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RURAL & COMMUNITY HEALTH

# 2021 EVALUATION & MANAGEMENT DOCUMENTATION & CODING BOOTCAMP

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- For many years, we have had less than perfect guidance regarding E&M service leveling…providers have used the "*note bloat*" mentality suggesting that more documentation should equate to higher levels of service.

- This course is approved for 4 CEU / Category I CME credit hours

# Our Agenda

- History of Evaluation and Management (E&M) codes
- Outpatient versus inpatient services (BIG 2021 changes for outpatient E&M)
- New patient outpatient visits (99202-99205), established patient visits (99211-99215)
- "*Problem-oriented*" versus "*preventive*" E&M services
- Reporting services during the COVID-19 PHE
- "Key components" and contributory factors (still in effect for non-outpatient E&M)
- Defining and documenting time to support E&M service codes
- Relaxed documentation restrictions introduced in 2019 and March 2021 updates
- Overview of many other E&M service categories and subcategories
- CPT preventive service codes 99381-99397, and Medicare-specific G-codes (e.g., IPPE/AWV) for reporting many approved preventive services
- Calculating medical decision making versus using time to drive levels of E&M service
- Auditing reminders when reviewing E&M services in 2021 and beyond

# Special FQHC and RHC Considerations

- Medicare Benefit Policy Manual, Chapter 13 (http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf)
  - Multiple visits may be allowed on the same day (Ch. 13, Section 40.3)
    - Patient seen and treated at two distinct times and for two distinct purposes
    - Medical and a mental health visit performed on same date of service
    - **RHCs only**… IPPE and medical and/or mental health visit on the same date (up to 3-4 visits)

- Medicare Claims Processing Manual, Chapter 9 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

# Helpful Resources from CMS

## Rural Health Clinics:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

## Federally Qualified Health Centers:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf

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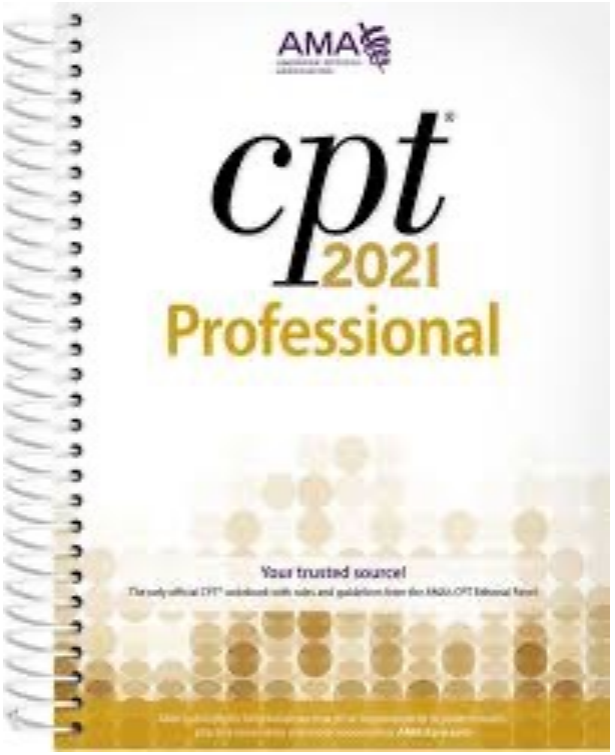
# Section I

# History of CPT Evaluation and Management (E&M) Services Codes and Current HIPAA Covered Code Sets

# Applicable HIPAA Covered Code Sets

- CPT ®
  - Authored by AMA (updated annually – except for vaccine [2 times/year), and COVID-19 PHE
  - CPT is currently identified by the Centers for Medicare and Medicaid Services (CMS) as Level I of the Healthcare Common Procedure Coding System.
  - Typically, effective January 1st each year. New CPT update calendar on pg xiii of 2021 CPT
  - Became effective first in 1966, E&M guidelines began in 1992, revised in 1995 and 1997 with emphasis on history, physical examination and medical decision making (MDM)
- HCPCS II
  - Created by CMS to demonstrate supplies, DME, drugs, temporary codes, etc
  - Many temporary and Medicare / Medicaid specific codes (e.g. T1015, Q0091, G0438-9, G0101, G0402, etc)
  - HCPCS is currently identified by the Centers for Medicare and Medicaid Services (CMS) as Level II of the Healthcare Common Procedure Coding System.
- ICD-10-CM
  - Overseen by Cooperating Parties AHIMA, AHA, CMS and NCHS (National Center Health Statistics), WHO
    - New codes become effective on October 1 each year (released in the Summer)

# 2021 CPT Layout




AMA, 2021 CPT®

- Introduction
- **Evaluation and Management (99xxx)**
- Anesthesia (0xxxx)
- Surgery (1xxxx – 6xxxx)
- Radiology (7xxxx)
- Pathology and Laboratory (8xxxx)
- Medicine (9xxxx)
- Category II (xxxxF)- outcomes measures
- Category III (xxxxT)- emerging technology
- Appendix A-P
  - Category I and II codes released by September, effective January
  - Cat III codes released Jan 1, effective July 1

# Evaluation and Management (E&M) History

- CPT was first published in 1966 but E&M guidelines were not introduced in 1992. E&M guidelines were later revised in 1995, 1997 and most recently, 2021.
  - 1992 E&M documentation guidelines were based entirely on time
  - 1995 E&M documentation guidelines were forged using a methodology of counting "*body areas*" and/or "*organ systems*"
  - 1997 E&M documentation guidelines were drafted using a methodology of counting "*elements*" or "*bullets*"
  - Some relaxed restrictions were approved in 2019 (became official with 2020 MPFS Final Rule) and sweeping changes took effect January 2021 for office/outpatient E&M codes, 99202-99215. These changes have taken place for a multitude of reasons:
    - Reduce documentation burden for qualified providers
    - Eliminate "note bloat" and need to "re-document" certain aspects of the record
    - Reduce professional dissatisfaction and provider "burnout"
    - Encourage more time with patients and less time with unnecessary paperwork

# Notable Changes Impacting Code Selection in 2021

- The "*new*" E&M guidelines only apply to codes 99202-99215. These are used to report office and other outpatient services.
- Time in the office and other outpatient setting is no longer defined as *face-to-face* time
- Medical decision making requires reference to the new terms in 2021 CPT for office and other outpatient services (e.g., *unique test, independent historian, independent reviewer, external*, etc.)
- The traditional framework for selecting E&M services (e.g., history, physical examination, medical decision making, etc.) are still required for non-office/outpatient evaluation and management services (ED, Obs, etc.)
- Providers are not *required* to document HPI (2019) but must review/confirm
- Auditing E&M services will require a firm understanding of MDM and TIME as defined in 2021 CPT.

# CPT Editorial Panel Update (February 2021)

- Recently approved "major revisions" to the "other sections" of the E&M chapter in CPT (to take effect January 2023)
- Also approved "*immediate revisions*" to the existing guidelines, effective retroactively to January 2021
  - Provides specific definition of "*Analyzed*"
  - Clarifies the definition of "*unique test*"
  - Clarifies meaning of "*discussion*" between other providers and patients
  - Provision of a clearer definition of "*minor*" vs "*major*" surgery
  - Clarification of activities NOT included in the CPT definition of time
    - For more information, CLICK HERE

# E&M Services During the COVID-19 PHE

- Figures in the United States (Updated June 1, 2021)
  - Total cases: 33.3 million cases in United States
  - Total deaths: 595,000 in United States
- President Trump declared national emergency March 13, 2020 (see press release)
- 3/27/20: Coronavirus Aid, Relief and Economic Security Act (CARES Act)
  - Section 3704 authorized RHCs and FQHCs to furnish "distant site" telehealth services.
  - Originating site (beneficiary location), Distant site (provider location)
- Billing and Coding information updated December 3, 2020 (MLN SE20016)
  - The beneficiary's diagnosis does not need to be COVID-19 related and allows citizens to follow CDC guidance including '*social distancing*' to reduce the increased risk of COVID-19 transmission. **Revised February 23, 2021. Effective January 1, 2021, the payment rate for distant site telehealth services is updated to $99.45.**

# Overview of Telehealth Service Coding and Billing

| Telehealth Service | Service Description | Billing Guidance | Reimbursement |
|---|---|---|---|
| Telehealth Visits | Substitutes for in-person visits https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes | G2025<br>Reported on CMS-1450 (UB-04)<br>Revenue code 052X<br>Modifier -95 not required<br>Modifier –CS to waive cost-sharing | ~~$92.03~~<br>**$99.45 effective January 1, 2021** |
| Virtual Check-In and Virtual Care Communication | Remote evaluation or brief communication of patient (> 5 minutes)<br>CPT codes G2010 / G2012 | G0071<br>Reported on CMS-1450 (UB-04)<br>Revenue code 052X<br>No modifier requirement | $24.76 |
| E-Visits | On-line digital patient evaluation using patient portal | G0071<br>Reported on CMS-1450 (UB-04)<br>Revenue code 052X | $24.76 |
| Telephone and Audio-Only Visits | Telephone evaluation and management<br>(CPT codes 99441-99443) | G2025<br>Reported on CMS-1450 (UB-04)<br>Revenue code 052X | ~~$92.03~~<br>**$99.45 effective January 1, 2021** |

