Coding and Government Relations
Coding Update
3:03-3:25 PM

Gary N. Gross, MD, FACAAI

Disclosures

• Nothing to disclose
Goal for the next 22 minutes

• Relevant changes, modifications and implementation of CPT and ICD-10 coding for 2021 and 2022
• Where to find answers to these changes, etc

Get A New Book Every Year and Read Allergy Section
What to Document  (EVERYTHING)

- Documentation Supporting Medical Necessity must be complete, legible, and include, at a minimum:
  - Name of person providing the services or items
  - Date of services or items
  - Signed orders for services or items and the clinical rationale for the orders
  - Rationale for the level of care given
- Other Documentation
  - Appropriate History and Physical Exam
  - Description of what was done and why

Codes Affected in 2021

- New patient office visits
  - Level 2-5 (level 1 deleted)
  - 99202-99205
- Follow up patient office visits
  - Level 2-5
  - 99212-99215
Determine Level of Service

- **Time**
- **Medical Decision Making**
  - Must still complete medically appropriate history and/or physical exam but they do not determine level of service (CPT code to be used)

**TIME**

- Time is inclusive of all time spent by physician or other qualified health professional (QHP) for patient **the date of face-to-face visit**
- Time includes non face-to-face time
- Time is defined in increments
- If time exceeds level 5, add-on codes can be used (prolonged service)
What is a QHP?

- Physician (MD/DO)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- These are the people who can bill EM codes.
  - RN, MA, other office staff are not QHP

TIME

- Face-to-face with physician or other QHP is required but non face-to-face time for prolonged service counts
  - Review of tests
  - Obtain history or review separately obtained history
  - Medically appropriate exam or evaluation
  - Counseling and educating patient/family/caregiver
  - Ordering tests, medication, procedures
  - Referring and communicating with other HCP
  - Documenting in electronic or other health record
  - Independently interpreting result and communicating results to patient/family/caregiver
- Do NOT Count
  - Other Services reported separately (PFTs, Skin Test, etc)
  - Staff Time
  - Teaching that is general, not required for management of specific patient
Time to Determine Level

- **99202** 15-29 minutes of total time is spent on the date of the encounter.
- **99203** 30-44 minutes
- **99204** 45-59 minutes
- **99205** 60-74
  - For services 75 minutes or longer, see Prolonged Services

- **99212** 10-19 minutes
- **99213** 20-29 minutes
- **99214** 30-39 minutes
- **99215** 40-54 minutes
  - For services 55 minutes or longer, see Prolonged Services

New Prolonged Service Code
HCPCS code G2212

- **Prolonged office or other outpatient evaluation and management 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**
- **Do not report G2212 for any time unit less than 15 minutes**

MDM

- Maintained three current MDM elements
  - Number and complexity of problem(s)
  - Amount or complexity of data to review/analyze
  - Risk of complications or morbidity

Types of MDM

- Straightforward
- Low
- Moderate
- High
### Elements of Medical Decision Making

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>Code</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>99204</td>
<td>1 or more chronic illnesses with exacerbation, progressive, or side effects of treatment or 2 or more stable chronic illnesses or 1 undiagnosed new problem with uncertain prognosis or 1 acute illness with systemic symptoms or 1 acute, complicated injury</td>
<td>&quot;Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.&quot;</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment Example only: Prescription drug management Decision regarding minor surgery with identified patient or procedure risk factors Decision regarding elective major surgery without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
</tbody>
</table>

**Category 1: Tests, documents, or independent history/ies**
- Any combination of 3 from the following:
  - Review of prior external note(s) from each unique source;*
  - Review of the result(s) of each unique test;*
  - Ordering of each unique test;*
  - Assessment requiring an independent historian(s) or

**Category 2: Independent interpretation of tests**
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

**Category 3: Discussion of management or test interpretation**
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
AMA CPT code set – technical corrections

- Since Category I codes are only released once per year, the AMA, several times a year, releases editorial updates to the AMA website.
  - Technical Corrections – Represents revisions to the CPT code set which are needed to clarify or correct unforeseen or unintended issues following publication. They do not represent changes in intended use and thus are effective retroactively. They have greater force than educational materials.
  - Errata – Represents revisions to the CPT code set which are needed to correct editorial errors.
- These revisions, when applicable, are published to the AMA website on the first of the month.

