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2020 CODING BOOTCAMP WEB SERIES

Session 4: 2021 Evaluation and Management (E&M) Coding Part 2 – Are you ready for the 2021 changes?

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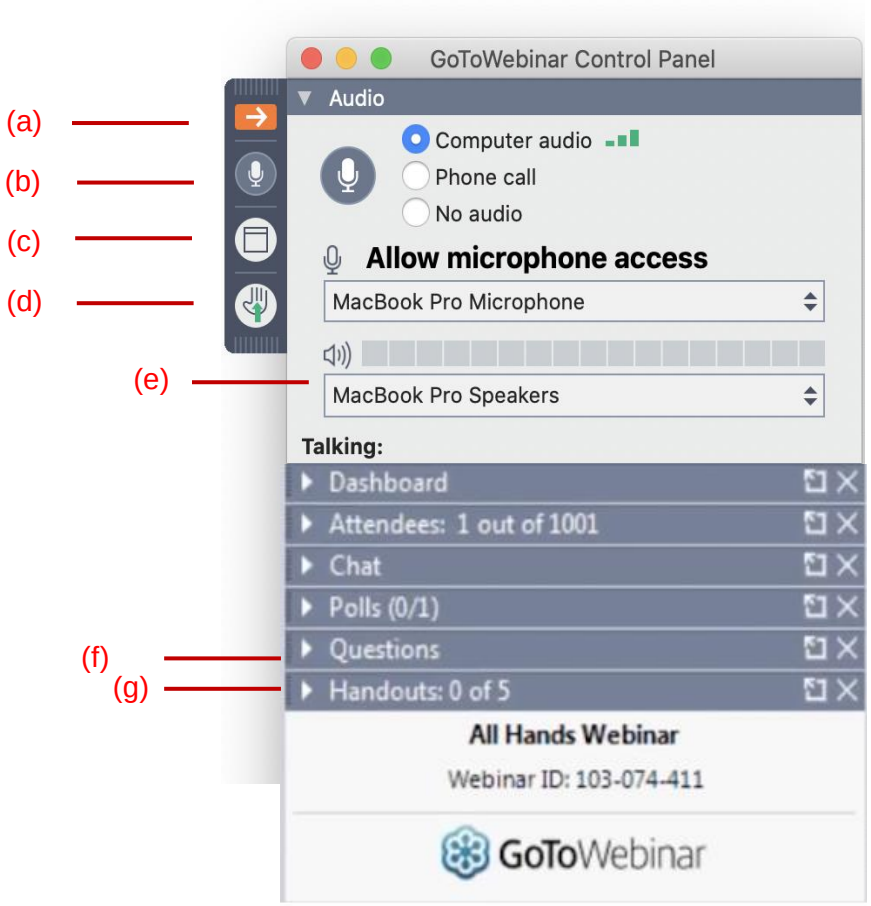

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Objectives

- Other 2021 E/M changes
- Potential financial impacts relevant to these changes.
- What are we hearing from the payers?
- Applying the Office and Outpatient E/M principles to actual documentation samples.
- Education and auditing tips.

Other 2021 Evaluation & Management Changes

Prolonged Services

▲ +99354

Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour

(List separately in addition to code for outpatient **Evaluation and Management** or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])

▲ 99356

Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation **Evaluation and Management** service)

▲ +99415

Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient **Evaluation and Management** service)

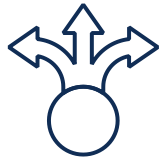
Prolonged Office/Outpt 99417

Definition

Prolonged office or other outpatient E/M **(beyond the total time of the primary procedure which has been selected using total time)**, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes

Guidelines

- ✓ List separately in addition to CPT codes 99205, 99215 for office or other outpatient E/M
- ✓ Only reported when time is used to select E/M
- ✓ Only time of the physician and QPP is counted



CMS Final Rule

- Created own code to resolve discrepancies – G2212
- CMS changed the code definition to clarify the max time must first be met – then each add'l 15 minutes

Prolonged Service 99417 – CPT Guidance

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1, 99417 x 1
90-104 minutes	99205 x 1, 99417 x 2
105 or more minutes	99205 x 1, 99417 x 3 or more for each additional 15 minutes

