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CMS Finalizes Major Changes to E/M Coding and Documentation Requirements in 2021 – Will You Be Ready?

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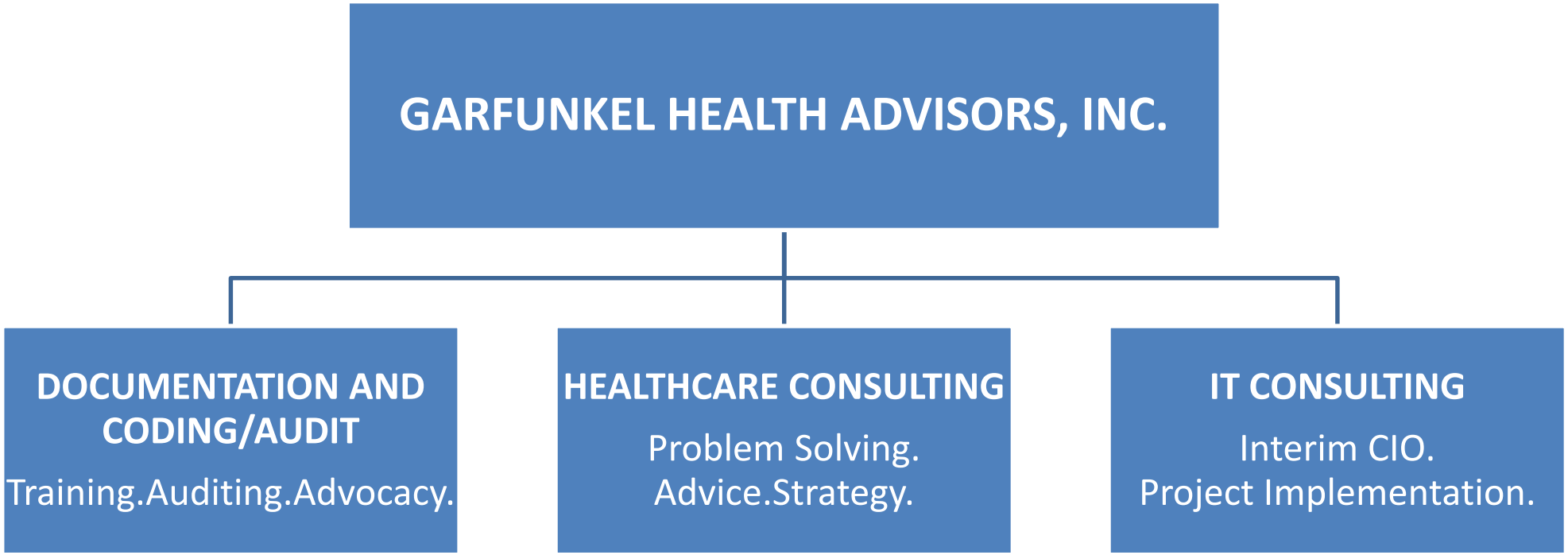

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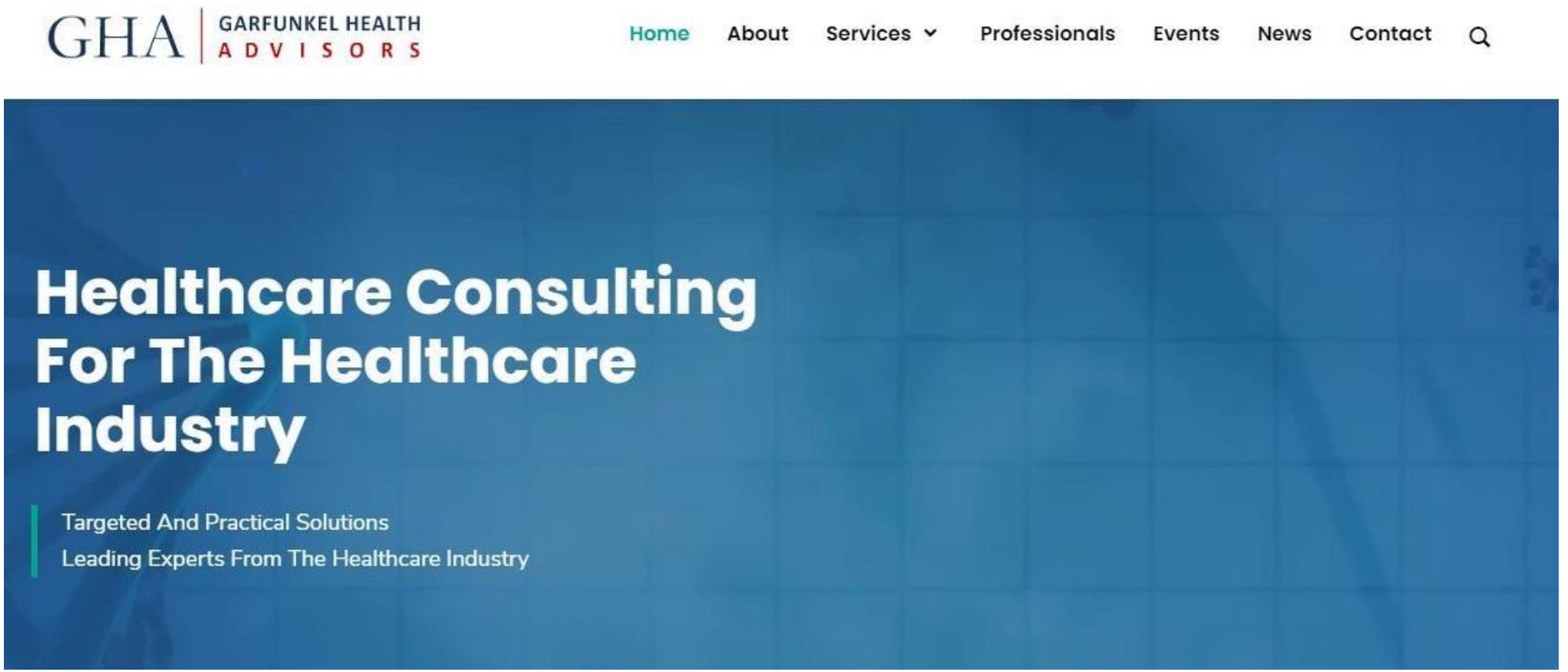

