2021 Practice Enhancement Seminar

2021 Office E&M Changes: The Old is New

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Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or
  - 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives

- Know the definitions of the types of conditions that we use in our evaluation and management services as well as how to determine whether a patient is new or established in a practice
- Be able to correctly apply time-based coding in the ambulatory office practice setting
- Define the 2021 Medical Decision-Making components and be able to correctly apply them clinically

Changes….? What changes….?

- Massive overhaul in E/M in the outpatient office setting across all specialties
  - Designed to simplify code selection and decrease documentation burden
  - No longer 99201, still with 99202-99215 (so, 99211 still exists). No bundling.
  - RVUs adjusted variably; conversion factor was adjusted DOWN – then UP (~ -2%)
- The 1995 and 1997 Guidelines are no longer to be used in ambulatory office setting
  - The "history" and "exam" are no longer "Key Components" to support billing
  - Document such now when "medically appropriate" and report when "reasonable and necessary and clinically appropriate"[1]
  - Code selection can be made based on Time or on Medical Decision Making (both defined differently in 2021)
- New codes for time related to prolonged service

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

What has NOT changed in the office setting….?

- Who is "new" and "established"?[1]
- New Patients
  - One who has NOT received any face-to-face professional service from the physician/qualified healthcare professional ("Provider") OR another Provider of the exact same specialty/subspecialty who belongs to the same group practice within the last three years
    - If so, then established
  - If employed by a medical group/system, then all those of the same specialty/subspecialty taxonomy would limit the new patient options within three years

[1] CPT 2021 Professional Edition, pp5-8.

Other Considerations

- FQHC/RHC
  - … "any provider" within the organization. Once seen, not "new"

- Advanced Practice RNs (Nurse Practitioners, NPs) and Physician Assistants (PAs)
  - No specialty/subspecialty designation
    - First time visit to a NP/PA is new, all other visits within the organization are established within the three-year window

Time Changes….? What changes….?

- Definitions[1] are placed in CPT for clarity
  - Time: can use to select level of E/M in the ambulatory space except for 99211 and 99201 – does not need to be >50% counseling/care coordination
    - Total time spent by the provider on a given day in clinical work related to a patient
      - Review of test(s), review of separately obtained history, performing an exam, ordering medications/tests/procedures, referring/communicating with other providers, documentation in the clinical record, independent interpretation of tests (not separately reported*), and communicating such to family/caregiver, care coordination (not separately reported*)
      - *Not separately reported: if you get paid to do this otherwise, then it is not MDM related time
    - For ambulatory office care, it does NOT have to constitute >50% of time spent in care coordination or counseling. In other E/M services, it does. Still not allowed in ED.

[1] CPT 2021 pp 5-17

Billing Basis: Time-based

- Specific for codes 99202-99205, 99212-99215
  - Time can be assigned based on TOTAL TIME rendered by a Provider in a CALENDAR DAY.
    - Review of test(s), review of separately obtained history, performing an exam, ordering medications/tests/procedures, referring/communicating with other providers, documentation in the clinical record, independent interpretation of tests (not separately reported*), and communicating such to family/caregiver, care coordination (not separately reported*)
    - *Not separately reported: if you get paid to do this otherwise, then it is not MDM related time
    - With split/shared visits (physician and other qualified health care professional(s) both deliver care), only count the times spent together once.
    - Staff time does NOT count in this total time calculation
    - DOCUMENT TIME IN THE NOTE to support the billing level IF time is the driver of charge

CPT 2021 Professional Edition pp5-17

Time-based Calculation 2020 vs 2021

New Patient E/M Code	Typical Time (2020)	TOTAL Time (2021)
~~99201~~	~~10 minutes~~	~~DELETED~~
99202	20 minutes	**15+** minutes
99203	30 minutes	**30+** minutes
99204	45 minutes	**45+** minutes
99205	60 minutes	**60+** minutes

