2021 E/M Changes: Strategies for Tackling and Mitigating Risks

Pam D'Apuzzo, CPC, ACS-EM, ACS-MS, CPMA

Disclaimer

Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Center for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

CPT Disclaimer

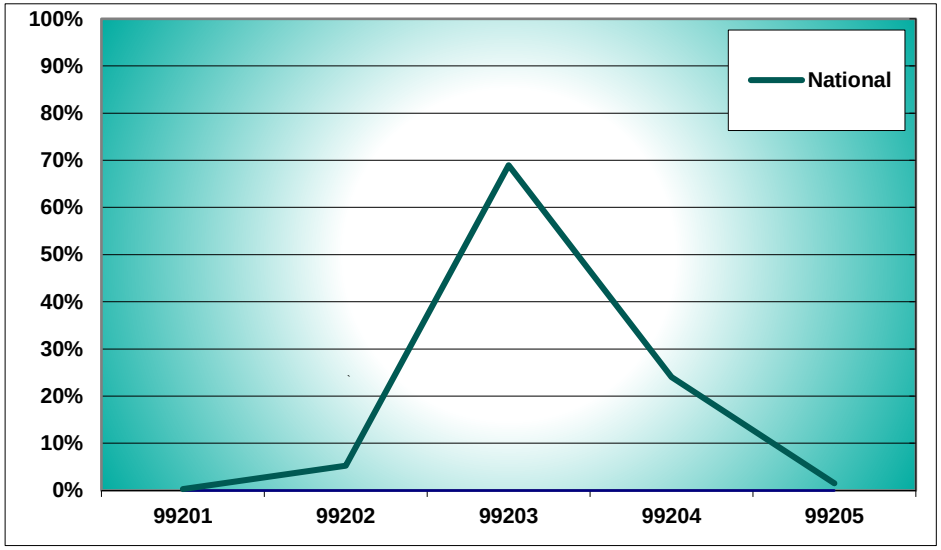
Learning Objectives

- Identifying Risk Areas
- What hasn’t changed
- 2022 Compliance Strategies

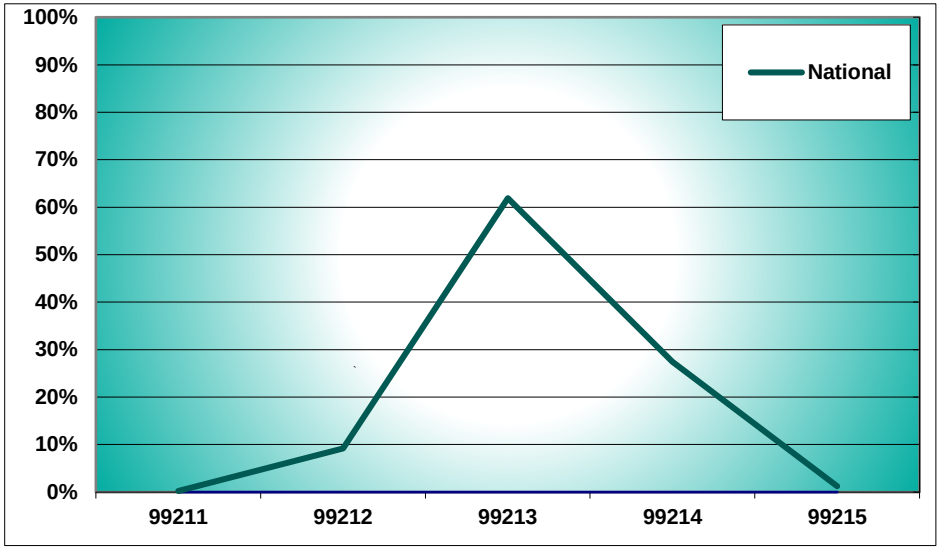
Identifying Risk Factors

E/M Bell Curve Data – Orthopedic Surgery

Orthopedic Surgery – New Patient Office Visits



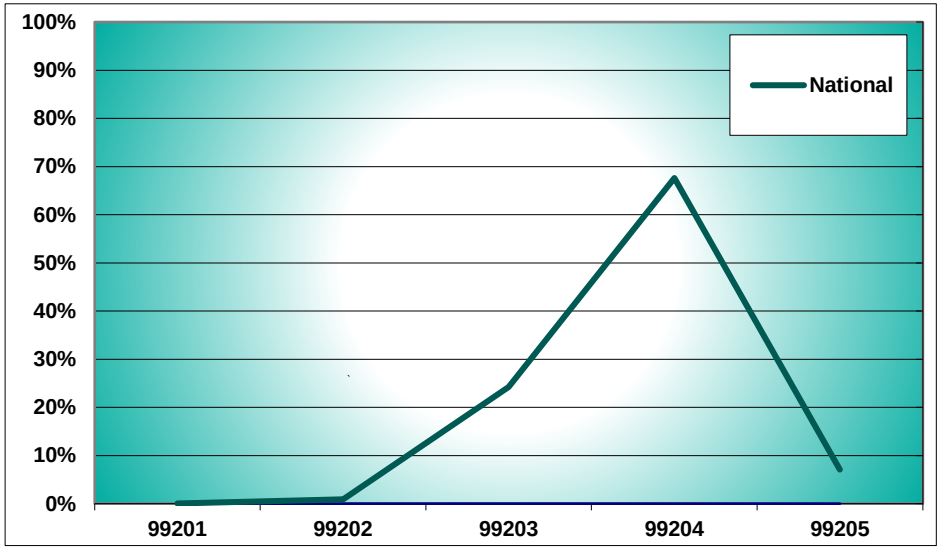
Orthopedic Surgery – Established Patient Office Visits



