ArchProCoding
RURAL & COMMUNITY HEALTH

Chart Auditing to Improve QOC and Maximize Shared Savings

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- For many years, the guidance we've received regarding E&M service leveling has been less than perfect...providers often thought more documentation simply meant higher levels of service could be reported. This "*note bloat*" mentality is no longer relevant with changes that took effect January 2021. Limited changes for 2022 will be discussed.

Required FQHC Resources

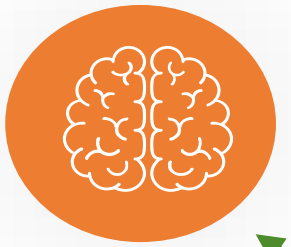
- Medicare Benefit Policy Manual, Chapter 13 http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf
  - Multiple visits may be allowed on the same day (Ch. 13, Section 40.3)
    - Patient seen and treated at two distinct times and for two distinct purposes
    - Medical and a mental health visit performed 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

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

What Path Do We All Share?

GREET THE PATIENT:
How does insurance type impact which claim form we use, patient cost sharing, and our revenue?



PREPARE TO SEE THE PATIENT:
Are you truly ready to handle the advanced issues of operating in a RHC/FQHC?

TREAT AND DOCUMENT THE VISIT:
Train staff on the actual documentation guidelines found in CPT, HCPCS-II, and ICD-10-CM manuals rather than shortcuts.

CODE THE FULL ENCOUNTER:
Manage the link(s) between the medical record and the "encounter form" and clarify who is truly "responsible" for coding.

CONFIRM DOCUMENTATION AND BILL:
Getting paid everything you deserve and meeting ACO/MCO reporting rules.

What is “quality” and why is it important?

IMPACT:

- From a public health perspective - state/federal governments, non-profits, grant-based health programs, and other parties are trying to use our data from the past to predict and impact future “outcomes.”

- Additionally, existing data related to a patient’s diagnosis/previous treatments may more easily identify and encourage patients to be referred to disease-specific programs

Applicable HIPAA Covered Code Sets

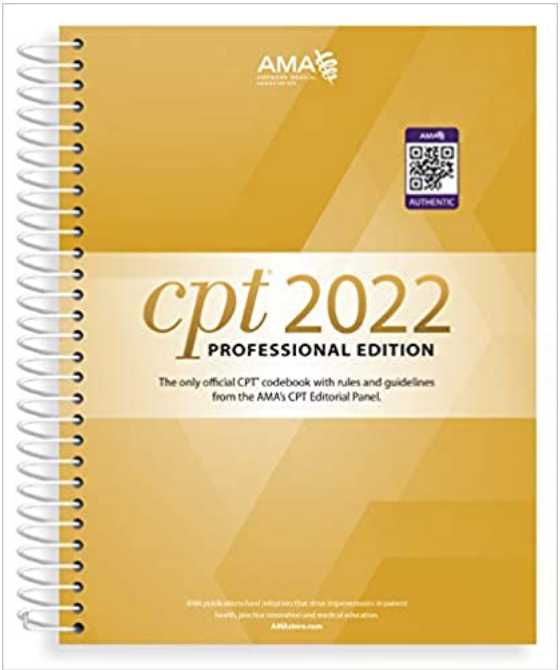
- CPT ®
  - Authored by AMA (updated annually – except for vaccine [2 times/year), and COVID-19 PHE
  - CPT is currently identified by the Centers for Medicare and Medicaid Services (CMS) as Level I of the Healthcare Common Procedure Coding System.
  - Typically, effective January 1st each year. New CPT update calendar in 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)

HIPPA Code Sets Impacting Quality & Care Management

- Behavioral & Primary Care Integration intent via BHI & Psych CoCM (*CPT/HCPCS-II/ICD-10-CM*)
- Care Management Services (*CPT/HCPCS-II*)
- Hierarchical Conditions Categories (HCC) concepts also known as “Risk Adjusted Coding” (*solely ICD-10-CM*)
- Healthcare Effectiveness Data & Information Set (HEDIS) measures (*combines CPT/HCPCS-II, and ICD-10-CM*)
- Performance Measurements (CPT Category II)
- Preventive medicine options (*CPT/HCPCS-II*)
- Social Determinants of Care/Population Health such as impact on lack of transportation, access to nutritional food, and housing instability (*primarily ICD-10-CM*)
- Substance/Opioid Disorders (SUD/OUD) and Medication-Assisted Treatment (MAT) (*combines CPT/HCPCS-II, and ICD-10-CM*)