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-59 minutes	99215 x 1, 99417 x 1
70-84 minutes	99215 x 1, 99417 x 2
85 or more minutes	99215 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Service G2212 – CMS Guidance

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
89-103 minutes	99205 x 1 and G2212 x 1
104-118 minutes	99205 x 1 and G2212 x 2
119 or more minutes	99205 x 1 and G2212 x 3 or more for each additional 15 minutes

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
40-54 minutes	Not reported separately
69-83 minutes	99215 x 1 and G2212 x 1
84-98 minutes	99215 x 1 and G2212 x 2
99 or more minutes	99215 x 1 and G2212 x 3 or more for each additional 15 minutes

▶Comparison of Prolonged Services Codes (99354, 99355, 99356, 99357, 99358, 99359, 99417) Table◀

▶Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use In Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service
+99354	Face-to-Face Only	30 minutes (Beyond listed typical time)	90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483	99202-99205, 99212-99215, 99415, 99416, 99417	99358, 99359
+99355	Face-to-Face Only	Each additional 15 minutes (Beyond 99354)	99354	99202-99205, 99212-99215, 99415, 99416, 99417	99358, 99359
+99356	Face-to-Face and Unit/Floor Time	30 minutes (Beyond listed typical time)	90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310		99358, 99359
+99357	Face-to-Face and Unit/Floor Time	Each additional 15 minutes (Beyond 99356)	99356		99358, 99359
99358	Non-Face-to-Face Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99205, 99212-99215, 99417 On same date of service	99354, 99356
+99359	Non-Face-to-Face Only	Each additional 15 minutes (Beyond 99358)	99358	99202-99205, 99212-99215, 99417 On same date of service	99354, 99356
+99417	Face-to-Face and/or Non-Face-to-Face	Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more ***(Total time on the date of encounter)***	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A

Prolonged Time Vs Prolonged NFTF Code

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CMS Prolonged Code G2212

- CMS was concerned about the lack of clarity with the AMA code referencing "total time" and "usual service"
- They also did not want the greater than half the time threshold to apply
- CMS created their own code and revised the code description was
- "Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) "(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))."

Prolonged NFTF 99358 & 99359

- CMS Comments: "Regarding prolonged visits, we finalized separate payment for a new prolonged visit add-on CPT code (CPT code 99XXX), and discontinued the use of CPT codes 99358 and 99359 (prolonged E/M visit without direct patient contact) to report prolonged time associated with O/O E/M visits"
- "We also note that we are not opposed in concept to reporting prolonged office/outpatient visit time on a date other than the visit. However, we continue to believe there should be a single prolonged code specific to office/outpatient E/M visits that encompasses all related time"
- "For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203,99204, 99205, 99211, 99212, 99213, 99214, 99215), see 99358, 99359…Do not report 99XXX in conjunction with…99358, 99359".

We believe if you want to report time on day of E/M use the add on code. For time on a day other than E/M use prolonged NFTF do not count time on day of visit. We anticipate add'l info.

CMS APPROVES SEVERITY CODE – G2211

1. **Definition**

Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

(Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."

2. **Specialty Care**

"Recognize the resources inherent in engaging the patient in a management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience.

Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals."

3. **Modifier 25**

G2211 is not billable with an E/M service **reported with modifier 25**

Monitor payers and local MACs.

4. **Utilization**

Have not implemented any additional policies that restrict the billing of this code, and so we are assuming that **utilization will be 90 percent of office/outpatient E/M visits** instead of the 100 percent that we assumed in the proposed rule.

SEVERITY CODE WITH “25” MODIFIER

From CMS Final Rule”

“As we noted above, while we would not expect that HCPCS add-on code G2211 would be reported when the office/outpatient E/M visits is reported with a payment modifier, such as a modifier -25, we are not establishing any policies that prohibit reporting the add-on code under those circumstances.”

“Thus, we will continue to include office/outpatient visits reported with a modifier -25 in our utilization assumptions for HCPCS code G2211 as part of calculating the budget neutrality adjustment for the policies we are finalizing in this rule. As we noted above, we would not expect HCPCS add-on code G2211 to be reported when the visit is reported with a modifier -25, and will consider whether to establish an explicit prohibition in future rulemaking.”

