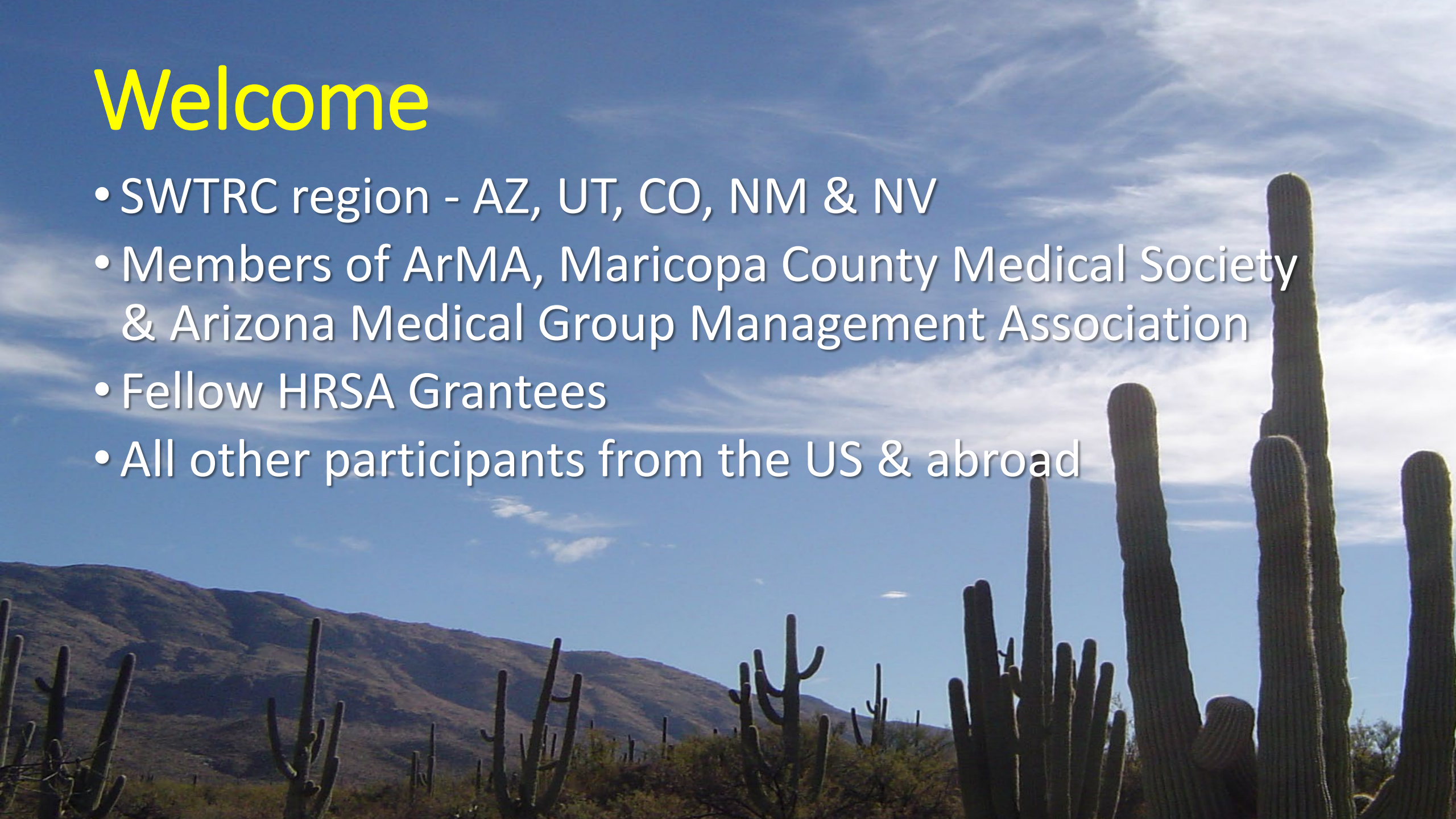
Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, Arizona Medical Association, Maricopa County Medical Society and Arizona Medical Group Management Association

Welcome

- SWTRC region - AZ, UT, CO, NM & NV
- Members of ArMA, Maricopa County Medical Society & Arizona Medical Group Management Association
- Fellow HRSA Grantees
- All other participants from the US & abroad



