Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, and the Arizona Department of Health Services

Welcome

- SWTRC region - AZ, UT, CO, NM & NV
- Fellow HRSA Grantees
- All other participants

The **Arizona Department of Health Services, the Arizona Telemedicine Program,** and **the Southwest Telehealth Resource Center** welcome you to this free webinar series.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

Webinar Tips & Notes

- When you joined the webinar your phone &/or computer microphone was muted
- Time is reserved at the end for Q&A, please use the **Chat function** to ask questions
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted on the ATP website
    - http://telemedicine.arizona.edu/webinars/previous

Carol Yarbrough

“Update to the 2021 Evaluation and Management Guidelines”

Objectives (déjà vu!)

1. Learn about the duration of the PHE and its effect on Phys Fee Reimb by CMS (originating site)
2. Understand 2021 AMA Office or Other Outpatient Services E/M Guidelines including documentation guidelines and maximizing efficiency
3. Review possible scenarios for post-PHE

Definitions and References

- Public Health Emergency (PHE)
  - New deadline: Jan 21+90 days = Apr 21, 2021
  - https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-07Jan2021.aspx
  - Ltr to Governors Jan 22, 2021: end of CY2021 at a minimum (next slide)
- 2021 AMA E/M Guidelines
  - Updated office or other outpatient guidelines – Patients Over Paperwork
- Video Visits
  - Synchronous, face-to-face provider and patient encounter
- Federal Register Final Medicare Physician Fee Schedule:
  - https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

PHE Ltr to Governors Jan 22, 2021

- “To assure you of our commitment to the ongoing response, we have determined that the PHE will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, HHS will provide states with 60 days’ notice prior to termination,” reads the letter to governors
- “Predictability and stability”
- Prior to end – 60 days’ notice to change systems *could be* longer

https://f.datasrvr.com/fr1/621/80970/PHE_Extension.HHS_letter_to_Governors.pdf

Final Rule

CMS clarifications on Dec 10, 2020

E/M Final Policies

- We clarified the reporting times for prolonged office/outpatient E/M visits. To avoid double-counting time, finalized HCPCS code G2212 to report these services.
- Revised the times used for ratesetting for this code set.
- Revalued the following code sets that include, rely upon, or are analogous to office/outpatient E/M visits in line with the increases to office/outpatient E/M visits:
  - End-Stage Renal Disease Monthly Capitation Payment Services
  - Transitional Care Management Services
  - Maternity Services
  - Cognitive Impairment Assessment and Care Planning
  - Initial Preventive Physical Examination and Initial and Subsequent Annual Wellness Visits
  - Emergency Department Visits
  - Therapy Evaluations
  - Psychiatric Diagnostic Evaluations and Psychotherapy Services

New Permanent Codes

CY 2021 Medicare Telehealth List

We permanently added these services to the Medicare telehealth services list:

- Group Psychotherapy (CPT code 90853)
- Psychological and Neuropsychological Testing (CPT code 96121)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Office/Outpatient E/M Services (HCPCS code G2212)

Full Definitions

Service Type	HCPCS Code	Service Description
Group Psychotherapy	90853	Group psychotherapy (other than of a multiple-family group)
Neurobehavioral Status Exam	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
Care Planning for Patients with Cognitive Impairment	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: [see CPT for rest of definition]
Domiciliary, Rest Home, or Custodial Care services	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: [see CPT for rest of definition]
Home Visits	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; least 2 of these 3 key components: : [see CPT for rest of definition]
	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: [see CPT for rest of definition]

Here are Categories of TH CPT Additions

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.
- Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient.

Category 3

- Services that are likely to provide clinical benefit via telehealth yet lack sufficient clinical evidence to evaluate making them permanent under Category 1 or Category 2, above. These are to remain in effect until the end of the calendar year in which the PHE ends (not when the PHE ends).

