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ACG
2023

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VANCOUVER

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Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.

Exit

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 21 – Thursday, May 25, 2023
The Role of Non-Invasive Modalities in Colorectal Cancer Screening
Faculty: Douglas J. Robertson, MD, MPH
Moderator: T.R. Levin, MD, FACP
At Noon and 8pm Eastern

Week 22 – Thursday, June 1, 2023
Prior Authorization in GI: Tips from the ACG Prior Authorization Task Force
Faculty: Baharak Moshiree, MD, MSc, FACP, and Stephen T. Amann, MD, FACP
Moderators: Daniel J. Pambianco, MD, FACP, and Dayna S. Early, MD, FACP
At Noon and 8pm Eastern

Visit gi.org/ACGVGR to Register

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 <p>Moderator: Asma Khapra, MD</p>	 <p>Panelist: Shubha Bhat, PharmD, MS</p>
 <p>Speaker: Jami Kinnucan, MD, FACP</p>	 <p>Panelist: Erin Forster, MD, MPH</p>


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Optimizing your clinical reimbursement and winning the prior authorization game



Jami Kinnucan, MD
Mayo Clinic Florida
ACG VGR May 2023



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Optimizing your reimbursement in clinic

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Disclaimer

I am not a billing expert/coder but a clinician who has spent considerable time learning the details about E/M billing

I recommend that before implementing any billing/coding changes to your practice that you work with your compliance/billing person or team

In addition, some reimbursement is geographically driven, important to work with your main payers



Watch for the pearls

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Outline

1. Billing terminology
2. Current billing requirements for evaluation & management services
3. Prolonged service billing
4. Consultation billing
5. E-Visit billing

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What is the single most important aspect about submitting billing codes?



Estimates that 80% of medical bills contain errors

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A few words on billing terminology

Work RVU (wRVU) + Practice Expense RVU + Malpractice Expense RVU = Total RVU × Conversion factor = Payment rate

Relative value unit

- RVU measures amount of provider work
- RVU is tied to a CPT code
- CPT= Current Procedural Terminology ie. 99214
- Government insurance pays less/RVU
- Commercial insurance pays more/RVU
- Consult vs. Non-consult
- E/M= Evaluation & Management Services

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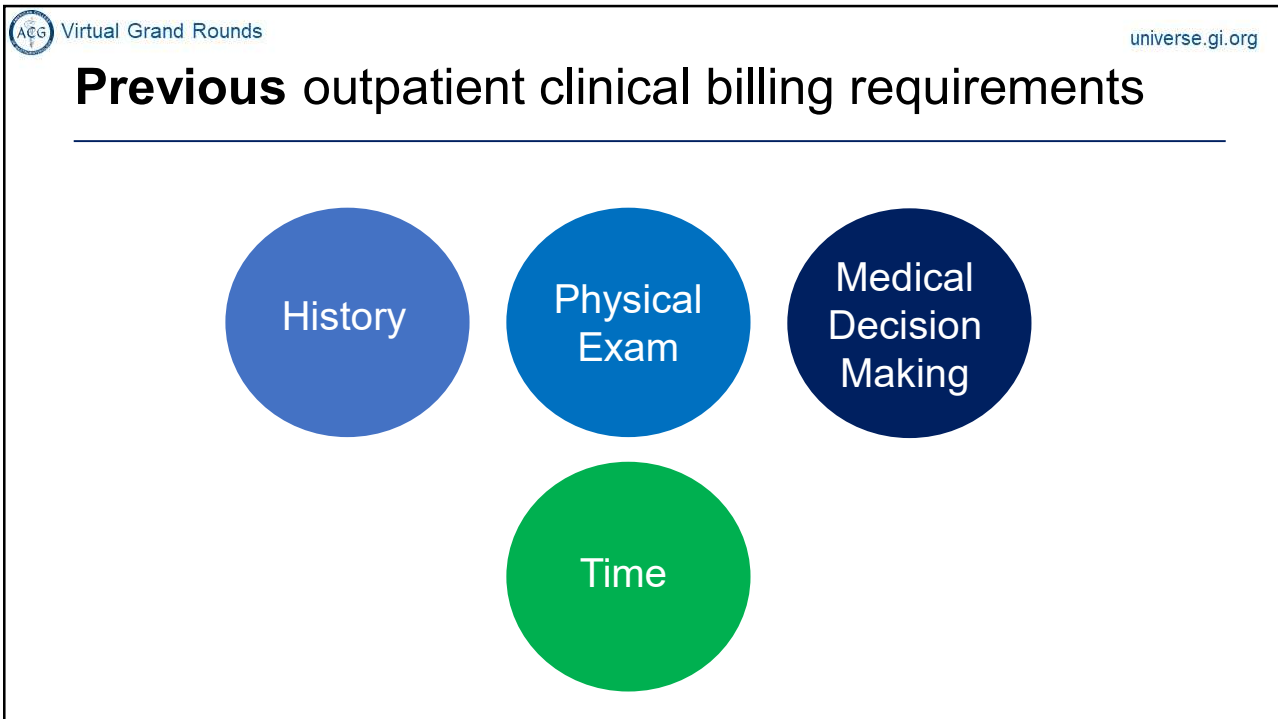
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Don't make these common billing mistakes

