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Coding

For E/M visits, remind providers they can rein in the review of systems

Taking history and physical exams out of the calculations for level-based E/M services was on the wish lists of CMS and health care leaders for several years (*PBN blog 9/12/17, PBN 7/24/17*). That wish started to come true in 2021, the first year that office/other outpatient visits (**99202-99215**) were coded based on medical decision-making (MDM) or time.

However, you may have noticed that your providers continued to document that they reviewed 10 or more body systems for every patient, and you may be wondering if that is a problem.

Excessive ROS still a red flag

From a coding standpoint, the review of systems (ROS) can't influence the code for an office/other outpatient visit, so you don't need to worry that it will cause upcoding. Auditors must follow the guidelines that are in effect based on the date of service, so an auditor should not downcode claims for visits performed on or after Jan. 1, 2021, based on the ROS alone. Effective Jan. 1, 2023, you will not need to worry about the rest of the level-based codes because the MDM or time guidelines will apply to the remainder of the E/M suite.

However, a 14-point ROS for every patient might still be a cause for concern. For example, the treating provider could be wasting their time because they're in the habit of doing the work to justify a certain level of service.

The chart is also a clinical record, and an inaccurate record can have a negative impact on patient care.

"I think the risk now is not from coding but from a clinical perspective: Is it accurate?" says Betsy Nicoletti, CPC, president of North Andover, Mass.-based Medical Practice Consulting.

This isn't a new problem, and the novel coding system doesn't do away with the clinical risk. "We've all seen notes with the completely negative ROS which is contradicted in the [history of present illness] or the assessment and plan," Nicoletti says. "In the old system that was a problem for the level of service, but even more, how would the next practitioner who sees the patient know what was accurate in the ROS?"

In-depth ROS for each patient might also be a sign that providers are still using the 1995 or 1997 E/M documentation guidelines.

"I have just finished a 223-chart audit where I did not see the documentation change from the 1997 guidelines to the current 2022 ones," says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati.

The classic guidelines cannot be used for office/other outpatient visits. Continuing to use the 1995 or 1997 guidelines can not only cause improper coding, but also alert an external auditor from a Medicare administrative contractor (MAC) or private payer, who might assume that the practice doesn't care about compliance — or worse, that the practice is deliberately ignoring new guidelines. The first is a sign of abuse or waste; the second is a sign of fraud.

Confusing or out-of-date templates could also be tripping up providers. Electronic health record (EHR) systems had to run two operating systems in 2021 and 2022: The office/outpatient guidelines and the classic guidelines. Depending on how the EHR is set up, it could be easy for a provider to use the wrong template for their visits.

"I am certainly recommending that the templates get updated," Nicoletti says.

You should be prepared to work with your vendor on the next E/M update if you want a system that is ready to go by Jan. 1, 2023. For example, you could ask the vendor to remove the ROS checklist and replace it with an open comment box. And make sure the vendor understands that the classic guidelines should not be a choice for visits with a date of service after Dec. 31, 2022.

Use a few more training tips

If you feel you're still a bit behind on the new guidelines, you aren't alone. "I think many practices do not understand the new method of documentation," Lewis says.

When training providers, remind them that "the important items in the ROS and exam are those that contribute to the MDM," Lewis says. "However, sometimes the ROS has an item the provider wants to examine further and that may contribute to a new diagnosis or MDM." This should be in the history of present illness or chief complaint, Lewis adds.

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You also should emphasize the fact that if they use the guidelines it should reduce their workload. "The AMA has tried to ease the problem of chart notes as related to coding and reimbursement but it hasn't worked so far. More education is needed," Lewis says. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Compliance

Not fine: Jail threat in compounded drug HIPAA breach serves warning

A doctor faces a year in prison on HIPAA violation charges — a rare but real threat when prosecutors find providers or other health care workers flouting protected health information (PHI) rules in a way that calls for more than the usual fines and sanctions.

While the bar for this is pretty high, you should take care to reduce your chances, especially if you're involved in a practice that may have a high likelihood of official scrutiny — such as those involved in the prescription of compounded drugs.

Behind the HIPAA breach

On Oct. 6, 2022, the U.S. Attorney for New Jersey announced that Frank Alario had pleaded guilty to "conspiracy to wrongfully obtain and disclose individually identifiable health information." At sentencing, he faces up to a year in jail and a $50,000 fine.