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on RHC/FQHC Revenue
Care Management Services	✓	✓	✓	HIGH
CPT Category II Performance Measures	✓			LOW
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchal Conditions Categories (HCC)			✓	MEDIUM
HEDIS measures	✓	✓	✓	LOW
Population Health Prevention via Social Determinants of Health			✓	MEDIUM (as of 2021)
Primary Care & Behavioral Health Integration (ex. SUD/OUD/MAT/BHI/Psych CoCM)	✓	✓	✓	HIGH

2022 CPT Layout



AMA, 2022 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

Changes Impacting E&M Code Selection Introduced 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 requires a firm understanding of MDM and TIME as defined in CPT
  - Of course, auditing based on time seems easier in pure evaluation and management services
  - Be mindful of macros and templates… do not "clone" times to appear like all cases are the same
  - Using time requires the provider to carve out time offering other services, so MDM is typically the going to be the best option in these cases

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 Reported on CMS-1450 (UB-04) Revenue code 052X Modifier -95 Modifier –CS to waive cost-sharing	**$97.24 effective January 1, 2022**
Virtual Check-In and Virtual Care Communication	Remote evaluation or brief communication of patient (> 5 minutes) CPT codes G2010 / G2012	G0071 Reported on CMS-1450 (UB-04) Revenue code 052X No modifier requirement	**CY 2022 rate is $23.88**
E-Visits	On-line digital patient evaluation using patient portal	G0071 Reported on CMS-1450 (UB-04) Revenue code 052X	**CY 2022 rate is $23.88**
Telephone and Audio-Only Visits	Telephone evaluation and management (CPT codes 99441-99443)	G2025 Reported on CMS-1450 (UB-04) Revenue code 052X	**$97.24 effective January 1, 2022**

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 Z20.822 (Contact with and (suspected) exposure to COVID-19)
- 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 Z11.52 (Encounter for screening for COVID-19)

New ICD-10-CM Codes effective April 1, 2022

  - Z28.310 Unvaccinated for COVID-19
  - Z28.311 Partially vaccinated for COVID-19
  - Z28.39 Other underimmunization status
- 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*)

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'?