# Reporting Telehealth to Medicare

**FQHC Claims for Telehealth Services starting July 1, 2020**

| Revenue Code | HCPCS Code | Modifiers |
|---|---|---|
| 052X | G2025 | 95 (optional) |

**RHC Claims for Telehealth Services starting July 1, 2020**

| Revenue Code | HCPCS Code | Modifiers |
|---|---|---|
| 052X | G2025 | 95 (optional) |

CMS' COVID-19 FAQs can be accessed here:
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Source: MLN SE 20016_July 6, 2020

AMA COVID-19 related coding scenarios:
https://www.ama-assn.org/system/files/2020-05/covid-19-coding-advice.pdf

# Excerpt From CMS Approved Telehealth List

**LIST OF MEDICARE TELEHEALTH SERVICES**

| Code | Short Descriptor | Status |
|---|---|---|
| 99201 | Office/outpatient visit new | |
| 99202 | Office/outpatient visit new | |
| 99203 | Office/outpatient visit new | |
| 99204 | Office/outpatient visit new | |
| 99205 | Office/outpatient visit new | |
| 99211 | Office/outpatient visit est | |
| 99212 | Office/outpatient visit est | |
| 99213 | Office/outpatient visit est | |
| 99214 | Office/outpatient visit est | |
| 99215 | Office/outpatient visit est | |
| 99217 | Observation care discharge | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99218 | Initial observation care | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99219 | Initial observation care | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99220 | Initial observation care | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99221 | Initial hospital care | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99222 | Initial hospital care | Temporary Addition for the PHE for the COVID-19 Pandemic |
| 99223 | Initial hospital care | Temporary Addition for the PHE for the COVID-19 Pandemic |

# Some of the Approved Telehealth Services

- Office/Other Outpatient visits (99202-99215)
  - 99201 was deleted for 2021
- Initial/Subsequent/Discharge Hospital services (99221-99239)
- Observation services (99217-99220, 99234-99236)
- Emergency Department services (99281-99285)
- Critical Care (99291-99292) and Neonatal Pediatric Critical Care (99468-99476)
- Nursing Facility, Domiciliary, Rest Home and Home services (99304-99350)
- Psychiatric Interviews and Psychotherapy (90791-90875)
- ESRD related services (90951-90970)
- Eye examinations (92002-92014)
- Speech/Hearing services (92507-92604)
- Cardiac Rehabilitation (93797-93798)
- Ventilation Management (94002-94005)
- Behavioral/Developmental/Psychological services (96110-96171)

# Other Telehealth Considerations

- On December 1, 2020, CMS released the 2021 Final Rule including making permanent certain telehealth services, even after the PHE has ended READ MORE
- Q3014 is still used for "originating site" telehealth services (not for distant site)
- Costs for telehealth services (both originating and distant site costs) must be captured on cost report
  - Rural Health Clinics (CMS-222-17, line 79 of worksheet A, "costs other than RHC services")
  - Federally Qualified Health Centers (CMS-224-14, line 66 of worksheet A, "other FQHC services)
- Modifier –CS
  - Used by RHCs and FQHCs to waive patient cost-sharing (e.g., coinsurance) for COVID-19 related services
  - Remember modifier -95 is optional, effective July 1, 2020

# COVID-19 Testing Related HCPCS II Codes

- AMA released 2 new codes September 8, 2020:
  - **99072**- Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease
  - **86413**- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative

| CPT/HCPCS Code | Laboratory Code Long Descriptor |
|---|---|
| | **COVID-19 Related Codes** |
| U0001 | CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel |
| U0002 | 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC) |
| U0003 | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), 2 amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R |
| U0004 | 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R |
| 87635 | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique |
| 86769 | Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) |
| 86328 | Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) |

# New Covid-19 Vaccine & Administration Codes

CPT Release November 11-18, 2020

**91300**
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use

**91301**
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use

**91302**
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use

[CLICK HERE FOR AMA GUIDANCE FOR COVID-19 REPORTING]

**0001A**
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose

**0002A**
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose

**0011A**
Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose

**0012A**
Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose

**0021A**
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose

**0022A**
second dose

# ICD-10-CM Diagnosis Coding Reminders for COVID-19

- Code only CONFIRMED cases. For possible exposure to COVID-19 with the disease ruled out, report Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out). For actual exposure to COVID-19, report Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases)
- For SCREENING, asymptomatic individuals being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59 (Encounter for screening for other viral diseases)
- Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC).
- For asymptomatic individuals who test positive for COVID-19, assign code U07.1
- U07.1 (*COVID-19*) is coded "principle" except in pregnancy, childbirth, and the puerperium (I.C.15.s. ). Should code of O98.5 (*Other viral diseases complicating pregnancy, childbirth and the puerperium*, followed by code U07.1, *COVID-19*)

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# Section II:

# Evaluation and Management (E&M) Codes and Documentation / Reporting Requirements

# Common Documentation Deficiencies

- "Missing" documentation
- Lack of '*medical necessity*'
- Inadequate time documentation
  - For time-based E&M coding and Psychotherapy (mid-point?)
- Lacking "key component" documentation
- Lacking or untimely signatures
- "One-coding" and "block billing"
  - Ever look at your provider's billing 'patterns'?

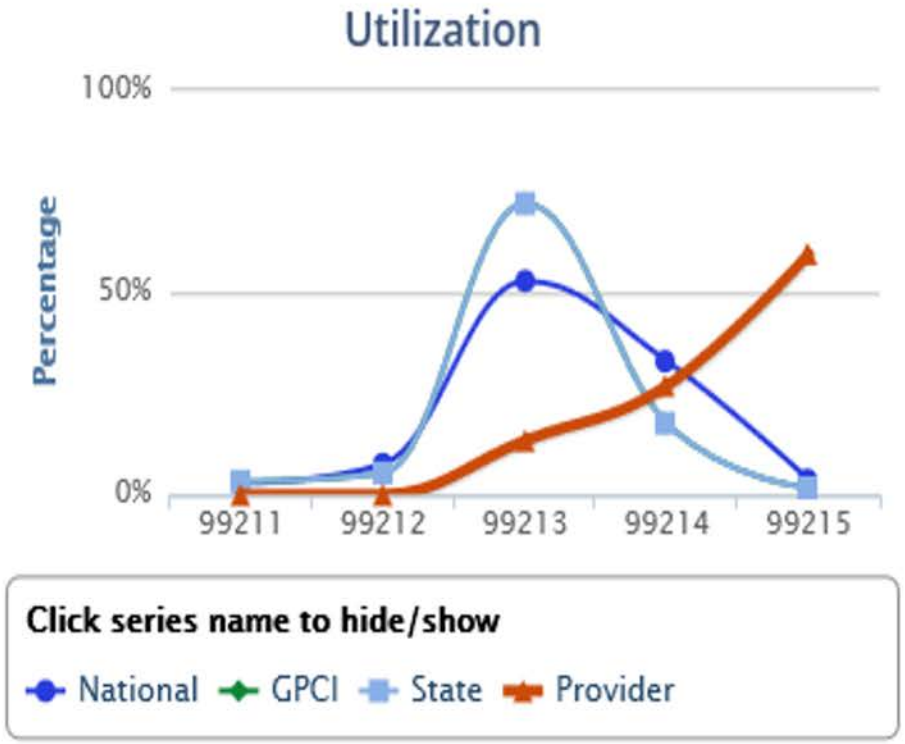
# E&M Utilization Patterns

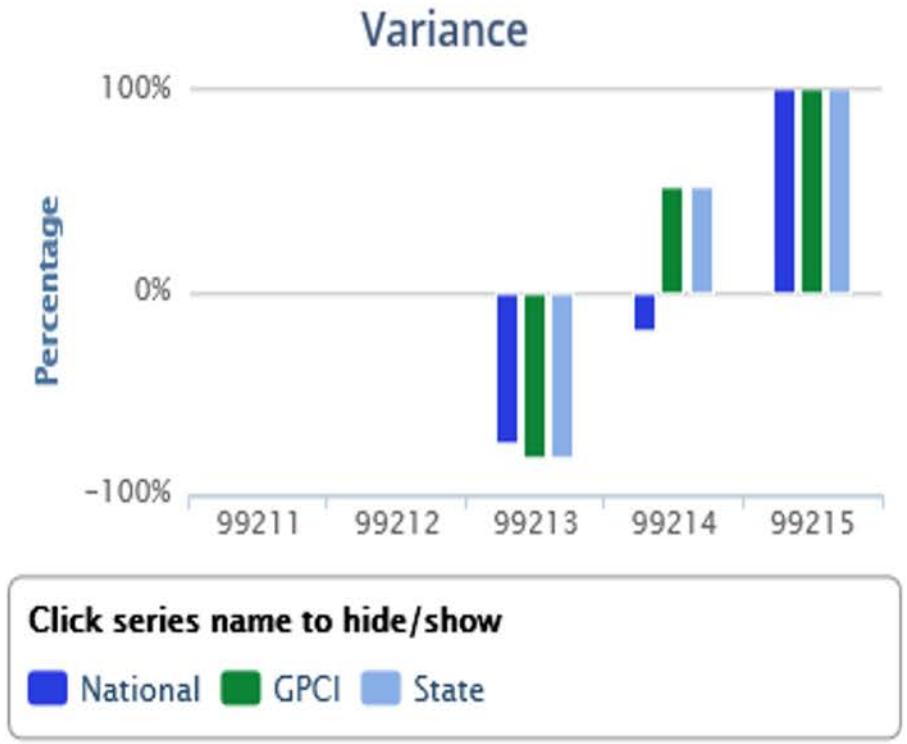
**Utilization**

| | |
|---|---|
| 99211: | 0 |
| 99212: | 0 |
| 99213: | 144 |
| 99214: | 290 |
| 99215: | 641 |

Update Worksheet

**Table 2 - Established Office Visits**




View Data

Source: Doctors Metrics

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/MedicareUtilizationforPartB.html

# Problem-Oriented or Preventive E&M?

- A preventive E/M service differs from a problem-oriented E/M service because one lacks a chief complaint or presenting problem

- Introductory pages in the E&M section of CPT provide some excellent tables [*code selection charts*] designed to assist users with assigning the accurate 'levels' of E&M service
  - Who are you seeing?
    - New, initial, established, subsequent, consultation, etc.
  - Where are you seeing them?
    - RHC, FQHC, other outpatient, inpatient, ER/ED, home, etc.
  - Why are you seeing them?
    - Preventive? Problem-oriented?

