Changes to E&M Services from Medicare

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- NO DISCLOSURES
- This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion

Patients Over Paperv

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patientcare.
- This Administration has listened and is taking action.
- The Physician Fee Schedule final rule addresses those problems by streamlining documentation requirements to focus on patient care and modernizing payment policies so seniors and others covered by Medicare can

Why Change?

- Stakeholders have said that the E/M documentation guidelines and the code set itself are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.

- According to stakeholders, some aspects of required documentation are redundant

- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.

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Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is necessary for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.

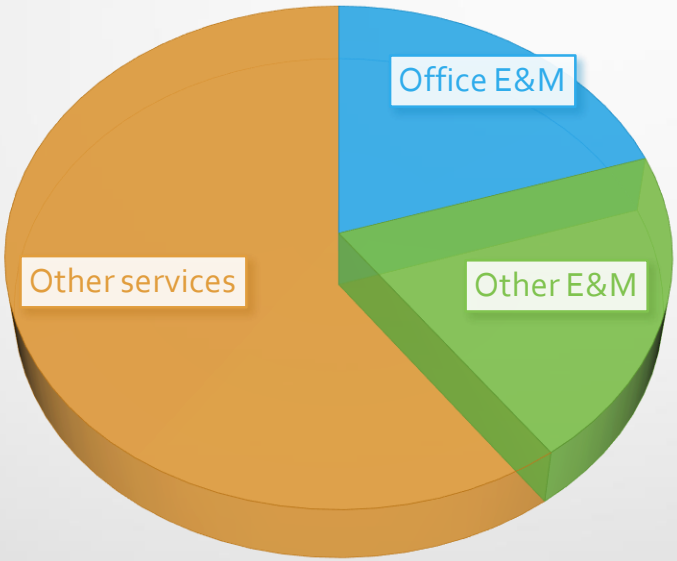
Levels of E/M Visits and PFS Payment

- Physicians and other practitioners paid under the PFS bill for office/outpatient E/M visits using a set of CPT codes that distinguish visits based on level of complexity, site of service, and whether the patient is new or established.
- The three key components when selecting the appropriate code to bill are **history**, **examination**, and **medical decision making (MDM)**. For visits that consist predominantly of counseling and/or coordination of care, time (in conjunction with MDM) can be used as the key or controlling factor determining visit level.
- There are currently five levels of office/outpatient visits (reported using CPT codes 99201-99215). Payment increases with each level.

Evaluation & Management Visits Per CMS

- E&M visits comprise
  - 40% of allowed charges for PFS services
- Office/outpatient E/M
  - 20% allowed charges for PFS

PFS CHARGES



Podiatric Evaluation and Management Services (HCPCS codes GPD0X and GPD1X)

- NOT FINALIZED FOR 2019
- Proposal was to create two codes
  - GPD0X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient)
  - GPD1X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient), to describe podiatric evaluation and management services.

Outpatient Therapy

- **Discontinue Functional Status Reporting Requirements**
- Currently, outpatient therapy claims need to include non-payable HCPCS G-codes and modifiers to describe a patient's functional limitation and severity
  - Requirements are outdate
- •Medicare will no longer requ tient therapy services furnished on or after January

Self Care G-code Set:

- G8987 Self care current status
- G8988 Self care goal status
- G8989 Self care D/C status

Other PT/OT Primary G-code Set:

- G8990 Other PT/OT current status
- G8991 Other PT/OT goal status
- G8992 Other PT/OT D/C status

- **Mobility G-code set:**
- G8978 Mobility status
- G8979 Mobility goal status
- G8980 Mobility D/C status

Outpatient Therapy

- **Therapy Services Furnished by Therapy Assistants**
- The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service, effective January 1, 2022.
- The law requires CMS to establish a new modifier by January 1, 2019.
  - One modifier for therapy services furnished in whole or in part by a physical therapy assistant
  - Second modifier for therapy services furnished in whole or in part by an occupational therapy assistant
- Modifiers will be required on Outpatient Physical and Occupational Therapy claims as of January 1, 2020.