Let's Look

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
99476	Ped crit care age 2-5 subsq	Available up Through the Year in Which the PHE Ends		
99477	Init day hosp neonate care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99478	Ic lbw inf < 1500 gm subsq	Available up Through the Year in Which the PHE Ends		
99479	Ic lbw inf 1500-2500 g subsq	Available up Through the Year in Which the PHE Ends		
99480	Ic inf pbw 2501-5000 g subsq	Available up Through the Year in Which the PHE Ends		
96160	Pt-focused hlth risk assmt		Yes	
96161	Caregiver health risk assmt		Yes	
96164	Hlth bhv ivntj grp 1st 30		Yes	
96165	Hlth bhv ivntj grp ea addl		Yes	
96167	Hlth bhv ivntj fam 1st 30		Yes	
96168	Hlth bhv ivntj fam ea addl		Yes	

Review the codes on the list:
96161 – Permanent code on the list
99477 – Temporary during the PHE
99476, 99478, 99479 and 99480 – Category 3 codes

When PHE is over and the patient is in an HRSA-eligible geographic location at an eligible originating site, 99476 will be reimbursed through the end of CY202X. It will not be reimbursed the following calendar year, unless evidence collected confirms eligibility. At that time, then, it will be moved over to permanent status

Like Category 3, this will possibly end w PHE

Virtual Supervision

For the duration of the PHE, to limit infection exposure, we revised the definition of direct supervision to include virtual availability of the supervising physician or practitioner using interactive audio/video real-time communications technology.

We finalized the continuation of this policy through the end of the PHE or December 31, 2021, whichever is later. This will give us time to continue to evaluate whether this policy should be adopted permanently.

When the PHE ends – 1135 exceptions no longer

- Home as originating site no longer 100% eligible
  - Unless patient has home dialysis
  - Substance Use Disorder management visits
  - Home Health Agency telehealth aspects written into care plan
- HRSA Payment Eligibility Analyzer back in effect: https://data.hrsa.gov/tools/medicare/telehealth
- Act of Congress to extend reach of originating site to urban sites and homes
  - Exception: Stroke available for urban ED visits

New Finalized Policies – No Change After PHE

Other Finalized Policies

- Expanding the types of practitioners who may provide communication technology-based services and clarify which practitioners may bill for eVisits
- Amending the frequency limitations on subsequent nursing facility visits
- Allowing auxiliary personnel to provide certain remote monitoring services under a physician's supervision
  - Auxiliary personnel can include contracted employees
- Clarifying the definition of a medical device supplied to a patient as part of a remote monitoring service and that the device must be reliable, valid, and the data must be electronically collected and transmitted rather than self-reported

More finality!

Teaching Physicians and Residents

1. We finalized the following policies for teaching physicians billing for services they provide involving residents in training sites of a teaching setting that are outside of a metropolitan statistical area (i.e., rural settings).

    a) Teaching Physician – can meet the requirement to be present for the key portion of the service using audio/video real-time communications technology to interact with the resident, including when involving the resident in providing Medicare telehealth services.

    b) Primary Care Exception – Teaching physicians at primary care centers can provide the direction, management and review of a resident's services using audio/video real-time communications technology. These residents may provide an expanded set of services to patients, including communication technology-based services and inter-professional consults.

2. Resident Moonlighting – For both rural and non-rural settings, the services of residents that are not related to their approved GME programs and are provided to inpatients of the training program hospital are separately billable physicians' services under the PFS.

3. Policies implemented for the PHE will remain in place for the duration of the PHE.

Telemental Health - Caveats

- “The bill did add critical access Hospitals (CAHs) and small, rural hospitals with less than 50 beds to the list of sites eligible for reimbursement through Medicare for certain telehealth services, opening the door to the expansion of telehealth services in parts of the country where access is a challenge. And it eliminates geographic restrictions for the mental health treatment delivered via telehealth, while also allowing patients to be treated in their homes.”
- “…the telemental health coverage comes with the condition that patient and provider meet in person within six months of the first telehealth session and have in-person exams at regular intervals.”