REASON BEHIND OUR “SOFT LAUNCH”

- No delay on these major Office/Outpatient (O/OP) Evaluation and Management (E/M) Guideline changes
- Providers are running out of time to prepare for implementation

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Alicia has over 36 years of clinical and administrative healthcare experience, specializing in documentation and coding, revenue cycle integrity, and has a strong background in both voluntary and mandatory compliance program development and implementation.

She frequently works with business litigation and health law practices on fraud and abuse intervention teams and providing litigation support

Alicia has presented educational and training seminars nationally on compliance, documentation and coding, and practice management. She is a frequent author for online physician blogs, and journals.

She is an Accredited Health Care Fraud Investigator (AHFI), and is certified in Healthcare Compliance (CHC, CPCO). She is a Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA), certified in Risk Adjustment Coding (CRC) , and is a Certified Professional Practice Manager (CPPM).

OBJECTIVES

- 2021 office and O/OP E/M Guideline changes
- What is and is not changing
- The impact to documentation, workflow and revenue
- How to prepare for these major changes

CMS announced that New O/OP E/M Guidelines go into effect January 1, 2021

Are you ready?

WHY THE CHANGE?

CMS started the process in 2019

CMS received significant push-back on the proposed changes, which included code consolidation and a single or blended rate

The goal remains the same:

- Reduce administrative burden
- Improve payment accuracy
- Update the code set to reflect current medical practices

WHY THE CHANGE?

- Clinicians and medical coders have complained about the complexity of the 1995/1997 guidelines for years
- Evaluation and management E/M services make up approximately 40% of allowed charges under the Physician Fee Schedule (office/outpatient services comprise approximately 20% of allowed charges)
- E/M errors are costly – Medicare reports that upcoding resulted in hundreds of millions of dollars in overpayments for office visits in 2017/2018
- 10 % of new visits, and 2.6 % of established visits, are paid improperly

DOCUMENTATION IS KEY

- Providers are responsible for documenting each patient encounter completely, accurately and on time
- Incomplete and inaccurate documentation can result in:
  - Unintended and dangerous patient outcomes
  - Audits and overpayments, including significant financial and regulatory consequences
  - Potential civil and criminal enforcement

REDUCE FRAUD, WASTE, ABUSE & REGULATORY RISK

The False Claims Act and other federal and state fraud and abuse laws remain in effect

Documentation & coding compliance provides protection from audits, regulatory actions and licensure inquiries

WHAT IS CHANGING?

