue with outside sources: A practitioner's conversation with a parent or a parole officer may be used to code Levels 3, 4 and 5 E/M office visits (**99203-99205, 99213-99215**).

Make sure providers and coding staff understand when and how to count exchanges with appropriate sources and independent historians toward the amount and/or complexity of data reviewed and analyzed element for medical decision-making (MDM).

Term review: Appropriate sources

First of all, note the difference between an appropriate source and an independent historian. An appropriate source is a professional other than a health care professional who is involved in managing the patient. Examples include lawyers, parole officers and teachers. Family members and informal caregivers are not appropriate sources, but may be independent historians if they provide additional information.

When a practitioner discusses management of a patient with an appropriate source, the discussion counts toward the moderate and extensive data review levels.

The discussion with the appropriate source does not have to take place in person or on the same day as the encounter with the patient. But the practitioner must communicate directly with the appropriate source, and the exchange should be completed within a couple of days, according to an update in the Errata and Technical Corrections for CPT 2021, issued March 9.

Term review: Independent historians

An independent historian "provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history," according to the 2021 CPT manual.

The billing physician or qualified health care professional (QHP) uses the information in the assessment of the patient, explained Barbara Levy, M.D., co-chair of the CPT/RUC Workgroup on E/M, during the virtual CPT and RBRVS 2021 Annual Symposium, Nov. 17-20, 2020.

Assessment of an independent historian's information is associated with low, moderate and extensive data review.

Examples of independent historians include:

- The parents of a pediatric patient who is too young to talk.
- The guardian of a schizophrenic patient who can't give a reliable history.
- The spouse and adult child of a patient who has advanced Alzheimer's disease.

An independent historian may provide the entire history, and the billing practitioner may use information from multiple independent historians to gain a complete history.

An interpreter is not an independent historian, Levy said. "An independent historian is someone whose increased information about the history is important to the medical decision-making. When you're using an interpreter, it is the patient's history that you're getting through the interpreter," Levy explained in response to a question during the symposium.

By the same token, a person who accompanies a patient to the visit and speaks to the practitioner but does not provide additional, medically necessary information does not count as an independent historian.

Definition clarified

The Errata and Technical Corrections for CPT 2021 clarifies that the practitioner does not have to obtain information from the independent historian in person, which indicates a phone call or email exchange would be allowed.

The update also states that the physician or QHP must also obtain information directly from the independent historian.

Documentation details

Tell practitioners that it will speed up coding if they spell out to whom they spoke and why. A statement such as "Spoke to Jane Smith about John Smith's condition," doesn't give the coder enough to go on.

However, "John Smith was unable to provide a full history because of continued cognitive decline. I called his daughter Jane Smith and she provided the following information," would indicate an independent historian. When in doubt, coders should ask the billing physician or QHP for clarification and explain why they need the information.

To complete the record, the practitioner should note how the discussion took place — for example, in person or by phone. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCE:

Errata and Technical Corrections for CPT 2021: *www.ama-assn.org/system/files/2020-12/cpt-corrections-errata-2021.pdf*

E/M 2021

Review guidance for reporting time-based encounters

This is part one of a two-part series on the new 2021 E/M office visit guidelines from guest contributor Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O, director of HIM and coding for HCPro in Middleton, Mass. Look for part two in an upcoming issue of APCPS.

The most impactful overhaul to the E/M coding and documentation guidelines in 25 years went live Jan. 1. The updated guidelines eliminate medical history and physical examination as required elements for reporting E/M codes **99202-99215.** E/M coding for outpatient visits is now based on documentation of medical decision-making (MDM) or time spent on the encounter.

E/M coding has always been a subjective area of CPT coding. Historically, discrepancies have existed between the AMA's CPT guidelines and payer-specific guidance for E/M coding.

As part of its 2021 update to the E/M guidelines, the AMA added helpful definitions of time, history, examination, complexity of problems addressed and MDM; however, payers continue to interpret these concepts differently, which may impact reimbursement for visit services.

Time as controlling factor

Under the updated guidelines, time alone may be used to select the appropriate code level for office or other outpatient E/M codes. Using total time spent on an encounter as the basis for E/M coding may sound simple, but there have been questions on how this should be done.

The 2021 E/M guidelines define time as "total time spent on the date of the encounter."

Therefore, coders should not count any activities done on another date of service relating to a patient visit — such as record review the day prior to a visit — or review diagnostic test results returned a day or more after a face-to-face visit.

Note: Many coders have been confused by AMA and CMS references to "within three days prior or seven days after the visit date." This language only applies to the valuation process (i.e., relative value unit determination) for physician services that encompass pre-service, intra-service and/or post-service work. This concept has no relevance to E/M level selection, whether based on time or MDM.

Prolonged service add-on code

For 2021, the AMA introduced a new CPT add-on code, **99417,** for reporting prolonged services with high-level office visit codes 99205, which is based on 60-74 minutes of total, and 99215, based on 40-54 minutes of total time.