Alario was originally charged along with pharmaceutical executive Keith Ritson on several counts, including conspiracy to commit health care fraud and wire fraud and conspiracy to commit money laundering, as well as the HIPAA charge to which Alario has pleaded out.

The charges stemmed from the prescription of compounding drugs, which are drugs custom-made by pharmacists, usually at specialty pharmacies, to alter off-the-shelf prescriptions for the clinical needs of a particular patient.

Alario, an internist with offices in New Jersey, Florida and New York, worked with Ritson, founder of the now-defunct Life Sciences Medical LLC, and the unindicted but named co-conspirator William Hickman, a pharmaceutical representative, to receive these drugs from Central Rexall, a retail pharmacy in Louisiana which is now out of business. The CEO of Central Rexall pleaded guilty to conspiracy to commit fraud in 2020.

While compounding drugs is a legitimate practice, the HHS Office of Inspector General (OIG) has had its eye on such prescriptions in recent years and, noting a "significant growth in spending" in that area, has a work plan item on the subject with a report due in 2023.

The original complaint alleges that Alario and Ritson conspired to fraudulently obtain "thousands of dollars for an individual's one-month supply of certain prescription medications" from the pharmacy benefits manager of a local public employees' health benefit plan. Further, Alario "signed prescriptions for the individuals without examining, meeting or consulting with them prior to authorizing the prescriptions," according to the complaint.

Alario also allowed Ritson "to have access to patients' confidential, individually identifiable health information or protected health information." In some instances, Alario introduced Ritson to some patients as his nephew in order to give the impression "that [Ritson] was an employee or affiliated with the medical practice," under which guise he could obtain further PHI, prosecutors further allege.

Compounding the problem?

Again, compounding drugs is generally legitimate and can be genuinely useful. However, Ryan O'Neill, a partner with the Riker Danzig LLP law firm in Morristown, N.J., understands how the practice might invite misuse and arouse suspicion among regulators and prosecutors

"First of all, they're not FDA approved, so you have doctors trying to get familiar with compound pharmacies that can be hard to vet," O'Neill says. "It can even be hard to ensure that the prescriptions are actually going to the compound pharmacies they think they're going to. So [providers] have to rely on the reps."

In such cases, representatives can be very helpful, says Joey Mattingly, PharmD, associate professor of practice, science and health outcomes research at the University of Maryland School of Pharmacy. That's particularly true if the rep is, or works with, a trained medical science liaison who can meaningfully advise on the compounding. "The pharmaceutical industry does a fantastic job of educating physicians," Mattingly says. "It's not always about selling the product."

O'Neill adds that compounds tend to be expensive and, since they're tailored for individual cases,

their medical necessity can be hard to explain. Take compounded creams with gabapentin or lidocaine, for example: "The decision to prescribe has to be incredibly well-documented: Why are we using this instead of an over-the-counter medication?" O'Neill says. "Medicare wants to know because they don't want to pay $2,000 for a cream you can get [for much less]. But maybe the doctor is prescribing it a lot because it's working for the patient because there's less irritation."

Which HIPAA breaches earn jail?

It remains to be seen whether Alario will go to prison. O'Neill notes that, in the superseding indictment, many of the fraud charges originally laid on both Alario and Ritson are missing, which suggests that he may have gotten out from under the worst of it. "I think it suggests this person might have fallen [in status] from a suspected heavy defendant in the case to a lesser participant," she says.

Most HIPAA charges of the sort the HHS Office for Civil Rights (OCR) churns out lead only to fines and agreements that the offender meet certain oversight targets (*PBN 4/25/22*). But "criminal HIPAA" charges that can earn actual prison sentences are a growing threat, O'Neill says.

Health care workers have been on notice that HIPAA violations can mean jail since 2010, when a former employee at the University of California at Los Angeles Health System (UCLA) who looked up celebrities' PHI was sentenced to four months and a $2,000 fine; the sentence was challenged but upheld by the U.S. Court of Appeals for the Ninth Circuit in 2012.

By statute, you can get up to 10 years in prison for criminal HIPAA violations. Generally jail-worthy HIPAA charges have had to do with egregious unmasking of PHI for money or out of malice. Joshua Hippler, a Texas hospital employee who got 18 months in prison in 2015 for obtaining "protected health information with the intent to use it for personal gain," is an example of the former; Dustin James Ortiz, an Iowa man who conspired to obtain his ex-partner's mental health records for "personal gain and malicious harm" and got 17 months in June 2022, is an example of the latter.