ICD-10 Changes

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning Accidental (unintentional)</th>
<th>Poisoning Intentional Self-harm</th>
<th>Poisoning Assault</th>
<th>Poisoning Undetermined</th>
<th>Adverse effect</th>
<th>Underlying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add: Cannabinoids, synthetic</td>
<td>Add T40.721</td>
<td>Add T40.722</td>
<td>Add T40.723</td>
<td>Add T40.724</td>
<td>Add T40.725</td>
<td>Add T40.726</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Revise from T40.711</td>
<td>Revise to T40.712</td>
<td>Revise from T40.713</td>
<td>Revise to T40.714</td>
<td>Revise from T40.715</td>
<td>Revise to T40.716</td>
</tr>
<tr>
<td>Cannabis (derivatives)</td>
<td>Revise from T40.711</td>
<td>Revise to T40.712</td>
<td>Revise from T40.713</td>
<td>Revise to T40.714</td>
<td>Revise from T40.715</td>
<td>Revise to T40.716</td>
</tr>
<tr>
<td>Central nervous system</td>
<td>- depressants</td>
<td>T42.71</td>
<td>T42.72</td>
<td>T42.73</td>
<td>T42.74</td>
<td>T42.75</td>
</tr>
<tr>
<td>- - cannabis/oral</td>
<td>Revise from T40.711</td>
<td>Revise to T40.712</td>
<td>Revise from T40.713</td>
<td>Revise to T40.714</td>
<td>Revise from T40.715</td>
<td>Revise to T40.716</td>
</tr>
</tbody>
</table>
ICD-10 Changes

- No Change: *Allergy, allergic (reaction) to* T78.40
- No Change: - food (any) (ingested) NEC T78.1
- No Change: - status (without reaction) Z91.018
- **Add:** - beef Z91.014
- **Add:** - lamb Z91.014
- **Add:** - mammalian meats Z91.014
- **Add:** - pork Z91.014
- **Add:** - red meats Z91.014
- No Change: - milk protein (see also Allergy, food) Z91.011
- Revise from: - *proctocolitis K52.82
- Revise to: - *proctocolitis K52.29
- Revise from: - proctocolitis K52.82
- Revise to: - proctocolitis K52.29

ICD-10 Cough

- Cough (affected) (epidemic) (nervous) R05.9
  - with hemorrhage -see Hemoptysis
  - acute R05.1
  - bronchial R05.8
  - - with grippe or influenza -see Influenza, with, respiratory manifestations NEC
  - chronic R05.3
  - functional F45.8
  - hysterical F45.8
  - laryngeal, spasmodic R05.8
  - paroxysmal, due to Bordetella pertussis (without pneumonia) A37.00
  - - with pneumonia A37.01
  - persistent R05.3
  - psychogenic F45.8
  - refractory R05.3
  - smokers' J41.0
  - specified NEC R05.8
  - subacute R05.2
  - syncope R05.4
  - tea taster's B49
  - unexplained R05.3
My Favorite Allergy Coding Site

My Favorite CPT Code Site
My Favorite ICD-10 Site

Search Results
500 results found. Showing 1-25:

- ICD-10-CM Diagnosis Code K28
  - Eosinophilic gastritis; eosinophilic gastritis with hemorrhage; eosinophilic gastroenteritis

- ICD-10-CM Diagnosis Code K27.81
  - Eosinophilic gastritis; Eosinophilic gastritis with hemorrhage; Eosinophilic gastroenteritis; Gastric hemorrhage due to eosinophilic gastritis; Gastritis; eosinophilic; eosinophilic esophagitis; eosinophilic enteritis
The Importance of the Physician Advocate

James M. Tracy, DO, FACAAI
Chairman - Advocacy Council
of the ACAAI

The Advocacy Council is like air-conditioning on a hot summer day - only missed if we’re not working!
Objectives

At the end of this discussion participants will be able to:

• Who is the Advocacy Council of the ACAAI?
• Understand what is a physician advocate?
• Who are we advocating for?
• What are the critical issues currently being faced by providers and patients and how do advocate to address them?
• How is the ACAAI Advocacy Council doing their job?
• How can you be a Physician Advocate?
• Understand the efforts of the ACAAI in response to the COVID-19 Pandemic.