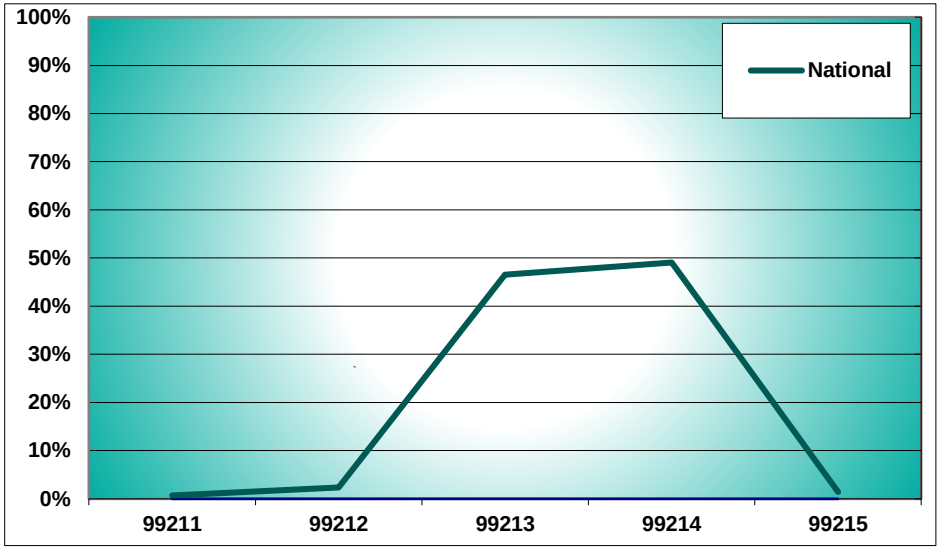
2021 E/M Bell Curve Data Book

E/M Bell Curve Data – Pain Management

Pain Management – New Patient Office Visits



Pain Management – Established Patient Office Visits



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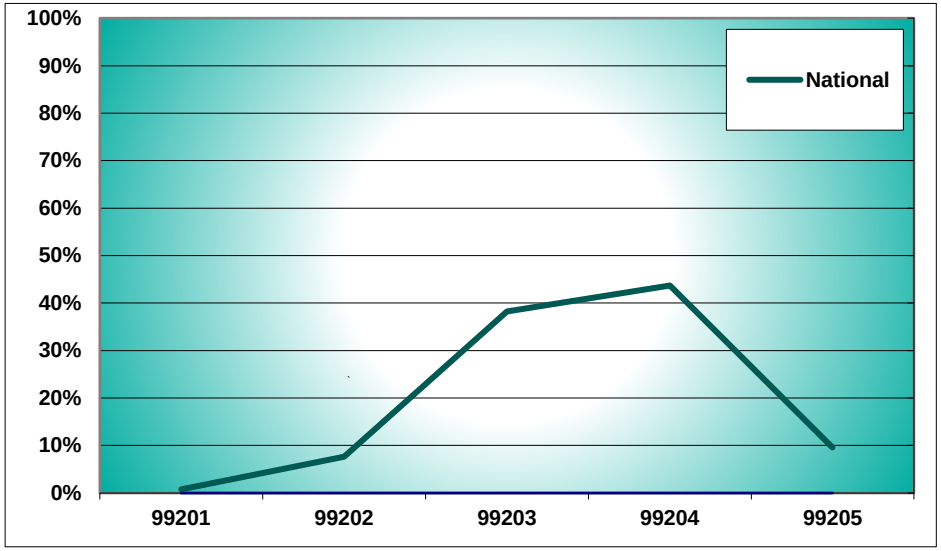
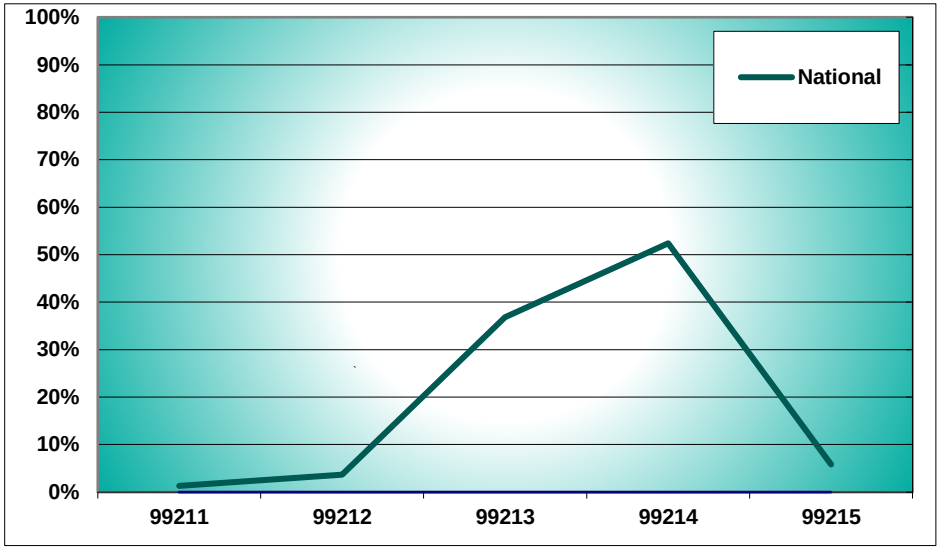
E/M Bell Curve Data – Pediatric Medicine

Pediatric Medicine – New Patient Office Visits



Pediatric Medicine – Established Patient Office Visits



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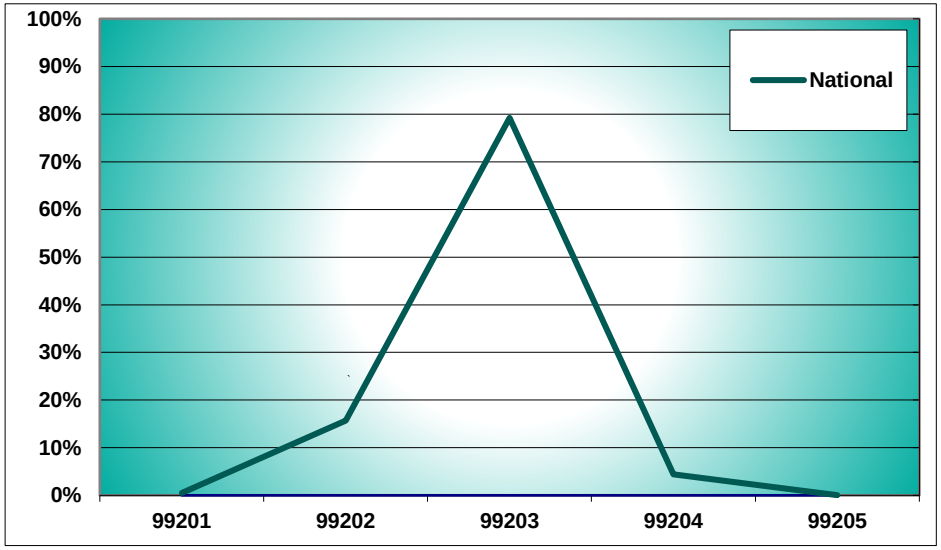
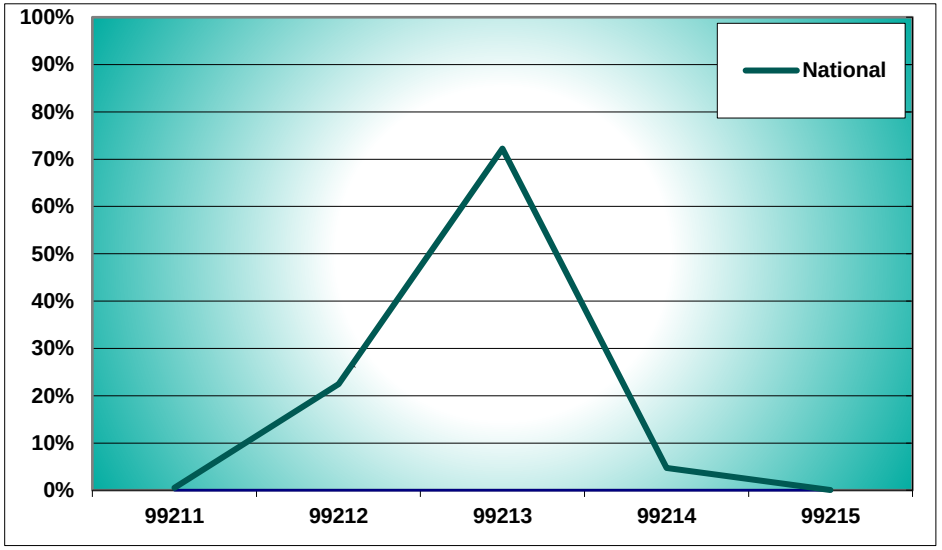
E/M Bell Curve Data – Podiatry

Podiatry – New Patient Office Visits



Podiatry – Established Patient Office Visits



2021 E/M Bell Curve Data Book

Common Audit Findings of Non-Compliance

Copy & Paste Cloned Notes – Safeguards

Non-Compliant	Compliant
Copying from outside the chart	Include interval history
Using pre-populated smart phrases or smart texts for initial exams	Note "unchanged" elements of PFSH/ROS/Physical Exam from last visit **(reference date of previous exam)** **OR** Note pertinent changes to PFSH/ROS/Physical Exam from last visit **(reference date of previous exam)**
Copying assessment and plan **without** updates	Use customized Smart List/Smart Blocks/NoteWriter Manually add current findings Update assessment and plan

Common Audit Findings of Non-Compliance

Copy & Paste Example

Assessment Plan
Mr. Smith is a 35-year-old male with a history of obesity class II, OCD, plantar fasciitis, chronic ACL tear who presents for weight management follow-up. Today we talked about his progress.

Copied by: John Doe, MD
at 8/22/2018 8:50 AM
From Progress Notes by Doe, John, MD at 7/19/2018 10:30 AM

#Obesity
Continue low glycemic diet
Patient will put me in touch with his RD
Continue to use shakes for meal replacements
Continue exercise
Increase Saxenda to 1.8 mg daily
Next steps: Topamax for OCD/appetite – I discussed this idea with Mr. Smith's psychiatrist, and we are in agreement.
Follow up in 6 weeks for next office visit
Avoid: Stimulants

#Plantar fasciitis/chronic ACL tear: Following with Dr. Plantar
#OCD: Following with psych, continue Prozac, I have been in touch with psychiatrist
#Hyperkalemia: Repeat labs at next visit

The total amount of time spent talking on the phone with Mr. Smith was 15 minutes regarding his weight loss progress thus far, medication use and side effects, and adjustments in medication dosage.

Common Audit Findings of Non-Compliance

Compliant Templates

Physical Examination:

@VS@

General appearance: The patient is well-appearing. @CAPHE@ is awake, alert, and oriented. @CAPHE@ demonstrates *** breathing.

Neurological/Psychiatric: The patient is alert and oriented to ***. The patient has a *** mood and affect.

Skin Examination: The skin over the right lower extremity and left lower extremity is ***

Cardiovascular Examination: There are *** varicosities, capillary refill ***, arterial pulses ***, ***edema, ***with|without any evidence of infection or rash.

Right Knee Examination:

Examination of the right knee reveals the skin to be ***. There is *** obvious swelling.

There is *** tenderness to palpation.

Range of motion is *** extension to *** degrees of flexion.

The knee is ***unstable|stable.

There is *** grinding with range of motion.

There is *** patellofemoral crepitus.

