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.
How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR
ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2021 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2022 for this activity.

MOC QUESTION
If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement. THESE ANSWERS WILL BE REVIEWED.
ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!

Week 24, 2021
Intestinal Failure and Short Bowel Syndrome
Dejan Micic, MD
June 17, 2021 at Noon Eastern

Week 25, 2021
ACG 2021 Clinical Guideline: Management of Irritable Bowel Syndrome
Brian E. Lacy, MD, PhD, FACC
June 24, 2021 at Noon Eastern

Visit gi.org/ACGVGR to Register

Disclosures:

Speaker: Jami A.R. Kinnucan, MD
Advisory Committee/Board Member: Bristol Myers Squibb, Janssen Pharmaceuticals, Pfizer; Consultant: Genetech, Pfizer

Speaker: Jason N. Rogart, MD
Consultant: Boston Scientific; Speakers Bureau: Boston Scientific

Panelist: Sofia Yuen, MD, MBA
Advisory Committee/Board Member: Olympus; Consultant: Olympus

Moderator: Kara De Felice, MD
Honorary speaker for AbbVie and Takeda

*All of the relevant financial relationships listed for these individuals have been mitigated.
Clinical billing in a virtual care world

Jami Kinnucan, MD
Assistant Professor of Medicine
Michigan Medicine, University of Michigan
ACG Special Edition Virtual Grand Rounds 2021

Outline

1. Review previous and current billing requirements
2. Billing based on medical decision making (MDM)
3. Billing based on time (minutes)
4. Prolonged service billing
5. Modifiers
6. Virtual care billing
Don’t make these common billing mistakes

- Submitting lower level of service than MDM
- Submitting high level of service than MDM
- Forgetting modifier coding
- Lacking appropriate documentation for billing
- Over documentation or cut/paste
- Delay in billing

Previous clinical billing requirements

- History
- Physical Exam
- Medical Decision Making
- Time
Current clinical billing requirements

Medical Decision Making

Time

What changed in January 1, 2021?

1. Eliminated History and Physical Exam key elements for code selection
2. Deleted new patient visit code 99201
3. Level of service (LOS) based on Medical Decision Making (MDM) or Time
4. Revision of MDM and Time Requirements
5. New prolonged services code for office visits
Billing Basics

- What is an RVU?
  
  RVU = Relative Value Scale

- Resource-Based Relative Value Scale (RBRVS)
  - Implemented in 1992

  Total RVU = Work RVU (wRVU) + Practice Expense RVU + Malpractice Expense RVU

- wRVU = Time, Technical Skill and Physical Effort, Mental Effort and Judgement, Psychological Stress

Billing based on Medical Decision Making (MDM)

1. Problems
2. Data
3. 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

Highest TWO Determines MDM Level
### 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><strong>Minimal</strong></td>
<td><strong>Low</strong></td>
</tr>
<tr>
<td>• 1 self-limited or minor problem</td>
<td>• 2+ self-limited or minor problems</td>
</tr>
<tr>
<td>• 1 stable chronic illness</td>
<td>• 1+ chronic illness with exacerbation, progression or tx SE</td>
</tr>
<tr>
<td>• 1 acute, uncomplicated illness or injury</td>
<td>• 1 undiagnosed new problem uncertain prog</td>
</tr>
</tbody>
</table>

### Data

**Tests, outside records, or independent historian(s)**

**Independent interpretation of tests**

**Discussion with other professionals**

**Data Billing**

**Category 1:** Any combination 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
Risk Assessment

Minimal risk of morbidity from additional diagnostic testing or treatment

Low risk of morbidity from additional diagnostic testing or treatment

Moderate risk of morbidity from additional diagnostic testing or treatment

High risk of morbidity from additional diagnostic testing or treatment

- Prescription Drug management
- Decision for minor surgery + risk factors
- Decision for major surgery without risk factors
- Diagnosis limited by social determinants of health
### Risk Assessment

