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JUNE 2021

Coding&Billing Quarterly

Editor's Letter

Welcome to the June edition of the ATS Coding and Bill Quarterly. In this edition you will finding coding guidance on how to report treating patients with long haul COVID-19 symptoms, a comprehensive article from our colleagues at the American Lung Association about state-based coverage for smoking cessation programs, and lots of answers to member questions.

After 13 years of service, I am stepping down as editor of the ATS Coding and Billing Quarterly newsletter (CBQ). The concept of the ATS CBQ was developed by the ATS Clinical Practice Committee, approved by the ATS (thanks to Gary Ewart) and published initially in 2007. Since that time, it has been nourished by the Advisory Board Members, Clinical Practice Committee members, Gary Ewart and the ATS advisory staff, initially with Diane Krier-Morrow, MPH and more recently with Denise Merlino. Their input has driven the quality and accuracy of the CBQ. I had hoped that this newsletter would help our members and their staff code and bill for pulmonary, critical care and sleep services more accurately, with clarity and confidence. Based on the feedback I have received over the years, this newsletter has been helpful to many members in improving their coding and billing practices. It has been my privilege and pleasure to work with both colleagues and staff to create a newsletter that provides valuable information to our members. The success of the CBQ is due to their amazing efforts.

I am pleased to share with you that the new editor of the newsletter is my colleague Katina Nicolacakis, MD, from the Cleveland Clinic and long-time member of the Joint ATS/CHEST Clinical Practice Committee. I am confident that Dr. Nicolacakis will provide a fresh perspective, new features and generally continue the fine tradition of the ATS Coding and Billing Quarterly. I know I leave this publication in competent and loving hands. It has been one of the highlights of my career serving as the inaugural editor of the ATS Coding and Billing Quarterly.

Sincerely,

Alan L. Plummer MD
Editor (one last time), ATS Coding and Billing Quarterly

IN THIS ISSUE

Diagnostic Coding in the Post-COVID Era

Amy M. Ahasic, MD, MPH

In the last year, the CDC has developed new ICD-10-CM codes to capture more information about COVID-19 through claims and other surveillance data (https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-19-508.pdf). Additional up to date coding guidance related to COVID-19 is available from the American Hospital Association (AHA) (https://www.aha.org/system/files/media/file/2020/03/Frequently-Asked-Questions-Regarding-COVID-19_v3.pdf).The newly developed ICD-10-CM codes include:

- COVID-19 (**U07.1**)
- Encounter for screening for COVID-19 (**Z11.52**)
- Contact with and (suspected) exposure to COVID-19 (**Z20.822**)
- Personal history of COVID-19 (**Z86.16**)
- Multisystem inflammatory syndrome (MIS) (**M35.81**)
- Other specified systemic involvement of connective tissue (**M35.89**)
- Pneumonia due to coronavirus disease 2019 (**J12.82**)

More and more patients with a history of COVID-19-related disease and symptoms are being seen in outpatient practices. Many centers are building post-COVID clinics for "long-haulers" with ongoing symptoms. Questions are arising as to what diagnostic codes to use for these patients. There is currently no code for Post-Acute COVID-19 Syndrome, or PACS, as Dr. Fauci has dubbed it, although the World Health Organization (WHO) has created code **U09.9** (Post COVID-19 condition, unspecified) which is being proposed for adoption into ICD-10-CM used in the United States. This may occur later in 2021 but has NOT yet been adopted and should not be used. Thus, coding must use current symptoms or other identifiable diagnoses (e.g. dyspnea, or interstitial lung disease). Also, it is important that providers NOT use the code **U07.1** (COVID-19) outside of acute active COVID-19 disease, although asymptomatic patients who test positive would be appropriately coded using **U07.1**. For patients who are suspected to have COVID-19, but without confirmed diagnosis, then **Z20.822** (Contact with and (suspected) exposure to COVID-19) can be used, and can be coded in conjunction with symptoms such as fever, cough, etc. The **Z20.822** code can also be used for an encounter for testing of an asymptomatic patient with actual or suspected exposure to COVID-19. This is an updated code to be used for encounters after January 1, 2021, and thus replaces prior guidance to use **Z20.828** (Contact with and (suspected) exposure to other viral communicable diseases). Be careful not to use **B34.2** (Coronavirus infection) as this is an unspecified code, and COVID-19 infection and its sequelae should be specified. For post-acute patients, **Z86.16** (Personal history of COVID-19) can be used along with any other appropriate symptoms or disease entities for encounters after January 1, 2021. Encounters prior to 2021 would use **Z86.19** (Personal history of other infectious and parasitic diseases). Per guidance from the AHA, if the provider specifically documents that symptoms are the result (residual effect) of COVID-19, then coding for the specific symptoms in additional to coding for **B94.8** (Sequelae of other specified infectious and parasitic diseases) should be used rather than **Z86.16**. If a patient has multisystem inflammatory syndrome (MIS) related to COVID-19 in the acute setting, then the primary code should be **U07.1** with secondary code of **M35.81**. If MIS develops as a result of a previous COVID-19 infection, assign codes **M35.81** (Multisystem inflammatory syndrome) and **B94.8** (Sequelae of other specified infectious and parasitic diseases). If an individual with a history of COVID-19 develops MIS and the provider does not indicate the MIS is due to the previous COVID-19 infection, assign codes **M35.81** and **Z86.16** (Personal history of COVID-19).