Teaching Physician Documentation

MCM Chapter 12 Sec100.1.1

A. General Documentation Instructions and Common Scenarios

- For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:
  - That they performed the service or were physically present during the key or critical portions of the service when performed by the resident

    AND
  - The participation of the teaching physician in the management of the patient

- CMS/Medicare felt there were
  - "duplicative requirements for notations that may have previously been included in the medical records by residents or other members of the medical team."

Teaching Physician Documentation

- CMS/Medicare in looking to "reduce burden and duplication of effort for teaching physicians" have made the following changes :
  - The medical record must document that the teaching physician was present at the time the service was furnished
  - The presence of the teaching physician during procedures and E/M services may be demonstrated by the notes in the medical records made by a physician, resident, or nurse
  - The medical record must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary, and that the extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

- The accuracy of the documentation that shows the teaching physicians involvement in an E/M Service along with the review and verification of the accuracy of notations included by residents and members of the medical team, are still the responsibility of the teaching physician.

Home Visits

- Previously
  - The beneficiary need not be confined to the home to be eligible for visit
  - However, Medicare Claims Processing Manual provision requiring that the medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit
  - Payment Higher in Home setting
- Final rule 2019 finalized the policy change to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office, as proposed, effective January 1, 2019.

Final Policies for Office/Outpatient Visits Starting in 2019

- For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for office/outpatient visits, that do not require changes in coding/payment.
  - Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit

Final Policies for Office/Outpatient Visits Starting in 2019

- For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for office/outpatient visits, that do not require changes in coding/payment.
  - For established patients history and exam, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.
  - Additionally, we are clarifying that for new and established patients chief complaint and history, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

2019 – Office E&M Only(99201-99215) New & Established

- Chief Complaint and History
  - Practitioners need not re-enter in the medical record, information that has already been entered by ancillary staff or the beneficiary.
  - The practitioner may simply indicate in the medical record that they reviewed and verified this information

- Nothing specific in final rule on what language should be used to accomplish this
  - Suggestion use prior documentation requirement
    - Reference document, by name
    - Reference date of that document
    - State any changes

1995 & 1997 Evaluation and Management Guidelines

- Currently, both the guidelines provide such flexibility for certain parts of the history for established patients, stating, "A Review of Systems "ROS" and/or a pertinent past, family, and/or social history (PFSH) obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information.
- This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - Noting the date and location of the earlier ROS and/or PFSH.

2019- Office Established Only 99211-99215

- Established Patients - History and exam
  - If relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit or on pertinent items that have NOT changed
  - Practitioners need not re-record the defined list of elements if there is evidence that the practitioner had reviewed the previous information and updated it as needed

- Nothing specific in final rule on what language should be used to accomplish this
  - Suggestion use prior documentation requirement
    - Reference document, by name
    - Reference date of that document
    - State any changes
    - Note of pertinent positives and pertinent negatives

New Technology Based Service Code for 2019

- G2012 - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

G2012 – Virtual Check In

- Only established patients
- Only real-time audio only telephone interactions in addition to synchronous, two way audio interactions enhanced with video or other kinds of data transmission
- Verbal consent needs to be noted in the record for EACH instance of use of code
- No frequency limitations at this time
- Co-Pays apply
- Must be performed by a billing provider
  - Clinical staff contact not billable
- Not considered Telehealth (none of their restrictions)

New Technology Based Service Code for 2019

- Historically, any routine non face-to-face communication that takes place before or after an in-person visit to be bundled into the payment for visit
- Amount of face-to-face work for certain kinds of patients rise higher than for others
  - Creates disparities in payment
- Advances in communication technology have changed patients' and practitioners' expectations regarding the quantity and quality of information that can be conveyed via communication technology
- Brief check in services via communication technology to evaluate whether or not an office visit or other service is warranted
  - When furnished prior to an office visit
    - Considered bundled in
  - When check in service does not lead to an office visit
    - No office visit to bundle into

New Technology Based Service Code for 2019

- G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

- Follow up with patient
  - Phone call
  - Audio/video communication
  - Secure text messaging
  - Email
  - Patient portal communication