#### Minimal risk of morbidity from additional diagnostic testing or treatment
- 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

#### Low risk of morbidity from additional diagnostic testing or treatment

#### Moderate risk of morbidity from additional diagnostic testing or treatment

#### High risk of morbidity from additional diagnostic testing or treatment

### Level of Service - MDM Table

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>DATA</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99203 2 or more self-limited or minor problems;</td>
<td>Category 1: Tests and reports</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99213 1 stable chronic illness;</td>
<td>• Any combination of 2 from the following:</td>
<td>• Drug therapy with intensive monitoring for toxicity</td>
</tr>
<tr>
<td>99204 3 or more chronic illnesses with minor problems;</td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td>• Decision regarding major surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td>99214 1 undiagnosed new problem with uncertain prognosis;</td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td>• Decision regarding elective major surgery without identified patient or procedure risk factors</td>
</tr>
<tr>
<td>99205 4 chronic illness with severe exacerbation, progression, or side</td>
<td>• Ordering of each unique test*;</td>
<td>• Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
<tr>
<td>99215 1 acute or injury that poses a threat to life or bodily function</td>
<td>• Re-evaluation of previous diagnosis by another physician/other qualified healthcare professional (not separately reported)</td>
<td></td>
</tr>
</tbody>
</table>

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American College of Gastroenterology
MDM billing seems complex huh?

Meet the MDM Billing Calculator!
Billing based on TIME

- Previously was based only on face-to-face time on the day of the encounter

- Currently based on face-to-face time + non face-to-face time on the date of the encounter
  - Does not have to be continuous
  - No longer limited to time spent in counseling or care coordination for the patient

- Activities spent by physician or other qualified health care professional
  - Preparation to see patient (review)
  - Review of separately obtained history
  - Performing medically appropriate examination
  - Counseling and education of patient/family/caregiver
  - Ordering meds, tests or procedures
  - Communication with other health care professionals
  - Documentation in medical record
  - Independent review of testing/results
  - Care coordination

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

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

**Same Day Prolonged Service Codes**
- Each additional 15 min
  - Can bill multiple
  - Prolonged office or other outpatient E/M when primary encounter billed based on time
  - Only billed based on time spent on the day of service

American College of Gastroenterology
Prolonged Services Billing (99358-99359)

<table>
<thead>
<tr>
<th>99417/G2212</th>
<th>99358/99359</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Additional time spent with patient same day as E/M service</td>
<td></td>
</tr>
<tr>
<td>• When E/M service is billed by TIME</td>
<td></td>
</tr>
<tr>
<td>• Billed in increments of 15 min</td>
<td></td>
</tr>
<tr>
<td>• Added to 99205 (NP5) or 99215 (RV5)</td>
<td></td>
</tr>
<tr>
<td>• Can’t be reported with 99358/99359</td>
<td></td>
</tr>
<tr>
<td>• Additional time spent with patient on different day (before or after) E/M service</td>
<td></td>
</tr>
</tbody>
</table>

What qualifies?
- Review of medical records
- Discussion with care providers
- Coordination of care

What must you document?
*Prolonged Non-Face-To-Face Services were provided for [patient name] on [date(s)] for a total of *** minutes for companion encounter date ***. Services provided included the following ***, these were medically necessary for the care of this patient because ***.*

<table>
<thead>
<tr>
<th>Billing</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99358</td>
<td>2.1</td>
</tr>
<tr>
<td>99359</td>
<td>1</td>
</tr>
<tr>
<td>99417</td>
<td>0.61/15m</td>
</tr>
</tbody>
</table>

Common clinic billing modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC</td>
<td>Service has been performed in part by a resident under the direction of a teaching physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telehealth Code</th>
<th>Modifier Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT</td>
<td>Audiovisual, provider onsite</td>
</tr>
<tr>
<td>GTAO</td>
<td>Audio only, provider onsite</td>
</tr>
<tr>
<td>GTHA</td>
<td>Audio only, provider onsite</td>
</tr>
<tr>
<td>GTHV</td>
<td>Audiovisual, provider onsite</td>
</tr>
</tbody>
</table>
### Telephone Encounter Billing