The **M35.89** code for "Other specified systemic involvement of connective tissue" is without much specific guidance from CDC and should be used at the provider's discretion.

Navigating Tobacco Cessation Coverage Variations by State

Anne DiGiulio - National Director | Lung Health Policy American Lung Association

Ranjana Kodwani, MPH – National Specialist | Cessation Policy American Lung Association

The Affordable Care Act (ACA) recognizes the importance of prevention by requiring most health plans, including any Medicaid expansion plan and any plan sold in the exchange, to cover any treatment or intervention that earns an "A" or "B" grade by the United States Preventive Services Task Force (USPSTF). Tobacco cessation for non-pregnant adults receives an "A" for both pharmacotherapy and behavioral interventions and is required to be covered without cost-sharing in those plans. This includes the seven Food and Drug Administration (FDA)-approved medications *(NRT Gum, NRT Patch, NRT Lozenge, NRT Nasal Spray, NRT Inhaler, Bupropion and Varenicline)* and the three forms of counseling *(Individual, group and phone. Coverage of quitline services is one way to cover phone counseling).*

The American Lung Association collects and publishes data on tobacco cessation coverage in state Medicaid programs and state employee health plans (State Tobacco Cessation Coverage Database). The Lung Association has also analyzed tobacco cessation coverage data on plans sold on the healthcare.gov exchange (Exchange Data, 2020).

The standard Medicaid coverage data (as of April 1, 2021) show that 42 state Medicaid programs cover all seven FDA–approved cessation medications for all standard Medicaid enrollees. However only 13 of those state Medicaid programs cover individual, group and phone counseling for all standard Medicaid enrollees. Additionally, all but four state Medicaid programs impose at least some barriers to access cessation treatment.

All plans sold in either state-based exchange or the federally facilitated exchange should also be covering a comprehensive benefit without cost-sharing. In 2020, the American Lung Association collected tobacco cessation coverage data on plans sold in the federally facilitated exchange in 35 states. These data showed that most states had plans covering all seven FDA-approved cessation medications (22 states out of 35 states on healthcare.gov). Plans in 29 states indicated they had coverage of counseling but did not specify what type of counseling was covered. As for barriers, 32 out of 35 states covered at least some cessation medications without cost-sharing and 31 states covered at least some cessation medications without prior authorization.

Despite robust requirements for tobacco cessation treatment, Smoking Cessation: A Report of the Surgeon General found that only four out of nine smokers received advice from a healthcare provider to quit. Part of this might be due to the variation in coverage both between types of health plans and within types of health plans.

There are lessons for clinicians surrounding the variability of coverage for public health plans as well. Although most plans require some level of coverage, those requirements vary. For example, Medicare does not cover any over-the-counter (OTC) medications, including the NRT Gum, NRT Patch or NRT Lozenge. Medicaid programs and most private insurance plans do cover all seven medications, however, the OTC medications need a prescription, so a patient can get them without cost-sharing. Additionally, standard Medicaid enrollees might need a prior authorization or have required counseling that needs to be documented prior to accessing the medication.

