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JUNE 2-4, 2023 | RENAISSANCE HOTEL WASHINGTON, DC

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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.

ACG Virtual Grand Rounds

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**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

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Optimizing your clinical reimbursement and winning the prior authorization game

Jami Kinnucan, MD
Mayo Clinic Florida
ACG VGR May 2023
Optimizing your reimbursement in clinic

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 in geographically driven, important to work with your main payers.
Outline

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

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

Estimates that 80% of medical bills contain errors
A few words on billing terminology

- 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

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!
Previous outpatient clinical billing requirements

- History
- Physical Exam
- Medical Decision Making
- Time

Current outpatient clinical billing requirements

- Medical Decision Making
- Time

If you meet highest level of billing for time...
STOP!
You are done
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

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)
### Outpatient E/M Time-based Billing:

**New Time Requirements**

<table>
<thead>
<tr>
<th>LOS</th>
<th>New Patient CPT</th>
<th>Total Time (min)</th>
<th>Previous</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP2</td>
<td>99202</td>
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<td>15</td>
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<tr>
<td>RV4</td>
<td>99214</td>
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<td>25</td>
</tr>
<tr>
<td>RV5</td>
<td>99215</td>
<td>40-54</td>
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</table>

**Established Visit**

**Make Level of Service Buttons**

**Meet your E/M Level of Service Calculator**

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</tr>
<tr>
<td>RV5</td>
<td>99215</td>
<td>40-54</td>
</tr>
</tbody>
</table>
But what if you spent MORE time?

Prolonged Service Codes

<table>
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<td>99215</td>
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</table>

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

 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!
Option 2:
Medical Decision Making (MDM)

Highest TWO Determines MDM Level

Problems
Data
Risk

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

MDM: Problems

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 99212</td>
<td>99203 99213</td>
</tr>
<tr>
<td>Minimal</td>
<td>Low</td>
</tr>
<tr>
<td>• 1 self-limited or minor problem</td>
<td>• 2+ self-limited or minor problems</td>
</tr>
<tr>
<td></td>
<td>• 1 stable chronic illness</td>
</tr>
<tr>
<td></td>
<td>• 1 acute, uncomplicated illness or injury</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

American College of Gastroenterology
MDM: Data

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

Data: Example

You did all this work... but you have to ensure to document it!
MDM: Risk Assessment

- Diagnostic testing
- Hospital/ER
- Procedures
- Social Determinants of Health
- Medications

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 3
- OTC drug management
- Decision for minor surgery without risk factors
- Non-cardiovascular imaging ordered
- Physical therapy
- Occupational therapy
<table>
<thead>
<tr>
<th>Level</th>
<th>Risk Assessment</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td><strong>Minimal</strong> risk of morbidity from additional diagnostic testing or treatment</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Low</strong> risk of morbidity from additional diagnostic testing or treatment</td>
<td></td>
</tr>
</tbody>
</table>
| 4     | **Moderate** 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 |
| 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
Example Revisited

• 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
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

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)

<table>
<thead>
<tr>
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<th>Consult CPT</th>
<th>Total Time (min)</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>CONS4</td>
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<td>40</td>
</tr>
<tr>
<td>CONS5</td>
<td>99245*</td>
<td>55</td>
</tr>
</tbody>
</table>

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

**Documentation Requirements**
- Request for consultation
- MDM + medical appropriate examination
E-Visit Reimbursement

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>HCPCS Code</th>
</tr>
</thead>
</table>
| 99421-99423 G2061-G2063 | **E-Visit Care**  
Patient initiated portal message | G2061-G2063 |
| 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
Prior Authorization- Outline

**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)

Important basics around medication prior authorizations
Important basics around medication prior authorizations

Medical Benefit

Pharmacy Benefit

Ustekinumab (Stelara)
Risankizumab (Skyrizi)

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
Learning to play the prior authorization game

- Denial (15.2%)
- Appeal (1st level)
- Appeal (2nd level)
- External Review
- Commercial insurance?
  - Consider pharmaceutical free drug programs

Top reasons that insurance deny medication or treatment prior authorizations

- Inadequate clinical information included in initial PA
  - Provide adequate clinical information from the start
  - Standardize your PA process
  - Investing time up front will reduce your denial rate

- Non-formulary request
  - If your practice has a pharmacy tech they can run a test-claim to determine payor formulary
  - If biosimilar related, write for "infliximab"

- Step Therapy!
  - Step Therapy is illegal in many states!

- Non-FDA approved dosing non-FDA approved indication
  - Optimization of therapy is essential in many patients
  - Always write a letter when asking for off-label therapy
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 it 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

### 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!
How to appeal the denial

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

Appeal Packet
• Letter* with specific addressing directly the why of the denial
• Last office visit note
• Last labs, endoscopy, imaging, TDM
• Literature (at least one article supporting your decision)

Appeal Status
• Have team follow-up on appeal status:
  • 3d (urgent appeal)
  • 7d (regular appeal)
  • 30d (some payors)

Peer to Peer
• Doesn’t have to be a physician or advanced practice provider- consider PharmD
• Ask for this early in the appeal process
• Recognize this person doesn’t have your level of experience- teach them!

*Crohn’s and Colitis Foundation Appeal Letters!

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
You finally get someone on the phone

- Request to speak with gastroenterologist or specialty 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

You have exhausted the denial pathway…

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

- Copayment Assistance Cards
- Charitable Foundations
- Manufacturer Programs
- Bridge Programs

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

Jada pays $25 of total cost

Jada’s medication costs $200

Jada uses her co-pay card to pay the other $175

Only $25 is applied to Jada’s deductible
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

Thank you

Special thank you to Shubha Bhat, PharmD

@ibdgijami