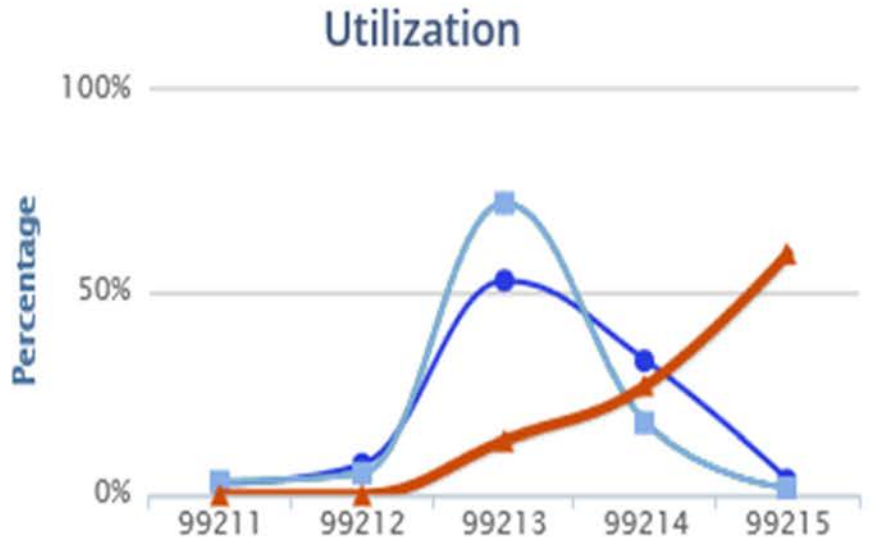
E&M Utilization Patterns

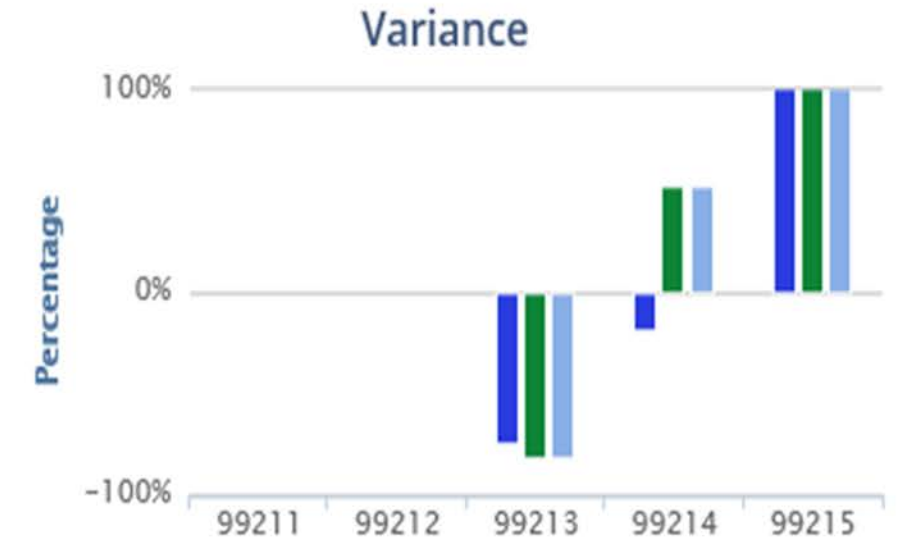
Utilization

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?
    - FQHC, RHC or 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 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.

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

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

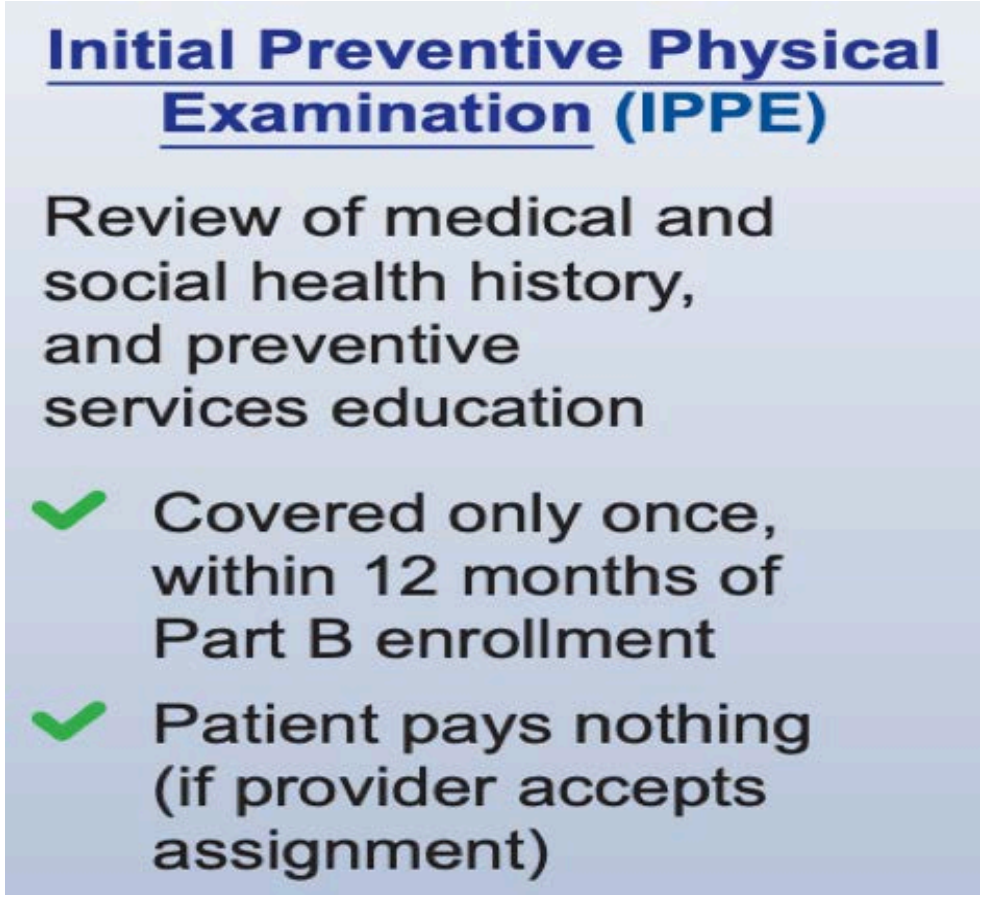
- Not covered by Medicare; prohibited by statute
- Patient pays 100% out-of-pocket