Considerations Specific to Medicaid

Individuals enrolled in standard Medicaid can still face cost-sharing for tobacco cessation medications, while their counterparts enrolled in Medicaid expansion and private health insurance do not face that barrier, per ACA regulations. Fourteen states impose cost-sharing for some or all standard Medicaid enrollees. State Medicaid programs often impose annual and duration limits on tobacco cessation treatment, meaning only paying for treatment with a set number of quit attempts per year, often just two.

Thirteen states impose a limit on the number of prescriptions that Medicaid enrollees can fill per month.[1] Most states provide the ability to override this limit, but it would require more work on the part of the provider. Some state Medicaid programs limit the types of providers who can either bill for tobacco cessation counseling or prescribe cessation medication. It is important to be aware of these limitations and barriers when treating patients with tobacco dependence.

Considerations for Private Insurance

Most private insurance plans, including any plan sold in the exchange are required to cover a comprehensive cessation benefit without cost-sharing. However, there are many non-compliant health plans that do not have to provide this coverage.

An example of a non-compliant health plan is a grandfathered health plan. While these plans are very rare on the individual market, data show that 13% of workers in employer-sponsored insurance (ESI) are in a grandfathered plan and approximately 22% of companies offering ESI had at least one grandfathered plan. This means that new employees could move from a compliant health plan to a grandfathered plan that is not required to cover preventive services, including tobacco cessation treatment.[2]

The Tax Cuts and Jobs Act of 2017 reduced the penalty for not having ACA-compliant insurance to $0. This coupled with changes to regulations around short-term, limited-duration plans (STLD) and association health plans have created an environment for non-ACA compliant health plans to grow. Most of these plans, along with healthcare sharing ministries and farm bureau plans have no requirement to cover tobacco cessation treatment and many do not. Unfortunately, patients often are unaware their coverage is not comprehensive when purchasing these non-compliant health plans.

The other factor that may be influencing patients is the tobacco surcharge. Patients may face higher premiums due to their tobacco use and may try to quit or participate in a quit program to avoid a surcharge. States can limit or prohibit the surcharge, and some do.[3]

In addition to covering tobacco cessation treatment, payors are now doing more to incentivize providers to treat tobacco dependence. For example, the National Quality Forum (NQF) Measure #0028: Tobacco Use Screening and Cessation Intervention is included in the Core Quality Measures Collaborative (CQMC) Accountable Care Org/Patient-Centered Medical Homes/Primary Care core set; Behavioral Health core set: and the Cardiology core set.[iv] These core sets can be used by private and government payors as they move to value-based payments. As the United States continues to shift to paying for value in healthcare as opposed to paying for volume, incentivizing cessation can improve health outcomes for numerous comorbidities.

There are many nuances to tobacco cessation coverage in the United States, which in turn creates challenges in billing and reimbursing for these important services. Variation in coverage across types of insurance plans adds to these challenges but ultimately, treating tobacco dependence will reduce morbidity and mortality among patients. And most health plans – both private and public offer at least some coverage of cessation treatment.

Below are tables with state-by-state information about state standard Medicaid program's tobacco cessation coverage. These tables should help you and your patients understand the coverage tobacco cessation benefit in your state. Additional information on cessation coverage can be found at www.lung.org/policy-advocacy/tobacco/cessation/state-cessation-coverage.

State Medicaid Programs Coverage of Tobacco Cessation Counseling for Standard Medicaid Enrollees, April 2021
(Continued on next page)

State	Group Counseling	Individual Counseling	Phone Counseling
Alabama	No	P	Yes
Alaska	No	Yes	No
Arizona	Varies	No	Yes
Arkansas	No	Yes	No
California	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes
Delaware	Yes	Yes	No
District of Columbia	No	Yes	No
Florida	Varies	Yes	Yes
Georgia	Varies	Varies	Varies
Hawaii	Varies	Yes	Varies
Idaho	No	Yes	No
Illinois	No	Varies	No
Indiana	Varies	Varies	Yes
Iowa	No	Varies	Yes