**You call the patient back**

<table>
<thead>
<tr>
<th>When can you use this?</th>
<th>When can you not use this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initiated by <strong>established</strong> patient or</td>
<td>• Physician initiated (ie. Calling patient to review results)</td>
</tr>
<tr>
<td>care giver/guardian</td>
<td>• Calling insurance for P2P</td>
</tr>
<tr>
<td>• Billing is based on time</td>
<td>• Office visit &lt;7d or generates E/M service within 7d or next available</td>
</tr>
<tr>
<td>• No prior 99441-99443 in the last 7 days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOS</th>
<th>Time (min)</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>5-10m</td>
<td>0.25</td>
</tr>
<tr>
<td>99442</td>
<td>11-20m</td>
<td>0.5</td>
</tr>
<tr>
<td>99443</td>
<td>21-30m</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**What must you document?**

• Patient initiated request for care and consented to care by phone
• Time spent during that telephone call

**Example**

*Patient initiated request for care and consented to telephone care. I spent *** minutes during the care of this patient.*

### Portal Message Billing

**You respond to a patient initiated portal message**

<table>
<thead>
<tr>
<th>When can you use this?</th>
<th>When can you not use this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initiated by <strong>established</strong> patient or</td>
<td>• Physician initiated (ie. Portal to patient to review results)</td>
</tr>
<tr>
<td>guardian</td>
<td>• Office visit &lt;7d or generates E/M service within 7d or next available</td>
</tr>
<tr>
<td>• Billing is based on time</td>
<td></td>
</tr>
<tr>
<td>• No prior 99421-99423 in the last 7 days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOS</th>
<th>Time (min)</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99421</td>
<td>5-10m</td>
<td>0.25</td>
</tr>
<tr>
<td>99422</td>
<td>11-20m</td>
<td>0.5</td>
</tr>
<tr>
<td>99423</td>
<td>21-30m</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**What must you document?**

• Patient initiated request for care
• Time you spent during portal encounter

**Example**

*Patient initiated request for care. I spent *** minutes during the care of this patient.*
GI Endoscopy Practical Billing and Coding Tips
June, 2021
Jason Rogart, MD, FASGE
Director of Therapeutic Endoscopy
Capital Health Center for Digestive Health
Pennington, NJ
The Endoscopist’s Coding Goals

• Make sure someone is checking your work
• Your practice or employer should have a good coding expert on staff to correct your mistakes whether that be upcoding or downcoding, and who stays up to date with the changes in GI.
• Maximize billing by using as many codes as can be justified
• Make sure you are not billing fraudulently
• Understand how coding translates into your income (see next slide)

Understand how you get paid and/or evaluated

• Billing and collections based
  • More common in private practice (money in must equal money out)
  • Terrible system if you are employed
• wRVU based
  • Becoming more common for employed physicians
  • Can compare yourself more easily to peers
  • Don’t have to worry about what different insurers reimburse or if a patient even has insurance at all
  • Know your compensation model- e.g. base + bonus with $xx per wRVU paid once you reach a “threshold” (e.g. 50th %ile MGMA)
> Keep a procedure and billing log so you can track your productivity and make sure you are being fairly rewarded.

> Compare your numbers monthly to reports your institution/practice should provide you (e.g. productivity reports).

*If I see a more than 5% discrepancy I flag it and if it is not corrected by next month’s reports, then I ask for a review.*
Most endoscopists will never become coding experts

- It is way too confusing
- Rules change all the time
- Insurance companies try to not pay you
- You have more important things to do... take care of patients, spend time with your family, exercise, etc.

Try to bill with as many codes as possible

- Generally, more codes = more money and/or more wRVUs
- If your compensation is tied to billing, in dollars: know how much money you are getting for each code for Medicare and each of the private insurers and understand when you are only getting 50% of the second / lesser code billed
- If your compensation depends on wRVUs, know the wRVU value for each code you use, and also know whether you are getting full wRVUs for all billed codes or if wRVUs are being “washed”.
When to use modifiers
And will they affect your compensation?