# E&M: New Versus Established Patients (per CPT®)

A new patient is one who has not received any face to face professional service from the physician/qualified healthcare professional

**or**

another physician/qualified healthcare professional of the exact same specialty/subspecialty who belongs to the same group practice

within the past 3 years

Is “new patient” defined the same in all places of service?

# Definition of "New" Patient in FQHC

- Per chapter 13 of the Medicare Benefits Policy Manual, "*a new patient is one who has not received any professional medical or mental health services* from any provider *within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service*"

- The regulations state, "*to qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy*"
  - ✓ "*If a new patient is receiving* ***both a medical and mental health visit on the same day****, the patient is considered* ***"new" for only one of these visits****, and FQHCs should not use G0469 to bill for the mental health visit; instead, FQHCs should use G0466 to bill for the medical visit and* ***G0470 to bill for the mental health visit***"

# New & Established Outpatient E&M Visits

- **99202-99205**
  - ✓New patient visits
  - ✓Require all 3 "key" components
  - ✓Remember new patients have not received professional services within previous three (3) years
    - ✓In 2021, history and exam are NOT required "key" components

- **99211-99215**
  - ✓Established patient visits
  - ✓Require 2 of the 3 "key" components
    - ✓CPT code 99211 does not qualify as eligible encounter (e.g., AIR / PPS rates)
  - ✓In 2021, history and exam are NOT required "key" components

# New Patient Office/Outpatient E&M Services

| | |
|---|---|
| **99202** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter. |
| **99203** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. |
| **99204** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. |
| **99205** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. |

# Established Patient Office/Outpatient E&M Services

| | |
|---|---|
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter. |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter. |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. |

# Medicare G-Codes for FQHC Visits

- **G0466 FQHC visit, New Patient**
  - A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit
- **G0467 FQHC visit, Established Patient**
  - A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
- **G0468 FQHC visit, IPPE or AWV**
  - A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
- **G0469 FQHC visit, Mental health, New Patient**
  - A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
- **G0470 FQHC visit, Mental Health, Established Patient**
  - A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

# CPT Code 99211

- 99211- “Nurse Visits”
  - Unique E&M code (no ”provider” presence required)
  - NEVER should be billed for MD, DO, PA, NP services
  - Any ancillary service provider is approved
  - Anytime a patient is evaluated in the office by anyone other than a “qualified” provider
- Does not qualify for FQHC/RHC encounter rate
- Remember, CPT code 99201 has been deleted for 2021

# Hospital Observation Services

- Observation "status" occurs in *outpatient* hospital setting.
  - *Initial observation (*99218-99220)
  - *Subsequent observation (#*99224-#99226)
  - Observation discharge (99217)
  - Be sure to consider POS code (#22) and understand the 8-hour rule for #99234-#99236 (same day initial and discharge)

- New outpatient rules will NOT apply in 2021 and history, examination and medical decision making must be consulted

# Hospital Inpatient Care

- 99221-99223 for initial hospital care ("admits")
  - Defined as the "*first hospital inpatient encounter by the admitting physician*"
- 99231-99233 for inpatient rounds
  - *"Clustering" levels of E/M for subsequent hospital visits can be an audit target*
- 99238, 99239 for inpatient discharges
  - *You MUST document ">30 minutes" to support 99239*
- 99234-99236 for same day initial hospital care "admit" and discharge
  - Same codes as observation but require POS 21 (and 8 hour threshold)

- New outpatient rules will NOT apply in 2021 and history, examination and medical decision making must be consulted

# Emergency Department Services

- Only covered for patients registered in the emergency department of a hospital-based facility
- No distinction between new or established patients in the ED
- Includes History, Exam, and Decision Making
  - All 3 key components required
  - *PFSH 2 of the 3 elements of PFSH comprise "complete"*
  - What if patient is unable to provide this information?
  - No typical time associated with these codes

- New outpatient rules will NOT apply in 2021 and history, examination and medical decision making must be consulted

# Chronic & Principle Care Management Services (Medicare)

- Initially CCM was intended for patients with 2+ chronic conditions expected to last a minimum of 12 months and likely until the death of the patient. G0511 is also now used for PCM services as well
- Initiated at E&M visit, IPPE or AWV.
- Paid using the AIR or PPS payment methodology
- RHCs and FQHCs must report using G0511 or G0512 with rev code 052X
- These are subject to deductible and coinsurance

| | |
|---|---|
| G0511 | Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month |
| G0512 | Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month |

# Advanced Care Planning

- Allows patients to discuss advanced legal directives with their healthcare provider (face-to-face) including legal directives such as healthcare proxies, power of attorney appointments, living wills and medical orders for life-sustaining treatment (MOLST)
- Report using CPT code 99497 (*Advance care planning…by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate*)
  - Serves as a stand alone visit in the RHC (as of January 1, 2016)
  - Midpoint concept may be applied
  - CPT code 99498 may be reported if 46+ minutes are documented

| | |
|---|---|
| 99497 | Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate |
| 99498 | Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure) |

# TCM: Transitional Care Management

- Must have a firm understanding of medical decision making to report these services accurately
- Refer to CPT codes 99495 (TCM requiring moderate complexity MDM) or 99496 (TCM requiring high complexity MDM)
- In order to report CPT code 99496, the face-to-face visit must occur within 7 days after discharge
- Can not bill during same time period as CCM services

| | |
|---|---|
| 99495 | Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge |
| 99496 | Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge |

# Preventive Medicine Services (per CPT)

| CPT code's 5th digit | Patient's age |
|---|---|
| 1 | < 1 |
| 2 | 1-4 |
| 3 | 5-11 |
| 4 | 12-17 |
| 5 | 18-39 |
| 6 | 40-64 |
| 7 | 65+ |

- 99381-99387 (new), 99391-99397 (established)
- Medicare DOES NOT pay for an "annual physical"
- According to CPT, modifier -25 may be used for "significant" E&M
- These codes do not require a "chief complaint"

For FQHCs and RHCs, Refer to CMS Preventive Service Charts

## Rural Health Clinics:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

## Federally Qualified Health Centers:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-Preventive-Services.pdf

# “Routine” Physicals

- *“While I’m here, I’ve had some problems I’d like to talk about”*
- *“But Medicare pays for an annual physical”*
- *“Medicare/Medicaid pays for everything"*
- *“I don’t have to meet a deductible or coinsurance for any preventive service, including the Annual Wellness Visit”*
- *“I’ve never had to pay for this before”*
- *“I was never informed that I had a financial obligation”*

**Routine Physical Examination (See Section 90)**

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury

- Not covered by Medicare; prohibited by statute
- Patient pays 100% out-of-pocket