State Medicaid Programs Coverage of Tobacco Cessation Counseling for Standard Medicaid Enrollees, April 2021 *(Cont'd)*

State	Group Counseling	Individual Counseling	Phone Counseling
Kansas	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes
Louisiana	Varies	Varies	Yes
Maine	Yes	Yes	Yes
Maryland	Varies	Varies	Varies
Massachusetts	Yes	Yes	Yes
Michigan	Varies	Yes	Yes
Minnesota	Yes	Yes	Varies
Mississippi	No	P	Varies
Missouri	Yes	Yes	Yes
Montana	No	Yes	Yes
Nebraska	No	Yes	Yes
Nevada	Varies	Varies	Varies
New Hampshire	Varies	Varies	Varies
New Jersey	Varies	Varies	Varies
New Mexico	Varies	Varies	Varies
New York	Yes	Yes	Varies
North Carolina	No	Yes	Yes
North Dakota	Yes	Yes	Yes
Ohio	Yes	Yes	Yes
Oklahoma	No	Yes	Yes
Oregon	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Varies
Rhode Island	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes
South Dakota	No	P	No
Tennessee	Varies	Varies	No
Texas	Varies	Yes	Varies
Utah	Varies	Yes	Varies
Vermont	No	Yes	No
Virginia	No	Varies	No
Washington	No	Varies	Varies
West Virginia	Varies	Varies	Varies
Wisconsin	Yes	Yes	No
Wyoming	No	Yes	No

Yes – Treatment is covered for all standard Medicaid enrollees;

Varies – Coverage of treatment varies by plan or pregnancy status;

No – Treatment is not covered for any standard Medicaid enrollee in the states;

P – Covered for pregnant women only.

Yes	18	33	24
Varies	16	14	15
No	17	1	12
Pregnant Women Only	0	3	0

State Medicaid Programs Coverage of Tobacco Cessation Medications for Standard Medicaid Enrollees, April 2021

(Continued on next page)

State	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Inhaler	NRT Lozenge	Varenicline (Chantix)	Bupropion (Zyban)
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	Yes	No	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	Yes	Yes	Yes	Yes
California	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Delaware	Yes	Yes	Yes	Yes	Yes	Yes	Yes
District of Columbia	Yes	Yes	Varies	Varies	Yes	Yes	Yes
Florida	Varies	Varies	Varies	Varies	Varies	Varies	Varies
Georgia	Varies	Yes	Varies	Varies	Varies	Varies	Yes
Hawaii	Yes	Yes	Varies	Varies	Varies	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Minnesota	Yes	Yes	Varies	Varies	Yes	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Missouri	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Montana	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nevada	Varies	Varies	Varies	Varies	Varies	Varies	Yes
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes
South Dakota	No	No	No	No	No	Yes	Yes
Tennessee	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Texas	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes	Yes	Yes	Yes

State Medicaid Programs Coverage of Tobacco Cessation Medications for Standard Medicaid Enrollees, April 2021
(Cont'd)

State	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Inhaler	NRT Lozenge	Varenicline (Chantix)	Bupropion (Zyban)
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	Varies	Varies	Yes	Yes	Yes
Washington	Yes	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wyoming	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	47	48	43	42	46	48	50
Varies	3	2	7	7	4	3	1
No	1	1	1	2	1	0	0

Yes – Treatment is covered for all standard Medicaid enrollees;

Varies – Coverage of treatment varies by plan or pregnancy status;

No – Treatment is not covered for any standard Medicaid enrollee in the states;

P – Covered for pregnant women only.

State Medicaid Programs Barriers to Tobacco Cessation Treatment for Standard Medicaid Enrollees, April 2021
(Continued on next page)