- 59: distinct procedure
  - For example when doing a colon snare and a biopsy, bill as 45385 + 45380-59
- 52: reduced procedure (e.g. failed ERCP cannulation)
- 53: discontinued procedure (e.g. incomplete colon)
  - If you are wRVU based and get the full wRVU value of a code despite it’s modifier, then use the modifier as it gets you more than billing a flex sig
- 25 (separate service)
  - Use if you see a consult and do a procedure same day
  - Example: level 3 inpatient consult plus EGD-bleeding control same day would be billed 43255 + 99255-25

Example

- You find a 5mm polyp during colonoscopy and remove it with cold snare (45385).
- You then find a 2 mm polyp... do you
  - a) cold snare it because you already have the cold snare open
  - b) Remove it with jumbo biopsy forceps?
- Answer: remove it with forceps so you can bill 45385 + 45380.
Example

- You find a 2cm polyp in the ascending colon. You lift it with submucosal injection and therefore delineate its borders with injection as well as NBI examination. You proceed to resect it with snare cautery and close with 3 hemoclips.
- Question 1: What are your billing options?
  - a) 45385 (snare) + 45381 (injection)
  - b) 45390 (colon EMR)
  - c) a or b
- Answer: C

Example, Continued

- Question 2: Which of those two options should you bill
- Answer: It depends on how you get paid
  - If you are dollars-based, then it depends on which codes get you more money, which depends on insurance contracts
  - If you are wRVU based
    - snare (4.57) + injection (3.56) = 8.13
    - Colon EMR = 6.04
  - Note: you cannot bill for prophylactic clipping
More Examples

• If you are going to sample a small sessile gastric polyp in the stomach: using biopsy forceps (43239) = 2.39 wRVU vs. 3.47 wRVU for cold snare (43251)

• Do you sample a 2mm rectal hyperplastic appearing polyp in a patient who you cold snared a 6mm polyp? If you do, then you would get an extra 3.56 wRVUs (45380)

• When doing RFA for Barretts are you billing 43229 (Esophagoscopy with ablation) or 43270 (EGD with ablation)? The latter gets you an additional 0.52 wRVUs (4.01 vs. 3.49)

More Examples

• During EGD, do you have a reason to do a biopsy even if everything looks normal (e.g. to r/o H.pylori, r/o celiac disease)? A biopsy gets you an additional 0.30 wRVUs (2.39 for 43239 vs. 2.09 for 43235).

• When performing balloon dilation during an EGD, make sure you bill 43245 instead of 43249 if you are dilating the antrum, pylorus or duodenum... difference of 0.41 wRVUs (3.08 vs. 2.67)

• When performing balloon enteroscopy, if you think you got to the ileum, use the ileum (not jejunum) codes
  • Biopsy: 5.42 wRVU vs. 2.77
  • Treatment of bleeding: 7.02 wRVU vs. 4.3
More examples- EUS/ERCP

- If you are doing a diagnostic EUS and you also do a mucosal biopsy (e.g. r/o celiac, r/o h. pylori), you will get an additional 2.39 wRVUs on top of the 4.04 wRVUs for 43259.
- For ERCPs....
  - Bill for each stent you place in a different location
    - Bilateral stents for hilar obstruction and prophylactic PD stent: 43274 + 43274-59 + 43274-59
  - If you biopsy ampulla and say you biopsied via ERCP scope.. can bill 43261
  - If you include language that you interpreted fluoro images, then bill for it (74328 for cholangiography, 74329 for pancreatography)... it adds up

Thank you!
Questions?

Speaker: Jami A.R. Kinnucan, MD
Speaker: Jason N. Rogart, MD
Panelist: Sofia Yuen, MD, MBA
Moderator: Kara De Felice, MD