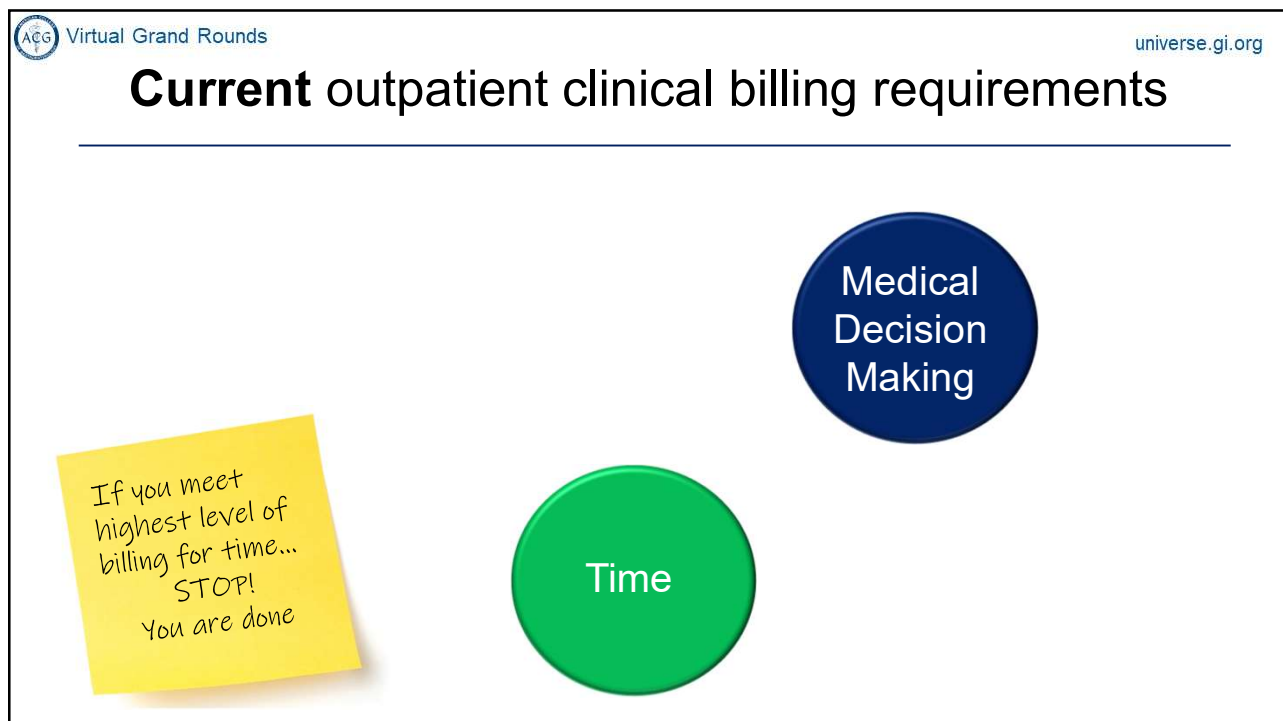
- ✓ Submitting lower level of service than MDM
- ✓ Submitting higher level of service than MDM
- ✓ Lacking appropriate documentation for billing
- ✓ Over documentation or cut/paste
- ✓ Delay in billing

Many EHR have billing calculators!

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Example

- 45-year-old female with ulcerative colitis well controlled on biologic combination therapy with immunomodulator presents for follow-up 3-month visit
 - ✓ Reviewed prior outpatient note
 - ✓ Reviewed recent lab and stool testing (patient requires Q3m labs)
 - ✓ Review images from colonoscopy performed by partner
 - ✓ Reviewed pathology report
 - ✓ Orders placed for further lab testing, DEXA, vaccinations, consult to dermatology
 - ✓ Time: Spent 20 minutes with the patient + 10 minutes documenting/coordination of care/orders

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Option #1

E/M Time-based Billing: It's that easy!



Prior to 2021

Based on only on face-to-face time on the date of the encounter

After Jan 2021

Face-to-face + non face-to-face time date of encounter

What activities qualify?