“We continue to believe that separately identifiable visits occurring on the same day as minor procedures (such as zero-day global procedures) have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment. We are also analyzing our data to determine if separately identifiable visits occurring on the same day as another visit have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment.”

We are reviewing services where our Medicare MAC requires the 25 modifier and the potential impact. Examples: office visit with an EKG, Device check, Med Administration, split billing EM, etc.

Chronic Care Management

99490

Chronic care management services with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored;

first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

+99439

each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Medicare Final Rule on G2058: “Beginning CY 2021, CPT 99439 will replace HCPCS G2058”

Complex Chronic Care Management

99487

Complex chronic care management services, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored,
- moderate or high complexity MDM;

first 60 minutes of clinical staff time directed by a physician or other QHP professional, per calendar month.

+99489

each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Brief Recap of Office/Outpt E/M
What are We Hearing from Payers?

PROVIDER SELECTION
OFFICE/OUTPT E/M SERVICE

The level of the medical decision making (MDM) as defined for each service.

OR

The total time for E/M services performed on the date of the encounter.

LEVEL OF MDM

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	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

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

Complete table available from resource link to the AMA Items shown in red are now defined

LEVEL OF MDM

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
			• **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)
				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

Complete table available from resource link to the AMA Items shown in red are now defined

TIME – COUNTED DIFFERENTLY

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E&M 1995 & 1997 Guidelines

- Only the face-to-face time spent in counseling and coordination of care.
- Count only when greater than 50% of service is in counseling.
- No credit for any time to collect history, exam, etc.

2021 – "Total Time Day of Visit"

- Preparing to see the patient (review of tests, records, etc.)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam and or evaluation
- Counseling and educating the pt./family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately billed i.e. TCM, CCM)
- Documenting clinical information in the record
- Independently interpreting results (not separately reported)
- Communicating results to the pt/family/caregiver
- Care coordination (not separately billed i.e. TCM, CCM)

TIME DEFINITIONS & COMPARISONS

- Component time – includes pre, intra and immediate post time
- AMA CPT 2021 coding book as range definitions of time
- Clinicians who choose to bill based on time will need to document time.
- A brief statement discussing elements counted in support of time billed is recommended.

CPT Code	Short Description	RUC Recommended Total Time	AMA CPT 2021 Time Day of Encounter	CMS Final Rule Actual Total Time (Sum of Component Times - Pre, Intra and Immediate Post)
99202	Level 2 NP Office/Outpt Visit	22 mins	15-29 mins	20 mins
99203	Level 3 NP Office/Outpt Visit	40 mins	30-44 mins	35 mins
99204	Level 4 NP Office/Outpt Visit	60 mins	45-59 mins	60 mins
99205	Level 5 NP Office/Outpt Visit	85 mins	60-74 mins	88 mins
99212	Level 2 Established Office/Outpt Visit	18 mins	10-19 mins	16 mins
99213	Level 3 Established Office/Outpt Visit	30 mins	20-29 mins	30 mins
99214	Level 4 Established Office/Outpt Visit	49 mins	30-39 mins	47 mins
99215	Level 5 Established Office/Outpt Visit	70 mins	40-54 mins	70 mins

FCSO FAQ's

E/M Guideline Changes

Q: Do the 2021 E/M code and guideline changes apply to all categories of E/M services?

A: No. The E/M code and guideline changes are specific for office and other outpatient visits and apply to codes 99201–99205 and 99211–99215.

- Note: Based on the CPT changes, code 99201 is no longer valid for dates of service on and after January 1, 2021

Q: For dates of service on and after January 1, 2021, how are the levels of E/M services provided in an office/outpatient setting determined?

A: Effective for dates of service on and after January 1, 2021, you would select the appropriate level of E/M service based on the following:

- The level of the MDM as defined for each service; or
- The total time for the E/M performed on the date of the encounter.

MedAxiom FYI:

- ✓ Remember CPT code 99202-99215 may be billed in a hospital setting for POS observation, ER or outpatient.
- ✓ Medicare does not recognize consult codes
- ✓ Some payers have stated they will audit based on what benefits the provider MDM or time

FCSO FAQ's

Medical Decision Making

Q: Does the revised MDM table for 2021 provided by the AMA apply to all E/M services?