State	Annual limits	Limits on duration	Prior authorization required	Co-payments required	Stepped-care therapy required	Counseling Required for Medications	Dollar Limit	Lifetime limits
Alabama	Yes	Yes	Yes	Yes	No	Yes	No	No
Alaska	Yes	Yes	Yes	Yes	No	No	No	No
Arizona	Varies	Yes	No	Varies	No	No	No	No
Arkansas	No	No	No	No	No	No	No	No
California	Varies	Varies	Varies	No	Varies	No	Varies	No
Colorado	Yes	Yes	No	No	No	Yes	No	No
Connecticut	Yes	Yes	Yes	No	No	No	No	No
Delaware	No	No	No	No	Yes	No	No	No
District of Columbia	Varies	Varies	Varies	No	No	No	No	No
Florida	Yes	Yes	Varies	No	No	No	No	No
Georgia	Varies	Varies	Varies	Yes	Varies	Varies	No	No
Hawaii	Yes	Varies	Varies	No	Varies	Varies	No	No
Idaho	Yes	Yes	Yes	No	Yes	Yes	No	No
Illinois	Varies	Varies	No	Varies	No	No	No	No
Indiana	Varies	Varies	No	No	Varies	Yes	No	No
Iowa	Yes	Yes	No	No	Yes	Yes	No	No
Kansas	Yes	Yes	No	No	No	No	No	No

State Medicaid Programs Barriers to Tobacco Cessation Treatment for Standard Medicaid Enrollees, April 2021

(Continued on next page)

State	Annual limits	Limits on duration	Prior authorization required	Co-payments required	Stepped-care therapy required	Counseling Required for Medications	Dollar Limit	Lifetime limits
Kentucky	No	No	No	No	No	No	No	No
Louisiana	Varies	Varies	Yes	No	No	Yes	No	No
Maine	No	No	Yes	No	Yes	No	No	No
Maryland	Yes	Yes	Yes	No	Yes	No	No	No
Massachusetts	Yes	Yes	Varies	No	Varies	No	No	No
Michigan	Varies	Varies	No	No	No	No	No	No
Minnesota	No	Varies	Yes	No	No	No	No	No
Mississippi	Varies	Varies	Yes	Varies	No	No	No	No
Missouri	No	No	No	No	No	No	No	No
Montana	Yes	Yes	Yes	No	No	No	No	No
Nebraska	Yes	Yes	Varies	Varies	No	Varies	No	No
Nevada	No	No	Varies	No	No	No	No	No
New Hampshire	Varies	Varies	Varies	Varies	Varies	No	No	No
New Jersey	Varies	Varies	Varies	No	No	No	No	No
New Mexico	Varies	Varies	No	No	No	Varies	No	No
New York	No	No	No	Varies	No	No	No	No
Kansas	Yes	Yes	No	No	No	No	No	No
Kentucky	No	No	No	No	No	No	No	No
Louisiana	Varies	Varies	Yes	No	No	Yes	No	No
Maine	No	No	Yes	No	Yes	No	No	No
Maryland	Yes	Yes	Yes	No	Yes	No	No	No
Massachusetts	Yes	Yes	Varies	No	Varies	No	No	No
Michigan	Varies	Varies	No	No	No	No	No	No
Minnesota	No	Varies	Yes	No	No	No	No	No
Mississippi	Varies	Varies	Yes	Varies	No	No	No	No
Missouri	No	No	No	No	No	No	No	No
Montana	Yes	Yes	Yes	No	No	No	No	No
Nebraska	Yes	Yes	Varies	Varies	No	Varies	No	No
Nevada	No	No	Varies	No	No	No	No	No
New Hampshire	Varies	Varies	Varies	Varies	Varies	No	No	No
New Jersey	Varies	Varies	Varies	No	No	No	No	No
New Mexico	Varies	Varies	No	No	No	Varies	No	No
New York	No	No	No	Varies	No	No	No	No
North Carolina	Yes	Yes	Yes	No	Yes	No	No	No
North Dakota	No	Yes	No	No	No	No	No	No
Ohio	Yes	Yes	No	No	No	No	No	No
Oklahoma	Yes	Yes	No	No	No	No	No	No
Oregon	Varies	Varies	Varies	No	Varies	No	No	No
Pennsylvania	Varies	Varies	Varies	No	Varies	No	No	No
Rhode Island	Varies	Varies	Varies	No	Varies	No	No	No
South Carolina	Yes	Yes	No	No	No	No	No	No
South Dakota	No	No	No	Yes	No	No	No	No
Tennessee	Yes	Yes	Yes	Yes	Yes	No	No	No
Texas	Varies	Varies	Yes	No	No	No	Varies	No
Utah	Varies	Varies	Varies	Varies	No	No	No	No
Vermont	Yes	Yes	Yes	No	Yes	No	No	No
Virginia	No	No	Varies	Varies	No	No	No	No