2021 E/M CHANGE HIGHLIGHTS

- The changes apply to new and established office and outpatient visits only
- All other E/M Service levels are still based on the 1995/1997 guidelines (for now)
  - Commercial carrier consults
  - Inpatient/Skilled Nursing Facility

2021 E/M CHANGE HIGHLIGHTS

- **99201 level of care will be deleted**
- Since the medical decision making (MDM) for 99201 and 99202 are both “straightforward,” the decision was made to delete 99201
- Because 99211 has traditionally been used for “nurse visits," there is no MDM attached, so it will remain active next year

2021 O/OP E/M CHANGE HIGHLIGHTS

- The history and physical exam will no longer be **COUNTED** as key components of documentation, **however**….
- **Visits will include a medically appropriate history and exam when performed**

2021 O/OP E/M CHANGE HIGHLIGHTS

- The level of care will be determined by time spent **OR** by the medical decision making
- Providers will have a choice – on each and every patient
- Important to understand the necessary requirements and how to apply them to different patient encounters

CALCULATING TIME IN 2021

- Currently, E/M "time" is based only on face-to-face activities with the patient
- Beginning on January 1st, E/M "time" will include both non- face-to-face activities, as well as face-to-face activities on the day of the encounter
- New times and clearly defined ranges of minutes for new and established patients
- Time is available as an option whether or not counseling and coordination of care predominates 50% or more of the visit—a change from current rules
- Document the actual time and activities performed
  - For example: "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."

Office Visits
New Patients vs. Established Patients

Evaluation & Management Code (New Patients)	Current Time	Average Time
99202	20 minutes	15 – 29 minutes
99203	30 minutes	30 – 44 minutes
99204	45 minutes	45 – 59 minutes
99205	60 minutes	60 – 74 minutes

Evaluation & Management Code (Established Patients)	Current Time	Average Time
99212	10 minutes	10 - 19 minutes
99213	15 minutes	20 – 29 minutes
99214	25 minutes	30 - 39 minutes
99215	40 minutes	40 – 54 minutes

DOCUMENTATION OF TIME INCLUDES

Face to Face

- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver

Non-Face to Face

- Preparing to see the patient
- Obtaining and/or reviewing separately obtained history
- Ordering medications, tests or procedure
- 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)

NEW MDM CALCULATIONS

- There will be a new table for calculating medical decision-making (MDM) in 2021
- No change to the three current MDM sub-components (DX/Data/Risk), **but**
- Extensive edits to the elements for code selection
- 2 out of 3 elements must be met or exceeded

MDM COMPONENTS

- ❑ Number and complexity of problems addressed
- ❑ Amount and/or complexity of data reviewed and analyzed
- ❑ Risk of complications and/or morbidity or mortality

Data will be divided into three categories:

- Category 1: tests, documents, orders, and review of prior external note(s) from each unique source or independent historian(s) — each unique test, order, or document is counted to meet a threshold number (not reported separately)
- Category 2: independent interpretation of tests not reported separately
- Category 3: discussion of management or test interpretation with external physician/other qualified health care provider/appropriate source (not reported separately)

UNDERSTANDING MDM DATA COMPONENTS

- As per the AMA, if you **bill** for the test, do not count it as ordered or reviewed
- The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately
- No MDM credit for tests that are separately reported/billed by the physician/medical practice

Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**	**MDM**	**CODE LEVEL**
☐ 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment	SF	99202 99212
☐ 2 or more self-limited or minor problems OR ☐ 1 stable chronic illness; OR ☐ 1 acute, uncomplicated illness or injury	(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)	Low risk of morbidity from additional diagnostic testing or treatment	LOW	99203 99213

Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management	MDM	CODE LEVEL
☐ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR ☐ 2 or more stable chronic illness; OR ☐ 1 undiagnosed new problem with uncertain prognosis; ☐ OR ☐ 1 acute complicated injury	(Must meet the criteria of at least 1 of the 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 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 determinates of health	MOD	99204 99214

Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management	MDM	CODE LEVEL
☐ 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	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 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	HIGH	99205 99215

NEW ADD ON CODES

- New G code (G2211) for increased medical complexity and/or primary care
- New prolonged services code (G2212) for new and established office visits

NEW ADD ON CODES

- **New G code (G2211) for increased medical complexity and/or primary care**
- **G2211** 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 condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
- **G2211** is not intended to reflect a difference in payment by enrollment specialty, but rather a better recognition of differences between kinds of visits
- Some commercial plans may pay
- wRVU (0.33) national payment rate of $15.88

EXAMPLES FOR ADDING G2211 - NEW AND ESTABLISHED PATIENTS

Providing ongoing care for a single, serious, or complex chronic condition

- Rheumatologist - RA, MS, Lupus, Psoriatic arthritis, etc.
- Internal Med - DM, COPD, CHF, CAD, etc.
- Neurologist – Epilepsy, etc.
- Endocrinology- DM, Thyroid, etc.