# Who Can Perform IPPE and AWV Services?

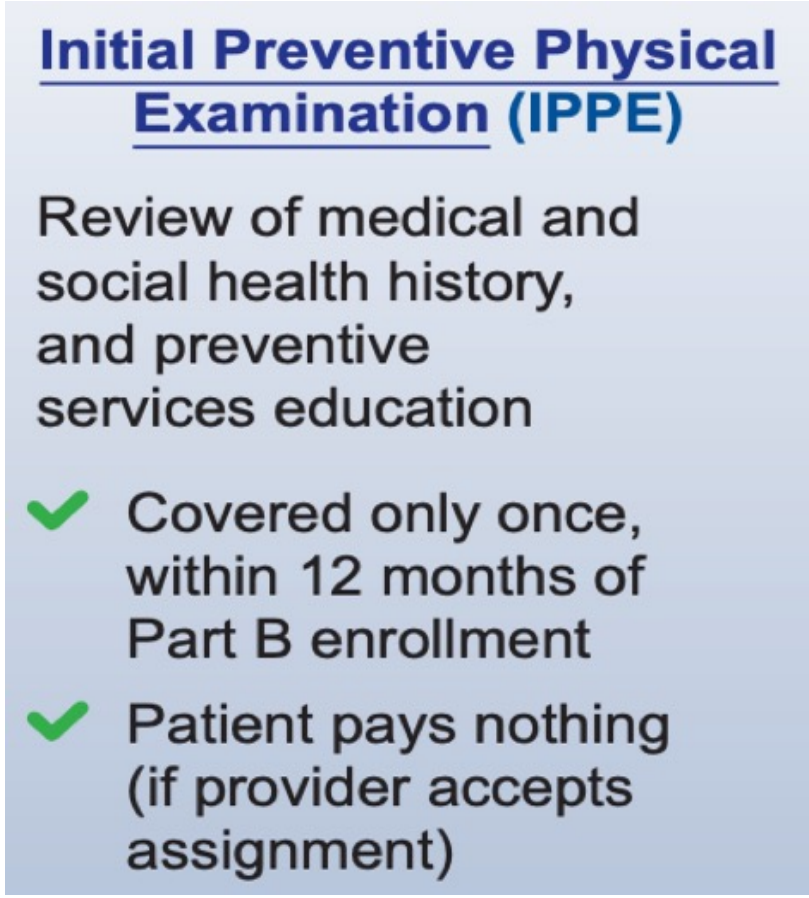
- IPPE must be performed by a physician or practitioner (defined section 1861 of SSA)
- The AWV can be performed by those mentioned above or by a health educator, registered dietician/nutrition professional or other licensed practitioner… (still requires the "*face-to-face*" to qualify for a "per diem" payment [e.g., AIR/PPS])
- IPPE can not be combined with AWV (mutually exclusive)
- The IPPE is the only '*physical*' Medicare pays for and the AWV is not a 'physical'
- FQHCs report G0468 along with the HCPCS II code (G0402, G0438, G0439)
- No cost sharing for the patient (e.g., coinsurance, deductible)
- 7 elements for IPPE, 11 elements for initial AWV, 9 elements for subseq. AWV

# Initial Preventive Physical Examination (IPPE)

**HCPCS II code G0402**

- *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*

- Referred to as a "*Welcome to Medicare*" physical (Affordable Care Act)
- Provides a written plan of care to the patient detailing any follow-up screening or preventive services necessary
- Deductible and co-pay are waived for the IPPE, but not for the EKG



# 7 Elements of the IPPE

1. Review the beneficiary's medical and social history
2. Review the beneficiary's potential risk factors for depression and other mood disorders
3. Review the beneficiary's functional ability and level of safety
4. Physical examination (height, weight, BMI, BP, visual acuity screen, other factors deemed appropriate based on past and social history)
5. End-of-life planning, on beneficiary agreement
6. Educate, counsel, and refer based on the previous five components
7. Educate, counsel, and refer for other preventive services

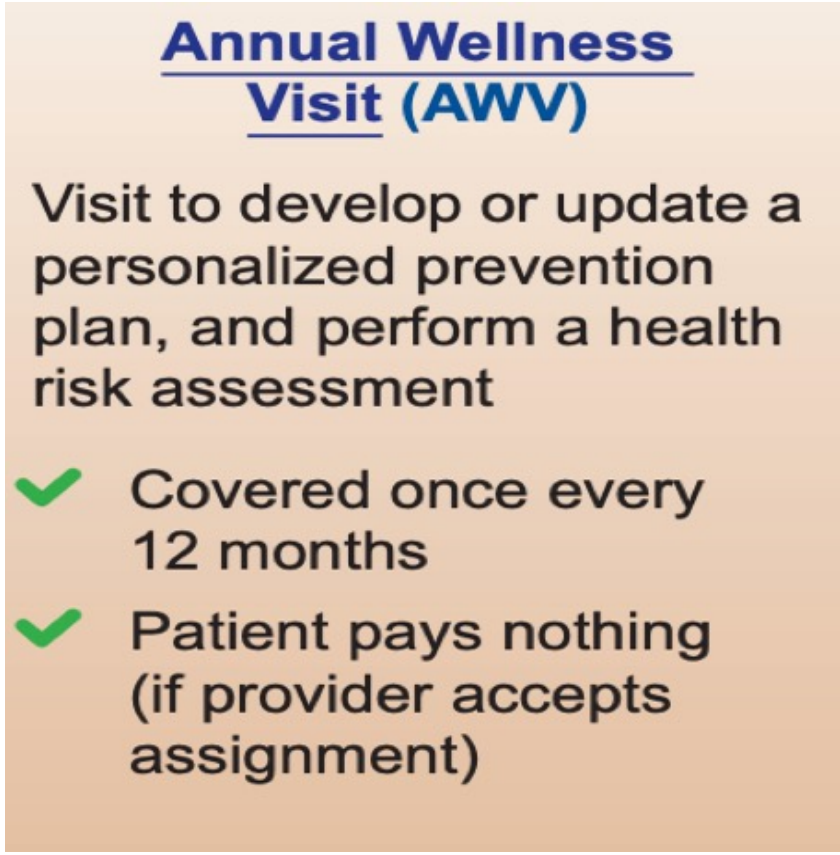
MLN Booklet for IPPE

# Annual Wellness Visits (AWV)

The annual Wellness Visit (AWV) was initiated as part of the Affordable Care Act. There are 2 codes, one for an “initial” AWV and a second for a “subsequent” AWV

- **HCPCS II code G0438** (Annual wellness visit; includes a personalized prevention plan of service (PPS), **initial** visit)

- **HCPCS II code G0439** (Annual wellness visit, includes a personalized prevention plan of service (PPS), **subsequent** visit)



# Documentation Components of the AWV

## *Initial Annual Wellness Visit (G0438)*

**May be paid only once in the beneficiary lifetime**

1. Performance of HRA (health risk assessment)
2. Establish medical and family history
3. Establish a list of current providers/suppliers
4. Measure height, weight, BMI, BP, and other factors deemed appropriate based on past and social history
5. Detect any cognitive impairment for beneficiary
6. Review potential risk factors for depression and mood disorders
7. Review functional ability and level of safety
8. Establish written screening schedule (e.g., 5 to 10 year checklist) based on HRA and USPSTF/ ACIP
9. Establish list of beneficiary risk factors for which interventions are recommended or underway
10. Furnish the beneficiary personalized health advice and appropriate referrals to health education or preventive counseling services or programs
11. Furnish, at the beneficiary's discretion, advance care planning services

# Documentation Components of the AWV

## *Subsequent Annual Wellness Visit (G0439)*

**May be paid once per year following the initial AWV**

1. Review and update the HRA (health risk assessment)
2. Update the beneficiary's medical/family history
3. Update the list of current providers and suppliers
4. Measure weight (waist circumference), BP, and other factors deemed appropriate
5. Detect any cognitive impairment the beneficiary may have
6. Update the written screening schedule for the beneficiary (based on HRA and USPSTF/ ACIP)
7. Update the beneficiary's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway
8. Furnish and update, as necessary, the beneficiary's PPPS, which includes personalized beneficiary health advice and a referral, as appropriate, to health education or preventive counseling services or programs
9. Furnish and update, at the beneficiary's discretion, advance care planning services

# Smoking and Tobacco Use Cessation Visits

- First covered in 2014 resulting from the Affordable Care Act (ACA)
- Became effective for reporting in FQHCs and RHCs in 2016
- Refer to Medicare Preventive Service Charts for FQHC and RHC specific details
  - FQHC - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-Preventive-Services.pdf
  - RHC - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf
- Covered for Tobacco use screening for all adults and adolescents, Tobacco cessation counseling for adults and adolescents who use tobacco, and expanded counseling is available for pregnant women
- CPT codes 99406-99407 are covered for telehealth during the COVID-19 pandemic
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

# Documentation Requirements

- For Medicare patients to qualify for smoking cessation counseling they must :
  - Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
  - The patient must be competent and alert at the time of counseling.
  - Counseling must be provided by a qualified physician or practitioner
  - Must document the patient's tobacco use
  - Patient must be advised to quit and impact smoking has on health
  - *Assessed willingness* to attempt to quit
  - Providing methods and skills for successful cessation
  - Medication management of smoking session drugs / products
  - Resources should be provided
  - Should attempt to establish a "quit" date
  - Follow-up should be arranged as necessary
  - Amount of time spent counseling patient to qualify for either 99406 or 99407

# Process and Documentation Considerations

- As part of  intake, the patient's smoking/vaping use and/or history should be captured
- Is there a way your EHR can capture and track tobacco use history? Ask your vendors!
- Document the patient's current use (vaping, cigarettes, pipe tobacco, snuff/dip/chew, etc.) and the frequency of use. Be sure to document dosage as well (e.g., pack/can per day)
- Ask the patient if they would consider quitting and describe local, state and national resources are available including prescription medications that may be available

| Publication Number | Manual Section Number | Manual Section Title |
|---|---|---|
| 100-3 | 210.4.1 | Counseling to Prevent Tobacco Use |
| **Version Number** | **Effective Date of this Version** | **Implementation Date** |
| 2 | 9/26/2017 | 9/26/2017 |

**Indications and Limitations of Coverage**
**B. Nationally Covered Indications**

Effective for claims with dates of service on or after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries

1. Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease;
2. Who are competent and alert at the time that counseling is provided; and,
3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

Intermediate and intensive smoking cessation counseling services will be covered under Medicare Part B when the above conditions of coverage are met, subject to frequency and other limitations. That is, similar to existing tobacco cessation counseling for symptomatic individuals, CMS will allow 2 individual tobacco cessation counseling attempts per 12-month period. Each attempt may include a maximum of 4 intermediate OR intensive sessions, with a total benefit covering up to 8 sessions per 12-month period per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than 3 minutes but less than 10 minutes), or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

Access NCD here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017downloads/R3848CP.pdf

# MEDICARE PREVENTIVE SERVICES




## Counseling to Prevent Tobacco Use (NCD 210.4.1)

PRINT THIS SERVICE

### HCPCS/CPT Codes

**99406** — Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

**99407** — Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

**What's Changed?**

- No 2021 second quarter changes

### ICD-10 Codes

F17.210, F17.211, F17.213, F17.218, F17.219, F17.220, F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, and Z87.891

**NOTE:** Additional ICD-10 codes may apply. See the CMS ICD-10 webpage for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and contact your MAC for guidance.