- Preparation to see patient (review of records)
- Obtained history outside of visit
- Medical appropriate examination
- Counseling and education of patient, family, caregiver
- Ordering medications, testing, procedures
- Communication with other healthcare professionals
- Documentation (yes- writing or dictation of note!)
- Independent review of testing
- Care coordination- prior auths! (same day only)

Non-continuous

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Outpatient E/M Time-based Billing: New Time Requirements

New
Evaluation

LOS	New Patient CPT	Total Time (min)	Previous
NP2	99202	15-29	20
NP3	99203	30-44	30
NP4	99204	45-59	45
NP5	99205	60-74	60

Established
Visit

LOS	Return Patient CPT	Total Time (min)	Previous
RV2	99212	10-19	10
RV3	99213	20-29	15
RV4	99214	30-39	25
RV5	99215	40-54	40

RV4: 99214

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Make Level of Service Buttons Meet your E/M Level of Service Calculator

LOS	New Patient CPT	Total Time (min)
NP2	99202	15-29
NP3	99203	30-44
NP4	99204	45-59
NP5	99205	60-74

LOS	Return Patient CPT	Total Time (min)
RV2	99212	10-19
RV3	99213	20-29
RV4	99214	30-39
RV5	99215	40-54

Wrap-Up

Reference | Print Patient Appointment Guide | 2021 Billing Guidance

Patient Instructions | Communications | LOS | Charge Capture | Follow-up | Episodes | Review | Ext Provider Info

Level of Service

N3 30-44

N4 45-59

N5 60-88

CON4 (60)

CON5 (80)

E3 20-29

E4 30-39

E5 40-68

99417

NO LOS

T1 (5-10)

T2 (11-20)

T3 (21+)

PM1 (5-10)

PM2(11-20)

PM3 (21+)

Level of service: ↕

Modifiers: ↕ Add Modifier


Level Of Service Calculator

Patient type: New Established Service type: Non-Gov N/E

Medical Decision Making | Time | List | + Additional E/M

Total time: Total time (minutes) | 10 Minutes | 20 Minutes | 30 Minutes | 40 Minutes

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But what if you spent MORE time? Prolonged Service Codes

LOS	New Patient CPT	Total Time (min)
NP2	99202	15-29
NP3	99203	30-44
NP4	99204	45-59
NP5	99205	60-74

LOS	Return Patient CPT	Total Time (min)
RV2	99212	10-19
RV3	99213	20-29
RV4	99214	30-39
RV5	99215	40-54

99417= Commercial
G2212= Medicare

Same Day Prolonged Service

- Each additional 1-15 min spent
 - Can bill multiple 99417
- Outpatient when primary encounter billed based on time
- Only billed based on time spent on the date of service

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Didn't meet the level billing code for time spent?


Review requirements for medical
decision making (MDM)

Many EHR
systems have a
MDM calculator-
USE IT!

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Option 2: Medical Decision Making (MDM)



Number and complexity of **problems** addressed

Amount and/or Complexity of **Data** to be Reviewed and Analyzed


Risk of Complications and/or Morbidity or Mortality of Patient Management

Highest TWO Determines MDM Level

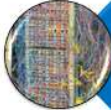
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MDM: Problems



Quantity



Complexity


99202 99212	99203 99213	99204 99214	99205 99215
Minimal • 1 self-limited or minor problem	Low • 2+ self-limited or minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury	Moderate • 1+ chronic illness with exacerbation, progression or tx SE • 2+ stable chronic illness • 1 undiagnosed new problem uncertain prognosis • 1 acute illness systemic symptoms • 1 acute complicated injury or illness	High • 1+ chronic illness with severe exacerbation, progression, or treatment side effects • 1 acute or chronic illness or injury that poses threat to bodily function

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MDM: Data


Level 4- 1 of 3
Level 5- 2 of 3



Tests, outside records, or independent historian(s)



Independent interpretation of tests



Discussion with other professionals

Data Billing

Category 1: Any combination 2 of 3 from below

- Review of external note(s) from each unique source
- Review of result(s) from each unique test
- Ordering of each unique test
- Assessment requiring independent historian

Category 2:

- Independent interpretation of test perform by another physician or qualified HCP

Category 3:

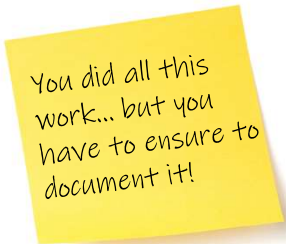
- Discussion of management with external physician or other qualified HCP

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Data: Example

Level 4- 1 of 3
Level 5- 2 of 3



You did all this work... but you have to ensure to document it!

Data Billing

Category 1: Any combination 2 of 3 from below

- Review of external note(s) from each unique source ✓
- Review of result(s) from each unique test ✓
- Ordering of each unique test ✓
- Assessment requiring independent historian ✓