So, remember for 99202-99205: 15 – 30 – 45 – 60 as the minimum total time thresholds

Time-based Calculation 2020 vs 2021

Est. Patient E/M Code	Typical Time (2020)	TOTAL Time (2021)
99211	5 minutes	Time Threshold Removed
99212	10 minutes	**10+** minutes
99213	15 minutes	**20+** minutes
99214	25 minutes	**30+** minutes
99215	40 minutes	**40+** minutes

Remember for 99212-99215: 10 – 20 – 30 – 40 as the minimum total time thresholds

Prolonged Care Code for Time-based coding (2021)

- G2212 (Medicare patients)
  - Use this for prolonged care associated with the highest new and established office visit codes 99205 and 99215 ONLY
  - Use instead of 99358 (1st hr non-FTF), 99359 (ea. 30 min more), 99417 (Commercial)
  - Add-on code for 15+ minutes spent in addition to the UPPER TIME THRESHOLD for these codes
    - 99205 (60-74 minutes) add G2212 when more than 15' (74+15= **89**) minutes total time
    - 99215 (40-54 minutes) add G2212 when more than 15' (54+15= **69**) minutes total time
      - For EACH additional 15+ minutes, then add the G2212 code
  - Document the TOTAL TIME to support the billing
- 99417:
  - Add-on code for prolonged care, but the threshold is on the LOWER time (60' and 40')
  - Commercial payors: often to each his own, so ask how they define it.

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

Time take-aways

- Total time for THAT DAY…finish notes "after midnight"…not included
- Staff time does NOT count, only provider time related to ONE patient
- ALL time counts – including dictation of notes (be reasonable), review of labs, talking to family or other providers. Add it up and make a note in record.
- Waiting on the phone for a consultant or auth # is NOT countable
- The time it takes for you to read an EKG or CXR IS countable if you are billing based on TIME….unless you are getting paid to read the EKG or CXR, etc.*
- I see time trumping MDM when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

If not Time, then Medical Decision Making (MDM)

- Similarities to the 2020 version of MDM: 3 components, different verbiage
  - **Diagnoses** managed (number and type) → Number and Complexity of **Problems**
  - **Data** reviewed to manage diagnoses of visit → Amount/Complexity of **Data** Reviewed/Analyzed
  - **Risk** associated with the management plan → **Risk** of Complications and/or Morbidity/Mortality of Patient Management
- Similarities to the 2020 version of MDM: 2 of 3 needed to meet MDM
- Similarities to the 2020 version of MDM: A Very Busy Chart …… !!!!

MDM Changes….? What changes….?

- Definitions of illnesses that are addressed/managed[1]:
  - Minimal: May not require the presence of a Provider, but care is delivered under their supervision (nurse collected BP check*)
  - Self-limited/minor: Problem that runs a definite course, is transient in nature, and not likely to permanently alter health status (contusion, superficial abrasion*)
  - Stable, chronic illness: Expected duration of at least one year, or until death. Risk of morbidity without treatment is significant. "Stable" is defined by the treatment goals and if not at goal, then is not stable. (controlled BP, stable DM w A1c 7, etc.*)
  - Chronic illness with exacerbation, progression, treatment side effects: A condition that is not at goal and needs management. Hospitalization is not considered. (uncontrolled BP, diabetic with A1c 8, etc.*)
  - Chronic illness with severe exacerbation … : Severe exacerbation and hospitalization is considered. (AECOPD with in-office treatment, close f/u in lieu of hospitalization*)

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions

MDM Changes….? What changes….?