Criminal HIPAA is getting fresh looks, O'Neill thinks, in part because bringing those charges can be a prosecutor's "tool" to shake out information in health care fraud cases — "a lesser charge that might please both defense counsel and the government."

Don't go directly to jail

Nonetheless, you don't want to experience even the threat of so heavy a penalty, so take this advice:

- **Compounding? Be clear, keep it clean.** While pharma reps can be helpful to doctors, O'Neill warns that sometimes "there's a normalization that happens" in busy offices that can turn these relationships into something problematic.

"Office staff get complacent and allow assistance with paperwork for one particularly difficult patient, then suddenly, it's all patients," she says. "Again, who wouldn't want the help? Offices, especially those in pain management, deal with a very difficult patient group who, by the nature of their prescriptions, need them fast and without any hiccups in coverage."

Also, prescribers who write compounding orders ought to be extra clear in their note about why they're taking that route. "The decision to prescribe has to be incredibly well-documented," O'Neill says.

Before using a compounding pharmacy, "prescribers should conduct due diligence into the pharmacy's licenses and certifications, safety record and reputation for quality," says Andrew Wirmani, a partner in the Dallas office of Reese Marketos LLP. "They should also understand the environment in which drugs are being compounded and whether there have been contamination issues in the past."

Mattingly reminds you that you can visit public sources such as FDA's warning letters and violation notices library to see whether there are any issues with the prescriber your representative recommends (*see resources, below*).

- **Don't get sloppy about HIPAA risk.** Since the days of routine HIPAA audits, you may have eased off on your security risk assessment and other due diligence (*PBN 1/16/17*). Stephen Toland, an attorney with Ferguson Braswell Fraser Kubasta PC and head of the Austin office, suggests you revisit and tighten up: Make sure, for example, that you have a HIPAA officer on board who is "familiar with the criminal provisions of HIPAA and [can] maintain responsibility for ensuring consistent compliance throughout the practice."

And keep those business associate agreements (BAAs) up to date. Remember, there may be more than money at stake. — *Roy Edroso* (redroso@decisionhealth.com) ■

(continued on p. 6)

Benchmark of the week

Heaps of 'after-hours' codes reported, and all denied

Despite a non-payable status under Medicare, a series of six codes that reflect care provided during irregular or emergency hours garnered hundreds of thousands of claims – and returned zero dollars – in 2021.

Contained within the "special services, procedures and reports" section of the Medicine chapter in the CPT Manual, codes **99050**-**99060** are meant to cover services that occur during non-office hours, such as weekends and holidays, as well as services reported out of the office at the patient's request and other emergency services. They're accepted by a number of, but not all, commercial insurers.