A: No. - The CPT E/M code and guideline changes for 2021 and subsequent MDM table apply to office/outpatient E/M services beginning January 1, 2021. Office/outpatient E/M services provided prior to January 1, 2021, and all other E/M categories and codes continue to follow the 1995 and/or 1997 E/M guidelines

Q: When auditing MDM, is there a list of drugs considered "drug therapy requiring intensive monitoring for toxicity"?

A: CMS itself has not provided such a list for use with the 1995 or 1997 guidelines.

MedAxiom FYI:

- ✓ Table of Risk still applicable to other E/M Categories – definitions not applied to guidelines prior to 1/1/2021
- ✓ Individual MACs may post "examples" of drug therapy requiring intensive monitoring. Important to remember not just about being on the drug – need documentation of monitoring, etc. and you still must meet another element of MDM (Dx or Data)

WPS FAQ's

Medical Decision Making

Q: The patient has a chronic condition. The condition has not changed, but they are not at goal. How do I count this?

A:This would fall into the Moderate category of the number of diagnosis and management options. Chronic illness with exacerbation, progression, or side effects of treatment include a patient who is not at goal.

Good documentation would include the goal and the patient's status toward that goal.

Q:When we see the patient today, my practitioner orders labs for two weeks before the next encounter. The practitioner reviews the results of the lab with the next encounter. How do we count this?

A:You can count the order and review as separate bullet points. Count the review in the same encounter as the order. You would not count the review as part of a subsequent encounter. This is part of the AMA instructions.

MedAxiom FYI:

- ✓ Documentation tip for providers to document not only stable but if the patient is not at goal
- ✓ Document specific labs – Lipid panel, CMP, AIC, CBC, etc.
- ✓ Each unique test may be counted (Driven by the CPT code

WPS FAQ's

Medical Decision Making

Q: How will Medicare determine "minor" or "major" surgery?

A: We will identify based on the CMS physician fee schedule of 0, 10, or 90 days.

We would also review any medical record data that is specific to that patient.

MedAxiom FYI:
- ✓ EP Studies and Ablations no global
- ✓ Device implants 90 day global

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MDM Example

- Est patient visits cardiologist for appointment complaining of occasional chest discomfort during exercise. Patient has history of hypertension and high cholesterol which are currently under control with prescribed medications. Physician completes examining and assessing the patients and determines patient needs a cardiovascular stress test. Its ordered and performed that day same by same provider
- Which E/M code should be reported?

Comments from Noridian

If physician/other provider is reporting separate reportable CPT code that includes interp and/or report	If physician/other provider is reporting separate service for discussion of management with physician/another provider	Refer specifically to the term “double dipping”
• Interp and/or report should not be counted in medical decision-making for code selection	• Discussion is not counted in MDM when selecting the code	

Novitas FAQ's Reporting by Time

Q: When coding by time, is the day of encounter by calendar date or 24-hour period?

A: When coding by time, only the time spent on the actual date of the encounter is applicable

MedAxiom FYI:

- ✓ "Qualified healthcare professional" is someone who can separately bill for their services – MAs, LPN, RN, etc. do NOT count.
- ✓ Cannot double count provider time – example: time used for other services CCM or TCM visits.
- ✓ Further clarification expected for teaching services

Q: How is time counted under the CPT E/M code and guideline changes for 2021?

A: Except for code 99211, per AMA, beginning with CPT changes 2021, time alone may be used to select the appropriate code level for the office or other outpatient E/M service codes (99202-99205, 99212- 99215).

- Time may be used to select a code level in office or other outpatient services <u>whether counseling and/or coordination of care dominates the service.</u>
- When time is used to select the appropriate level for E/M service codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or QPP.

WPS FAQ's

Non-physician practitioner (NPP)

Q: Can the non-physician practitioner (NPP) document the physician's time during a shared/split service?

A: Each practitioner would document his/her own time. The medical record would show both the face-to-face and non-face-to-face time with/for that patient. We would not expect the NPP to document the physician's time.

Q: How do you count time when the physician and non-physician practitioner are providing a shared/split service?

A: You can count the time spent by each practitioner. If both practitioners were providing services during the same physical time, (10:00 – 10:15), count that time once.