G2010 – Store and Forward

- Only for established patients
- Practitioner's evaluation of a patient generated still or video image transmitted by the patient
  - Subsequent communication of the practitioner's response to the patient
    - Unlike G2012 which is realtime
- Verbal consent needs to be noted in the record for EACH instance of use of code
- No frequency limitations at this time
- Co-Pays apply
- Must be performed by a billing provider
  - Clinical staff contact not billable
- Not considered Telehealth (none of their restrictions)

Payment to Nonexcepted Hospital Off-Campus Provider-Based Departments

- Amendments made by section 603 of the Bipartisan Budget Act of 2015
- •Prohibits certain off-campus provider-based departments from billing the Hospital Outpatient Prospective Payment System (OPPS)
- •Current payment is 40 percent of the OPPS rate
- •Next year, payment will be 40 percent of the OPPS rate
- •No other changes for 2019 regarding which departments would be considered excepted from these requirements; also, no changes in the relocation requirements

TABLE 18: Key Component Documentation Requirements for Level 2 vs. 3 E/M Visit

Key Component*	Level 2 (1995)	Level 3 (1995)	Level 2 (1997)	Level 3 (1997)
History (History of Present Illness or HPI)	Review of Systems (ROS) n/a	Problem Pertinent ROS: inquires about the system directly related to the problem(s) identified in the HPI	No change from 1995	No change from 1995
Physical Examination (Exam)	A limited examination of the affected body area or organ system	A limited examination of the affected body area or organ system and other symptomatic or related organ system(s)	General multi-system exam: Performance and documentation of one to five elements in one or more organ system(s) or body area(s). Single organ system exam: Performance and documentation of one to five elements	General multi-system exam: Performance and documentation of at least six elements in one or more organ system(s) or body area(s). Single organ system exam: Performance and documentation of at least six elements

TABLE 18: Key Component Documentation Requirements for Level 2 vs. 3 E/M Visit

Key Component*	Level 2 (1995)	Level 3 (1995)	Level 2 (1997)	Level 3 (1997)
Medical Decision Making (MDM) Measured by:** 1. **Problem** – Number of diagnoses/treatment options 2. **Data** - Amount and/or complexity of data to be reviewed 3. **Risk**- Risk of complications and/or morbidity or mortality	Straightforward: 1. Minimal 2. Minimal or no data review 3. Minimal risk	Low complexity: 1. Limited 2. Limited data review 3. Low risk	No change from 1995	

Final Policies for E&M Office/Outpatient Visits Starting in 2021

- Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/outpatient visits, specifically:
  - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
  - Add-on codes for level 2-4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care;
  - A new "extended visit" add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
  - For level 2 through 5 visits, choice to document using the current framework, MDM or time;

Final Policies for E&M Office/Outpatient Visits Starting in 2021

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).

2021 – Office E&M ONLY- 99201-99215

- Single payment rates for levels 2 through 4
  - Maintaining payment rates for level 5
- New Add on codes for level 2-4 visits
  - Code that describe additional resources inherent in visits in primary care and particular kinds of non-procedural specialized medical care
  - Extended visit codes to account for additional resources required when practitioner needs to spend additional time with patients.

2021 – Office E&M ONLY- 99201-99215

- Choices in documentation for level 2-5 visits
  - Current guidelines
    - 1995 & 1997
  - Medical Decision Making
  - Time*

2021 – Office E&M ONLY- 99201-99215

- Medical Decision Making
- Still need medical necessity in documentation
- Time*
  - Total time of the visit
    - Regardless of counseling or coordination of care time

E&M Payment Amounts

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	*Visit Code Alone**	*Visit Code Alone Payment*	*Visit Code With Either Primary or specialized care add-on code***	*Visit Code with New Extended Services Code (Minutes Required to Bill)*	*Visit with Both Add-on and Extended Services Code Added***	*Current Prolonged Code Added (Minutes Required to Bill)**
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.
**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

2021 – Office E&M ONLY (based on 2018 rates)

NEW PATIENT

- 99202 - $130.00
- $76.00
- 99203 - $130.00
- $110.00
- 99204 - $130.00
- $167.00
- 99205 - $211.00