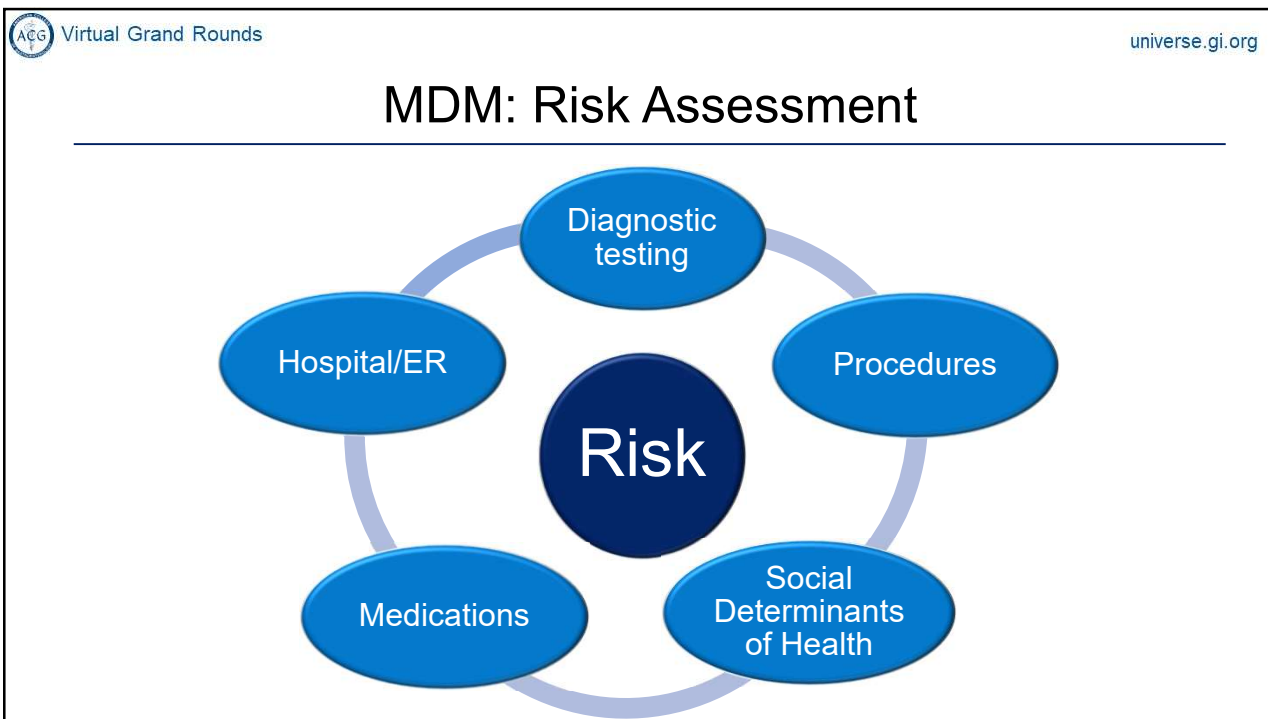
Category 2:

- Independent interpretation of test perform by another physician or qualified HCP ✓

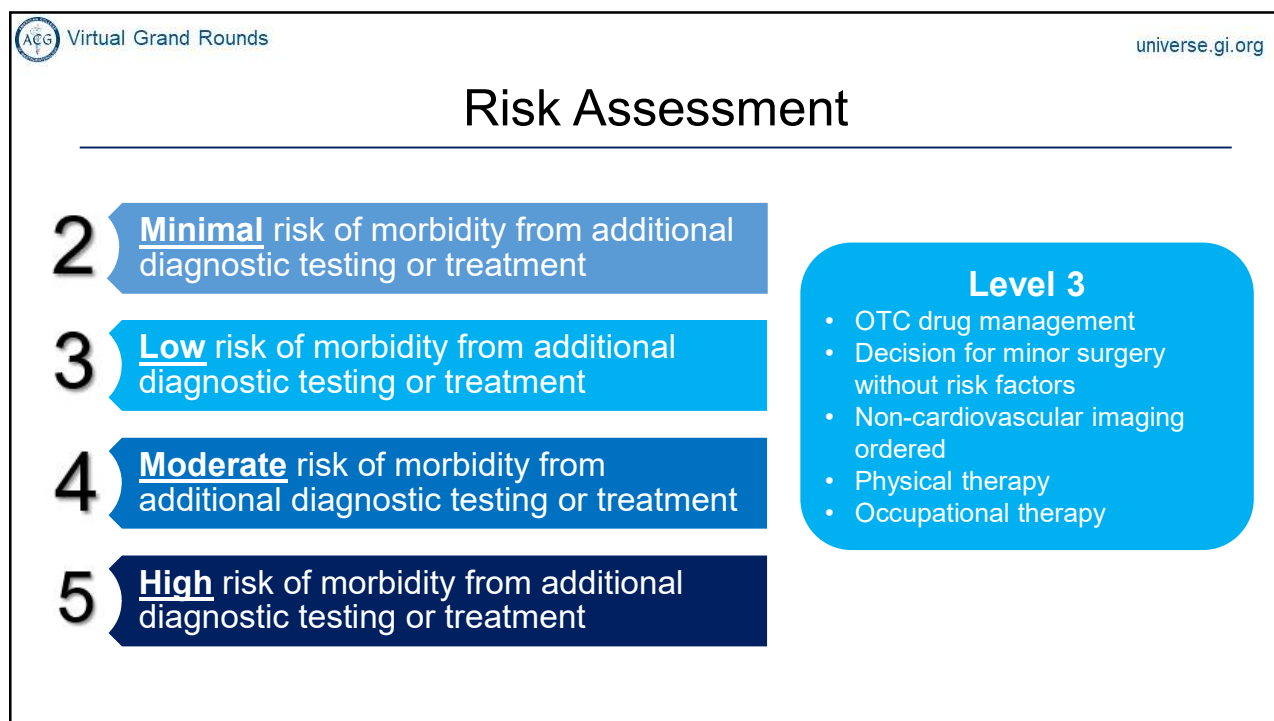
Category 3:

- Discussion of management with external physician or other qualified HCP

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Risk Assessment

2 Minimal risk of morbidity from additional diagnostic testing or treatment

3 Low risk of morbidity from additional diagnostic testing or treatment

4 Moderate risk of morbidity from additional diagnostic testing or treatment

5 High risk of morbidity from additional diagnostic testing or treatment

Level 4

- Prescription Drug management
- Decision for minor surgery + risk factors
- Decision for major surgery without risk factors
- Diagnosis limited by social determinates of health

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Risk Assessment

2 Minimal risk of morbidity from additional diagnostic testing or treatment

3 Low risk of morbidity from additional diagnostic testing or treatment

4 Moderate risk of morbidity from additional diagnostic testing or treatment

5 High risk of morbidity from additional diagnostic testing or treatment

Level 5

- Drug therapy with intensive monitoring for toxicity
- Major surgery + risk factors
- Emergency major surgery
- Decision for hospitalization
- DNR or de-escalation of care due to poor prognosis

Q3 month

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ACG Virtual Grand Rounds **Epic** Level of Service- MDM Check out your EPIC Calculator universe.gi.org

Wrap-Up

Level Of Service Calculator

Patient type: New Established Service type: Non-Gov N/E

Medical Decision Making Time List Additional E/M

Level	Problems Addressed	Amount and/or Complexity	Risk
2	<input type="checkbox"/> 1 Self-limited or minor problem	<input checked="" type="checkbox"/> Minimal or None	<input type="checkbox"/> Minimal
3	<input type="checkbox"/> 2 or more self-limited or minor problems <input type="checkbox"/> 1 stable chronic illness <input type="checkbox"/> 1 acute, uncomplicated illness or injury	<input type="radio"/> Limited Any combination of 2: Review of prior external notes from unique source 1 2 3+ Review of the results from each unique test 1 2 3+	<input type="checkbox"/> Low • OTC drugs • Minor surgery with no identified risk factors

No suggested level of service

If you use MDM this will change your life

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ACG Virtual Grand Rounds Example Revisited universe.gi.org

- 45-year-old female with ulcerative colitis well controlled on biologic combination therapy with immunomodulator presents for follow-up 3-month visit

Time-based Billing

- 20 minutes with patient + 10 minutes outside of visit= 30

99214= RV4

MDM Billing

- Data
- Risk

99215= RV5

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Example 2.0

- 45-year-old female with ulcerative colitis well controlled on biologic combination therapy with immunomodulator presents for follow-up 3-month visit however patient has concerns about long-term effects of combination medical therapy

Time-based Billing

- 50 minutes with patient + 10 minutes outside of visit= 60

99215= RV5 +
99417 Prolonged

MDM Billing

- Data
- Risk

99215= RV5

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A brief word on outpatient billing for Consultations

- ✓ Reimburse at a higher level than non-consultation codes
- ✓ Not reimbursed by all payors (Medicare/Medicaid + some commercial)

LOS	Consult CPT	Total Time (min)
CONS2	99242	20
CONS3	99243	30
CONS4	99244	40
CONS5	99245*	55

*prolonged service codes (99417) can be used when ≥ 70 minutes

Documentation Requirements

- ✓ Request for consultation
- ✓ MDM + medical appropriate examination

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E-Visit Reimbursement

- Read August 203 edition of AGA The New Gastroenterologist (Nieto, Kinnucan)

CPT Code HCPCS Code	Description
99421-99423 G2061-G2063	E-Visit Care Patient initiated portal message
99441-99443	Telephone Care Patient initiated phone call to speak with provider
G2012	Virtual Check-in (Medicare) Communication initiated by patient, provider can respond by phone, text, portal, email, A/V