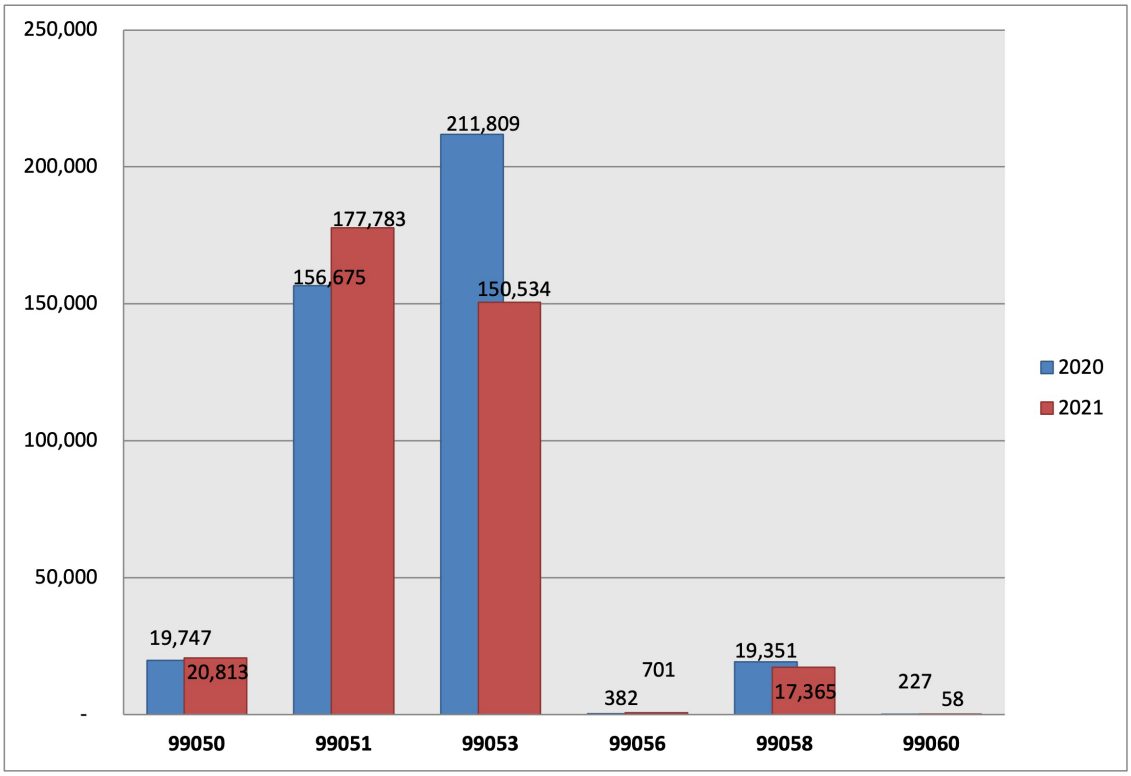
In 2021, practices reported code 99051 (Service[s] provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service) more than 177,700 times, an increase of the 157,000 claims for the service in 2020, according to the latest available Medicare claims data.

The prior-year leader, 99053 (Service[s] provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service), saw its claims drop from 211,800 in 2020 to 150,000 in 2021. Other codes, including 99050 (Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed [eg, holidays, Saturday or Sunday], in addition to basic service) and 99058 (Service[s] provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service), were reported about 20,000 times in 2021.

Out-of-office codes 99056 (Service[s] typically provided in the office, provided out of the office at request of patient, in addition to basic service) and 99060 (Service[s] provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service) had far fewer claims, peaking at 701 for 99056 in 2021.

Not a single claim was reimbursed under the Part B fee schedule in 2021. In 2020, a lone claim for 99051 slipped through the cracks, paying $40. Thirteen specialties reported at least 1,000 claims for 99051 in 2021, led by nurse practitioner (44,849 claims), family practice (40,575) and physician assistant (25,076). Despite their efforts, all claims went unpaid. – *Richard Scott* (rscott@decisionhealth.com)

Utilization of 'after-hours' codes, 2020-2021



Source: Part B News *analysis of 2020-2021 Medicare claims data*

(continued from p. 4)

RESOURCES

- FDA's warning letters and violation notices library: www.fda.gov/drugs/enforcement-activities-fda/warning-letters-and-notice-violation-letters-pharmaceutical-companies
- DOJ, "Physician and Sales Representative Charged in $2.5 Million Health Care Fraud and with Unlawful Disclosure of Patient Information," Sept. 10, 2020: www.justice.gov/usao-nj/pr/physician-and-sales-representative-charged-25-million-health-care-fraud-and-unlawful
- DOJ, "Doctor Admits Criminal HIPAA Scheme for Wrongful Disclosure of Protected Patient Health Information to Pharmaceutical Sales Representative," Oct. 7, 2022: www.justice.gov/usao-nj/pr/doctor-admits-criminal-hipaa-scheme-wrongful-disclosure-protected-patient-health

Coding

Look for severity of dementia to discern ICD-10-CM code selection

Coders must review updates to the ICD-10-CM code set to stay current, and for 2023 you will find several new codes in the "Mental, Behavioral, and Neurodevelopmental Disorders" chapter for dementia.

According to the Centers for Disease Control and Prevention (CDC), a diagnosis of dementia is not specific, but mentions the traits of impaired memory, thinking, or decision-making, especially when these lapses interfere with everyday activities. This is not a normal process of getting older, but rather an issue of blood flow to the brain.

The 2023 ICD-10-CM update, effective Oct. 1, includes new codes and guidance in the following categories:

- **F01** (Vascular dementia).
- **F02** (Dementia in other diseases classified elsewhere).
- **F03** (Unspecified dementia).