Potential Example: Tandem Visits

- ✓ NP sees an established patient reviews history and documents = 10 minutes
- ✓ Physician and NP see the patient and completes the encounter (HP, assessment, plan, etc.) = 15 minutes
- ✓ Immediately post visit NP submits Rxs = 4 minutes
- ✓ Immediately post visit MD completes the documentation in the EMR = 10 minutes

= Total Time 39 minutes = Established Patient visit 99214

WPS FAQ's

Prolonged Services

Q: We provided more than 7.5 minutes of extended care. Can we round up to use an additional unit of extended time?

A: No. You have to meet the exact times. For example, 99205 is 60 to 74 minutes. For Medicare you must provide 89 minutes or more to submit the G2212. In order to submit a second unit, you would have to document at least 104 or more minutes.

Q: We are choosing a level 99205 or 99215 based on MDM. Can we use the new extended time procedure code G2212?

A: No. This code is an add-on code to 99205 or 99215 when choosing the level of service using time.

MedAxiom FYI:
- ✓ Verify if private payers will accept G codes
- ✓ Review how time will be tracked and documented
- ✓ Verify if any updates to EMR

Novitas – Use of G2211

- ✓ Medicare specific add-on code
- ✓ Used to report office/outpatient E/M visit complexity
- ✓ Code reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients and to address the majority of patients' health care needs with consistency and continuity over longer periods of time
- ✓ Not restricting billing based on specialty
- ✓ Certain specialties may furnish these types of visits more than others

** MedAxiom FYI - Do not forget Modifier 25 guidance, application and processes.

Applying the new guidelines to real CV case examples

Case 1 Example

DOS: 12/01/2020 Patient in for follow up. PMH of HLD, HTN and PVD, presents in clinic after 2.5 years. The patient c/o SOB at rest and exertion. LE edema is controlled with medication. Denies any CP/pressure, palpitations or syncope

Assessment/Plan:

1. Chest pain, unspecified – Patient with recurrent episode of retrosternal pressure, on some occasion provoked by exertion. ECG reveals sinus rhythm without acute ischemic changes. Plan: Lexiscan myocardial perfusion imaging
2. Essential (primary) hypertension – Review of Holter monitor data revealing sinus and junctional bradycardia. Recommend following regiment with starting Diovan 160/25mg in AM. LE edema improved. Off Diltiazem 90mg BID with resolution of BL LE edema
3. Hyperlipidemia, unspecified – Tolerates statins Rx, continue as prescribed. 8/17 - Chol -233; HDL-42; LDL-154 TRG-243
4. Shortness of breath – Hx of exertional DOE. Improves with BP control
5. Edema, unspecified - Improved LE edema w/ Diovan/H CTZ and stopping CCB Plan: Continue current Rx
6. Bradycardia, unspecified - Sinus bradycardia while on multiple AVB agents Off Atenolol, Metoprolol and Diltiazem. Plan: Continue Carvedilol
7. PVD, unspecified – Severe stenosis involving the P2 segment of the right PCA. If indicated, consider CTA for further evaluation. Possible focal stenosis involving a proximal M2 branch of the right MCA

Case 1 Example Continued

Procedures Reviewed:

Echo: (12/18/19) Left ventricular systolic function is normal. Ejection Fraction= 55-60%.There is borderline concentric left ventricular hypertrophy . The left ventricular wall motion is normal.There is mild tricuspid regurgitation. Right ventricular systolic pressure is 25-30mmHg .Mild aortic regurgitation. Trace pulmonic valvular regurgitation.There is no pericardia! effusion.Diastolic dysfunction, Grade II, consistent with elevated left atrial pressure.

Carotid (3/2017) - Right internal carotid artery: 0-49% stenosis . Left internal carotid artery: 0-49% stenosis.Antegrade flow is noted in the left vertebral artery. Right vertebral artery is not visualized

Exercise MPI (10/2017) LV myocardial perfusion was normal. LV myocardial perfusion was c/w no CAD. Global stress LV function was normal.

MRI of Brain with/without contrast MWH: (3/2017) Extra-axial enhancing left frontal lobe mass measuring up to approximately 1.7 cm. Differential diagnosis is led by meningioma. Follow MRI would be helpful to evaluate for stability. Sellar/suprasellar mass measuring up to approximately 1.4 cm. Mild mass effect upon the inferior aspect of the optic chiasm suspected. Differential diagnosis is led by pituitary macroadenoma.