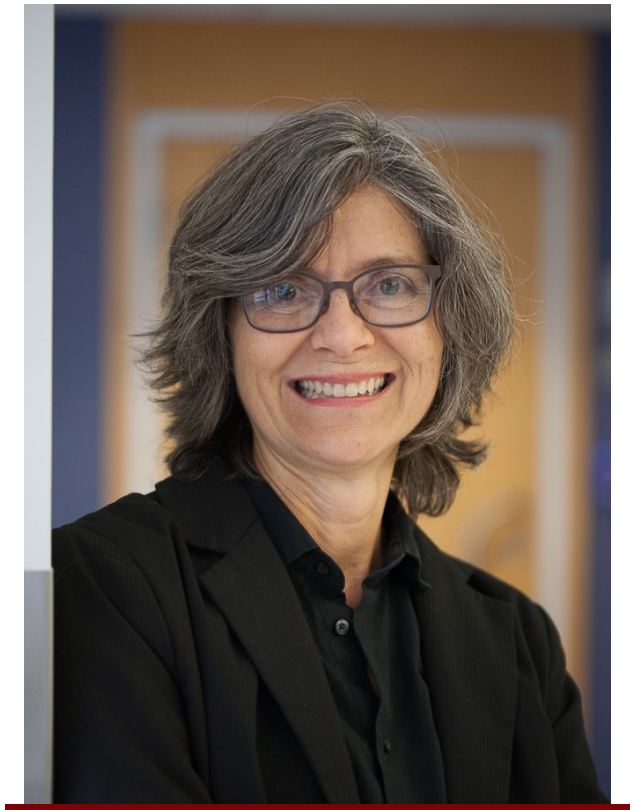
The **Arizona Medical Association, Maricopa County Medical Society and Arizona Medical Group Management Association, Arizona Telemedicine Program,** and **Southwest Telehealth Resource Center** welcome you to this free webinar series.

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

"Billing for Telehealth in 2020 & Beyond"

Objectives

1. Understand 2021 AMA Office or Other Outpatient Services E/M Guidelines including documentation guidelines and maximizing efficiency
2. Learn about the duration of the PHE and its effect on TH Payment by CMS and AZ
3. Review possible scenarios for post-PHE

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 you perform for the patient on the day of the visit which fall into a specific duration
- We're done!

Just kidding – Please consider:

- What type of person are you?
  - Daily habits – do you have them?
  - Are you spontaneous and prefer to mix things up?
- What is your practice?
  - Adult or Pediatrics?
  - Primary or Specialty Care?
  - Physician-based clinic or outpatient hospital clinic?
- How do you practice medicine?
  - No right answer! It can be a mix
  - Once a visit is over “on to the next person” – or find yourself musing?

Definitions

- Public Health Emergency (PHE)
  - Currently set to expire January 21, 2021
  - https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx
- 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 Draft Medicare Physician Fee Schedule: https://www.govinfo.gov/content/pkg/FR-2020-08-17/pdf/2020-17127.pdf

The guidelines say 2021 – it's 2020 *still*

Interim Final Rule of March 30, 2020 announced option to use *similar* rules to that of 2021 AMA E/M guidelines

- Assign 99201-99215 based on either of the following:
  - Total time for all services done for the patient the day of visit based upon current CPT times
  - MDM – current 2020 MDM (not updated)

https://www.cms.gov/files/document/covid-final-ifc.pdf

Time, time, time … is on my side, yes it is

- As the Rolling Stones sang (sorry for the ear worm)
- If you are a person driven by marking time (like me)
- Let’s look!

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

Time Spans - Not “abouts”

CPT	Before	Interim	CMS 2021	AMA
99201	17	17	n/a	n/a
99202	22	22	22-39	15-29
99203	29	29	40-59	30-44
99204	45	45	60-84	45-59
99205	67	67	85 - ?	60-74
99211	7	7	No time	No time
99212	16	16	18-29	10-19
99213	23	23	30-48	20-29
99214	40	40	49-69	30-39
99215	55	55	70 - ?	40-54
99417	n/a	n/a	15	15
GPC1X	n/a	n/a	11	11

CMS Time and wRVUs – Draft PFS

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
99XXX	N/A	N/A	15	0.61
GPC1X	N/A	N/A	11	0.33

Final Rule – PFS 2020

TABLE 33: Proposed Total Practitioner Times for Office/Outpatient E/M Visits When Time Is Used to Select Visit Level