Currently, physician documentation only needs to confirm the diagnosis of dementia and whether the patient is exhibiting behavioral disturbances. For example, coders have options to report dementia with and without behavioral disturbance using ICD-10-CM codes **F01.50** (Vascular dementia without behavioral disturbance) and **F01.51** (Vascular dementia with behavioral disturbance).

The most common behavioral disturbance reported in patients with vascular dementia is wandering. This behavior is reported separately using code **Z91.83** (Wandering in diseases classified elsewhere). Other behavioral disturbances may be documented, such as anxiety, psychosis, agitation, aggression, disinhibition or sleep disturbances. When the physician's notes identify any of these additional diagnoses, they must also be reported.

Identify 2023 ICD-10-CM updates

Effective Oct. 1, 2022, coders will be able to report codes for dementia with behavioral symptoms such as:

- F01.50 (Vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety).
- **F01.511** (Vascular dementia unspecified severity, with agitation).
- **F01.518** (Vascular dementia, unspecified severity, with other behavioral disturbance).
- **F01.52** (Vascular dementia, unspecified severity, with psychotic disturbance).
- **F01.53** (Vascular dementia, unspecified severity, with mood disturbance).
- **F01.54** (Vascular dementia, unspecified severity, with anxiety).

These new codes require the physician to document the severity of the dementia (unspecified, mild, moderate, or severe), as well as whether behavioral disturbances are identified.

Effective Oct. 1, coders may report the following new codes for mild dementia:

- **F01.A0** (Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood, disturbance, and anxiety).
- **F01.A11** (Vascular dementia, mild, with agitation).
- **F01.A18** (Vascular dementia, mild, with other behavioral disturbance).
- **F01.A2** (Vascular dementia, mild, with psychotic disturbance).

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

- **F01.A3** (Vascular dementia, mild, with mood disturbance).
- **F01.A4** (Vascular dementia, mild, with anxiety).

Coders must carefully review encounter notes to find supporting details. Patients diagnosed with mild dementia have begun to experience memory lapses. They will find daily activities, such as paying the bills, more challenging. These individuals find discussing their thoughts and ideas more difficult, and family may determine that some assistance is necessary.

New codes for moderate dementia are:

- **F01.B0** (Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood, disturbance, and anxiety).
- **F01.B11** (Vascular dementia, moderate, with agitation).
- **F01.B18** (Vascular dementia, moderate, with other behavioral disturbance).
- **F01.B2** (Vascular dementia, moderate, with psychotic disturbance).
- **F01.B3** (Vascular dementia, moderate, with mood disturbance).
- **F01.B4** (Vascular dementia, moderate, with anxiety).

For these patients, a caregiver is required. The patient struggles with increased memory loss, as well as sleep interruptions resulting in napping during the day, restlessness, and sundowning (cognitive abilities decline as it gets later in the day).

Friends and family will notice a dramatic change in the patient's personality as they exhibit suspicion, lack of trust of others and increased irritability. Further, the patient will need help with their activities of daily living (ADL), which include the ability to change their clothing, take a shower, or comb their hair.

Patients with severe dementia have experienced considerable cognitive decline. They have difficulty performing ADLs, as well as with functional mobility. Bladder and bowel function control may be lost and patients are at heightened risk of infections, including pneumonia and influenza. Affected individuals require daily, and often continuous, assistance. New codes for severe dementia are:

- **F01.C0** (Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood, disturbance, and anxiety).
- **F01.C11** (Vascular dementia, severe, with agitation).
- **F01.C18** (Vascular dementia, severe, with other behavioral disturbance).
- **F01.C2** (Vascular dementia, severe, with psychotic disturbance).
- **F01.C3** (Vascular dementia, severe, with mood disturbance).
- **F01.C4** (Vascular dementia, severe, with anxiety).

Coders will find that two code categories have been expanded in the same structure as F01:

- **F02** (Dementia in other diseases classified elsewhere).
- **F03** (Unspecified dementia).

The 2023 ICD-10-CM Official Guidelines for Coding and Reporting include the addition of guidance for these combination codes, including the directive: "Selection of the appropriate severity level requires the provider's clinical judgment and codes should be assigned only on this basis of provider documentation."

Given that the updates have taken effect, now is the time to speak with your providers and educate them on these new requirements for specific details relating to dementia diagnoses.