Case 1 – Applying the new guidelines

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1 # and Complexity of Problems Addressed

- Chest pain = Undiagnosed new problem w/uncertain prognosis. Conflicting info in HPI says no chest pain but has DOE.
- HTN and Hyperlipidemia– chronic stable
- Improved edema/SOB seems to be related to chronic HTN – conflicting HPI
- Not clear if Bracycardia a “new problem” or related to HTN
- PVD chronic

2 Amt and Complexity of Data

- EKG – Done at office?
- Lexiscan ordered
- Review of holter monitor w/summary – was this interp/billed by MD seeing pt.
- ? Lipids reported from 2017
- Consider CTA?
- Procedures reviewed from previous years 2017/2019 pt. seen 2021

3 Risks

- Prescription Drug Management

Case 1 = 99214

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

Case 2 Example

DOS: 11/05/2020 New patient presents with dyspnea. PMH: Bladder surgery. Social History: History of tobacco use, quit 10 years ago.

Assessment/Plan:

1. Heart failure, unspecified – patient with recent suspected decompensated heart failure with unknown ejection fraction in the setting of weight gain, dyspnea on exertion and bilateral leg edema. Lasix 40 mg for 10 days has improved patient's weight and leg edema, however patient still has **mild** DOE. Cardiac auscultation unremarkable for obvious valvular pathologies. Plan: BP log at home. Ordered echo. ACE or ARBs to be considered.
2. Ventricular premature depolarization – Known hx of PVCs. Plan: 48 hour Holter monitor to access PVC burden and to rule out arrhythmia
3. Dyspnea, unspecified – Slowly progressive DOE. ECG performed today revealed no diagnostic ischemic changes. Plan: Lexiscan myocardial perfusion imaging to rule out ischemic heart disease
4. Edema, unspecified – Lower extremity edema has improved with 10 days Lasix 40 mg therapy. Plan: Low-sodium diet and BP controlled discussed with patient
5. Type 2 DM without complications – AI c-7.5%
6. CKD, unspecified – Cr range 1.3- 2.1 after Lasix Rx Reviewed chest x-ray 09/08/20 no acute abnormality

Case 2 – Applying the new guidelines

1. # and Complexity of Problems Addressed
   - New pt. to the provider
   - Heart failure – selected unspecified. Was decomp but says improved today
   - Hx of PVCs
   - Progressive DOE - ?
   - Edema related to CHF
   - Chronic DM and CKD
2. Amt and Complexity of Data
   - EKG performed
   - Ordered echo
   - Ordered holter
   - Reported AI-C and Creatinine
   - Reviewed previous CXR documented findings
3. Risks
   - Prescription Management

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:**
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			• 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
			• **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)
				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

Case 2 = 99204
***Provider documentation of risk could push to 99205. ?
Consideration hospital care

Case 3 Example

DOS: 11/04/20 74 year old female established patient w hx MV/TV repair presents w/ progressive palpitations and dyspnea/fatigue. No edema. HR 125-130 at home. Had STAT echo yesterday. Normal EF and valve function but was found to be in A Flutter RVR. CHADSVASC 2-3. These symptoms started 6 weeks ago. ECG ordered and reviewed today: AFL RVR 2:1 130, RBBB.

Assessment/Plan:

1. Atrial Flutter with rapid ventricular response
2. H/O mitral valve repair

Impression Summary:

The patient has persistent atrial flutter. Her symptoms with the arrhythmia have included palpitations and dyspnea. According to CHADS2 recommendations, anticoagulant therapy is indicated. She is not on Antiplatelet/Anticoag.

Other patient data: hyperthyroidism, valve surgery. Her last known ejection fraction: Echo (EF 0.60) 11/03/20. The current primary treatment strategy for her arrhythmia is RATE CONTROL. She is currently not in sinus rhythm.