E-Visit (Portal Message) Requirements

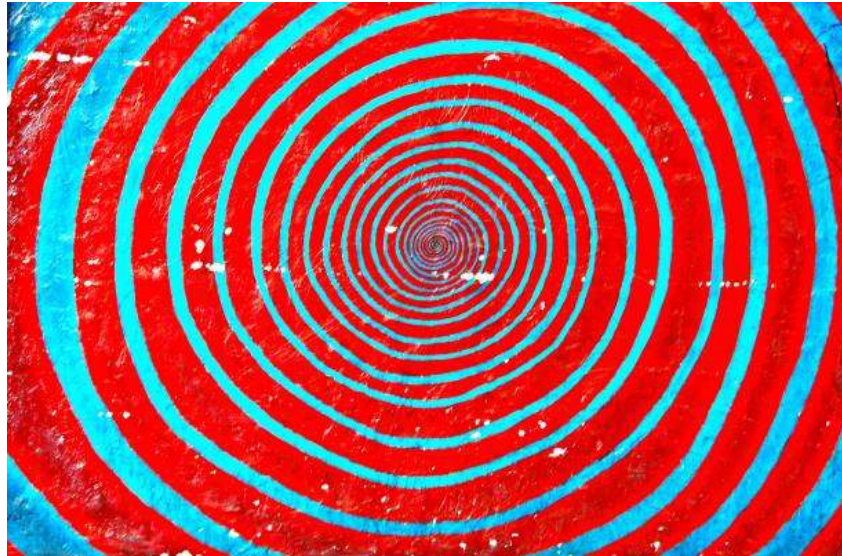
- ✓ Check with you institution or practice if codes active
- ✓ Patient initiated communication
- ✓ No prior E/M within 7 days (for same chief complaint)
- ✓ Billing based on time alone (minimum 5 min)
- ✓ Evaluation & management performed

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Winning the prior authorization game

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Prior Authorization- Outline



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Important basics around medication prior authorizations



Medical Benefit

- Medications given in office or infusion center
- Can be injectable or infusion (most likely)




Pharmacy Benefit

- Self-administered medications
- Can be oral, injection or on-body injector (OBI)

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Important basics around medication prior authorizations




Medical Benefit

+

Pharmacy Benefit

Ustekinumab
(Stelara)

Risankizumab
(Skyrizi)




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Prior authorization process & challenges

- Need to establish medical necessity for
 - Health care service
 - Treatment plan
 - Prescription drug
 - Durable medical equipment
- This is prior authorization, prior approval for precertification process
- Goals?
 - Reduce cost of expensive diagnostics, treatments
 - Avoid dangerous combinations
 - Minimize unnecessary services, treatments