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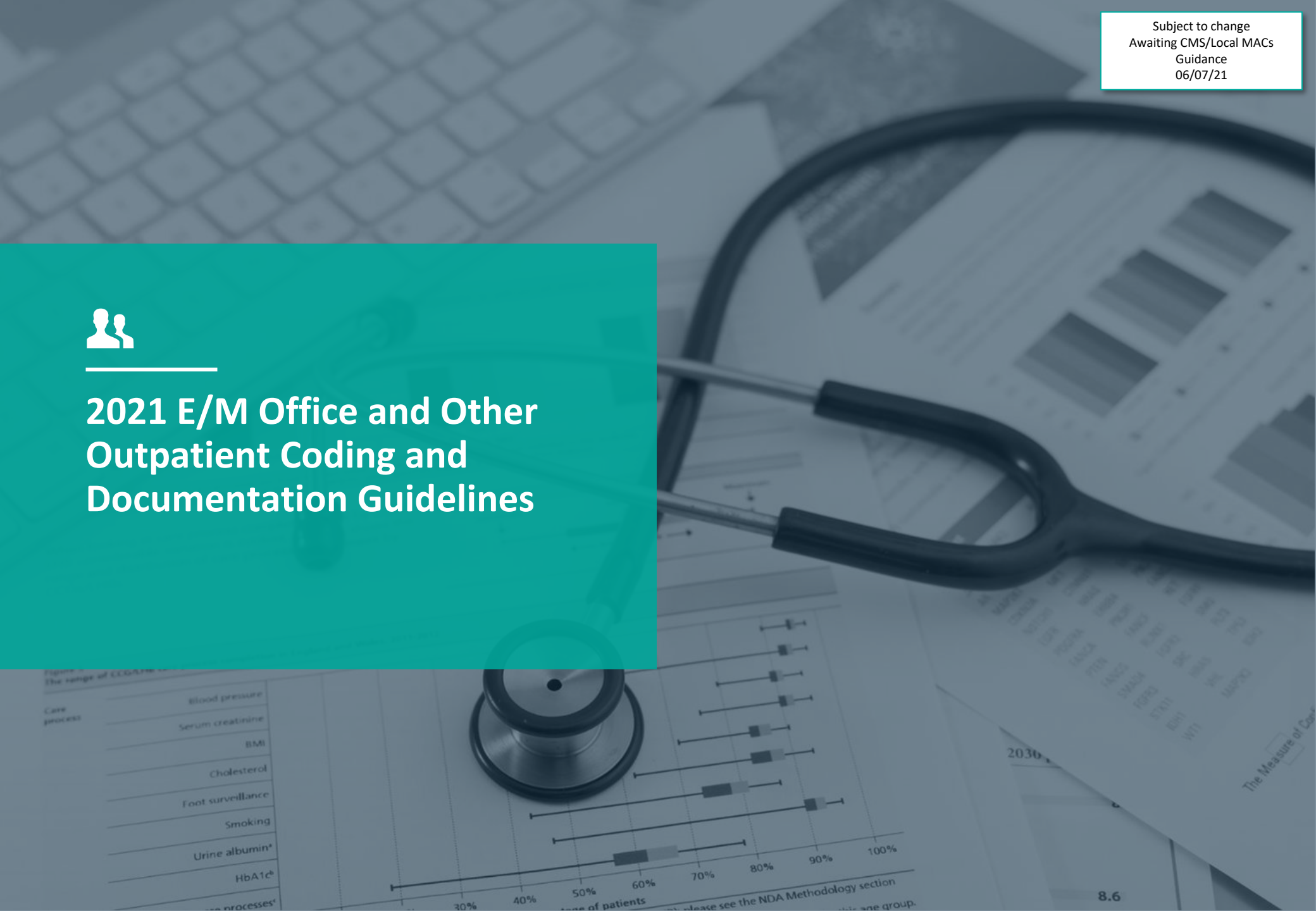
2021 E/M Office and Other Outpatient Coding and Documentation Guidelines



E&M Component	2019	2020	2021
Chief Complaint	No changes	**No changes**	No changes
History of Present Illness (HPI)	CMS now allows ancillary staff to document the HPI on behalf of the provider. The provider is responsible for verifying the accuracy of the collected information. Please note this is a CMS change and therefore you should consult individual commercial payers and state Medicaid programs to see if they are following CMS. Additionally, CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of HPI elements still apply.	**No changes**	HPI should describe the nature and severity of the patient's presenting problem(s) as medically indicated but will no longer be scored for the purposes of the E&M documentation requirements. Please note it will still be needed to support medical necessity for the encounter.
Review of Systems (ROS)	CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of ROS elements still apply.	**No changes**	ROS should specify whether organ systems are or are not impacted to demonstrate the complexity of the condition(s). This portion of the documentation will no longer be scored but will still be needed to support medical necessity.
Past, Family, Social, History (PFSH)	CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of PFSH elements still apply.	**No changes**	PFSH should be used to capture medically appropriate historical information but will no longer be scored for the purposes of the E&M documentation requirements.
Exam	**CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of exam elements (e.g. bullets for body areas, organ systems) still apply.**	**No changes**	The exam should be medically appropriate as determined by the provider of care. This component will no longer be scored for determining the level of E&M service, but it could still impact the level of service supported based on the medical necessity show in the documented exam.
Encounter Diagnosis	No changes	**No changes**	AMA E&M Guidelines indicate that only diagnoses documented as active treatment during the encounter will be credited for scoring purposes. The revised Table of Risk created by the AMA removes "additional work up" as a consideration of each diagnosis.
Data & Complexity	No changes	**No changes**	The AMA has taken most of the elements from the Marshfield chart of Data & Complexity and incorporated them here. Changes include new requirements for specific combinations of different work elements to support a specific level of service.
Table of Risk (TOR)	No changes	**No changes**	The AMA revised the TOR, consolidating it into one column on the new MDM table, and this column now uses only the last column on the original TOR (treatment options for the patient).
Time	No changes	**No changes**	There are 2 changes: 1) The limitation on the use of time is deleted. Therefore, there will be NO requirement that the visit must be "dominated" by the counseling and/or coordination of care. 2) Time spent now includes the rendering provider's total time spent on the day of the encounter, including non-face-to-face time spent on the specific encounter and patient.

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Although not required for billing purposes, documentation should include clinically appropriate information for medical/legal purposes.

Source: NAMAS E&M Comparison Chart

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Who Can Document? Payer Requirements

Billing Physician or Non-Physician Provider (APP) Rendering an E/M Service:

- History of Present Illness (HPI)
  - **Providers need not re-enter information on the patient's chief complaint and history that has already been entered by ancillary staff or the patient (e.g.; patient portal)**
  - **The billing provider may simply indicate in the medical record that he/she reviewed and verified this information**
- Physical Examination (PE)
  - **The billing provider may simply indicate in the medical record that he/she reviewed and updated, if needed, the previously recorded exam. *The date of the previous exam should be noted.***
- Medical Decision-Making (MDM)

Ancillary Staff (Medical Assistant/LPN/RN/Athletic Trainer/Scribe) May Only Document:

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

NOTE: Billing MD/APP must "review" the information, update, or supplement as deemed appropriate, all documentation entered by ancillary staff.

EXCEPTIONS = Residents/Fellows + Scribes

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2021 Evaluation and Management Office Visits

New Patient Visits

E/M Code	Minutes	MDM
99202	15-29	Straightforward
99203	30-44	Low
99204	45-59	Moderate
99205	60-74	High

OR

Established Patient Visits

E/M Code	Minutes	MDM
99211	No Time Component	Minimal
99212	10-19	Straightforward
99213	20-29	Low
99214	30-39	Moderate
99215	40-54	High

OR

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

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AMA AMERICAN MEDICAL ASSOCIATION

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
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

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

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

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A Closer Look at 2021 MDM: Moderate

Code	Level of MDM (Based on 2 out of 3 Elements on MDM)	Number & 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	Time
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 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 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 healthcare 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 ***(typically includes homelessness, food insecurity, unsafe living conditions (access to clean water, pollution free air), and economic insecurity)***	45-59 minutes 30-39 minutes

Subject to change
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A Closer Look at 2021 MDM: High

Code	Level of MDM (Based on 2 out of 3 Elements on MDM)	Number & 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	Time

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 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**
					60-74 minutes
					
					40-54 minutes

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Time

- **Total time** on the **date of the encounter** **includes**:
  - **Face-to-face time**
  - **Non-face-to-face time**
  - **Time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter**

- Time does **not** include time:
  - **Activities normally performed by non-clinical/ancillary staff and scribes**
  - ***Time spent by a resident/fellow may only be counted in a Primary Care Exception setting***
  - ***The performance of other services that are reported separately****
  - ***Travel****
  - ***Teaching that is general and not limited to discussion that is required for the management of a specific patient****

- **Physician/APP time includes** the following activities, when performed:
  - Preparing to see the patient (e.g., 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)

****Code and Guideline Changes_AMA Technical Corrections Posted March 9, 2021***

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Time Documentation Guidelines

Sample time statements:

"Total clinical time spent with patient @NAME@ on the date of this encounter was *** minutes including reviewing the chart in preparing to see patient @NAME@ and obtaining/reviewing/confirming history. The content of care is documented in my progress note and contained within this electronic medical record. Also included in this time was counseling patient @NAME@ regarding ***."