# Reporting and Billing

- April 2016, CMS discontinued the use of HCPCS II codes G0436 and G0437 and require use of CPT codes 99406 and 99407
- FQHCs and RHCs may be paid using PPS/AIR methodologies
- Rural Health Clinics (RHC) required to use modifier CG (Oct 2016). When a subsequent visit for different diagnosis/treatment is performed on the same date, report with modifier -59
- Must be reported with revenue code 052x or 0900
- Coinsurance and deductible (if applicable) are waived

# Medical Record Reminders

- **IF IT IS NOT DOCUMENTED,** it was not done
- **IF IT IS NOT LEGIBLE,** it does not exist
- According to CMS, §482.24(c)(1), *All patient medical record entries must be legible, complete, dated, timed, and **authenticated** in written or electronic form by the person responsible for providing or evaluating the service provided"*
- The medical record is the proof you may need to support payment
- The medical record may serve as a legal document!

# Signature Requirements

- Arch Pro Coding suggests that a "timely" record entry as one that occurs within 24-48 hours. Occasionally, up to 72 hours is acceptable. Many payers require this as a CoP.
- Check with your MAC. Some have specific language suggesting timely medical records and signatures. According to Noridian, "*notes would be signed at the time services are rendered*". Then there is WPS, that suggests "*a reasonable expectation would be no more than a couple of days away from the service itself*"
- "*For medical review purposes, Medicare requires that services provided/ordered /certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies*"
- When drafting policy language, be sure not to draft language that is more restrictive than providers are willing and able to adhere to or comply with

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

# Coding and Billing Are Not The Same Thing

- Coding turns clinical documentation into useable data regardless of whether it generates revenue or not
- Just because you bill it does not mean you'll be paid
- Just because you get paid doesn't mean you did it right
- Just because you didn't get paid doesn't mean you did it wrong
- Just because you got paid doesn't mean you get to keep the money
- Highly trust-based…be ready to prove it when documentation is requested
- To make things fun…all payers have some different rules to be aware of…
  - Know your regional MAC coverage guidance. For examples, see below:
    - NGS https://www.ngsmedicare.com/
    - Novitas https://www.novitas-solutions.com/
    - WPS https://www.wpsgha.com/
    - Palmetto https://www.palmettogba.com/

ArchProCoding
RURAL & COMMUNITY HEALTH

# Section III:

# New E&M Framework Used to Determine Office / Outpatient E&M Codes in 2021 & The Traditional Framework Used for All Other E&M Codes

# New E&M Guidelines for Office/Outpatient E&M Services (99202-99215)


- Beginning January 1, 2021, qualified healthcare practitioners are allowed to select levels of Office/Outpatient E&M service based on either:
  - Medical Decision-Making **OR**
  - Time
- History and physical examination are still to be documented in a "*medically appropriate*" manner but are not required "key components"

# E&M Documentation and Coding Framework For Other Evaluation and Management (E&M) Services

- History
- Physical Examination
- Medical Decision Making
- Nature of the Presenting Problem
- Counseling
- Coordination of Care
- Time

# Official E&M Documentation Guidelines

- Documentation guidelines are available at CMS' website:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

# History (Subjective)

- **Chief complaint** – clear, concise statement detailing the reason the patient is presenting today, usually in the patient's own words

  ✓According to CMS, the CC may be combined with the HPI

- HPI (history of present illness)
  - **Should be captured by** the provider
- ROS (review of systems)
- PFSH (past family social history)

# Determining the Level of History

| Subjective (history) | | |
|---|---|---|
| **History of Present Illness (HPI)**<br>Location<br>Quality<br>Severity<br>Duration<br>Timing<br>Context<br>Associated Signs & Symptoms<br>Modifying Factors | **Review of Systems (ROS)**<br>Constitutional<br>Eyes<br>Ears/Nose/Mouth/ Throat<br>Cardiovascular<br>Respiratory<br>Gastrointestinal<br>Genitourinary<br>Musculoskeletal<br>Integumentary<br>Neurologic<br>Psychiatric<br>Endocrine<br>Hematologic/ Lymphatic<br>Allergy/Immunologic | **Past, Family, and/ or Social History (PFSH)**<br>Past Medical<br>Family Medical<br>Social<br><br>**or document status of 3 chronic or inactive conditions** |

*start in the highest level

*element located in the lowest level will determine overall level

| Type of History | History of Present Illness (HPI) | Review of Systems (ROS) | Past, Family, and/or Social History (PFSH) |
|---|---|---|---|
| Problem Focused | Brief = 1 | N/A | N/A |
| Expanded Problem Focused | Brief = 1 | Problem Pertinent = 1 | N/A |
| Detailed | Extended = 4 | Extended = 2 | Pertinent = 1 |
| Comprehensive | Extended = 4 | Complete = 10 | Complete = 3 **2 for est/subs/ER** |

# Example: Determining the Level of History

| Subjective (history) | | |
|---|---|---|
| **History of Present Illness (HPI)**<br>Location<br>Quality<br>Severity<br>Duration<br>Timing<br>Context<br>Associated Signs & Symptoms<br>Modifying Factors | **Review of Systems (ROS)**<br>Constitutional<br>Eyes<br>Ears/Nose/Mouth/ Throat<br>Cardiovascular<br>Respiratory<br>Gastrointestinal<br>Genitourinary<br>Musculoskeletal<br>Integumentary<br>Neurologic<br>Psychiatric<br>Endocrine<br>Hematologic/ Lymphatic<br>Allergy/Immunologic | **Past, Family, and/ or Social History (PFSH)**<br>Past Medical<br>Family Medical<br>Social |

*start in the highest level

*element located in the lowest level will determine overall level

| Type of History | History of Present Illness (HPI) | Review of Systems (ROS) | Past, Family, and/or Social History (PFSH) |
|---|---|---|---|
| Problem Focused | Brief = 1 | N/A | N/A |
| Expanded Problem Focused ★ | Brief = 1 | Problem Pertinent = 1 ★ | N/A |
| Detailed | Extended = 4 | Extended = 2 | Pertinent = 1 |
| Comprehensive | Extended = 4 ★ | Complete = 10 | Complete = 3 ★ |

# History Reminders

- History will not be required as a necessary “key” component” for office/outpatient E&M codes selection beginning in 2021
- If unable to obtain history, be sure documentation clearly illustrates the reason(s) precluding the provider from getting the information
- Beginning in 2019, providers need not re-document history captured by ancillary staff
  - History (especially HPI) must be ‘*verified*’
- “*Medically appropriate*” history needs to be documented for 2021

# Physical Examination

| LEVEL OF EXAMINATION | 1995 CPT/AMA | 1997 General Multi-System | 1997 Single Organ System |
|---|---|---|---|
| **Problem Focused** | 1 | 1-5 | 1-5 |
| **Expanded Problem Focused** | **"Limited"** | 6-11 | 6-11<br>*except psych & eye |
| **Detailed** | **"Extended"**<br>**(Use MAC Guidance)** | 12-17 | 12-17<br>*except psych & eye |
| **Comprehensive** | 8+ Organ Systems | *Perform "All"<br>*Document 2 from 9 | *Perform "All"<br>*Document "All Shaded"<br>*Document 1+ "Unshaded" |

# Physical Examination, per CPT®

| EXAMINATION LEVEL / TYPE | BODY AREAS | ORGAN SYSTEMS |
|---|---|---|
| PROBLEM FOCUSED | • Head, incl. the face<br>• Neck<br>• Chest, incl. breasts and axillae<br>• Abdomen<br>• Genitalia, groin, buttocks<br>• Back, including spine<br>• Each extremity | • Constitutional (e.g., vital signs, gen appearance)<br>• Eyes<br>• Ears, nose, mouth and throat<br>• Cardiovascular<br>• Respiratory<br>• Gastrointestinal<br>• Genitourinary<br>• Musculoskeletal<br>• Skin<br>• Neurologic<br>• Psychiatric<br>• Hematologic/lymphatic/immunologic |
| EXPANDED PROBLEM FOCUSED | | |
| DETAILED | | |
| COMPREHENSIVE | | |

AMA authors the information above. Various MACs may impose more restrictive interpretations. For example, Novitas suggests following the “4 x 4 methodology” to satisfy the the detailed level (“extended” exam) while NGS suggests 6+ systems using more than simple checklists to qualify for detailed examinations

