AAPC of Kansas City WPS Education Day

Member Questions

03/14/2024

Q1: Where can we find the documentation requirements for group psychotherapy you mentioned, such as, the number of participants must be documented in every participant's progress notes and the start and stop time or total time must be documented in every participants progress notes?

Answer: We provide documentation and group size requirements for group psychotherapy in L34616 Psychiatry and Psychology Services.

You need not show start and stop times, but include the total time spent with the patient, in minutes, in the documentation. For group psychotherapy, the policy says the group size must be one the provider can successfully lead. Medicare expects documentation will show this. The record should include the number of participants.

Q2: How do we log into the WPS training center without a NPI or Medicare number?

Answer: When you register for one of our training events, please use an NPI and PTAN (Provider Transaction Access Number) for a provider you represent. If you do not represent a provider, please send an email to wps.gha.education@wpsic.com to explain your situation and you will receive instructions.

Q3: How to correctly bill for multiple units when the code's MUE adjudication Indicator MAI is 3; assuming documentation supports these services; I have reviewed CMS NCCI FAQ library and the MM8853 publication.

Example 1: CPT 88344 x 6 units. The MUE for this code is 6 units with a MAI of 3. Does this mean all 6 units can be billed on one line, 6 units, no modifiers OR does this mean that one line is billed with 1 unit and a second line is billed with 5 units with a 59 modifier?

Example 2: CPT 88344 x 7 unis. Does this mean that 6 units can be billed without the modifier and the 7th unit (now over the MUE) needs a modifier?

Answer: When billing 88344 with 6 units, you can send on one line of service with multiple units. You do not need to append a modifier. If you have more than the 6 units allowed by MUE, you continue to send on one line with the total units. When providing 7 units (exceeding the MUE), Medicare will deny the line. You can request an appeal to show the number of units provided and the medical necessity. You can find more information in Chapter 1 of the National Correct Coding Initiative Manual.

Q4: Clarification of use and application of MAI of 3.

Answer: The MAI of 3 is where CMS states units more than the MUE could be medically necessary and payable by Medicare. You can find more information in Chapter 1 of the National Correct Coding Initiative Manual.

Q5: G0444- Per the description this code should be at the threshold of 5 minutes documented in order to bill. If the provider documents (1-4 minutes), is this a billable code?

Answer: Current WPS GHA education for depression screening is consistent with verbiage in Screening For Depression in Adults National Coverage Determination (NCD) 210.9 that reads "up to 15 minutes."

The Depression Screening Fact Sheet on our website states coverage criteria that applies. This includes that this service includes time spent to administer a screening tool, interpret the results, and use the results as appropriate. A registered nurse can administer the screening, but interpretation of results (even a negative result) requires a "provider-level" comment in the documentation.

Documentation of all required elements is needed for WPS GHA to consider payment. Based on current published WPS GHA education, if providing all required elements and documented in 1-4 minutes, and Medicare otherwise covers the service, WPS GHA would allow payment.

Q6: Common time statement "at least 50 minutes was spent…" Does the "at least" disqualify the time statement of 45 minutes? For example, in an inpatient subsequent service " I spent at least 50 minutes reviewing the patients labs since yesterday, ordering new medications, reviewing input and output, blah blah blah" Could I code this as a 99233 based on time statement, or would I need to disqualify the time statement and default to MDM?

Answer: The statement "at least 50 minutes …" would be acceptable to choose procedure code 99233 based on time. If the documentation also has information showing the provider only provided 45 minutes on the patient's care, then you would need to down code the service or choose the MDM to level the service.

Q7: My questions have to do with the presentation for E/M: Leveling Your Service, in particular the risk element for medical decision making.

I believe that we were told during the presentation that the physician must document what the risk is to the patient (slide 21). Do the physicians have to literally state that the patient has straightforward, low, moderate or high risk and then describe what the risk is? If not, then how will a coder know which level of risk the documentation supports?

For example, for the moderate level of risk, the AMA lists prescription drug management as a moderate risk. I believe that we were told during the presentation that the physician needs to document the risk to the patient from taking the medication (slide 62). Again, if the physician documents what the risks are that the patient may face from the medication, how will the coder know which level of risk the documentation supports? If they document any risk, then do we automatically assume it is moderate risk? This requirement would also mean that the physician would need to document the risk for a medication for every encounter in order to count it as a risk element.

Below are the definitions for prescription drug management that I was able to locate. The first one is from WPS GHA and matches what was said during the presentation. The next three are from some of the other MACS – National Government Services (NGS), Noridian and Novitas. Their definitions appear to align with what I believe was the AMA's intent that prescription drug management is inherently moderate risk. They provide a description of the documentation required to show how the prescription drug is being managed by the physician rather than documenting what the risk may be.

Any further clarification would be greatly appreciated.

Answer: Prescription drug management is an example provided for the risk category. Yes, your practitioners need to show the risk to the patient from the medical decision and plan for that patient. The AMA addressed this question and has the response on their website.

Q8: Quantifying MDM when a resident is involved:

The resident performs the initial H&P and the patient is in respiratory distress. The resident reviews the note from the Emergency Department and Pulmonology. Two hours later the attending sees the patient on rounds and the patient is no longer in respiratory distress. Attending adds attestation to the H&P. "I spent a total time of 20 minutes taking care of the patient for the day, including a combination of the following: chart review, reviewing patient history, exam/evaluation at the bedside, counseling and/or education to the family, ordering medications/tests/procedures, chart documentation, communication with the care team, interpreting results, and care coordination. I directly supervised the formulation of plan of care for the day and agree with the exam findings and assessment and plan as documented above." (Canned statement)

Question: If the patient is no longer in respiratory distress at the time of the teaching physician's rounds or the attending does not comment on the patient's status, how is the Problem Addressed determined? Is the status of the Problem Addressed at the time of the teaching physician's service or at the time of the resident's involvement? Does the attending get Data credit for the resident's review of the ED and Pulmonary notes?

Answer: Medicare makes payment to the teaching physician when they provide the service to the patient or when they are present with the resident while the resident performs the service. If providing the service, documentation would need to support the level of service chosen. The teaching physician must document what they performed for the patient. If present while the resident provides the services, they can use an attestation statement to support their presence. Based on the information provided above, you could code based on the 20 minutes documented by the teaching physician.

Q9: How do we find the name of the Hospice?

Answer: The WPS Portal shows the NPI of the hospice. You can then use the National Provider Plan and Enumeration System (NPPES) to search for the name of the hospice. If you are seeing the Hospice information open, but do not see the NPI of the Hospice, please contact our Customer Service staff.

Q10: How do we find the Hospice terminal condition?

Answer: Talk to the patient or the Hospice.

Q11: Where can I find Medicare education for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHCs)?

Answer: Find CMS MLN booklets at:

Information for Rural Health Clinics (MLN006398 March 2024)

Federally Qualified Health Center (MLN006397 January 2024)