"Total unique clinician time spent by me (MD or APP) or and _____(MD + APP) on date of this encounter is *** minutes including preparing to see the patient, obtaining/confirming history, performing examination, *** and documenting clinical information in this electronic medical record."

Add:

counseling and educating the patient, family, and/or caregiver

ordering medications, tests, or procedures

referring and communicating with other healthcare professionals

independently interpreting results and communicating results to the patient, family, and/or caregiver

care coordination

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Split/Shared E&M Services

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06/07/21

CMS Shared/Split E/M Guidelines

The Shared/Split Visit guidelines apply only to the E/M visits identified below:

- Emergency Department (99281-99285)
- Initial Hospital Visit (99221-99223)
- Subsequent Hospital Visit (99231-99233)
- Discharge Day Management (99238-99239)
- Observation Care (99217-99220, 99234-99236)
- Prolonged Care (99354-99357)
- ***Office/Outpatient Visits (99202-99215)***

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CMS Shared/Split E/M Guidelines

The split/shared guidelines **do not apply** to:

- Procedures and diagnostic studies including, but not limited to:
  - ✓ Laceration repair
  - ✓ Closed fracture reduction
  - ✓ EKG
  - ✓ X-Rays
- Critical Care Services (99291-99292)

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Split/Shared Services

A split/shared service is an encounter where a physician and a NPP each personally perform a portion of an E/M visit. Here are the rules for reporting split/shared E/M services between physicians and NPPs:

In the office or clinic setting:

- For encounters with established patients who meet incident to requirements, use **either** practitioner's National Provider Identifier (NPI)
- For encounters that do not meet incident to requirements, **use the NPP's NPI**

Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:

- When the physician provides any face-to-face portion of the encounter, use either provider's NPI
- When the physician does not provide a face-to-face encounter, **use the NPP's NPI**

The following guidelines should be followed in addition to documentation guidelines for an E/M service:

- **Both** the Physician and APP **must personally document** his/her portion of the service
- The physician must clearly document that a face-to-face encounter took place
- Documentation should support the combined service level and medical necessity
- The attending physician will clearly indicate their participation in the visit by adding to or writing a **separate** note
- Both providers should indicate the service was "performed in conjunction with (APP or MD)"

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Shared/Split Sample

Documentation

The attending physician should reference the NP/PA documentation in a clear statement and add personal involvement.

"I have personally seen and examined this patient and have reviewed the NP/PA note authored by X dated Y" with the following comments:
Ms. X. is a 35-year-old woman with uncontrolled ulcerative colitis who has not been taking her medications who presents to Cobble Hill ED with 10 days of bloody diarrhea. Of note, she took azithromycin for bronchitis 2 weeks ago. She reports 15 lb. weight loss. On my examination, she is hemodynamically stable, but her pulse is 110. She is thin. She is diffusely tender in all four quadrants. Laboratory studies are significant for a microcytic anemia (HCT 33, MCV 81) and a leukocytosis (15K). There is no anion gap. LFTS are normal. AXR shows no free air. My differential is UC flare or C. diff infection or both. My plan is to call GI and send stool studies for C. diff and bacteria. We will hold off on steroids pending C. dif. We will hydrate with NS and keep NPO. Will give non-opiate pain meds."

The attending physician will bill the level of service based on the combined documentation of the APP note AND his/her personal documentation.

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through 7/21/21

Telehealth and Telephonic Documentation Details

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

Medicare Visit Types

Telehealth Services

New Patient	Established Patient
99201 DELETED	**99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (No time component)
99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter	**99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter
99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	**99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

Audio-Only Telephone E/M

New and Established Patients **Providers can now provide certain services by telephone during the COVID-19 PHE, to both new and established patients**
99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian **not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours** or soonest available appointment; **5-10 minutes of medical discussion**
99442: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian **not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours** or soonest available appointment; **11-20 minutes of medical discussion**
99443: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian **not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours** or soonest available appointment; **21-30 minutes of medical discussion**

Do Not Bill if:

- Audio-only is for lab, radiology and/or diagnostic results.
- Audio-Only is originating from a related E/M service provided within 7 days prior.
- Audio-only results in face-to-face visit within 24 hours or next available appointment for a related complaint.
- Less than 5 minutes is spent speaking to patient.

May Bill if:

- Audio-Only is UNRELATED to E/M service provided within 7 days prior.
- Audio-Only results from another Audio-Only service.
- Audio-Only is greater than 5 minutes spent speaking to patient.

Additional Requirements:

- Location of Patient
- Location of Provider
- Call Participants
- Call Start/Stop Times

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

Sample Documentation Templates

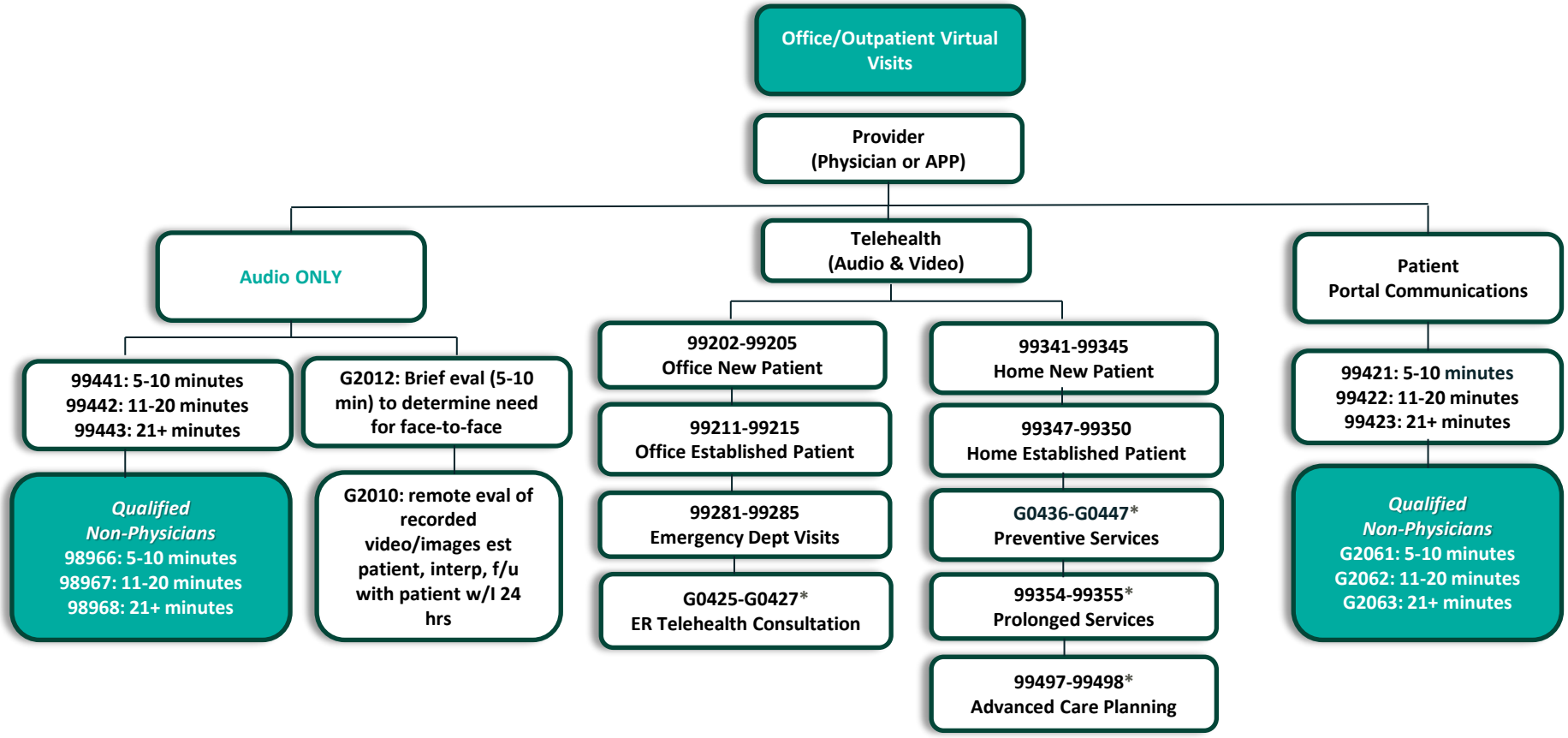
Patient has verbally consented to this telehealth visit. **If yes, check here: □**	
PATIENT NAME:	DATE:
Session Start Time:	**Names of all persons participating in this service:**
Session End Time:	
Location of Patient:	
Location of Provider:	
Chief Complaint/Reason For Visit:	
IMPRESSION/ASSESSMENT:	
PLAN:	
RECOMMENDATIONS FOR FURTHER TREATMENT:	
"Total clinician time spent on date of this encounter is _____ minutes including preparing to see the patient, obtaining/reviewing and confirming history, virtually examining patient, documenting clinical information in the EHR."	