Plan:

Tee/Cardioversion for today. Start Eliquis 5mg now, first dose given in office. eGFT > 60. Hb 8.2. Plat 199

Orders:

1. Tee/Cardioversion for today
2. Return to office with NPP in 1 week

Case 3 – Applying the new guidelines

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1 # and Complexity of Problems Addressed

- Aflutter with RVR – progressing symptoms
- MVR – “not addressed”

2 Amt and Complexity of Data

- Stat echo yesterday ordered and interp by same provider.
- EKG ordered and interp by provider today
- TEE and Cardioversion ordered
- Labs

3 Risks

- Prescription drug management
- What about not being a candidate for Anticoag – starting Eliquis and reporting Hb and Platelets?

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:
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				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*;
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				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

Case 3 = 99214 or 99215

Case 4 Example

DOS: 12/09/20 64 year old gentleman here today for follow up. He has a history of CAD and severe AI s/p AVR in May 2017. At last visit he noted some intermittent chest pain and we ordered a nuclear stress test which was normal. No further chest pain, SOB, orthopnea, PND, LEE, dizziness, or syncope. He notes an occasional irregular beat, nothing that persists.

Impression/Plan:

1. CAD in native artery: Hx of NSTEMI in May 2017. Recent nuclear stress was normal. No additional testing ordered at present
2. Essential hypertension: Metoprolol recently switched to amliodipine by PCP. BP slightly elevated in office today. He reports intermittent dizziness upon standing, likely secondary to OH.
3. S/P AVR. Hx of severe AR s/p AVR in May 2017. Doing well. Will continue to monitor
4. Palpitations: Rare episodes of isolated palpitation or irregular beat. Suspect just occasional PACs or PVC. Will continue to monitor.

Final Medication List:

1. Amlodipine 10 mg-atorvastatin 40 mg tablet
    1. Take 2 tablets by oral route every day
2. Folic acid 1 mg tablet
    1. Take 1 tablet by oral route every day
3. Furosemide 40 mg tablet
    1. Take 2 tablets by oral route every day
4. Lisinopril 10 mg tablet
    1. Take 1 tablet by oral route every day

Orders: Return to office visit with provider in 6 months

Case 4 – Applying the new guidelines

Case 1 = 99214

1. # and Complexity of Problems Addressed
   - 2 or more chronic conditions
   - New – palps will monitor
2. Amt and Complexity of Data
   - None = ordered and interp of nuclear previously
3. Risks
   - Prescription Drug management

Case 4 = 99214

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:**
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			  • Review of the result(s) of each unique test*;
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			• 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

Case 5 Example

DOS: 12/07/20 90 y.o. female presents for office follow up visit for preoperative evaluation and atrial tachycardia. She is planning to undergo back surgery for management of chronic back pain. The surgery is scheduled for next month. She denies having CP or SOB. She has chronic renal insufficiency. With regard to atrial tachy, she has this arrhythmia at today's visit, denies having palpitations. She has a history of pulmonary embolism and is on Eliquis.

Impression:

1. Preoperative evaluation – She does not have evidence for unstable angina or CHF. She had a nuclear stress test from June 2020 that I reviewed and showed a normal myocardial perfusion study. Overall, she has intermediate level of risk for surgery, particularly because of her age and chronic renal insufficiency. I have increased her metoprolol extended-release to 150 mg daily to help w rate control given that she is in atrial tachycardia at today's visit.
2. Atrial tachycardia – She has a heart rate of 104 beats per minute w this arrhythmia. She is asymptomatic. I have increased metoprolol extended-release to 150 mg daily to help w rate control.
3. Atrial Fibrillation – This is a paroxysmal condition. She underwent an ablation in December of 2017. I recommend that she continue Eliquis 2.5 mg twice daily. She is on the lower dosage of Eliquis because of her age and renal function. She can hold the medication for 48 hr prior to surgery and restart the next day. She is at low risk for stroke if she is off the medication for a short period of time.
4. Sick Sinus Syndrome – She does not require pacemaker at this time
5. Bifascicular block – This condition is stable and does not require pacemaker at this time
6. Pulmonary embolism – She will continue Eliquis

Case 5 Example

DOS: 12/07/20 90 y.o. female presents for office follow up visit for preoperative evaluation and atrial tachycardia. She is planning to undergo back surgery for management of chronic back pain. The surgery is scheduled for next month. She denies having CP or SOB. She has chronic renal insufficiency. With regard to atrial tachy, she has this arrhythmia at today's visit, denies having palpitations. She has a history of pulmonary embolism and is on Eliquis.