# 1997 Psychiatric Examination Guidelines

| EXAMINATION LEVEL / TYPE | 1995 EXAMINATION GUIDELINES ("BODY AREAS/ORGAN SYSTEMS") | 1997 EXAMINATION GUIDELINES PSYCHIATRIC EXAMINATION |
|---|---|---|
| PROBLEM FOCUSED | rea/Sy | 1 bullet |
| EXPANDED PROBLEM FOCUSED | -7 A /Syste | 6 bullets |
| DETAILED | *2-7* s/Systen OW MAC) | 9 bullets |
| COMPREHENSIVE | 8 OR MO AN SYSTEMS | ALL bullets |

| | |
|---|---|
| Constitutional | Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)<br>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) |
| Musculoskeletal | Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements<br>Examination of gait and station |

| Level of Exam | Perform and Document: |
|---|---|
| Problem Focused | **One to five** elements identified by a bullet. |
| Expanded Problem Focused | **At least six** elements identified by a bullet. |
| Detailed | **At least nine** elements identified by a bullet. |
| Comprehensive | Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border. |

- Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
- Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation
- Description of associations (eg, loose, tangential, circumstantial, intact)
- Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions
- Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)

Complete mental status examination including

- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration
- Language (eg, naming objects, repeating phrases)
- Fund of knowledge (eg, awareness of current events, past history, vocabulary)
- Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

# Physical Examination Reminders

- Physical examination will not be required as a necessary "key" component" for office/outpatient E&M code selection in 2021 and beyond
- "*Medically appropriate*" examination should be documented

# Medical Necessity (as defined by CMS)

From Chapter 12 of the Medicare Claims Processing Manual:

- *"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."*

# Medical Decision Making

Does not Apply to 99202-99215

**A. Number Of Diagnosis or Management Options**

| | Number | Points | Results |
|---|---|---|---|
| Self-limited or minor (stable, improved or worsening) | Max = 2 | 1 | |
| Est. problem: stable or improved | | 1 | |
| Est problem: worsening, failing to change | | 2 | |
| New problem: no additional work-up planned | Max = 1 | 3 | |
| New problem: additional work-up planned | | 4 | |
| | | Total: | |

# Medical Decision Making

## Does not Apply to 99202-99215

| **B. Amount and/or Complexity of Data to Be Reviewed** | |
|---|---|
| | Points |
| Review and/or order of clinical lab test | 1 |
| Review and/or order of tests in the radiology section of CPT | 1 |
| Review and/or order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtaining history from someone other than patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider | 2 |
| Independent visualization, tracing or specimen itself (not simply review of report) | 2 |
| **Total** | |

## C. TABLE OF RISK (RISK IS DETERMINED BY THE "BULLET POINT" FOUND IN THE HIGHEST LEVEL OF THE TABLE)

| | Presenting Problems | Diagnostic Procedures ordered | Management Options Selected |
|---|---|---|---|
| **Minimal** | • 1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis | • Lab tests requiring venipuncture<br>• EKG/EEG<br>• Urinalysis<br>• Ultrasound, X-RAYS<br>• KOH prep | • Rest<br>• Gargles<br>• Elastic bandages<br>• Superficial dressings |
| **Low** | • 2 or more self-limited or minor problems<br>• 1 stable chronic illness<br>• Acute uncomplicated illness or injury | • Physiologic test not under stress<br>• Non-cardiovascular imaging<br>• Superficial needle biopsies<br>• Clinical lab test requiring arterial puncture<br>• Skin biopsies | • Over-the-counter drugs<br>• Minor surgery w/ no identified risk factors<br>• Physical therapy<br>• Occupational therapy<br>• IV fluids without additives |
| **Moderate** | • 1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment<br>• 2 or more stable chronic illnesses<br>• Undiagnosed new problem w/ uncertain prognosis<br>• Acute illness with systemic symptoms<br>• Acute complicated injury | • Physiologic test under stress<br>• Diagnostic endoscopies w/no identified risk factors<br>• Deep needle or incisional biopsy<br>• Cardiovascular imaging studies w/contrast, no identified risk factors<br>• Obtain fluid from body cavity | • Minor surgery with identified risk factors<br>• Elective major surgery w/o risk (open,percutaneous, or endoscopic)<br>• Prescription drug management<br>• Therapeutic nuclear medicine<br>• IV fluids with additives<br>• Closed treatment of fracture or dislocation w/o manipulation |
| **High** | • 1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment<br>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function<br>• Abrupt change in neurologic status | • Cardiovascular imaging studies w/contrast w/ identified risk factors<br>• Cardiac eletrophysiological tests<br>• Diagnostic endoscopies w/indentified risk factors<br>• Discography | • Elective major surgery (open, percutaneous or endoscopic) w/risk<br>• Emergency major surgery (open, percutaneous or endoscopic)<br>• Parenteral controlled substances<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

# DETERMINING THE FINAL "COMPLEXITY" MEDICAL DECISION MAKING

Does not Apply to 99202-99215

Final Complexity of MDM is determined by 2 of the 3 elements from the table below:

| | | | | |
|---|---|---|---|---|
| A. Number of diagnoses or management options | ≤ 1 Minimal | 2 Limited | 3 Multiple | ≥ 4 Extensive |
| B. Amount and complexity of data to be reviewed | ≤ 1 Minimal | 2 Limited | 3 Multiple | ≥ 4 Extensive |
| C. Risk of complications and/or morbidity or mortality | Minimal | Low | Moderate | High |
| COMPLEXITY OF DECISION MAKING | Straight Forward | Low Complexity | Moderate Complexity | High Complexity |

**Per CMS and certain MACs, Medical Necessity Determines Payment.**

**"Medical necessity of a service is the overarching criterion for payment. Do not submit a higher level of E/M service when a lower level of service is warranted.** The volume of documentation should not be the primary influence upon which the service is submitted. Select the code for the service based upon the content of the service. The service furnished and submitted must meet the definition of the code."

# Established Patient Office/Outpatient Visits (2020)

| 99211 | 99212 | 99213 | 99214 | 99215 |
|---|---|---|---|---|
| N/A | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive |
| N/A | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive |
| N/A | Straightforward | Low | Moderate | High |

Start in highest level…established patients required 2/3 key components prior to 2021

# New Patient Office/Outpatient Visits (2020)

| 99201 | 99202 | 99203 | 99204 | 99205 |
|---|---|---|---|---|
| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| Straightforward | Straightforward | Low | Moderate | High |

Start in highest level…new patients required 3/3 key components prior to 2021

# New Patient Office/Outpatient Visits (2021)

| 99201 | 99202 | 99203 | 99204 | 99205 |
|---|---|---|---|---|
| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| Straightforward | Straightforward | Low | Moderate | High |

MDM or TIME are used to determine level of service

# 2021 Evaluation and Management Changes

- Clinicians will be able to select new and established patient (outpatient) visits based on time *or* medical decision making (MDM)
- Prolonged Service add-on code (+99417). CPT developed a prolonged care code, which is in the 2021 CPT, for each additional 15 minutes of time spent on the calendar day of service. This prolonged services code is used to report total time, both with and without direct patient contact, after the time threshold for 99205 or 99215 is met.
- There are new guidelines for reporting CPT® codes 99202-99215 with updated definitions for medical decision making
- 99201 will be deleted for 2021
- Required levels of history and physical examination will become obsolete 1-1-2021 and history and physical examination will not be required "key" components (99202-99215)
- Time will be defined as "*total time spent on the date of the encounter*", and will include non-face-to-face work done on the same day, and will no longer require time to be dominated by counseling

# Time Associated With Office/Outpatient E&M in 2021

- CPT codes 99202-99215 are reserved for outpatient and ambulatory settings. All patients are outpatient until an actual admission occurs
- Per CMS, “time must meet or exceed the specific CPT code billed and should not be ‘rounded’ to the next higher level”. Do not apply the “midpoint” concept for E&M codes
    - 99202- 15-29 minutes
    - 99203- 30-44 minutes
    - 99204- 45-59 minutes
    - 99205- 60-74 minutes
    - 99211- *no specified time*
    - 99212- 10-19 minutes
    - 99213- 20-29 minutes
    - 99214- 30-39 minutes
    - 99215- 40-54 minutes

# What Activities Are Included In "*Total Time*"?

- Since 1992, time-based E&M coding was required to be face-to-face time in the outpatient setting and required 50%+ counseling/coordination of care
- For 2021, total visit time will be defined as time as "total time" spent on the same calendar date of the encounter and includes:
  - preparing to see the patient (including reviewing notes and test results)
  - obtaining and reviewing subjective information (e.g., patient history)
  - performing a medically appropriate physical examination/evaluation
  - counseling and educating the patient, family, caregiver
  - ordering diagnostic tests, procedures and prescribing medications
  - referring and communicating with other healthcare providers
  - documenting in the medical record and electronic health record system
  - independently interpreting tests (not billed) and communicating results
  - care coordination services (not billed) such as CCM and TCM

# February 2021 Update

- The following activities are NOT included in time counted toward E&M code selection:
  - the performance of other services that are reported separately
  - travel
  - teaching that is general and not limited to discussion that is required for the management of a specific patient
  - The “ordering  and actual performance and /or interpretation of diagnostic tests during a patient encounter

# New Prolonged Service Code for 2021

**# ✚ ● 99417** Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

# Medical Decision Making: 2021

1. "**Number of Diagnoses and Management Options**"
   - ➢Will be revised to read **"Number and Complexity of Problems Addressed"**
2. "**Amount and/or Complexity of Data to be Reviewed**"
   - ➢Will be revised to read **"Amount and/or Complexity of Data to be Reviewed and Analyzed"**
3. "**Overall Risk of Complications and/or Morbidity or Mortality**"
   - ➢Will be revised to read **"Risk of Complications and/or Morbidity or Mortality of Patient Management"**