Patient has verbally consented to this telephonic visit. **If yes, check here: ☐**
Chief Complaint/Reason for Call:
Medical Discussion:
ASSESSMENT/RECOMMENDATIONS FOR FURTHER TREATMENT:
The total amount of time on the phone in medical discussion and care of this patient: * minutes.**

Telehealth Services Overview

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

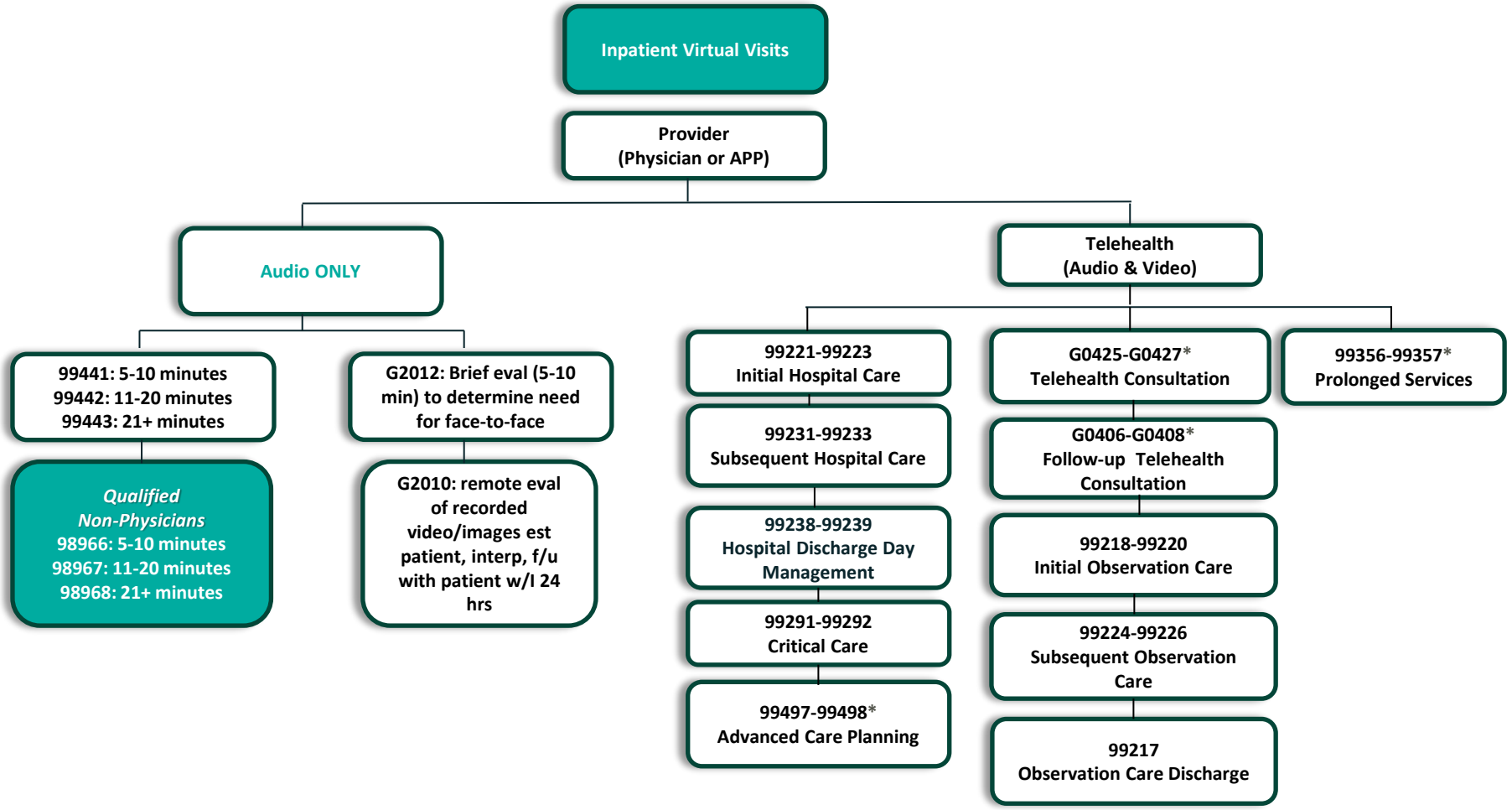
Outpatient Telehealth Services



**NOTE: Telehealth Services ALSO permitted to be performed via audio only effective April 30, 2020.*

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

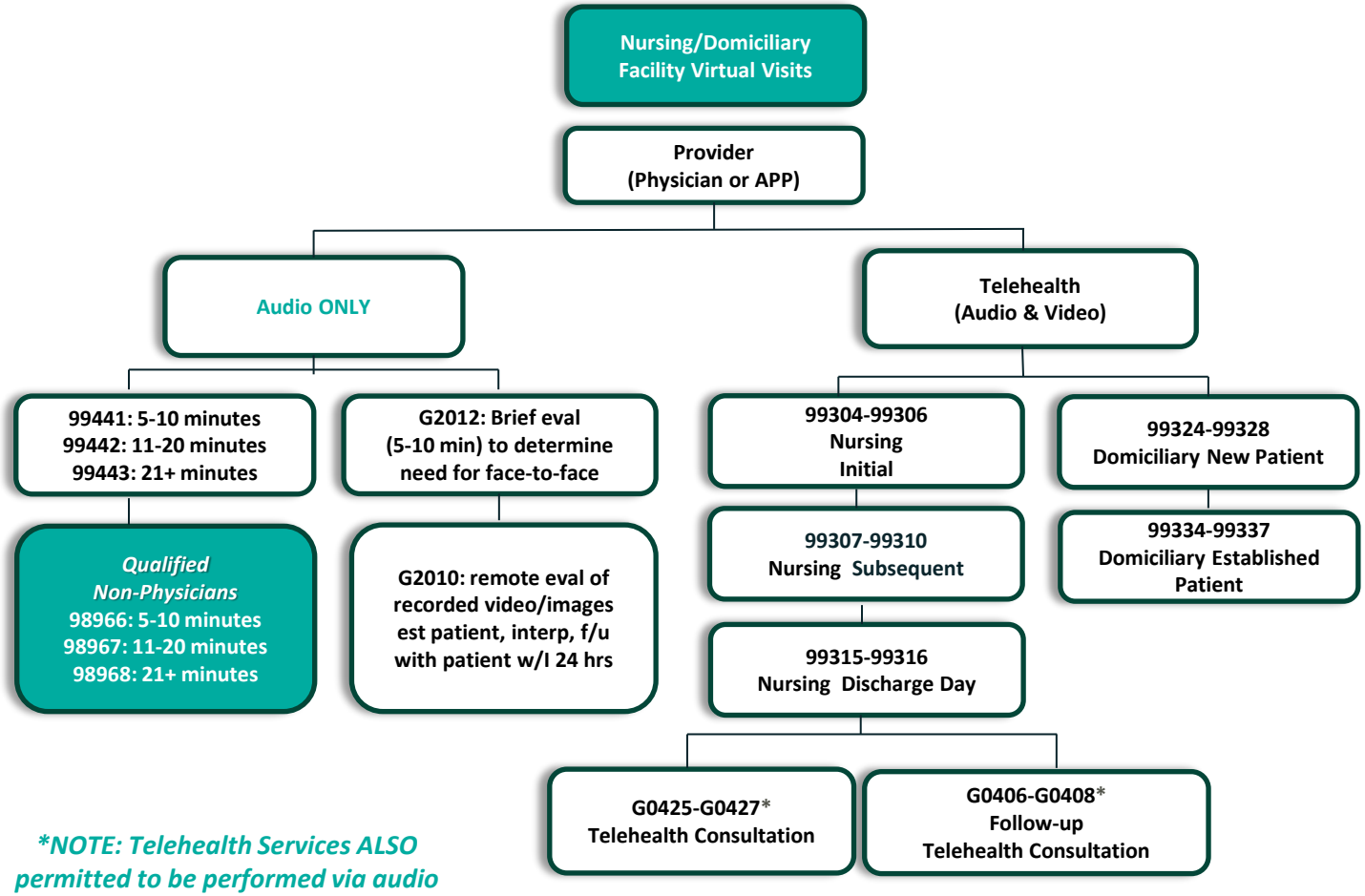
Inpatient Telehealth Services



NOTE: Telehealth Services ALSO permitted to be performed via audio only effective April 30, 2020.

Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

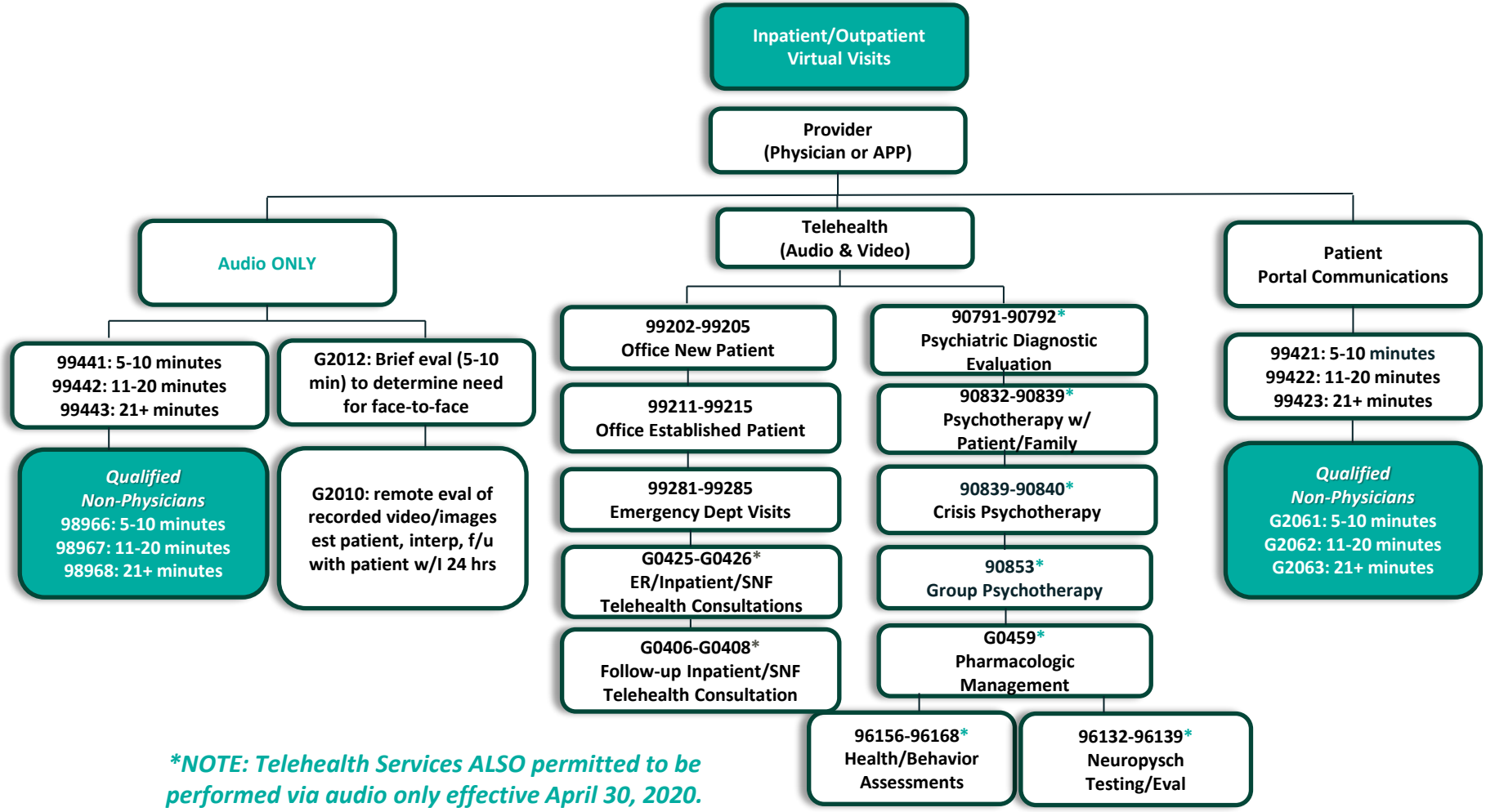
Nursing/Domiciliary Facility Telehealth Services



**NOTE: Telehealth Services ALSO permitted to be performed via audio only effective April 30, 2020.*

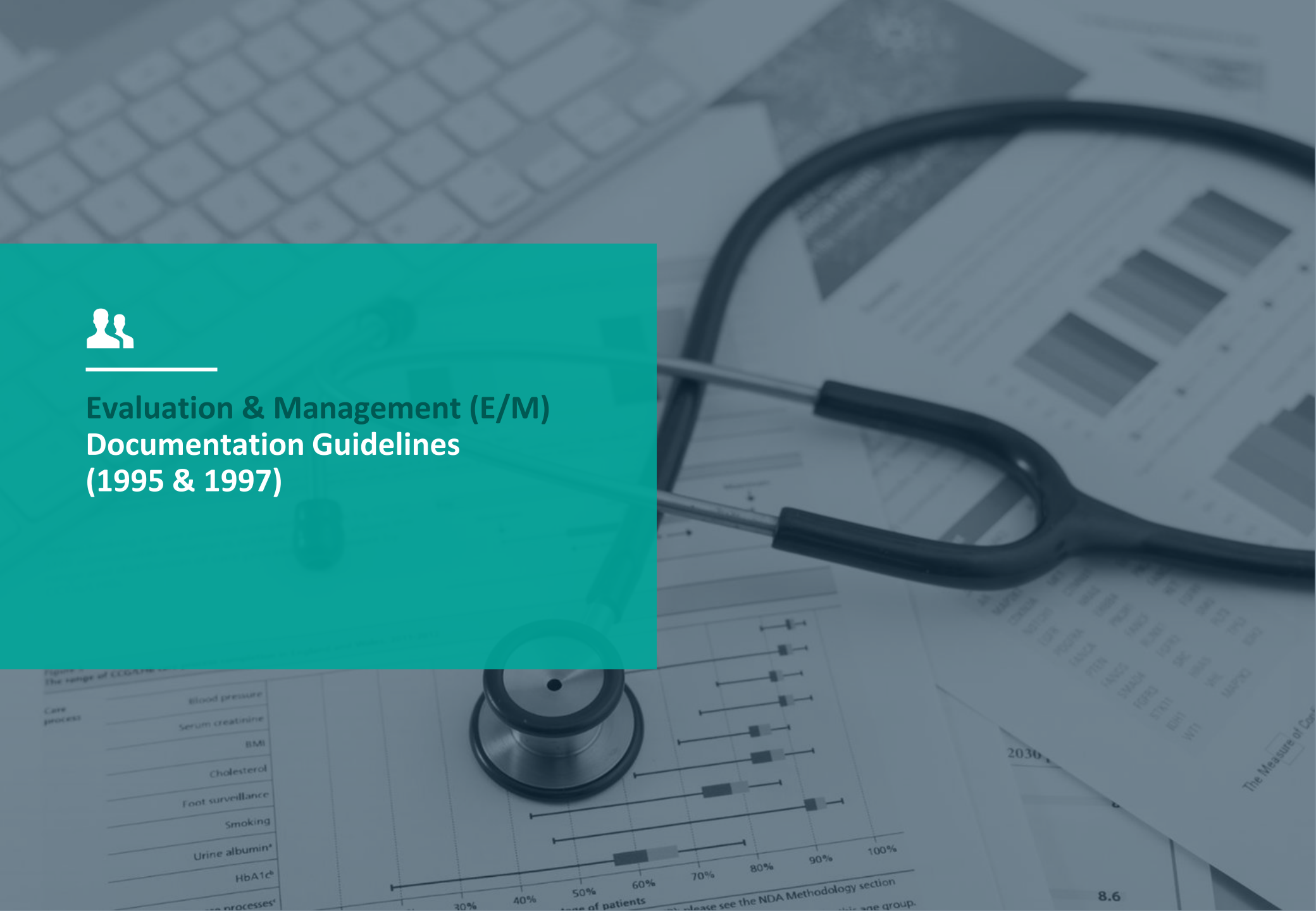
Subject to change
Throughout
COVID-19 Emergency
PHE Extended through
12/31/21

Telepsychiatry Services



**NOTE: Telehealth Services ALSO permitted to be performed via audio only effective April 30, 2020.*


What Hasn’t Change?
Blood pressure
Serum creatinine
BMI
Cholesterol
Foot surveillance
Smoking
Urine albumin
HbA1c
30%
40%
50%
60%
70%
80%
90%
100%
8.6



Evaluation & Management (E/M) Documentation Guidelines (1995 & 1997)

Elements for E/M Visits

History (HX)

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, Social History (PFSH)