The Advocacy Council: Who Are We?

• The group formerly know as the JCAAI
  – Transition in 2015
  – Structurally independent
• House of Delegates & Practice Management Committee now under same umbrella
• Current Staff and officers
  – James Sublett, MD, FACAAI - Executive Director, Advocacy and Governmental Affairs
  – James M. Tracy, DO, FACAAI – Chairman
  – Warner Carr, MD, FACAAI – Vice Chairman
  – Stephen Imbeau, MD, FACAAI – Immediate Past Chairman
  – Sue Grupe - Director of Advocacy Administration
  – Gary N Gross, MD, FACAAI – Coding Consultant
The Advocacy Council: Who Are We? Behind the Scenes... Lobbying

• **What is lobbying?**
  - Defensive lobbying – Watch for important legislation both nationally and locally
  - Use and access the critical tools for surveillance
  - Offensive lobbying –
    - Understand how the “Sausage is Made”
    - Legislative and policy making structure and help with accessibility to address relevant concern – i.e. Advocate for our patients and us

• **The ACAAI Team**
  - Capital Associate
    - Mr. Bill Finerfrock
    - Matt Reider
    - Weekly updates – i.e. COVID-19 Federal response
  - Legal Support
    - Becky Burke

What is a Physician Advocate?

• As physicians, we often find ourselves at the crossroads of a unique and sometimes intimate knowledge of patient needs.
• This places us at a point with the ability to leverage influence health care system delivery, social barriers, and even impact political policy.
• As physicians we need to be very familiar with both patient needs and incorporating social factors of health into patient care.
• Understanding and adapting to an ever-changing healthcare landscape is critical.
• Understand healthcare model as well as front line challenges
• Ensure practice financial viability, especially in the private practice arena
Who are we advocating for?

• First and for most we advocate for our patients...
  – Access to primary care
  – Access to specialty care
  – Affordable Medications with adequate reimbursement and coverage
  – Transparent and affordable coverage
• Second for our Community
  – Understand our community and its specific needs
• Third for ourselves and our Specialty
  – Physician often carry significant debt burdens
  – Adequate reimbursement
  – Recognition of differing population mixes
    • Urban, Suburban, and rural differences
• Make a living so as continue to address our patient and community responsibilities

Critical issues currently faced by allergists and our patients

• Step therapy
• Prior Authorization
• Co-pay Accumulator
• Non-Medical Switching
Step Therapy

- To get the medicine prescribed by their health care provider, patients must first prove that older, less expensive or insurer-preferred alternatives don’t work. That’s the crux of step therapy, or “fail first.”
- In some cases, step therapy makes sense. A logical progression of treatment options may represent best practice for certain diseases or reflect the wisdom of clinical guidelines.
- In other cases, step therapy can be excessive, arbitrary and even damaging to patients’ health. Insurers may use step therapy as a deliberate access hurdle meant to protect their own profits.
- Doing so hurts patients, whose condition may worsen or who may suffer unnecessarily in the process of failing insurer-preferred treatments. It also undermines the relationship between the physician and patient, to whom treatment decisions rightfully belong.

Prior Authorization

- Patients can be denied access to their medicine for days, even weeks because of a practice called “prior authorization.” It’s the process whereby insurance companies must approve a physician-prescribed medicine, procedure or test before a patient can get coverage.
- Delays can be frustrating, painful or even dangerous for patients—especially for patients with chronic conditions. Meanwhile, physicians and their staff spend hours filling out multi-page forms and submitting labs and patient records. Even then, approval is not guaranteed. If the insurer denies coverage, patients and their physicians can appeal. But that delays treatment even longer, and may not lead to approval.
- Insurers claim prior authorization stops unnecessary use of expensive treatments. But it’s become a cost-cutting tool that makes it hard for patients to access treatment, especially newer, more innovative medicines.
- In some cases, the frustrating process may lead patients to abandon treatment altogether.
Step Therapy & PA Issues