Administrative burden

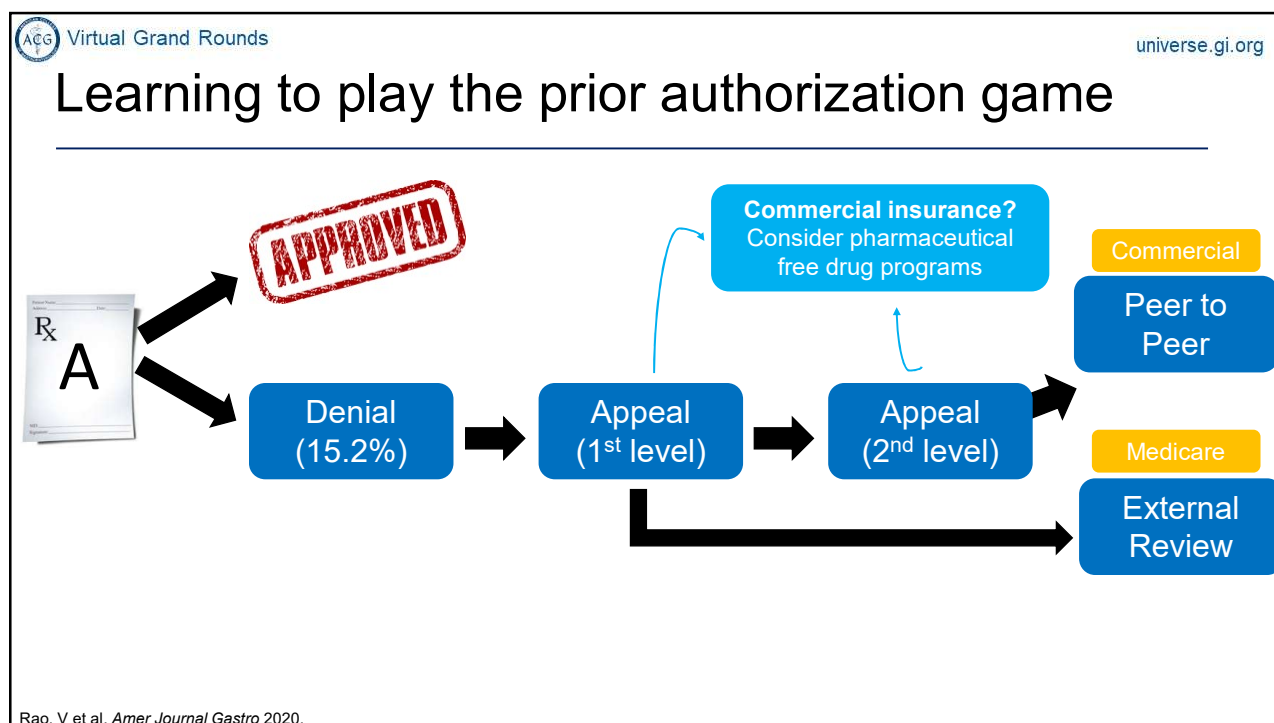
Step Therapy

Guideline disconnect

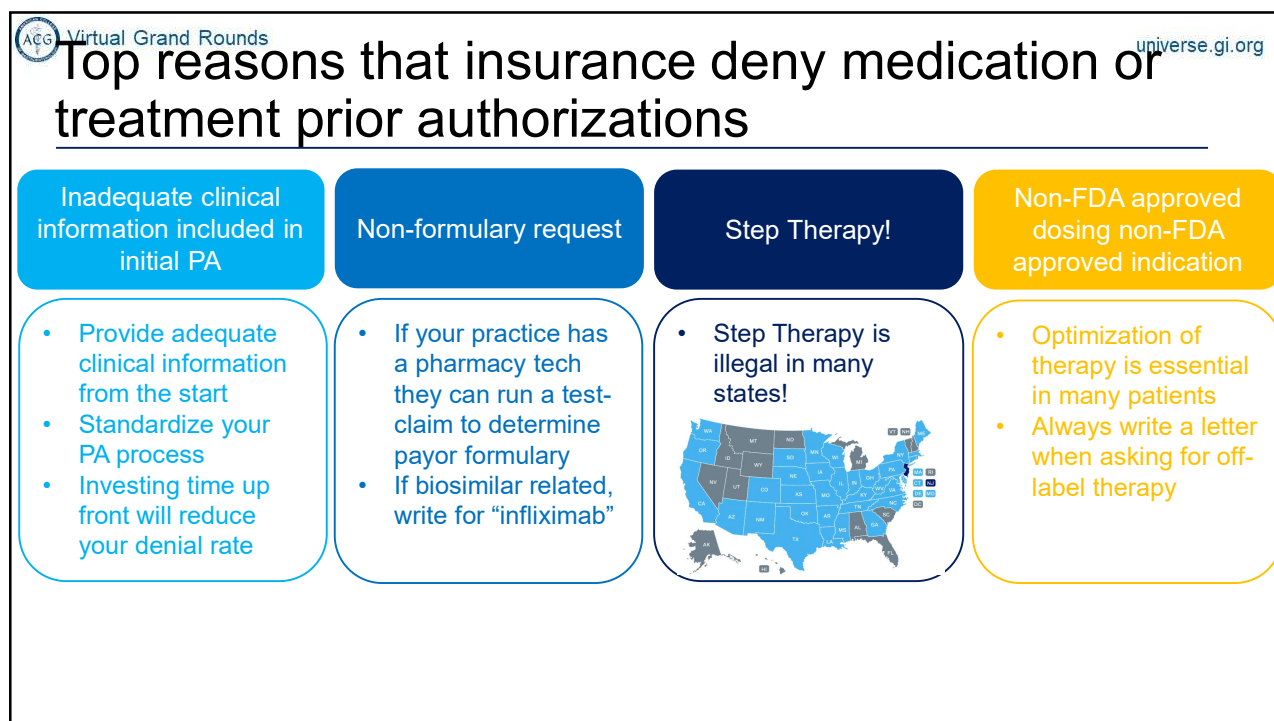
Dosing restrictions

Formulary restrictions

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Don't delay therapy: It is most important to get the patient started on therapy

- If you anticipate appealing a denial will take significant time and delay treatment for this patient, the most important thing is to get your patient connected with therapy (even if is not your first choice)
- Commercial insurance can benefit from "Bridge Programs"
- This might be different if you are seeking optimization or off-label therapy

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Set yourself up for success the first time

- Identify top payors in practice
- Know their formularies
- Identify a reliable contact at each plan
- The prior authorization process- select correct form
- Ensure clinical documentation is sent with PA
- Write a letter of medical necessity (LOMN) if you recognize high likelihood for denial
- Include a reference for justification (save for next time)
- Track your PA submission

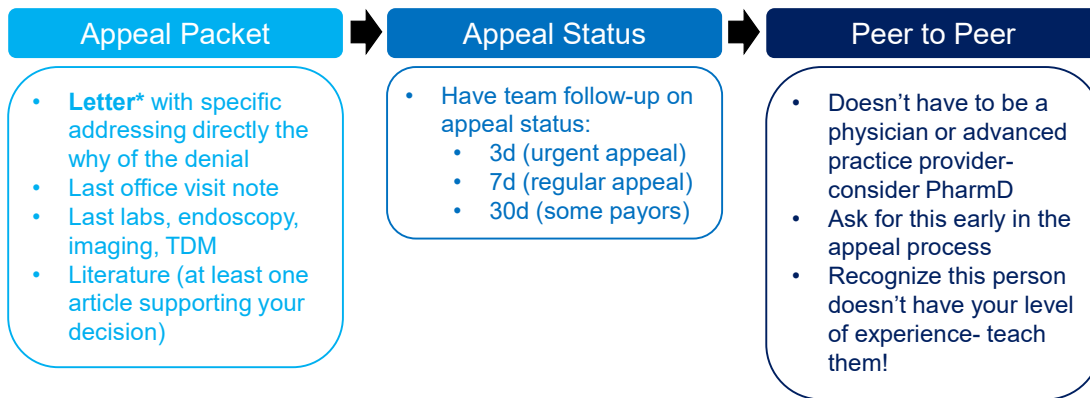
Key Information For Successful Prior Auth

- Patient's diagnosis
- Patient's disease severity
- Bonus: Prognosis information
- Prior Rx
- Bonus: Prior Rx failure reason
- Co-diagnosis or contraindications to Rx
- Why are you selecting this therapy or dose
- Data!