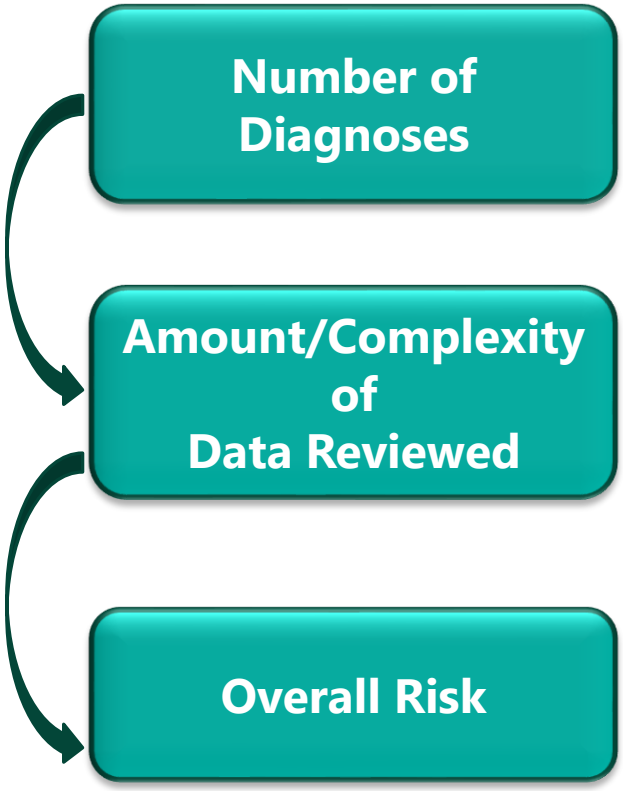
Physical Examination (PE)

- Number of organ systems and/or body areas examined (1995)
- Number of bullets for specialty exams (1997)

Medical Decision-Making (MDM)

- Number of diagnoses or management options
- Amount of data/complexity
- Risk level to patient

Medical Decision Making



Number of Diagnoses

Self-limited or Minor	**1 point each (2 max)**
Established Problem, Stable	**1 point**
Established Problem, Worsening	**2 points**
New Problem, no Additional Work-up	**3 points**
New Problem, with Additional Work-up	**4 points**

Amount & Complexity of Data

Review (and/or) Order of Laboratory Tests	**1 point**
Review (and/or) Order of Radiology Tests	**1 point**
Review (and/or) Order of Medical Tests - Includes EKG, Echo, PFT's	**1 point**
Discussion of Test with Performing MD	**1 points**
Independent Review of Test	**2 points**
Old Records or History from Another Person - Decision to do this - Review and summarize	 **1 point** **2 points**

TABLE OF RISK

Risk of complications and/or Morbidity or Mortality

Level of Risk	Presenting Problem (s)	Diagnostic Procedure (s)	Management Options
MINIMAL	▪One self-limited or minor problem, ex: cold insect bite, tinea corporis	▪Laboratory tests requiring venipuncture ▪Chest x-rays ▪EKG/EEG ▪KOH prep ▪Urinalysis ▪Ultrasound – ex: echocardiography	▪Rest ▪Gargles ▪Elastic bandages ▪Superficial dressings
LOW	▪Two or more self-limited or minor problems ▪One stable chronic illness, ex: well controlled hypertension, non-insulin dependent diabetes, cataract, BPH ▪Acute uncomplicated illness or injury, ex: cystitis, allergic rhinitis, simple sprain	▪Physiological test not under stress – ex: PFT ▪Non-cardiovascular imaging studies with contrast, ex: barium enema ▪Superficial needle biopsies ▪Skin biopsy ▪Clinical laboratory tests requiring arterial puncture	▪Over-the-counter drugs ▪Minor surgery with no identified risk factors ▪Physical therapy ▪Occupational therapy ▪IV fluids without additives
MODERATE	▪One or more chronic illnesses with mild exacerbation, progression, or side effects or treatment ▪Two or more stable chronic illnesses ▪Undiagnosed new problem with uncertain prognosis, ex: lump in the breast ▪Acute illness with systemic symptoms – ex: pyelonephritis ▪Pneumonitis, colitis ▪Acute complicated injury, ex: head injury with brief loss of consciousness	▪Physiological test under stress, ex: cardiac stress test, fetal contraction stress test ▪Diagnostic endoscopies with no identified risk factors ▪Deep needle or incisional biopsy ▪Cardiovascular imaging studies with contrast and no identified risk factors, ex: arteriogram, cardiac catheterization ▪Obtain fluid from body cavity, ex: lumbar puncture, thoracentesis, culdocentesis	▪Minor surgery with identified risk factors ▪Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors ▪Prescription drug management ▪Therapeutic nuclear medicine ▪IV fluids with additives ▪Closed treatment of fracture or dislocation without manipulation
HIGH	▪One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ▪Acute or chronic illnesses or injuries that pose a threat to life or bodily function, ex: multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ▪An abrupt change in neurological status, ex: seizure, TIA, weakness, sensory loss	▪Cardiovascular imaging studies with contrast with identified risk factors ▪Cardiac electrophysiological tests ▪Diagnostic endoscopies w/identified risk factors ▪Discography	▪Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors ▪Emergency major surgery (open, percutaneious, or endoscopic) ▪Parenteral controlled substances ▪Drug therapy requiring intensive monitoring for toxicity ▪Decision not to resuscitate or to de-escalate care because of poor prognosis

E/M History Requirements

HISTORY REQUIREMENTS	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPRE-HENSIVE
HPI (history of present illness) elements: Location Severity Timing Modifying factors Quality Duration Context Associated signs & symptoms	**Brief (1-3)**	**Brief (1-3)**	**Extended (4 +)**	**Extended (4 +)**
ROS (review of systems): Constitutional Ears, nose, mouth, throat Integumentary Endocrine Hematologic/Lymphatic Cardiovascular Gastrointestinal Genitourinary Musculoskeletal Eyes Respiratory Neurological Psychiatric Allergic/Immunology	**None**	**Pertinent to problem (1 system)**	**Extended (2-9 systems)**	**Complete (10 or more systems)**
PFSH (past medical, family, social history) areas: ▪ Past history (the patient's past experiences with illnesses, operation, injuries & treatment, allergies, medication review/reconciliation) ▪ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ▪ Social history (an age-appropriate review of past and current activities) {*COMPLETE PFSH: ALL 3 AREAS NEEDED FOR ALL *INITIAL* VISITS, 2 OF 3 NEEDED FOR ER visits}	**None**	**None**	**Pertinent (1 history area)**	**Complete (2 or 3 history areas)***

1995 Physical Examination (PE) Guidelines

1995 Guidelines	
Problem Focused	1 body area or organ system
Expanded Problem Focused	2 to 7 systems - **with minimal detail** (2-5 body areas or organ systems)
Detailed	2 to 7 systems - **with expanded detail** (6-7 body areas or organ systems)
Comprehensive	8 or more **organ systems** (or) **a complete exam of a single system**

Organ Systems

Constitutional
Eyes
ENT
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary
Neurologic
Psychiatric
Hematologic/lymphatic /immunologic

Body Areas

Head, include face
Neck
Chest, including breasts & axillae
Abdomen
Genitalia, groin, buttocks
Back, including spine
Each extremity

SPECIALTY EXAM: MUSCULOSKELETAL

HIC#	DATE OF SERVICE

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

Performed and Documented	Level of Exam
One to five bullets	Problem Focused
Six to eleven bullets	Expanded Problem Focused
Twelve or more bullets	Detailed
All bullets	Comprehensive

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

System/Body Area	Elements of Examination
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	(See Musculoskeletal and Skin)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity Note: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Musculoskeletal **NOTE:** Determine the number of body areas addressed within each bullet. Enter that number on the line beside each bullet. Total at the bottom of this box. Inspection, percussion and/or palpation: _____ Assessment of range of motion: _____ Assessment of stability: _____ Assessment of muscle strength and tone: _____ * Total Bullets: _____ (including gait and station)	• Examination of gait and station *(if circled, add to total at bottom of column to the left) Examination of joint(s), bone(s), and muscle(s)/tendon(s) of **four of the following six areas**: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements Note: For the comprehensive level of examination, all four elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

EXAM				
	One to Five Bullets	Six to Eleven Bullets	Twelve or more Bullets	All Bullets
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Note: The Chest (Breasts); Gastrointestinal (Abdomen); Genitourinary; Head/Face; Eyes; Ears, Nose, Mouth and Throat; Neck and Respiratory systems/body areas are not considered to be part of this Musculoskeletal exam.