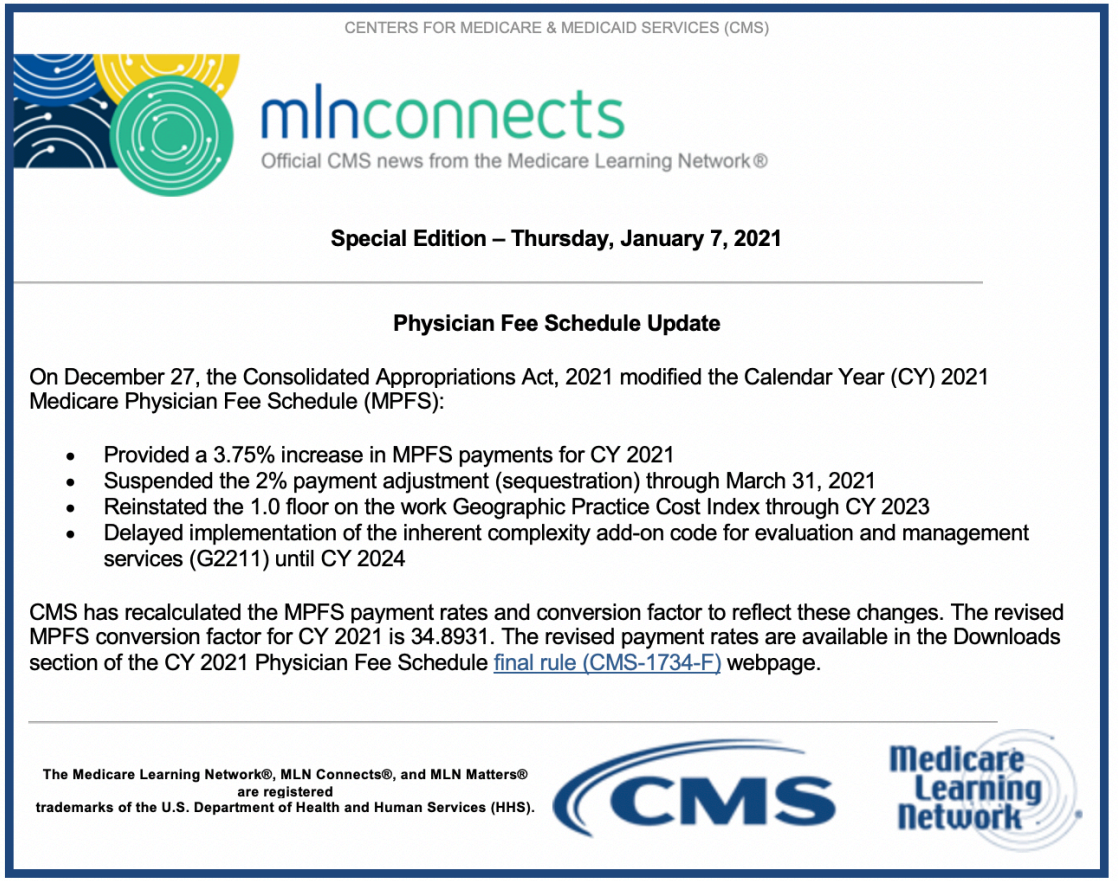
- https://mhealthintelligence.com/news/telehealth-supporters-see-little-to-celebrate-in-pandemic-relief-bill

Physician Fee Schedule and What it Means for 2021 E/M Outpatient Guidelines

Shenanigans – Jan 7, 2021

CF Originally reduced
- $36 to $32

Increased to $34.90
- CY2021
- wGPCI 1.0 floor
- Recalc of RVUs



CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects

Official CMS news from the Medicare Learning Network®

Special Edition – Thursday, January 7, 2021

Physician Fee Schedule Update

On December 27, the Consolidated Appropriations Act, 2021 modified the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS):

- Provided a 3.75% increase in MPFS payments for CY 2021
- Suspended the 2% payment adjustment (sequestration) through March 31, 2021
- Reinstated the 1.0 floor on the work Geographic Practice Cost Index through CY 2023
- Delayed implementation of the inherent complexity add-on code for evaluation and management services (G2211) until CY 2024

CMS has recalculated the MPFS payment rates and conversion factor to reflect these changes. The revised MPFS conversion factor for CY 2021 is 34.8931. The revised payment rates are available in the Downloads section of the CY 2021 Physician Fee Schedule final rule (CMS-1734-F) webpage.

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CMS

Medicare Learning Network

Please share this important information with your colleagues and encourage them to subscribe. Previous issues are available in the archive.

Due to Base Factor 1.0 for GPCI RVUs changed– Make Sure you have latest Addendum B

- Dec 2020 Final Rule RVUs

Addendum B – Relative Value Units and Related Information Used in CY 2021 Final Rule				
CPT[1]/ HCPCS	Description	Total Non-Facility RVUs[2]	Total Facility RVUs[2]	Global
99202	Office o/p new sf 15-29 min	2.13	1.42	XXX
99203	Office o/p new low 30-44 min	3.28	2.42	XXX
99204	Office o/p new mod 45-59 min	4.93	3.96	XXX
99205	Office o/p new hi 60-74 min	6.51	5.38	XXX
99211	Office o/p est minimal prob	0.68	0.27	XXX
99212	Office o/p est sf 10-19 min	1.67	1.06	XXX
99213	Office o/p est low 20-29 min	2.68	1.95	XXX
99214	Office o/p est mod 30-39 min	3.81	2.88	XXX
99215	Office o/p est hi 40-54 min	5.33	4.27	XXX