ESTABLISHED PATIENT

- 99212 – $90.00
- $45.00
- 99213 - $90.00
- $74.00
- 99214 - $90.00
- $109.00
- 99215 - $148.00

New Add-On Codes for 2021

- A new "extended visit" add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
- A new add-on codes that describe additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care
  - Would not be restricted by physician specialty
  - Reported with E&M outpatient/office level 2-4 visits

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- May be a new or established patient to the consultant
- May be a new or exacerbation of an existing problem to the patient
- Consultant should NOT have seen the patient face to face within the last 14 days
- Consultant should not report this service if the consultation leads to a transfer of care or a face to face service within 14 days or the next available appointment date of the consultant
  - Surgery
  - Hospital visit
  - Scheduled office evaluation

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- Do not separately report codes 99446-99449 or 99451 for review of
  - Pertinent medical records
  - Laboratory studies
  - Imaging studies
  - Medication profile
  - Pathology specimens etc
- These are included in the service

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- The majority of service time reported (greater than 50%) must be devoted to the medical consultative verbal or internet discussion

- If greater than 50% of time for service is devoted to data review and/or analysis do not report 99446-99449
  - OK to report 99451
    - Based on total review and inter-professional communication time

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- If more than one telephone, internet, electronic health record (TIHR)contact(s) is required to complete the consultation request the entirety of the service and the cumulative discussion and information review time should be reported with a single code
  - eg discussion of test results

- Do NOT report 99446-99449 and 99451 more than once in a seven day interval

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- The written or verbal request for THIR advice by the treating/requesting physician or other qualified health care professional (QHCP) documented in the record including reason for the request
- 99446-99449 conclude with
  - Verbal opinion report
  - Written report from the consultant to the treating/requesting physician or other QHCP
- 99451 concludes with only a written report

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- Treating/requesting physician or QHCP
  - 99452 - Time spent preparing for the referral and/or communicating with the consultant
    - 16-30 minutes
    - In a service day
    - Do not report more than once in a 14 day period

Inter-professional Telephone / Internet / Electronic Health Record Consultations - Guidelines

- Prolonged care
  - Patient is onsite
    - Time spent with THIR
    - Time exceeds 30 minutes beyond typical time of the appropriate E&M
    - Bill face to face prolonged care codes (99354-99355)
  - Patient is not onsite
    - Time spent with THIR
    - Bill non face-to-face prolonged care codes (99358-99359)

Inter-professional Telephone / Internet / Electronic Health Record Consultations

- Inter-professional Telephone / Internet / Electronic Health Record assessment and management service provided by a consultative physician, including verbal and written report to the patient's treating/requesting physician or other qualified health care professional;
  - 99446 – 5-10 minutes of medical consultative discussion and review
  - 99447 – 11-20 minutes of medical consultative discussion and review
  - 99448 - 21-30 minutes of medical consultative discussion and review
  - 99449 – 31 minutes or more of medical consultative discussion and review

Inter-professional Telephone / Internet / Electronic Health Record Consultations

- 99451 - Inter-professional Telephone / Internet / Electronic Health Record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

- 99452 - Inter-professional Telephone / Internet / Electronic Health Record referral service(s) provided by a treating requesting physician or other qualified health care professional, 30 minutes

Inter-professional Telephone / Internet / Electronic Health Record Consultations

- 99446 - .051 RVU
- 99447 – 1.01 RVU
- 99448 – 1.52 RVU
- 99449 – 2.02 RVU
- 99451 – 1.04 RVU
- 99452 – 1.04 RVU

Physician Supervision of Radiologist Assistants January 2019

- **Practice Flexibility for Radiologist Assistants**
- Diagnostic tests performed by a Radiologist Assistant, that would otherwise require a personal level of physician supervision, may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations
  - Personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by a Radiologist Assistant
  - Change will allow for Radiologists to make full use of Radiologist Assistants
  - Improve efficiency of care

CMS Levels of Supervision

Levels	Definition of Supervision
01 – General supervision	The procedure is furnished under the physician's overall direction and control, but the **physician's presence is not required** during the performance of the procedure. The training of the nonphysician personal that actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibilities of the physician.
02 – Direct supervision	In the office setting means the **physician must be present** in the office suite and immediately available to furnish the assistance and direction throughout the performance of the procedure. The physician does not need to be present in the room when the procedure is performed.
03 – Personal supervision	**A physician must be in attendance** in the room during the performance of the procedure.
09 = concept does not apply	