# Table 2 – CPT E/M Office Revisions
# Level of Medical Decision Making (MDM)

## Revisions effective January 1, 2021:

*Note: this content will not be included in the CPT 2020 code set release*

AMA AMERICAN MEDICAL ASSOCIATION

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Number and Complexity of Problems Addressed | Elements of Medical Decision Making<br>Amount and/or Complexity of Data to be Reviewed and Analyzed<br>**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|---|---|---|
| 99211 | N/A | N/A | N/A | N/A |
| 99202<br>99212 | Straightforward | **Minimal**<br>• **1** self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | Low | **Low**<br>• **2** or more self-limited or minor problems;<br>**or**<br>• **1** stable chronic illness;<br>**or**<br>• **1** acute, uncomplicated illness or injury | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | **Low risk of morbidity from additional diagnostic testing or treatment** |
| 99204<br>99214 | Moderate | **Moderate**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• **2** or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• **1** acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205<br>99215 | High | **High**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• **1** acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests** | **High risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

| Evaluation and Management Code (E&M Level) | Number and Complexity of Problems Addressed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | • 1 self-limited issue<br>• 1 minor problem | Straightforward |
| 99203<br>99213 | • 2+ self-limited problems<br>• 2+ minor problems<br>• 1 stable chronic illness<br>• 1 acute uncomplicated illness/injury | Low |
| 99204<br>99214 | • 1 or more chronic issues with exacerbation<br>• 2+ stable chronic illnesses<br>• 1 Undiagnosed problem with uncertain prognosis<br>• 1 Acute illness with systemic symptoms<br>• 1 Acute complicated illness | Moderate |
| 99205<br>99215 | • 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment<br>• 1 acute or chronic illness or injury posing threat to life/function | High |

****99211 does not require MDM and CPT code 99201 was deleted January 2021****

Source: AMA Revisions to MDM, effective 1/1/2021

# Number and Complexity of Problems Addressed

Define the problem:

- Self limited/minor – Runs its course without need for treatment/follow up
- Acute uncomplicated – short term with low risk of morbidity (e.g., allergic rhinitis)
- Chronic with exacerbation – acutely worsening/poorly controlled (e.g., asthma exacerbation)
- Undiagnosed new – new condition likely to result in high risk of morbidity (e.g., breast lump)
- Chronic with severe exacerbation - severe progression or side effects of treatment with significant risk of morbidity that may require hospital care (e.g., COPD with severe exacerbation

# 2021: New Terms For Needed for MDM Determination

- ***Problem***: refers to a "*disease, condition, illness, injury, symptom, sign, finding, complaint or other matter, with or without a diagnosis being established at the time of the encounter*"
- **Problem Addressed or Managed**: will refer to one "evaluated or treated at the encounter". Its important to mention that comorbidities or underlying disease are not to be considered in selecting the E&M level of service unless they are clearly addressed.
- ***Test***: refers to "*imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test*"
  - HINT: If a TEST is ordered AND reviewed as part of a particular encounter, it is only counted ONCE

# Clarification to the Term “Risk” (February 2021)

- Presenting problems/symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid
- The term “risk” relates to the risk of the condition. The risk of the condition is not necessarily the same as the risk of the management of a condition

| Evaluation and Management Code (E&M Level) | Amount and/or Complexity of Data to be Reviewed and Analyzed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal or none** | Straightforward |
| 99203<br>99213 | **Limited** (Must meet at least 1 of the following 2 categories)<br>• **Category 1: Tests and Documents**<br>• Any 2 of the following:<br>• **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test<br>• **Category 2: Assessment requiring "Independent Historian(s)"** | Low |
| 99204<br>99214 | **Moderate (**Must meet at least 1 of the following 3 categories)<br>• **Category 1: Tests, Documents and Independent Historian(s)**<br>• Any combination of 3 of the following:<br>• **1.** review of prior external note(s) from each unique source, **2.** Review results of each unique test, **3.** order of each unique test, **4.** Assessment requiring independent historian(s)<br>• **Category 2: Independent interpretation of test performed by another provider (not billed)**<br>• **Category 3: Discussion of Management or test interpretation with outside provider (not billed)** | Moderate |
| 99205<br>99215 | **Extensive**<br>• **Category 1**: **Tests, documents, or independent historian(s)** • Any combination of 3 from the following: **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test*; **4.** Assessment requiring an independent historian(s) ***or***<br>• **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); ***or***<br>• **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed) | High |

# 2021: New Terms For Needed for MDM Determination

- **External**: "*External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization*"
- **External physician or other qualified healthcare professional**: "*An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty*"
- **Independent historian(s)**: "*An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary*"
- **Independent Interpretation**: "T*he interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient*"

| Evaluation and Management Code (E&M Level) | Risk of Complications and/or Morbidity or Mortality of Patient Management | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal risk of morbidity from additional diagnostic testing or treatment**<br>• Rest, gargles and bandages | Straightforward |
| 99203<br>99213 | **Low risk of morbidity from additional diagnostic testing or treatment**<br>• OTC | Low |
| 99204<br>99214 | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br>• Prescription drug management (rx)<br>• Decision for minor surgery with identified patient or procedure risk factors (0, 10 days)<br>• Decision for elective major surgery without identified patient or procedure risk factors (90 days)<br>• Diagnosis or treatment significantly limited by *social determinants of health (SDoH)* | Moderate |
| 99205<br>99215 | **High risk of morbidity from additional diagnostic testing or treatment**<br>• Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.)<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis | High |

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# Section IV:

# E&M Case Studies / Audit Exercises

# Case #1 (Established patient)

Assessment:

1. Essential hypertension (I10), controlled on current prescription regimen (Lisinopril, 10mg, once orally per day). Refill rx order sent to CVS pharmacy for 60-day supply. Current BP 128/76. Patient to continue checking BP at home. Follow up 3 months.
2. Neuropathy (G62.9), currently under good control. Refill Gabapentin, 100mg, 3x orally per day.

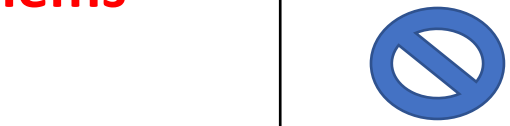
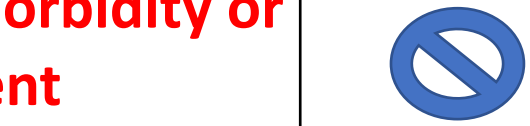
| Evaluation and Management Code (E&M Level) | Number and Complexity of Problems Addressed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | • 1 self-limited issue<br>• 1 minor problem | Straightforward |
| 99203<br>99213 | • 2+ self-limited problems<br>• 2+ minor problems<br>• 1 stable chronic illness<br>• 1 acute uncomplicated illness/injury | Low |
| 99204<br>99214 | • 1 or more chronic issues with exacerbation<br>• 2+ stable chronic illnesses<br>• 1 Undiagnosed problem with uncertain prognosis<br>• 1 Acute illness with systemic symptoms<br>• 1 Acute complicated illness | Moderate |
| 99205<br>99215 | • 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment<br>• 1 acute or chronic illness or injury posing threat to life/function | High |

| Evaluation and Management Code (E&M Level) | Amount and/or Complexity of Data to be Reviewed and Analyzed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal or none** | Straightforward |
| 99203<br>99213 | **Limited** (Must meet at least 1 of the following 2 categories)<br>• **Category 1: Tests and Documents**<br>• Any 2 of the following:<br>• **1.** review prior external … EACH unique test<br>• **Category 2: Assessm…** | Low |
| 99204<br>99214 | **Moderate (**Must m… 3 categories)<br>• **Category 1: T… …istorian(s)**<br>• Any combin… the follow…<br>• **1.** review o… rnal note(s) from … **2.** Review results of ea… est, **3.** order of each uniqu… ssessment requiring … an(s)<br>• **Category 2 … nt interpretation of test … ther provider (n…**<br>• **Category 3: … of Management or test inter… side provi… ed)** | Moderate |
| 99205<br>99215 | **Extensive**<br>• **Category 1**: **Tests, … dependent historian(s)** • Any … the following: **1.** Review of prior exte… of each unique test*; **3.** Ordering of each unique … n(s) ***or***<br>• **Category 2: Independent inte… …tion of a test performed by another physician/other qualified health care p…<br>• **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed) | High |

| Evaluation and Management Code (E&M Level) | Risk of Complications and/or Morbidity or Mortality of Patient Management | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal risk of morbidity from additional diagnostic testing or treatment**<br>• Rest, gargles and bandages | Straightforward |
| 99203<br>99213 | **Low risk of morbidity from additional diagnostic testing or treatment**<br>• OTC | Low |
| 99204<br>**99214** | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br>• **Prescription drug management (rx)**<br>• Decision for minor surgery with identified patient or procedure risk factors (0, 10 days)<br>• Decision for elective major surgery without identified patient or procedure risk factors (90 days)<br>• Diagnosis or treatment significantly limited by *social determinants of health (SDoH)* | **Moderate** |
| 99205<br>99215 | **High risk of morbidity from additional diagnostic testing or treatment**<br>• Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.)<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis | High |

# Case #1: DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by 2 of the 3 elements from the table below:

| | | | | |
|---|---|---|---|---|
| **Number and Complexity of Problems Addressed** |  |  | 2 Stable Chronic Conditions |  |
| **Amount and/or Complexity of Data to be Reviewed and Analyzed** |  |  |  |  |
| **Risk of Complications and/or Morbidity or Mortality of Patient Management** |  |  | Prescription Drug Management |  |
| LEVEL OF DECISION MAKING | Straight Forward | Low Complexity | Moderate Complexity | High Complexity |

**MODERATE COMPLEXTY FOR EST PATIENT = 99214**

# Case #2 (new patient)

CC: URI symptoms

History:

16-year-old new patient presents with 2-day history of coughing and shortness of breath. Patient denies chest pain.