Here's the full descriptor for the add-on code:

99417 (Prolonged office or other outpatient E/M service[s] beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time).

Some coders are confused about the application of this add-on code, since the code description states that it may be used once the minimum amount of time is surpassed by at least 15 minutes.

According to CMS, the use of add-on code 99417 can lead to duplicative counting of time. The agency urged the AMA to revise the code descriptor to describe services that exceed the maximum time for the related office visit (99205 or 99215).

Despite CMS' criticism of the code descriptor, the AMA retained the add-on code and associated guidelines as originally worded.

To resolve the dilemma, CMS created add-on code **G2212,** which it will instead require on appropriate Medicare claims in 2021. Here is the full descriptor:

G2212 (Prolonged office or other outpatient E/M service[s] beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact).

The code descriptor for G2212 merely states that this code is applicable once the maximum time frame of the primary code is surpassed by at least 15 minutes. For a prolonged service code (99417 or G2212) to be eligible, the service must be coded based on time (as opposed to MDM).

When calculating time beyond the primary E/M service, minutes may not be counted more than once. For example, if a visit requires the presence of a patient, interpreter and provider, only the time spent between the patient and the provider may be counted. Time spent by the interpreter translating the same information from the patient to the provider may not be counted toward total time on the date of the encounter.

Prolonged services without patient contact

There is also conflicting information regarding the application of CPT code **99358** (Prolonged E/M service before and/or after direct patient care; first hour) and add-on code **99359** (…; each additional 30 minutes). These codes were added to the Medicare physician fee schedule (MPFS) in 2017 and saw a tremendous increase in utilization, jumping from about 10,000 services reported since

the codes were first implemented in 1994 to approximately 126,000 in 2018, according to Medicare Provider Analysis and Review (MedPAR) data.

Coders should take note of the following CPT guidance for reporting these codes:

"Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). For prolonged total time in addition to office or other outpatient services (i.e., 99205, 99215) on the same date of service without direct patient contact, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to face encounter."

Several Medicare administrative contractors (MAC) have released statements that these codes cannot be used with the E/M office visit codes 99202-99205 and 99211-99215 in any situation. However, the CPT guidelines state that these codes "may be used for prolonged services on a date other than the date of a face-to-face encounter."

It may be rare for a provider to spend 30 or more minutes of non-face-to-face care management on another date of service, but it could happen if the patient's care requires extensive record review prior to the visit.

For example, if a provider spends 30 minutes doing record review prior to the visit and 20 minutes of intra-service face-to-face time with the patient on the same date, he or she could report E/M code 99215 for the 50-minute encounter, which is valued at approximately $183.

However, if 30 minutes of pre-visit record review is performed the day before the face-to-face visit, the provider could report 99358 (valued at $111) and E/M code 99213 for the 20-minute face-to-face visit. Reporting code 99358 in addition to 99213 (valued at $92) would benefit the provider by about $20.

In the final 2021 MPFS, CMS stated that it wanted to introduce an add-on code for prolonged services associated with E/M office visits. This led to the creation of E/M add-on code 99417. However, 99417 may only be used for services billed on a single date of service. There is still confusion surrounding time-based coding for prolonged non-face-to-face services performed on a separate date as a related E/M visit service. CPT codes 99358 and 99359 may be reported for work performed in this situation.

In cases where an E/M visit is reported and at least 30 minutes of additional care is provided on another date of service, the provider may benefit from basing code selection on MDM since MACs do not agree on the use of codes 99358 and 99359 in 2021. — *Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O* ■

Compliance

From HIPAA to Stark, connect with telehealth compliance

Practices must be careful about the compliance rules for coding and billing telehealth services, or they will be vulnerable to investigations and fines that could eradicate revenue.

Prolonged office visit time chart

Share the following chart to help coders quickly calculate how many units of service to report for a prolonged office visit add-on code based on whether the patient's health plan requires G2212 or 99417 (*see story, p. 4*).

Visit code +G2212	Total time required (minutes)	Visit code +99417	Total time required (minutes)
99205, +G2212 x 1	89-103	99205, +99417 x 1	75-89
99205, +G2212 x 2	104-118	99205, +99417 x 2	90-104
99205, +G2212 x 3	119-133	99205, +99417 x 3	105-119
99205, +G2212 x 4 or more for each additional 15 minutes.	134-148	99215, +99417 x 4	120-134
99215, +G2212 x 1	69-83	99215, + 99417 x 1	55-69
99215, +G2212 x 2	84-98	99215, +99417 x 2	70-84
99215, +G2212 x 3	99-113	99215, +99417 x 3	85-99
99215, +G2212 x 4	114-128	99215, +99417 x 4	100-114

Sources: CMS 100-04, Change Request 12071, 2021 CPT® Manual

It's no surprise that the HHS Office of Inspector General (OIG) put Part B claims for telehealth during the public health emergency (PHE) on its Work Plan in October 2020, or that it is "conducting significant oversight work assessing telehealth services during the public health emergency," according to a Feb. 26 announcement from the agency.