Established Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT code
40–54 minutes	99215
55-69 minutes	99215x1 and 99XXXx1
70-84 minutes	99215x1 and 99XXXx2
85 or more minutes	99215x1 and 99XXXx3 or more for each additional 15 minutes
New Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	**CPT code**
60-74 minutes	99205
75-89 minutes	99205x1 and 99XXXx1
90-104 minutes	99205x1 and 99XXXx2
105 or more minutes	99205x1 and 99XXXx3 or more for each additional 15 minutes

New Code: 99417

✚ ● 99417 Prolonged office or other outpatient evaluation and management service(s) (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 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

(Use 99417 in conjunction with 99205, 99215)

(Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)

(Do not report 99417 for any time unit less than 15 minutes) Can't get rid of the line space above

New Code: GPC1X

- Final rule: Dec 1, 2020
  - Finalized definition
  - Finalized code (this is a placeholder)
- Current definition from 2020 Final Rule:
  - “visit complexity inherent to evaluation and management 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, or complex condition.”

What about 99354 and 99355?

- Face-to-face prolonged care codes
- 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.

Finally – 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)
  - + 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)

What Adds To Total 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

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)."

Think back to slide 8 – your personality

- Can you track time and not put down the same # of minutes for every patient?
- Do you have it in you to change the time phrase every time you document?
- 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.”

Documentation based on Time – 99213 or 99215

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 – Too Big to Paste - 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

My favorite addition to risk: ICD 10 Codes re SDOH

- 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

Public Health Emergency effective dates

- Per CMS, in the draft PFS, CPT codes currently allowed for telehealth as Category 3 remain effective until end of calendar year during which the PHE ends

LIST OF MEDICARE TELEHEALTH SERVICES - NPRM 2021						
Code	Short Descriptor	Status *	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations	Proposed Permanent Addition for CY 2021	Proposed Temporary Addition for CY 2021
77427	Radiation tx management x5	Temporary Addition				
90785	Psytx complex interactive		Yes			
90791	Psych diagnostic evaluation		Yes			
90792	Psych diag eval w/med srvcs		Yes			
90832	Psytx w pt 30 minutes		Yes			
90833	Psytx w pt w e/m 30 min		Yes			
90834	Psytx w pt 45 minutes		Yes			

When the PHE ends - YES

- Home as originating site no longer effective
  - Unless patient has home dialysis
  - Substance Use Disorder management visits
  - Stroke to urban ED 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

CPT Codes and Telehealth Basics: Start with the Fee Schedule

CY 2021 PFS Proposed Rule Sample PE Worksheet (ZIP)

CY 2021 PFS Proposed Rule Addenda (ZIP)

CY 2021 PFS Proposed Rule Anticipated Specialty Assignment for Low Volume Services (ZIP)

CY 2021 PFS Proposed Rule Market-Based Supply and Equipment Pricing Update (ZIP)

CY 2021 PFS Proposed Rule Multiple Procedure Payment Reduction Files (ZIP)

CY 2021 PFS Proposed Rule Public Nominations of Potentially Misvalued Codes (ZIP)

CY 2021 PFS Practice Expense Methodology and Data Collection Research and Analysis Report (PDF)

CY 2021 PFS Proposed Rule List of Medicare Telehealth Services (ZIP)

CY 2021 PFS Proposed Rule Calculation of volume-weighted average of increase to Office Outpatient EM visits (ZIP)

CY 2021 PFS Proposed Rule Calculation of proposed RVUs for ESRD MCP and TCM services (ZIP)

Resources for CME and CEU Opportunities

- 2021 AMA E/M Guidelines
  - Effective January 1, 2021
  - Codes: 99202-99215, 99417
  - Time: https://edhub.ama-assn.org/cpt-education/interactive/18461930
  - MDM: https://edhub.ama-assn.org/cpt-education/interactive/18461932
- Noridian
  - first class Dec 10 – announced 11/12/20
  - https://med.noridianmedicare.com/web/jeb/article-detail/-/view/10525/2021-evaluation-and-management-change-preparation-webinars
- AAPC – Audit Tool – or as I call it – Helper Tool!
  - https://www.aapc.com/business/em-audit-tool-ebrief.aspx

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http://www.telemedicine.arizona

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https://www.surveymonkey.com/r/SWTRCWebinar

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