Supervision of Diagnostic Tests

- NP/PA may perform diagnostic tests, but may not supervise someone else (tech/nurse) performing the diagnostic test

- ""“Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who do not meet the definition of ‘physician’ may not function as supervisory physicians for the purposes of diagnostic tests,”
  - 2010 Hospital Outpatient Prospective Payment System (OPPS) Final Rule (Federal Register Nov. 20, 2009).

More Info

- Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act).
- However, when these practitioners personally perform diagnostic tests as provided under §1861(s)(2)(K) of the Act, §1861(s)(3) does not apply and they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision ("S) or collaboration.

Where do we look for Physician Supervision Requirements?

CMS.Gov

- Medicare Fee Schedule Data Base

2019 National Physician Fee Schedule Relative

CPT codes and descriptions only are copyright 2017 American Medica

Dental codes (D codes) are copyright 2018/19 American Dental Associa

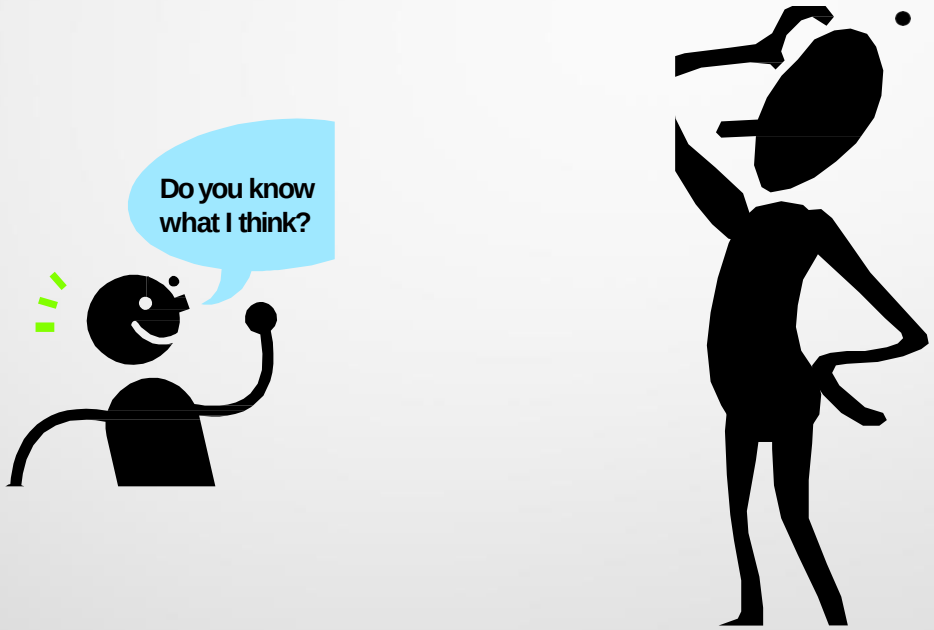
RELEASED 11/06/2018

HCPCS	MOD	DESCRIPTION	STATUS CODE	NOT USED FOR MEDICARE PAYMENT	PHYSICIAN SUPERVISION OF DIAGNOSTIC PROCEDURES
93000		Electrocardiogram complete	A		01
93005		Electrocardiogram tracing	A		01
93010		Electrocardiogram report	A		09
93015		Cardiovascular stress test	A		02
93016		Cardiovascular stress test	A		02
93017		Cardiovascular stress test	A		02
93018		Cardiovascular stress test	A		09
93024		Cardiac drug stress test	A		09
93024	TC	Cardiac drug stress test	A		03
93024	26	Cardiac drug stress test	A		09

Physician Supervision of Tests

- 01 = Procedure must be performed under the general supervision of a physician.
- 02 = Procedure must be performed under the direct supervision of a physician.
- 03 = Procedure must be performed under the personal supervision of physician.
- 09 = concept does not apply

FINAL QUESTIONS AND COMMENTS



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