- Jan 2021 Final Rule RVus

Addendum B – Relative Value Units and Related Information Used in CY 2021 Final Rule				
CPT[1]/ HCPCS	Description	Total Non-Facility RVUs[2]	Total Facility RVUs[2]	Global
99202	Office o/p new sf 15-29 min	2.12	1.43	XXX
99203	Office o/p new low 30-44 min	3.26	2.42	XXX
99204	Office o/p new mod 45-59 min	4.87	3.94	XXX
99205	Office o/p new hi 60-74 min	6.43	5.35	XXX
99211	Office o/p est minimal prob	0.66	0.26	XXX
99212	Office o/p est sf 10-19 min	1.63	1.04	XXX
99213	Office o/p est low 20-29 min	2.65	1.95	XXX
99214	Office o/p est mod 30-39 min	3.76	2.88	XXX
99215	Office o/p est hi 40-54 min	5.25	4.24	XXX

2021 AMA E/M Office Visit Guidelines

- Assign 99202-99215 based on either of the following:
  - The combo of medical decision-making elements to result in an E/M level; or
  - The total time for all services a provider performs for the patient on the day of the visit which fall into time buckets
- We're done!

Just kidding – Please consider:

- What type of clinicians are in the practice?
  - Daily habits – creatures of continuity?
  - Are they spontaneous and prefer to mix things up?
    - Payer mix, patient mix
- What type of practice?
  - Adult or Pediatrics?
  - Primary or Specialty Care?
  - Physician-based clinic or outpatient hospital clinic?
- How does a provider correctly document visits?
  - No right answer! It can be a mix
  - Once a visit is over “on to the next person” – or find yourself musing?

Time – What's the Difference?

Old (still holds for *all other* E/Ms)	New 2021 Outpatient E/Ms
Over 50% of which was spent in counseling and coordination of care	Total time including non face-to-face per patient per DAY
Like – 99221-99233; 99281-99285	JUST outpatient office codes – 99202-99215

Federal Register Changed the Total Time

TABLE 21: RUC-Recommended Pre-, Intra-, Post-Service Times, RUC-Recommended Total Times for CPT codes 99202-99215 and Actual Total Time

HCPCS	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Actual Total Time	RUC-recommended Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

- https://www.federalregister.gov/d/2020-26815

Time Spans - somewhat unclear

CPT	Before	Interim IFC	CMS Proposed Final Rule 2021	CMS 2021 per Federal Register	AMA
99201	17	17	n/a	n/a	n/a
99202	22	22	22-39	?-20	15-29
99203	29	29	40-59	21-35	30-44
99204	45	45	60-84	36-60	45-59
99205	67	67	85 - ?	61-88	60-74
99211	7	7	No time	?-7	No time
99212	16	16	18-29	8-16	10-19
99213	23	23	30-48	17-30	20-29
99214	40	40	49-69	31-47	30-39
99215	55	55	70 - ?	48-70	40-54
99417	n/a	n/a	15	XX	15
GPC1X	n/a	n/a	11	n/a until 2024	n/a

What Adds To Total Time and What Does Not

Yes	No
○ preparing to see the patient (eg, review of tests) ○ obtaining and/or reviewing separately obtained history ○ performing a medically appropriate examination and/or evaluation ○ counseling and educating the patient/family/caregiver ○ ordering medications, tests, or procedures ○ referring and communicating with other health care professionals (when not separately reported) ○ documenting clinical information in the electronic or other health record ○ independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver ○ care coordination (not separately reported)	Separate procedure or test (Meaning: anything that can be coded separately) Staff Time SLOW charting Anything done on a separate date

New Code: 99417 – CMS Not Reimbursing

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

New Code: G2212 – CMS Created for Reimb

- Based on *maximum # of minutes associated with 99205 and 99215*
  - 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)

Add it all together

- Per AMA:
  - … list total time and describe what activities were done. “I spent 45 minutes caring for this patient today, reviewing labs, records from another facility, seeing the patient, documenting in the record and arranging for a sleep study.”
- What about prolonged time?
  - ”I spent 120 minutes caring for this patient today …”
    - 99215 (70 min) + G2212 x 2 (30 min) = 115 minutes
    - 5 minutes are left over, as you cannot bill a portion of the prolonged care code. Only in total 15 minute increments.