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



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

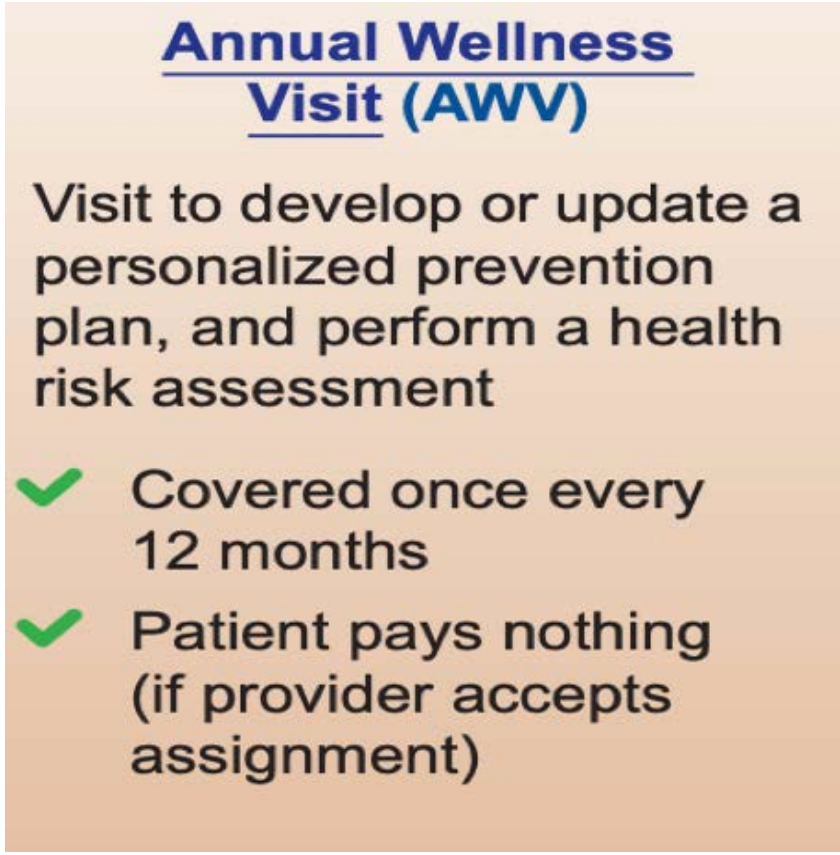
MLN Booklet for IPPE

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

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

SELECT A SERVICE | FREQUENTLY ASKED QUESTIONS | RESOURCES

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.

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/
    - Palmetto https://www.palmettogba.com/

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" as of 1/1/2021 for office and other outpatient E&M services

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)

Example: Determining the Level of History

Subjective (history)		
History of Present Illness (HPI) Location Quality Severity Duration Timing Context Associated Signs & Symptoms Modifying Factors	**Review of Systems (ROS)** Constitutional Eyes Ears/Nose/Mouth/ Throat Cardiovascular Respiratory Gastrointestinal Genitourinary Musculoskeletal Integumentary Neurologic Psychiatric Endocrine Hematologic/ Lymphatic Allergy/Immunologic	**Past, Family, and/ or Social History (PFSH)** Past Medical Family Medical 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 is not a required "key" component" for office/outpatient E&M codes selection (as of 1/1/2021)
- If unable to obtain history, be sure documentation clearly illustrates the reason(s) precluding the provider from getting the information
- As of 2019, providers need not re-document history captured by ancillary staff
  - History (especially HPI) must be '*verified*'
- "*Medically appropriate*" history must still be documented