- Advocacy Council joined a coalition that includes several physician and patient organizations in supporting both Federal and State legislation designed to address step therapy issues.
- Ohio has enacted legislation that promises to restrict the ability of insurers to impose unreasonable step therapy requirements.
- Bills are pending in Florida, Georgia, Maine, Massachusetts, New Mexico, Oregon, Rhode Island, Utah and Vermont.
- Close alliance with AfPA
- New Tool Kit on ACAAI website, partnership with industry

Co-pay Accumulator

- Co-pay coupons are a common tool to help patients with chronic conditions cover the cost of expensive medications. Historically, co-pay coupons’ value has counted toward a patient’s annual deductible. Once the deductible is met, the patients pays a modest co-pay – a fixed amount – per prescription
- Under co-pay accumulator programs, co-pay coupons still allow patients to access their medication. But health plans do not apply that assistance toward a patient’s deductible
- Once patients exhaust their co-pay coupon, they discover that they still have hundreds or thousands of dollars due in out-of-pocket payments before their insurance coverage applies
- That leaves patients with a difficult choice. They can pay the hefty out-of-pocket bill, or they can abandon the medication upon which they now depend
Non-Medical Switching

- For many patients with complex, chronic conditions, the process of identifying the right combination of medications takes considerable effort. Imagine then how patients feel when their insurance company forces them to change their medication on the basis of cost.
- The practice is called “non-medical switching.” It can take different forms. Insurers may simply stop covering a certain medication,
- for example, or place it on a specialty tier, which requires high cost sharing. The medication becomes unaffordable for patients—forcing them to switch to a cheaper, plan-preferred alternative.
- Regardless of approach, the switch prioritizes insurers’ interests over patients’ health. And it often comes with consequences: new side effects, re-emerging symptoms that had been under control, or adverse interactions with medication the patient takes for other conditions.
Advocacy Council Strike Force: May 6-8, 2019

• Held in conjunction with AAN Capitol Hill Day
  – Used shared talking points for both groups.
  – Joined by the Executive Vice president and President of the Academy.
• Appointments with Key decision makers:
  – HHS Secretary Azar’s Staff
  – House Energy and Commerce Committee (Majority)
  – Senate Finance Committee (Majority)
  – House Ways and Means Committee (Minority)
  – Senate HELP Committee (Majority)
  – Rep. Morgan Griffith (VA) - Thank you for USP help
  – Rep. Ro Khanna (CA) – Thank you for Food Allergy research funding

Focus:
  – Patient Access to Specialty Care – Surprise Medical Bills (Narrow Networks)
  – Physician Focused Payment Models
  – Alternative Payment Model (APM) for Patient-Centered Asthma Care
CMS Final Rule revising the Physician Payment Schedule for 2020

- The Advocacy Council's efforts to convince CMS to increase reimbursement for inhalant and venom antigens were successful.
- Percentage change 2019 - 2020 payments:
  - 95165 (allergy extracts) increased by 2.6%
  - Venom antigens (95145-95149) increased between 4-7.6% (the second of a 4-year phase-in)
  - Administration of immunotherapy injections (95115 and 95117) both increased by 0.1%
  - Spirometry (94010) increased by 0.1
- CMS has decided to delay its proposed E&M consolidation until 2021.

CMS Physician Fee Schedule for 2020

- 2021 E&M changes
  o Acceptance of the AMA RUC’s recommended values for the E/M outpatient visit codes;
  o Elimination of the use of history and physical or physical examination as a basis for selection of E/M code level;
  o Choice of time or medical decision making to decide E/M level;
  o Payment for prolonged office E/M code using a new CPT code based on each additional 15 minutes and no longer recognizing existing CPT Codes 99358-59. The new prolonged service codes can only be billed with level 5 visit codes selected based on time (i.e., 99205 and 99215).
  o Addition of a new code for complexity inherent in E/M billing, to be used by primary care and specialists. This code can be billed with any level E/M, will have and is expected to result in an additional payment of $18 per visit.
- If all are implemented in 2021, overall Medicare payments to allergists will increase by 7%.
Held in conjunction with AAN Capitol Hill Day