- Select the appropriate E/M level
  - ADD G2211

PROLONGED SERVICE CODE

- Prolonged services of less than 15 minutes total time on the date of the office visit or other outpatient service (i.e., 99205, 99215) is not reported
- G2212 Medicare only
- 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)
- Difference in code descriptors – max vs minimum required time of the E/M

WHAT IS NOT CHANGING

WHAT WILL NOT CHANGE

- Incident-to guidelines
- Modifier 25
- Post–op, modifier 24
- Well visits reported with a “sick” visit
- Status and determining if a patient is a new or established patient
- Multiple visits on the same date of service
- Patients admitted to observation or inpatient status from the office
- Reporting ancillary service associated with an office visit
- Signature guidelines

MEDICAL NECESSITY

- The most important concept that will not change and will become even more prominent in the code selection is the concept of Medical Necessity
- Driving factor for code level selection
- Complete and accurate diagnosis coding is essential for reporting medical necessity and patient acuity
- Documentation should be accurate and complete
- Following a SOAP note format will help ensure work is captured

DEFINITIONS ARE CLARIFIED - MEDICAL DECISION MAKING (99202-99215)

- **What is considered a "Problem"?** A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter
- **What is considered a "Problem Addressed"?** A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service
  - This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice
  - Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service
  - Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment **does not qualify as being addressed or managed** by the physician or other qualified health care professional reporting the service

DEFINITIONS ARE CLARIFIED: MEDICAL DECISION MAKING (99202-99215)

- Self limited or minor problems
- Stable chronic illness
- Acute, uncomplicated or injury
- Undiagnosed new problem with uncertain prognosis
- Acute illness with systemic symptoms
- Chronic illness with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illness or injury that poses a threat to life or bodily function
- Test
- External
- External QHP

KEY TAKEAWAYS

- Prepare now for the changes
- Audits will be critical to catch and correct issues early
- Make necessary adjustments to policies and workflow
- Update EMR templates and macros
- Encounter details must be clearly stated and documented to be counted

INTERACTIVE DISCUSSION

GHA PACKAGES

Education Only Plans

Plan #1

- 1 hour pre-recorded education session
- 30 minute live Q&A
- Office Resource Tool

$3,500

Plan #2

All benefits of Plan #1, **plus**

Additional 15 minute live Q&A

$3,600

Education, Record Review & Training Plans

Plan #3

- 1 hour pre-recorded education session
- Chart review & comparison (10 encounters)
- 45 minute live training session for physicians
- Office Resource Tool

$4,300

Plan #4

All benefits of Plan #3, **plus** an additional review of 10 encounters to show improvement, **plus** an additional 30 minute live post-audit session

$5,500

Custom Packages

Custom packages can be designed around the unique needs of the organization. Examples of additional features include:

Additional review comparisons for more providers

Chart review compliance

Reviewing EMR templates

Revisions of superbill forms

Training sessions of provider and coding staff

Ongoing quarterly chart reviews

1-1 provider follow-up and training

Helpline subscription

REGISTERING FOR PLANS & PACKAGES

WHERE CAN YOU FIND THE CODING PACKAGE REGISTRATION FORM?

Email us at info@garfunkeladvisors.com or Click Here.

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CODING PACKAGE REGISTRATION FORM

PLEASE COMPLETE THE REGISTRATION FORM AND SEND TO INFO@GARFUNKELADVISORS.COM

REGISTRATION INFORMATION

CLIENT NAME:		
CONTACT NAME:	PHONE:	EMAIL
ADDRESS:		
CITY:	STATE:	ZIP:
NUMBER OF PROVIDERS:	NUMBER OF OFFICE LOCATIONS:	

PLANS:

EDUCATION ONLY PLANS

☐ PLAN #1	• 1 hour pre-recorded education session • 30 minute live Q&A • Office resource tool $3,500
☐ PLAN #2	• All benefits of Plan #1 **plus** • Additional 15 minute live Q&A $3,600

EDUCATION, RECORD REVIEW & TRAINING PLANS

☐ PLAN #3	• 1 hour pre-recorded education session • Chart review & comparison (10 encounters) • 45 minute live training session for physicians • Office resource tool $4,300
☐ PLAN #4	• All benefits of Plan #3, **plus** an additional review of 10 encounters to show improvement, **plus** an additional 30 minute live post-audit session $5,500

CUSTOM PACKAGES

☐ PLAN #5	**Custom packages can be designed around the unique needs of the organization.** **Examples of additional features include:** • Additional review comparisons for more providers • Chart review compliance • Reviewing EMR templates • Revisions of superbill forms • Training sessions of provider and coding staff • Ongoing quarterly chart reviews • 1-1 provider follow-up and training • Helpline subscription

FOR ADDITIONAL INFORMATION OR QUESTIONS, PLEASE EMAIL INFO@GARFUNKELADVISORS.COM OR CALL (833) 355-1333.

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