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 *except psych & eye
Detailed	**"Extended"** **(Use MAC Guidance)**	12-17	12-17 *except psych & eye
Comprehensive	8+ Organ Systems	*Perform "All" *Document 2 from 9	*Perform "All" *Document "All Shaded" *Document 1+ "Unshaded"

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 must still 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."*

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

Recent Evaluation and Management Changes

- Clinicians will be able to select new and established patient (outpatient) visits based on time *or* medical decision making (MDM)
- There are new guidelines for reporting CPT® codes 99202-99215 with updated definitions for medical decision making
- 99201 was deleted in 2021
- 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

Medical Decision Making: 2021 & Beyond

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

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **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 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(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
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• 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
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• 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 99212	• 1 self-limited issue • 1 minor problem	Straightforward
99203 99213	• 2+ self-limited problems • 2+ minor problems • 1 stable chronic illness • 1 acute uncomplicated illness/injury	Low
99204 99214	• 1 or more chronic issues with exacerbation • 2+ stable chronic illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 Acute illness with systemic symptoms • 1 Acute complicated illness	Moderate
99205 99215	• 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment • 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

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 99212	**Minimal or none**	Straightforward
99203 99213	**Limited** (Must meet at least 1 of the following 2 categories) • **Category 1: Tests and Documents** • Any 2 of the following: • **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test • **Category 2: Assessment requiring "Independent Historian(s)"**	Low
99204 99214	**Moderate (**Must meet at least 1 of the following 3 categories) • **Category 1: Tests, Documents and Independent Historian(s)** • Any combination of 3 of the following: • **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) • **Category 2: Independent interpretation of test performed by another provider (not billed)** • **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	Moderate
99205 99215	**Extensive** • **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*** • **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); ***or*** • **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 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • OTC	Low
99204 99214	**Moderate risk of morbidity from additional diagnostic testing or treatment** • Prescription drug management (rx) • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • Diagnosis or treatment significantly limited by *social determinants of health (SDoH)*	Moderate
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis	High

Case Study (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.

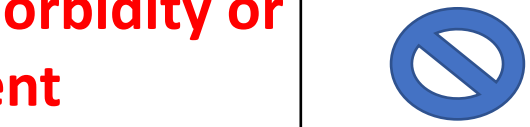
Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	• 1 self-limited issue • 1 minor problem	Straightforward
99203 99213	• 2+ self-limited problems • 2+ minor problems • 1 stable chronic illness • 1 acute uncomplicated illness/injury	Low
99204 99214	• 1 or more chronic issues with exacerbation • 2+ stable chronic illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 Acute illness with systemic symptoms • 1 Acute complicated illness	Moderate
99205 99215	• 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment • 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 99212	**Minimal or none**	Straightforward
99203 99213	**Limited** (Must meet at least 1 of the following 2 categories) • **Category 1: Tests and Documents** • Any 2 of the following: • **1.** review prior external …f EACH unique test • **Category 2: Assessn…	Low
99204 99214	**Moderate (**Must m… 3 categories) • **Category 1: T… …ents … …istorian(s)** • Any combin… …f the follow… • **1.** review o… …rnal note(s) from … …e, **2.** Review results of ea… …est, **3.** order of each uniqu… …ssessment requiring i… …ian(s) • **Category 2 …ent interpretation of test … …ther provider (n…** • **Category 3: …of Management or test inter… …side provi… …ed)**	Moderate
99205 99215	**Extensive** • **Category 1**: **Tests… …ependent historian(s)** • Any c… …the following: **1.** Review of prior exte… …of each unique test*; **3.** Ordering of each unique… …(s) ***or*** • **Category 2: Independent inte… …tion of a test performed by another physician/other qualified health care p… • **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 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • OTC	Low
99204 **99214**	**Moderate risk of morbidity from additional diagnostic testing or treatment** • **Prescription drug management (rx)** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • Diagnosis or treatment significantly limited by *social determinants of health (SDoH)*	**Moderate**
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • 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

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