- Definitions of illnesses that are addressed/managed[1]:
  - Acute, uncomplicated illness/injury: Low risk of morbidity where treatment is considered. Full recovery expected with treatment. (simple sprain, uncomplicated cystitis, allergic URI)*
  - Acute, complicated injury: This requires treatment with inclusion of evaluation of additional body systems not directly a part of the injured organ. (concussion with brief LOC, abdominal trauma with r/o splenic contusion)*
  - Acute illness with systemic symptoms: Symptoms are systemic or in a single system but there is a high risk of morbidity without treatment. (pyelonephritis[1], pneumonitis[1], colitis[1], COVID*, influenza*)
  - Acute/chronic illness/injury that poses a threat to life/bodily function: Self explanatory. (Angina in CAD patient, abdominal pain in colitis patient, AMS with UTI)*
  - Undiagnosed new problem with uncertain prognosis: The problem in the differential diagnosis representing the condition may result in a high risk of morbidity without treatment. (new adenopathy, new breast lump)*. A "new problem to the provider" is no longer - now patient directed
- A problem does NOT count in the billing of an encounter when documentation of your management is lacking (others manage and you just "list", or you see/refer without assessing)

[1] CPT 2021 pp 5-17

*Dr. Ulmer's suggestions

MDM Changes….? What changes….?

- Definitions that touch other aspects of our care[1]:
  - Test: Imaging, laboratory, psychometric, or physiologic data. Single vs multiple definitions follow CPT code set. A basic metabolic panel (80047) is ONE test, not several. A CMET and CBC is TWO….
  - Independent historian(s): An individual who provides history in addition to a history provided by the patient or who gives because the patient is unable to provide the information. Document reason historian needed…developmental stage, dementia, or psychosis prohibits adequate collection. (caregiver of a demented patient, mother of an infant)*
  - Independent interpretation: Interpreting a test with a CPT code and a report is customary. Documentation does not need to conform to the standards of a complete report. If compensated for the interpretation (professional component) already, then this cannot weigh into the MDM of the encounter (no double-dipping)
  - Drug therapy requiring intensive monitoring for toxicity: Monitoring provided for assessment of adverse effects and not primarily for assessment of therapeutic efficacy. Less than quarterly and not routine. (BMET 2 wks after starting combination ACE/Diuretic → yes; BMET yearly for a BP pt → no)*

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions

MDM Changes….? What changes….?

- Definitions that touch other aspects of our care[1]:
  - Social Determinants of Health
    - Economic and social conditions that influence the health of people and communities. Correct documentation includes the addition of the ICD-10 codes. (job loss, food insecurity, homeless state)*
    - Adding SDOH data to current risk prediction models increases accuracy for predictive modeling in costs of care
    - SDOH alone in one model predicted health outcomes and costs as well as one based on clinical comorbid conditions[2]

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions
[2] *Circ Cardiovasc Qual Outcomes.* June 2020, pp290-298 (AHA journal).

2021 OUTPATIENT MEDICAL DECISION MAKING (MDM) – 2 OF 3 NEEDED

E/M LEVEL and MDM (99201 deleted, 99211 N/A	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or document reviewed counts in Category 1 below)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99202 (15-29 min) 99212 (10-19 min) Straightforward MDM	MINIMAL NUMBER AND COMPLEXITY • One self-limited or minor prob. (abrasion)	Minimal but usually none	Minimal risk of morbidity from additional diagnostic testing. Consider: Rest, superficial dressings, labs, EKG, EEG, etc.
99203 (30-44 min) 99213 (20-29 min) Low MDM	LOW NUMBER AND COMPLEXITY • 2 or more self-limited or minor prob. ***OR*** • 1 chronic stable illness (HTN) ***OR*** • 1 acute, uncomplicated illness/injury (UTI)	**(Must Meet 1 of 2 Categories)** Category 1: Tests and documents (any 2) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test ***OR*** Category 2: Assessment requiring an independent historian	Low risk for undergoing additional management Consider: OTC drugs, non-contrast imaging, PT/OT, skin bx, minor surgery
99204 (45-59 min) 99214 (30-39 min) Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects (AECOPD) • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis (Breast Lump) • Acute illness with systemic symptoms (flu) • Acute complicated injury (concussion)	**(Must meet 1 of 3 Categories)** Category 1: Tests, documents, historian (any 3) 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 an independent historian ***OR*** Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another physician (not separately billed) ***OR*** Category 3: Discussion of management or test interpretation • Discuss mgmt./ interpretation of test with another provider (not separately billed)	Moderate risk of morbidity from additional tests/treatment Consider: Rx mgmt., Discussion regarding minor surgery w/ patient or procedure risk factors Discussion regarding elective major surgery w/o risk factors Diagnosis or treatment significantly limited by social determinants of health
99205 (60-74 min) 99215 (40-54 min) High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects (AECOPD w hypoxia) • Acute/chronic illness that may pose threat to life or bodily f(x) – (acute abd pain → ED)	**Must meet 2 of 3 Categories noted above in Moderate MDM**	High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care, Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to deescalate care/decide DNR due to poor prog