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How to appeal the denial

- You/your team review the denial letter- figure out the **why**



*Crohn's and Colitis Foundation Appeal Letters!

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Struggling to find the science to support your decision?

- Crohn's and Colitis Foundation Appeal Letters
 - Accommodations
 - Disability
 - Resources
 - Medication escalation
 - Treatment PA
 - Testing/procedures
- Pharmaceutical company medical science liaison (MSL)- you can ask them to run a literature search

Appeal Letters

Download Customizable Appeal Letters for Your Patients

Most people outside the medical community probably do not fully appreciate or understand the seriousness of inflammatory bowel diseases (IBD). As a healthcare provider, you know the special needs of your IBD patients. Below is a list of sample letters* which you can download and customize for each of your patients—so that they, in turn, can help the people in their lives better understand the illness and accommodate their unique health-related requirements.

*All letters are in Microsoft Word format. If there is a letter needed that is not listed below, please contact the IBD Help Center at (888) 694-8872 or email info@crohnscolitisfoundation.org

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You finally get someone on the phone



- **Request to speak with gastroenterologist or speciality pharmacists if able**
- Emphasize your patient's disease diagnosis, history, severity and prognosis
- Stress the cost of outcomes associated with either delay in therapy or initiation of inappropriate therapy
- Read the denial letter- if they asked for formulary Rx A, review contraindications or lack of data to support that
- Offer to provide further documentation if needed
- Reference clinical guidelines and references

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You have exhausted the denial pathway... Don't qualify for free drug... Now what?



- Patient can talk with human resources at their employer
- Patient to reach out to Consumer Assistance Program or Department of Insurance
- Patient can reach out to Jennifer Jaff Care Line:
<https://jenniferjaff.pafcareline.org/>
- Consider clinical trial program (similar mechanism?)
- Last resort: play the insurance game

Get active in the Crohn's and Colitis
Foundation & advocate

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Yay!!! you got coverage, but your patient can't afford the cost of drug therapy?



Copolyment Assistance Cards



Charitable Foundations



Manufacturer Programs

Bridge Programs

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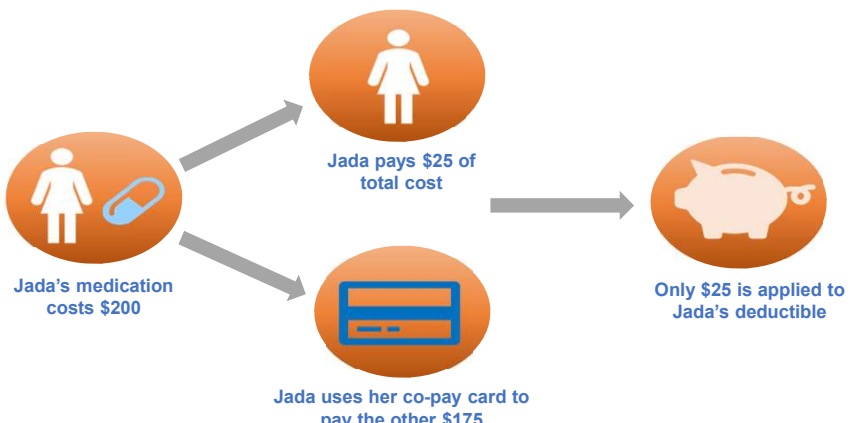
Assistance with drug costs: Co-pay Cards

Manufacture Co-Pay Assistance Cards

- Only available to those with commercial insurance
- Limits out of pocket cost*

***Co-Pay Accumulator**

- Only applies cost that patient pays to patient's deductible



```

graph LR
    A["Jada's medication costs $200"] --> B["Jada pays $25 of total cost"]
    A --> C["Jada uses her co-pay card to pay the other $175"]
    B --> D["Only $25 is applied to Jada's deductible"]
  
```

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Summary

- Your reimbursement is directly tied to your knowledge of E/M billing
- There is high cost of care for patients with IBD and high administrative burden in caring for IBD patients- develop processes now!
- Know your common payors to your practice- it will pay dividends
- Get approval the first time!
- If you get a denial use tips provided today to get approval the 2nd time
- Provide resources to your patient when needed
- Don't forget that the www.crohnscolitisfoundation.org site has **many** resources, appeal letters for you and your patients

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Thank you

Special thank you to Shubha Bhat, PharmD




@ibdgijami


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Questions




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ACG Hepatology Circle



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