Impression:

1. Preoperative evaluation – She does not have evidence for unstable angina or CHF. She had a nuclear stress test from June 2020 that I reviewed and showed a normal myocardial perfusion study. Overall, she has intermediate level of risk for surgery, particularly because of her age and chronic renal insufficiency. I have increased her metoprolol extended-release to 150 mg daily to help w rate control given that she is in atrial tachycardia at today's visit.
2. Atrial tachycardia – She has a heart rate of 104 beats per minute w this arrhythmia. She is asymptomatic. I have increased metoprolol extended-release to 150 mg daily to help w rate control.
3. Atrial Fibrillation – This is a paroxysmal condition. She underwent an ablation in December of 2017. I recommend that she continue Eliquis 2.5 mg twice daily. She is on the lower dosage of Eliquis because of her age and renal function. She can hold the medication for 48 hr prior to surgery and restart the next day. She is at low risk for stroke if she is off the medication for a short period of time.
4. Sick Sinus Syndrome – She does not require pacemaker at this time
5. Bifascicular block – This condition is stable and does not require pacemaker at this time
6. Pulmonary embolism – She will continue Eliquis

Case 5 Example Continue

Plan:

1. She can proceed with surgery without further cardiac studies
2. I increased her metoprolol extended-release dosage to 150 mg daily. Side effects were explained
3. She can hold Eliquis for 48 hr prior to surgery and restart the next day
4. Otherwise continue current medical regimen
5. Follow up with me in the office in 6 months

This was a 50 minute visit face-to-face managing multiple, medical problems including a preoperative evaluation and a new diagnosis of atrial tachycardia .

A medication change was made and side effects were explained. Recommendations were made.

Risks of surgery at her age and with her renal function was discussed. Extra time (10 minutes) was also spent discussing her case with the surgeon provider. I also spent 10 minutes this morning reviewing the patient's medical records before they came in for their appointment

Total of 70 minutes spent on this date of service seeing patient, speaking with surgeon and reviewing records

Case 5 = Based on Time =99215
Do we add G2212?

Prolonged Office/Outpatient E/M Visit Reporting - New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Education and Auditing Tips

Ancillary Staff Documentation

May only document history elements:

- Chief Complaint (CC) or Reason for Visit
- Review of Systems (ROS)
- Past, Family and Social History (PFSH)
- Vital signs

Although not for billing, providers should indicate reviewed, document any changes, etc.

Documentation Integrity of Templates

- Allow for a comprehensive history, when clinically appropriate
- Allow for a detailed or comprehensive physical examination when clinically appropriate
- Eliminate unnecessary autofill or prepopulated elements – CANNED statements
- Revise templates focusing on:
  - Problems addressed (status, treatment, management(=)
  - Specific tests ordered/reviewed,
  - Risk of patient management, including procedure risks
- Clear assessment and plan

Suggested Time Documentation

Example Only

- Document Chief Complaint and HPI
- Document medically necessary History and Exam (time spent by clinician performing and documenting counted)
- Document total time spent by any clinician both F2F and NF2F on date of encounter with details

Statement:

Total time spent on date of this encounter is _____ minutes including preparing to see the patient, obtaining and/or reviewing and confirming history, performing a medically necessary and appropriate examination and/or evaluation, documenting clinical information in the EHR or other health record.

Potential add ins:

- Counseling pt/family
- Orders
- Referrals/Communication
- Care Coordination

When Will We Add G2211 Severity Code and What to Document?

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No official guidance on documentation

Medicare specific add-on code

Modifier 25 usage not applicable

Consider description of the code:

- ✓ Code reflects time, intensity and practice expense
- ✓ Related to ongoing care and coordination

Not restricting billing based on specialty

Certain specialties may furnish these types of visits more than others

What Has Not Changed?

Purpose of documentation and demonstrating complexity: Documentation to support the service is still required	Coding requirements and documentation guidelines for all other E/M services remain the same	Do forget about Risk Adjustment and HCCs	Remember quality metrics	Communication and overall care of the patient is at the center
•Documentation to support medical necessity-Although history and exam is no longer scored, document as medically appropriate •History and exam may still be needed to support medical necessity				

Resources

- https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Q&A

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