However, Amy Turner, RN, BSN, MMHC, CPC, CHC, CHIAP, director with abeo Advisory Solutions, explained that telehealth services reach out and touch several compliance areas, including HIPAA, state licensure and anti-kickback laws.

Your practice should take steps to prevent — or stop — compliance slip-ups, including how it manages patient expectations, Turner said during the webinar Telehealth & Communications-Based Care 2021: Discover What's New and Code Correctly During and After the PHE, Feb. 17.

A patient who doesn't know what to expect from telehealth services may complain to the Medicare administrative contractor (MAC) or OIG if they believe the practice wasn't on the up-and-up. Start with getting the patient's consent, and "it's not a bad idea to document the patient consented to a telehealth visit," Turner said.

Even though you can continue to provide more than 200 telehealth services to any Medicare patient who wants them, you should regularly remind patients that telehealth has its limits and that some conditions may warrant an office visit.

"Let the patient know that there may be times that they still have to come to the office because of what's going on with them. Everything can't be handled via telehealth," Turner said.

Also, make sure your practice has a way to capture and respond to patient complaints about telehealth services, Turner said.

Catching, resolving and responding to patient complaints in a timely fashion will increase patient satisfaction and decrease the chance that the patient will get frustrated and turn to official channels for help.

Privacy and security concerns

In addition to reminding patients of the privacy and security risks of telehealth services, make sure they understand that there may be additional people in the room with the practitioner — such as a scribe or a trainee — to prevent misunderstandings, Turner said.

The treating clinician should also make sure he is talking to the right person at the start of each visit. This is especially important for telephone-only visits and new patients, Turner noted.

Practitioners should be aware of their workspace to avoid gaffes, such as unintentionally releasing a patient's protected health information (PHI), Turner said.

"When we talk about telehealth, we also have to think about, 'What does the area surrounding the [practitioner] look like? Does there happen to be any PHI behind you that a different patient could see?'" Turner said. For example, accidentally airing PHI could involve a white board with patient names and birthdays that is in view of the camera.

In addition, practitioners who are working outside of the office should make sure that no one can overhear an encounter, Turner cautioned.

The ease of recording an encounter may tempt practitioners, but it isn't a good idea to record and store visits because of the risk of security breaches, Turner cautioned.

Finally, the PHE is no excuse to slack off on standard security procedures, such as controlling access and passwords.

Licensure issues

State licensing requirements have been relaxed for the treatment of Medicare patients during the PHE, but for Medicare and non-Medicare patients you need to check your state laws before you provide telehealth services to a patient who is in another state, Turner said.

For example, if a practice in Missouri has some patients who live in Kansas, the patient would normally drive to the practice where the physician is licensed. But when the physician in Missouri provides a telehealth visit to a patient who is at home in Kansas you have to look at state licensure requirements.

"Most states have temporarily waived this if the providers is licensed and in good standing with another state," Turner said. But you have to do your due diligence to determine what your state licensure board requires, she added.

Remote prescribing

"Historically, you had to have seen the patient in person," but the Drug Enforcement Agency (DEA) worked with HHS to allow DEA-registered practitioners to write prescriptions for controlled substances to patients when they have not conducted an in-person visit,

Turner said. You can continue writing these prescriptions but you must meet the DEA's requirements. For example, you must use a real-time audio/video connection for the encounter. Telephone-only visits are not an option.

Turner recommended that practices use the DEA's decision tree. "They've got a really good flow sheet," Turner said. "If you are prescribing, consult it."

Copay waivers

The OIG softened its normal hard-line stance on copay waivers, but the change is restricted to telehealth services provided during the emergency, Turner noted.

Waiving a patient's copay for a telehealth service will not violate the anti-kickback statute, but if the patient comes to the practice for an in-person visit you would follow the normal copay waiver procedure, and that starts with letting the patient indicate they can't pay.

"We've got a little bit of grace," Turner said. "Just don't take advantage of it."

5 compliance tips

As a final safeguard, implement these five compliance tips that Turner highlighted in her presentation.

1. Stay up to date with the state and federal guidelines regarding the provision of telehealth services.
2. Confirm that providers consulted the guidelines for each state where they intend to provide telehealth services before they provide telehealth to patients in those states.
3. Develop a quick, easy-to-read list of the informed consent requirements for your top payers that providers can reference on a patient-by-patient basis. If the payer allows verbal consent, make sure the physician records and documents the patient's verbal consent as part of the patient's telehealth visit.
4. Monitor a certain number of provider visits to ensure that providers are following informed consent requirements.
5. Confirm that providers who issue prescriptions for controlled substances via telehealth are aware of the new DEA guidelines. Stay up to date on changes to these guidelines. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES:

HHS Office of Inspector General Work Plan: https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

HHS Office of Inspector General telehealth letter: https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp?

DEA decision tree: www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

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