Allergy & Asthma Network
35th Anniversary

AACAII House of Delegates - Leadership

Curtis Hedberg - Speaker
M. Razi Rafeeq – Vice Speaker
Andrej Petrov – Secretary

Super-delegates
Don Burkstein - Great Lakes Region
Anne Ellis – International Region
J. Wesley Sublett – Southeastern Region
Michael Volz - Mountain West Region
Michael Palumbo – Mid-Atlantic Region
Christopher Randolph – New England Region
Madeleine Ramos – West Coast Region
ACAAI House of Delegates

ACAAI House of Delegate – Regional Super Delegates

- Mid-Atlantic Region – Dr. Michael Palumbo
- Southeast Region – Dr. Wes Sublett
- New England Region – Dr. Christopher Randolph
- Great Lakes Region – Dr. Don Bukstein
- Inter-Mountain Region – Dr. Michael Volz
OTHER PROJECTS

Key points of the USP Chapter 797 revision

• Allergen extract is restored as a separate section of the proposed chapter.
• Confirmed previous allergen extract compounding requirements
  – Personnel training and evaluation.
  – Hygiene and garbing.
  – Updated documentation requirements.
• Also required either:
  – ISO Class 5, Primary Engineering Control (PEC), OR
  – Dedicated Allergenic Extracts Compounding Area (AECA)
Restrictions on 95165: Allergy Extracts

• CPT definition - Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
• Because of increased utilization, third party payers have been putting annual caps on the units, (e.g., 120/90)
• July 2016, Medicare began making public their MUE’s (Medically Unlikely Edits)
  – 95165 is 30 doses
  – Medicare does not follow the CPT definition, instead defines dose as 1ml
  – Does not pay for diluted vials made from the concentrated vial
• Many state Medicaid and some private payer’s have adopted these policies
• Cigna and Aetna nationally has raised the limit to 150 after correspondence from the AC
Advocacy Council APMs

- The Advocacy Council has developed an APM for allergists
- June 2018 Health and Human Services rejected all 12 physician-focused payment models submitted.
- Have submitted to PTAC with revisions reflecting current understanding of why they were rejected.
- Asthma APM is ready for testing

Impact of COVID-19 on A/I Practices:

Result of National Member Survey
The foxhole will protect you for awhile...
But eventually you have to move, or you will not survive.

College COVID-19 Activities

- Maintained operational awareness of the status of various practices during the healthcare emergency
- Adapted a format to effectively communicate timely issues early in the pandemic
- Analyzed and reported on federal COVID-19 regulations and waivers.
- Advocated for payment parity for telephone only and audio/video telehealth.
- Advocated for additional physician funding in COVID-19 Phase IV stimulus legislation.
- Personal Protective Equipment (PPE) – the College joined a bulk-purchasing consortium of medical specialties in partnership with Project N95 (PN95) – a non-profit that matches suppliers of personal protective equipment with providers who need it.
- Advocate to CMS and third-party payers for telehealth services and reimbursement to remain after the public health emergency at the same levels.
The College’s COVID-19 Resource Page is open to the public.

https://education.acaa.org/coronavirus

**College COVID-19 Communications**

- Weekly COVID-19 NewsBrief e-newsletter with articles and links to important resources.
- Weekly College Insider e-newsletter has prioritized COVID-19 information.
- Webpage with daily roundup of latest federal updates.
- COVID-19 patient page on public website.
- Alerts about potential supply chain issues.
- Three short patient videos related to COVID-19
- Three short “how to” telehealth videos
Clinical and Practice Management Webinars

The College has presented eight COVID-19 related webinars during the last three months, with more in the planning stages:

- COVID-19 for the Allergist Webinar (03/19)
- Telemedicine and COVID-19: Getting Started webinar (3/24)
- A/I Practice Survival during COVID-19: A Town Hall Webinar (4/2)
- HR Issues Related to COVID-19: A Town Hall Webinar (4/13)
- Practice Survival - Loans and Grants During COVID-19: A Town Hall Webinar (4/23)
- Next Steps - Moving Your Practice Forward Amid COVID-19: A Town Hall Webinar (5/14)
- Managing Your Asthma Patients During COVID Webinar (5/28)
- Strategic Marketing to Rebuild Your Practice Amid COVID-19

The Advocacy Council is like air-conditioning on a hot summer day in Tennessee - only missed if we’re not working!

Thank you for your support!
• Questions?