Examination:

General: WDWN 16-year-old male in NAD. BMI 20.27, Pulse 82, Temp 99.3, Height 5’ 8”, Weight 158 lbs.

Eyes: PERRLA. Ears: No pain, inflammation, TMs wnl. No lymphadenopathy. Heart: RRR, no murmur. Lungs: CTA, no wheezing.

Assessment/Plan:

1. Acute Respiratory Infection (URI) (J06.9)
   - Rx: ProAir HFA Aerosol Solution, 30 days, 1 refill, 2 puffs per day as needed
   - Rx: Zithromax 200 mg/5ml, orally once/day for 5 days
   - Follow up prn

| Evaluation and Management Code (E&M Level) | Number and Complexity of Problems Addressed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | • 1 self-limited issue<br>• 1 minor problem | Straightforward |
| **99203**<br>99213 | • 2+ self-limited problems<br>• 2+ minor problems<br>• 1 stable chronic illness<br>• **1 acute uncomplicated illness/injury** | **Low** |
| 99204<br>99214 | • 1 or more chronic issues with exacerbation<br>• 2+ stable chronic illnesses<br>• 1 Undiagnosed problem with uncertain prognosis<br>• 1 Acute illness with systemic symptoms<br>• 1 Acute complicated illness | Moderate |
| 99205<br>99215 | • 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment<br>• 1 acute or chronic illness or injury posing threat to life/function | High |

| Evaluation and Management Code (E&M Level) | Amount and/or Complexity of Data to be Reviewed and Analyzed | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal or none** | Straightforward |
| 99203<br>99213 | **Limited** (Must meet at least 1 of the following 2 categories)<br>• **Category 1: Tests and Documents**<br>• Any 2 of the following:<br>• **1.** review prior external … EACH unique test<br>• **Category 2: Assessm…** | Low |
| 99204<br>99214 | **Moderate (**Must m… 3 categories)<br>• **Category 1: T… …istorian(s)**<br>• Any combin… the follow…<br>• **1.** review o… rnal note(s) from … **2.** Review results of ea… est, **3.** order of each uniqu… ssessment requiring … an(s)<br>• **Category 2 … nt interpretation of test … ther provider (n…**<br>• **Category 3: … of Management or test inter… side provi… ed)** | Moderate |
| 99205<br>99215 | **Extensive**<br>• **Category 1**: **Tests, … dependent historian(s)** • Any … the following: **1.** Review of prior exte… of each unique test*; **3.** Ordering of each unique … n(s) ***or***<br>• **Category 2: Independent inte… …tion of a test performed by another physician/other qualified health care p…<br>• **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed) | High |

| Evaluation and Management Code (E&M Level) | Risk of Complications and/or Morbidity or Mortality of Patient Management | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | Minimal risk of morbidity from additional diagnostic testing or treatment<br>• Rest, gargles and bandages | Straightforward |
| 99203<br>99213 | Low risk of morbidity from additional diagnostic testing or treatment<br>• OTC | Low |
| **99204**<br>99214 | Moderate risk of morbidity from additional diagnostic testing or treatment<br>• **Prescription drug management (rx)**<br>• Decision for minor surgery with identified patient or procedure risk factors (0, 10 days)<br>• Decision for elective major surgery without identified patient or procedure risk factors (90 days)<br>• Diagnosis or treatment significantly limited by *social determinants of health (SDoH)* | **Moderate** |
| 99205<br>99215 | High risk of morbidity from additional diagnostic testing or treatment<br>• Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.)<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis | High |

# Case #2: DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by 2 of the 3 elements from the table below:

| | | | | |
|---|---|---|---|---|
| **Number and Complexity of Problems Addressed** | | **1 acute uncomplicated illness/injury** | | |
| **Amount and/or Complexity of Data to be Reviewed and Analyzed** | | | | |
| **Risk of Complications and/or Morbidity or Mortality of Patient Management** | | | RX MGT | |
| LEVEL OF DECISION MAKING | Straight Forward | Low Complexity | Moderate Complexity | High Complexity |

**LOW COMPLEXTY FOR NEW PATIENT = 99203**

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# Section V:

# Review Questions and Exercises

## Section Review and Exercises

To determine the complexity of medical decision making (MDM), how many of the 3 components of MDM are required?

a) 2 of the 3 MDM elements are required to determine overall “complexity”
b) Only the level of risk is required to qualify for a particular “complexity” of MDM
c) 2 of the 3 elements are required for established patient and all 3 for new patient E&M visits
d) All 3 MDM elements are required to determine the overall “complexity”

## Section Review and Exercises

In terms of reporting E&M codes from CPT, the user must consider which of the following?

a) The specific place of service
b) The type of patient being seen (e.g., new, established)
c) Whether the patient is presenting for a preventive service or a specific presenting problem or chief complaint
d) All of the above

# Section Review and Exercises

True or False?

Medicare IPPE is a once in a life-lime benefit offered to those enrolled to the Medicare program and must be performed within 24 months of enrollment?

a) True
b) False

## Section Review and Exercises

The Medicare Annual Wellness Visit codes (G0438 and G0439) are similar to the IPPE however, the AWV does not require the provider to _____ :

a) Perform and document a formal physical examination of multiple body areas/organ systems other than height, weight, BP and BMI and visual acuity examination
b) Provide a depression screening assessment
c) Establish an appropriate written screening schedule for the beneficiary
d) Review and/or update a health risk assessment (HRA)

## Section Review and Exercises

CPT provides a specific definition of a “new” patient suggesting that a new patient has not received any covered professional _____ service from the provider or any other provider of the same group in the same _____ in the previous ___ years:

a) E&M service, provider, 2
b) Face-to-face, specialty/subspecialty, 3
c) Surgical procedures, service location, 3
d) None of these responses are accurate

## Section Review and Exercises

CPT is authored by _____ and payment policy is maintained by _____:

a) Centers for Medicare and Medicaid Services, the American Medical Association (AMA)

b) The Department of Health and Human Services, the Centers for Medicare and Medicaid Services

c) The American Medical Association (AMA), various payers and their participation contracts / coverage guidelines

d) The American Medical Association (AMA), particular State Departments of Health

## Section Review and Exercises

All medical record entries must be complete, legible, dated and signed within _____:

a) 24 hours
b) There is not currently a specific CMS requirement however it would be wise to check with local carriers (e.g., MAC) to understand local guidance and to create policy language encouraging providers to sign and closed in a “reasonable” timeframe
c) no more than 5 days
d) no more than 1 month

## Section Review and Exercises

CPT codes are also known as:

a) Level I codes of the HCPCS family
b) Medicare and Medicaid endorsed codes that are all recognized by CMS as payable services
c) Category II codes
d) The only codes that can be submitted to payers for reimbursement

## Section Review and Exercises

CPT was first authored in 1966 but the 1st Evaluation and Management (E&M) documentation guidelines **with reference to history, examination and medical decision making** were introduced in _____:

a) 1997
b) 1992
c) 1988
d) 1995

## Section Review and Exercises

In terms of E&M guidelines in 2021, providers are required to select the overall level of office/outpatient E&M service based on:

a) Face-to-face time or medical decision making
b) History and physical examination
c) Medical decision making
d) Total time on the date of the encounter or medical decision making

## Section Review and Exercises

The appropriate HCPCS II code providers should select for Medicare covered distant site telehealth services is:

a) Q3014
b) G0438 or G0439
c) G2025
d) G0402

## Section Review and Exercises

In order for smoking and tobacco use cessation visits (CPT codes 99406 and 99407) to be payable, the provider must document _____:

a) the patient's tobacco use
b) the patient is willing to attempt to quit
c) the specific amount of time spent with the patient
d) all of the above

## Section Review and Exercises

Smoking and tobacco use cessation counseling visits first became payable in _____

a) 2014 under the Affordable Care Act
b) 1992 with the implementation of the RBRVS
c) 1996 under the Balanced Budget Act
d) March 2020 as a provision of the CARES Act

## Section Review and Exercises

True or False?

An “extended” HPI always requires that a minimum of 4 of the 8 elements of the HPI are documented

a) True
b) False

# Section Review and Exercises

1995 E&M guidelines require understanding Medicare MAC guidance and focus on the number of _____ that are physically examined while 1997 guidelines require us to count _____ to determine the level of examination performed:

a) “Bullets” or elements, organ systems
b) Body areas and/or organ systems, the specific amount of minutes it takes to perform the examination
c) Body areas and/or organ systems, the number of “bullets” or elements from a defined set of specific examination items
d) None of the above

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