What about 99354 and +99355?

- Face-to-face prolonged care codes
  - 99354: add'l 30 minutes
  - 99355: each add'l 30 minutes
- Still active, billable codes
- Do not report with 99202–99215
- **Do** report with
  - psychotherapy codes 90837, 90847,
  - office consultation codes 99241—99245,
  - domiciliary care codes 99324—99337,
  - home visit codes 99341—99350, and
  - cognitive assessment code 99483.

And 99358 and +99359?

- No longer applicable to same DOS as an E/M for prolonged non face-to-face time
- Still reportable
- CPT Definitions
  - 99358: Prolonged evaluation and management service before and/or after direct patient care; first hour (wRVU is 2.10) (didn't change)
  - + 99359: Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service) (wRVU is 1.00) (didn't change, either)

Split/Shared

"A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.

When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.

Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)."

Example: Documentation Based on Time

CC: sleep apnea

INTERVAL HISTORY: Feels tired. ROS is negative for cough, CP or SOB.

EXAM
BP 130/80, HR 72, RR 20
Lungs: CTA
Heart: RRR
BMP reviewed and is higher.

ASSESSMENT
Moderately unstable HTN

PLAN
Continue valsartan 160 mg PO QD.
Undergo sleep study and RTC in 3 months.

I spent 45 minutes caring for this patient today, reviewing labs, records from another facility, seeing the patient, documenting in the record and arranging for a sleep study.

***

ANALYSIS: CMS states that 45 minutes falls within the time span allocated to a 99213. The AMA states that 99215 should prevail. It might be better to rely on documentation for this patient.

Medical Decision Making

- Three Components – not a new concept
  - No MDM for 99211; but for 99202-99215

1. The number and complexity of problem(s) that are addressed during the encounter. (Different – no longer new, est worsening …)
2. The amount and/or complexity of data to be reviewed and analyzed. (Improved!)
3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). (Improved!)

MDM: old way *still* for everything else

MEDICAL DECISION

Type of Problem		**Amount/Type of Data**		**Risk Table**	**Time-Dominated**
○ Self-Limited, Minor	1 (Max 2)	○ Rev/Order Clinical Labs	1 (Max 1)	○ Minimal/Minor	○ Probable Time
○ Est, Improved, Stable	1	○ Rev/Order Imaging Studies	1 (Max 1)	○ Low	○ Discuss/Counsel
○ Est, Worsening	2	○ Rev/Order Medical Diagnostics	1 (Max 1)	○ Moderate	○ Time Doc:
○ New, No w/up or plan	3 (Max 1)	○ Discuss to Obtain Old Records	1	○ High	
○ New, w/up & plan	4	○ Discuss Results w/performing MD	1		
		○ Rev/Summ Old Records	2	Risk Support:	
		○ Independent Rev, Tracing, Image	2		
Total Points ☐		Total Points ☐		**Medical Decision/ Overall Risk** ☐	

MDM: Presenting Problem(s)

Type of Problem

○ Self-Limited, Minor	1 (Max 2)
○ Est, Improved, Stable	1
○ Est, Worsening	2
○ New, No w/up or plan	3 (Max 1)
○ New, w/up & plan	4

Total Points ☐

Number/Complexity of Problems Addressed - **Nature of Presenting Problem (Chart A)**

Minimal	☐ 1 Self-limited / minor problem
Low	☐ 2+ Self-limited / minor problem ☐ 1 Stable chronic illness ☐ 1 Acute uncomplicated illness / injury
Moderate	☐ 1+ Chronic illness w/ exacerbation, progression, or Tx side effects ☐ 2+ Stable chronic illness ☐ Undiagnosed problem w/ uncertain prognosis ☐ Acute illness w/ systemic symptoms ☐ Acute complicated injury
High	☐ Chronic illness w/ severe exacerbation, progression or Tx side effects ☐ Acute / chronic illness / injury that pose threat to life or bodily function

Data – Then and Now

Amount/Type of Data

○ Rev/Order Clinical Labs	1 (Max 1)
○ Rev/Order Imaging Studies	1 (Max 1)
○ Rev/Order Medical Diagnostics	1 (Max 1)
○ Discuss to Obtain Old Records	1
○ Discuss Results w/performing MD	1
○ Rev/Summ Old Records	2
○ Independent Rev, Tracing, Image	2

Total Points ☐

Medical Overall I

Tests & Documents (T&D)