Physicians know, more than anyone else, how important complete documentation is for the continuity of care. In addition, these details will help the patient and their family access resources through government and community agencies. Also, remember that coding with accurate specificity is required to ensure accurate reimbursement.

Diagnostic testing to determine a diagnosis of vascular dementia or other types of cognitive decline will typically include lab tests including serum cholesterol (CPT code **82465**), blood sugar (CPT code **82947**), and thyroid stimulating hormone (CPT code **84443**).

Imaging of the brain such as computed tomography (CT) scans (such as those reported with CPT codes **70450**, **70460** or **70470**) and/or a magnetic resonance imaging (MRI) (like for CPT codes **70551**, **70552** or **70553**) are often ordered, as well. Neuropsychological testing is often administered to help determine specific characteristics of different types of dementia (such as the disorders described by CPT codes **96132**, **96136**, **96138** or **96146**). — *Shelley C. Safian, PhD, RHIA, CCS-P, COC, CPC-I* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: *Shelley C. Safian, PhD, RHIA, CCS-P, CPC-H, CPC-I, of Safian Communications Services Inc. in Longwood, Fla., is an AHIMA-approved ICD-10-CM/PCS trainer who has been teaching for over a decade. Opinions expressed do not necessarily reflect those of HCPro, DecisionHealth or any of its subsidiaries.*

Ask Part B News

'After-hours' codes can add dollars, and so can 'during-hours' codes

Question: *One of our commercial payers offers extra payment from the add-on codes* ***99050*** *(Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed [eg, holidays, Saturday or Sunday], in addition to basic service) and* ***99051*** *(Service[s] provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service). I get the first code, but the second one just sounds like normal service during normal hours. What's the deal?*

Answer: Not all payers reimburse for these codes — Medicare certainly doesn't, though thousands of providers present claims for them to Medicare every year (*see benchmark, p. 5*). But of the payers that do, most include both, and while the first is self-evident the second needs some explanation.

You are likely to use 99051 when practices that have fairly normal operating hours (e.g. 9:00 a.m. to 5:00 p.m.) have been encouraged by the payer to expand their "regular" hours to accept patients at later or earlier times. The add-on code might be offered as an incentive to do so.

"Many practices save time blocks for unscheduled visits," says Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC emeritus, of Enos Medical Coding in Ft. Myers, Fla.

For example, orthopedic practices may, if the payer makes it worth their while, have physician assistants or nurse practitioners see injured patients on a walk-in basis. "If this is during their 'regularly scheduled office hours,' then the after-hours codes would not be reimbursable," Enos says.

Also, "99051 might be reimbursable if the payer contracts with primary care practices to encourage them to be available and extend office hours to evening, weekend and holidays to keep patients out of the emergency department for low-risk illness or injuries," Enos adds.

The payer may have made a calculation that chipping in extra for 99051 will save them money on steep hospital charges, while also saving the beneficiaries money, says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati. "If the patient goes to the ER or urgent care, his copayment is so much higher."

A 2007 story in DecisionHealth's Pediatric Coder's Pink Sheet reported that "many coders erroneously assume that after-hours codes are used only when your office is closed, when the pediatrician has to physically unlock the office." But according to orthopedic coding consultant Margie Scalley Vaught, CPC, COC, CCS-P, MCS-P, ACS-EM, ACS-OR, CPT guidelines for the code changed in 2006.

A 2010 edition of CPT Assistant reports that before 2006, "code 99050 described 'services requested after posted hours in addition to basic service.'" But "for 2006, code 99050 was revised" to its current definition, and 99051 was added "to delineate practices that regularly provide services at times other than regular daytime business hours … while the meaning of code 99050 remained essentially the same (ie, to describe services provided outside of regularly scheduled hours and during unscheduled weekend and holiday hours), the wording of the code was revised to provide clear differentiation from services described in code 99051."

Note: There are other time-and-place-specific codes in this series that commercial payers may reimburse, one of which, **99053** (Service[s] provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service), providers actually submit more often to Medicare — again, without getting paid — than 99050 or 99051.

Much less used are **99056** (… ; provided out of the office at request of patient, in addition to basic service), **99058** (… ; provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service), and **99060** (Service[s] provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service). — *Roy Edroso* (*redroso@decisionhealth.com*) ■