2021 Outpatient Medical Decision Making (MDM) – 2 of 3 Needed

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Amount and/or Complexity of DATA Reviewed

- Each test that is ordered or reviewed, or each document that is reviewed, counts
  - Order (or review) a CBC – one element of credit
  - Order (or review) a CHEM-7 – ONE (not 7) elements of credit
  - Review ED notes from last weekend – get ONE element of credit if you note such review in the chart
    - Order a CBC, CMET, TSH, and Lipid → get FOUR elements of credit
    - Order a CBC, review the CHEM 7 from the ED and review the ED note → THREE
    - Order a CBC and review it TODAY, then get ONE (not TWO) elements of credit
- If you are already getting paid to interpret the test, (i.e., you own the EKG machine and are billing for the global performance of the test), then you **CANNOT** get MDM credit (already getting paid for the EKG)*
- Independent interpretation does not have to have a "formal" report
- Independent historian must contribute to MDM collection (NO: interpreter of a patient with normal cognition, YES: Mother of a 5 year old)
- There are CATEGORIES that these elements make up; a minimum number of element reviews is needed to meet the requirements of the CATEGORY

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2021 Outpatient MDM (cont.) – 2 of 3 Needed

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Clinical Example: COPD

- 66 YO with COPD. Med compliant. Symptoms x 4d. Worse sputum, discolored. No other complaints. Happens each year.
- VSS except sat is 88% on exertion, 91% at rest (RA).
- Nebs in office, sats 92 on ambulation. You recommend hospitalization. He refuses due to care issues with wife at home.
- You treat OP with close f/u tomorrow.

MDM take-aways

- 2+ chronic problems that are stable on Rx → Mod MDM (level 4, new or established)
- 1 New problem w uncertain prognosis/1 chronic exacerbation + Rx → level 4
  - Patient-specific problem, not provider specific, unlike 2020
  - Work-up or not is the same, unlike 2020
- If you have someone clinically unstable enough to mention "hospital care" (ED, in house), then they need close f/u (if they refuse) and a "story" that shows illness … and level 5 for your MDM work – even if the time spent was minimal
- If you own your machine, don't take credit for MDM for that test (EKG, CXR)*
- Talk to a parent of a 5-year-old = Moderate MDM for DATA
- Social Determinants of Health = Moderate MDM for RISK
- I see MDM trumping time most often EXCEPT when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

E/M Complexity Add-On Code (2021)

- G2211
  - "*Visit complexity inherent* *associated with medical care services what serve as* *ed health care services and/or with medical care se* *part of ongoing* *to a patient's single, serious, or complex conditi*
  - Established or n
  - Focus is on cor care del continuous of time
  - Team based car to be a par olistic, p entered, integrated around the illne he patient's ne ordi f specialty care
  - Include patient e goal-setting, sha g. ("care plan")
    - Add-on of G221 cumentation sho eing delivered
    - RVU 0.33 ($10.69)

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

Thanks!!

- Questions…?

- Nick Ulmer, MD CPC
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