Review of prior **external note(s)** from each unique source*		x1 =	
Review of the **result(s)** of each unique test*		x1 =	
Ordering of each unique test*		x1 =	

Assessment requiring an independent historian(s) (IHx)

An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to patient	0 or 1 max	=	

Independent interpretation of tests (Intpr)

Independent **interpretation of a test performed by another** physician/other qualified health care professional (not separately reported);	0 or 1 max	=	

Discussion of management or test interpretation (DISC)

Discussion of management or test interpretation **with external physician**/other qualified health care professional\appropriate source (not separately reported)	0 or 1 max	=	

Data Table*

Category	Data Level
1 T&D	Minimal
2 T&D	Limited
1 IHx	Limited
1 T&D and 1 IHx	Limited
2 T&D and 1 IHx	Moderate
1 T&D and 1 Intpr	Moderate
1 T&D and 1 DISC	Moderate
2 T&D and 1 Intpr	Moderate
2 T&D and 1 DISC	Moderate
3+ T&D	Moderate

Category	Data Level
3 + T&D and 1 IHx	Moderate
1 Intpr	Moderate
1 DISC	Moderate
2 T&D and 1 IHx and 1 Intpr	High
2 T&D and 1 IHx and 1 Disc	High
3+ T&D and 1 Intpr	High
3+ T&D and 1 DISC	High
3+ T&D and 1 IHx and 1 Intpr	High
3+ T&D and 1 IHx and 1 DISC	High
1 Intpr and 1 DISC	High

*Thanks to Stephani Scott @ Healthicity

Risk Table – (a section = 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

Are you using SDOH to determine risk?

- See Chapter 21 of the ICD 10 Code Set:
  - Persons with Potential health hazards related to socioeconomic and psychosocial circumstances
    - Z55 – education/literacy, etc.
    - Z56 – employment/unemployment
    - Z57 – occupational hazards
    - Z59 – homeless/inadequate housing
    - Z60 – social environment
    - Z62 – upbringing
    - Z63 – primary support group
    - Z64 – certain psychosocial circumstances
    - Z65 - other psychosocial circumstances

https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Put it All Together – Acuity, Data and Risk

Draw a line down the column with 2 or 3 circles and circle the Overall MDM level OR draw a line down the column with the Center circle and circle the Overall MDM level					
A	Number/Complexity of problems - NPP	Minimal	Low	Moderate	High
B	Data to be Reviewed and Analyzed	None or Minimal	Limited	Moderate	High
C	Risk of Patient Management	Minimal	Low	Moderate	High
Overall MDM Level		**Straightforward**	**Low**	**Moderate**	**High**

Documentation for a 99214*

CC: HTN/dyslipidemia

INTERVAL HISTORY: No new complaints. ROS is negative for cough, CP or SOB.

EXAM
BP 130/80, HR 72, RR 20
Lungs: CTA
Heart: RRR
BMP reviewed and is normal. LDL is 70.

ASSESSMENT
Stable HTN
Stable dyslipidemia

PLAN
Continue valsartan 160 mg PO QD.
Continue simvastatin 20 mg PO QD.
RTC in six months with BMP and lipid panel.

***
ANALYSIS: This encounter qualifies for the 99214 level of care based on the moderate complexity MDM required for the visit. Moderate complexity MDM is attained due to the problems being addressed (two stable chronic illnesses), data reviewed (two lab panels reviewed and two lab panels ordered), and risk (prescription drug management).a

* Thanks to Pete Jensen, MD – E/M University

Where do I find all this, again?

https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f

Conclusion: Think back to slide 8 – Your Clinic

- Time
  - Can providers track time and not put down the same # of minutes for every patient?
  - Remember time should not add up to more than what is reasonable
- MDM
  - Complexity of patient
  - Data and factors

Resources

- CMS 12/4/2020: https://www.cms.gov/files/document/mln-understanding-4-key-topics-call.pdf
- 2021 AMA E/M Guidelines
  - Effective January 1, 2021
  - Codes: 99202-99215, 99417, G2212
  - Time: https://edhub.ama-assn.org/cpt-education/interactive/18461930
  - MDM: https://edhub.ama-assn.org/cpt-education/interactive/18461932
- AAPC – Audit Tool – or as I call it – Helper Tool!
  - https://www.aapc.com/business/em-audit-tool-ebrief.aspx

Questions

- If we've time – if not, please contact the sponsors who can route questions!

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