State Medicaid Programs Barriers to Tobacco Cessation Treatment for Standard Medicaid Enrollees, April 2021
(Cont'd)

State	Annual limits	Limits on duration	Prior authorization required	Co-payments required	Stepped-care therapy required	Counseling Required for Medications	Dollar Limit	Lifetime limits
Washington	Varies	No	No	No	Yes	No	No	Varies
West Virginia	Yes	Yes	Yes	No	Yes	Yes	No	No
Wisconsin	No	No	No	No	No	No	No	No
Wyoming	Yes	Yes	No	Yes	No	No	No	No
Yes	21	22	15	6	10	7	0	0
Varies	18	18	15	8	9	4	2	2
No	12	11	21	37	32	40	49	50

Yes – Treatment is covered for all standard Medicaid enrollees;

Varies – Coverage of treatment varies by plan or pregnancy status;

No – Treatment is not covered for any standard Medicaid enrollee in the states;

P – Covered for pregnant women only.

References

1. Kaiser Family Foundation. State Medicaid Prescription Limits. July 1, 2019. Accessed at: https://www.kff.org/other/state-indicator/state-medicaid-prescription-limits/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
2. Kaiser Family Foundation. 2019 Employer Health Benefits Survey, Chapter 13: Grandfathered Health Plans. September 25, 2019. Accessed at: https://www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/
3. Quality Forum. CQMC Core Sets. ND. Accessed at: http://www.qualityforum.org/CQMC_Core_Sets.aspx

Questions and Answers Medical Decision Making

QUESTION: My coding department and I are having a disagreement about ability to count ordering of certain test done in the office toward our MDM. We agree that interpretation and independent review cannot be counted; but I am being told that the ordering of the test cannot be counted either.

A patient is seen in our office and a PFT is ordered for a future day. The PFT is done in our office and interpreted by me. With the MDM rules, can I count the ordering of the PFT (1 point) towards MDM on the day of the visit? Are the rules different if the PFT is done on the same day?

ANSWER: The ordering of a test (such as an X-Ray or PFT) can be counted toward MDM in our opinion. It may be counted if on the same day or on a different day of the visits, as long as it is part of the MDM of that visit and in the window of the visit. We agree that if you are interpreting a test you have ordered you may not count it towards the visit as that would be double counting.

Below are a few good resources for the 2021 E/M guidelines as follows:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Evaluation-and-Management-Visits

Fact Sheet

https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

PFT Interpretation

QUESTION: When a PFT is ordered, does the interpreting physician bill with the test ordered diagnosis or the diagnosis of the actual interpreted test?

ANSWER: In general, it is acceptable to code using the results of any test if the test is definitive. If the test is not definitive or the test is negative, use the ordering reason for the test supplied by the ordering physician.

More information can be found on selection of ICD-10-CM coding at https://www.cms.gov/medicare/icd-10/2021-icd-10-cm

COVID Chart Review

QUESTION: During the Covid-19 surge, can I bill if I review a hospital chart and talk to the referring physician about recommendations but do not do a history or physical exam?

ANSWER: Interprofessional telephone/Internet/electronic health record consultation codes 99446-99449 may be used in this situation. These services require no direct patient contact, are time-based (at least 5 min) and require both a verbal and written report from the consultant to the treating/requesting provider. They may be used for both new and established patients. However they may not be used if the consultant has seen the patient within the last 14 days or if the interaction leads to a transfer of care or other face-to-face service within the next 14 days or next available appointment. They may be reported only once in a 7 day period, and <50% of the time must be devoted to data collection. If more than 50% of the time is devoted to data review or analysis, you may use 99451 instead with a minimum of 5 min. 99451 may be asynchronous and requires only a written report to the consulting provider. Additionally, remember you may also use the traditional inpatient initial or subsequent services (99221-3 or 99221-3) for virtual care if you are able to see the patient (on video, or through a window or from the door) and elicit a history and virtual exam.