Emergency Department Visit

MDM & Medical Necessity Should Drive Coding

Need 3 of 3 Elements Documented

CPT	99281 Level 1	99282 Level 2	99283 Level 3	99284 Level 4	99285 Level 5
HPI **ROS** **PFSH**	1	1 1	4 2 1	4 2 1	4 10 2
1995 Exam	1	2 to 7 systems **with minimal detail** (2-5 body areas or **organ systems)**	2 to 7 systems **with minimal detail** (2-5 body areas or **organ systems)**	2 to 7 systems **with expanded detail** (6-7 body areas or **organ systems)**	8 or more **organ systems** or a comprehensive exam of a **single system**
MDM	Straightforward	Low Complexity	Moderate Complexity	Moderate of High Complexity	High Complexity

Hospital Care

MDM & Medical Necessity Should Drive Coding

Initial Hospital Care *Need 3 of 3 Elements Documented*			
CPT	**99221** **Level 1**	**99222** **Level 2**	**99223** **Level 3**
HPI **ROS** **PFSH**	4 2-9 1	4 10 3	4 10 3
1995 Exam	2 to 7 systems **with expanded detail** (6-7 body areas or **organ systems)**	8 or more **organ systems** or a comprehensive exam of a **single system**	8 or more **organ systems** or a comprehensive exam of a **single system**
1997 Exam	12 or more Bullets	See specific specialty exam guidelines	See specific specialty exam guidelines
MDM	Straightforward - Low	Moderate	High
Time	30 min	50 min	70 min

Subsequent Hospital Care *Need 2 of 3 Elements Documented*			
CPT	**99231** **Level 1**	**99232** **Level 2**	**99233** **Level 3**
HPI **ROS** **PFSH**	1-3 Not Required Not Required	1-3 1 Not Required	4 2-9
1995 Exam	1 BA/OS	2 to 7 systems **with minimal detail** (2-5 body areas or **organ systems)**	2 to 7 systems **with expanded detail** (6-7 body areas or **organ systems)**
1997 Exam	1-5 Bullets	6-11 Bullets	12 or more Bullets
MDM	Straightforward - Low	Moderate	High
Time	15 min	25 min	35 min

Time

The time guidelines referenced by the CPT codebook **should not be utilized** unless counseling and/or coordination of care **dominates more than 50%** of the physician/patient and/or family encounter.

If more than 50% of the encounter is spent delivering counseling and/or coordination of care, then time may be considered the key or controlling factor to qualify for a particular level of E/M services.

- **Hospital time: includes face-to-face and "floor time" spent relative to the patient's care *(Hospital time excludes time spent caring for other patients)***

Examples include: Discussing changes in the patient's medical condition, lifestyle changes, new medications and new testing.

This also includes discussing referrals to other providers and ordering of tests if it meets the time criteria.

Inpatient Services

NEW PATIENT	Time Spent Face-to-Face (average)	ESTABLISHED PATIENT	Time Spent Face-to-Face (average)
99221 Level 1	30 min.	99231 Level 1	15 min.
99222 Level 2	50 min.	99232 Level 2	25 min.
99223 Level 3	70 min.	99233 Level 3	35 min.

Time

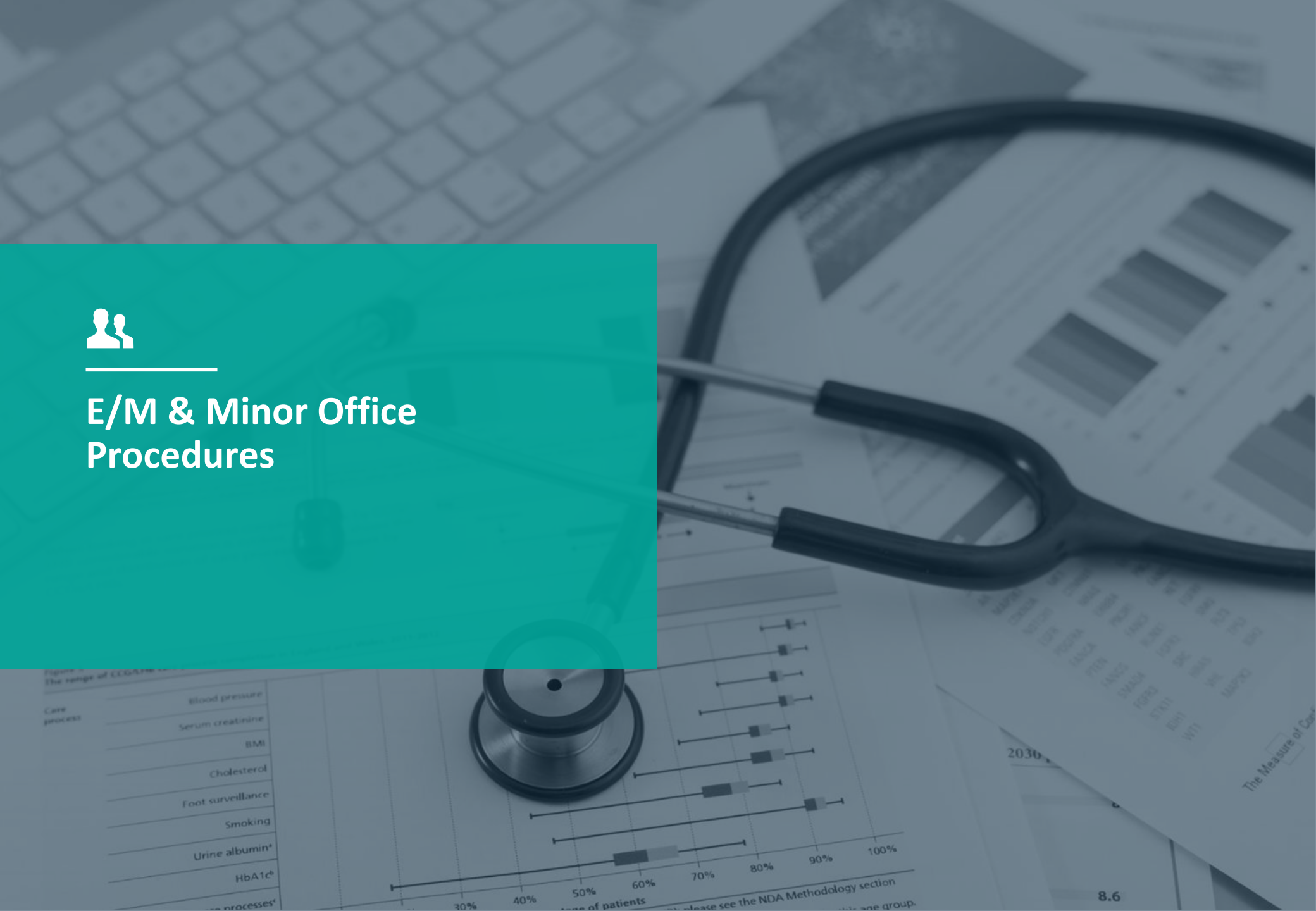
Documentation MUST Include:

- Total duration of face-to-face time
- The duration of counseling/coordination of care and medical decision making
- Detailed description of the coordination or care of counseling provided
  - Prognosis, risks and benefits of treatment options, instructions for treatment or follow-up, importance of compliance with medications or treatment plan, risk factor reduction, patient and family education, etc.

ACCEPTABLE:

Inpatient: *"@The total amount of time spent **face-to-face and floor time with this patient** was *** minutes and more than 50% of the time was spent counseling the patient and family and coordinating care @as outlined in A/P **OR** @as outlined below***"*

A detailed description of the counseling and/or coordination of care provided MUST be documented in the A/P section or follow the time attestation.



E/M & Minor Office Procedures

Modifier 25

Significant, Separately Identifiable Evaluation & Management Service by the Same Physician on the Same Day of the Procedure or Other Service

- The patient's condition required a significant, separately identifiable E/M service, ***above and beyond*** the usual pre-and post-procedure care associated with the procedure or service performed

- The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, ***different diagnoses are not required*** for reporting of the E/M services on the same date

The service could be a minor procedure, diagnostic service, E/M visit with a preventive service or E/M with a Medicare Well Visit or Well-Woman service

Modifier 25 Payer Policies

According to NCCI (chapter 11, Letter R.): "*The decision to perform a minor procedure is included in the payment for the minor procedure and should not be reported separately as an E&M service.* However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor procedure is separately reportable with modifier 25."

Check payer policies regarding E/M and minor procedure performed on the same date of service.

Example: Dermatology
According to the CMS National Correct Coding Initiative (NCCI) Policy Manual, the decision to perform surgery includes a pertinent history and examination of the lesion as well as determining the clinical risk the procedure poses on the patient if the provider of care decides to either proceed or forego performing the procedure. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.

In this case, the documentation is insufficient and cannot support a significant, separately identifiable E/M service by the same physician on the same day of the procedure. **Only the skin biopsy can be reported.**

Minor Procedure Documentation - Best Practice Recommendations

Injections

- The lot number and expiration date of the drug
- NDC number of the drug
- Site of administration
- Name, credentials and electronic signature of individual performing the injection
- How patient tolerated procedure and discharge instructions provided

Vaccine Administration

- The name of the vaccine and the manufacturer;
- The lot number and expiration date of the vaccine;
- The date of administration;
- The name, address, title and signature (electronic is acceptable) of the person administering the vaccine;
- The edition date of the Vaccine Information Statement (VIS) and date the patient or parent receives the VIS
- Site of Administration
- How patient tolerated procedure and discharge instructions provided

Venipuncture

Physician/QHP “Order” must be available. In addition, the following documentation is recommended:

- Time specimen was drawn
- Specific test requested (not just “labs sent”)
- Disposition of specimen
- Patient's tolerance of procedure
- Location specimen was drawn from (venipuncture site)
- Name, credentials and electronic signature of individual performing venipuncture

Consultation Services

Consultation Criteria

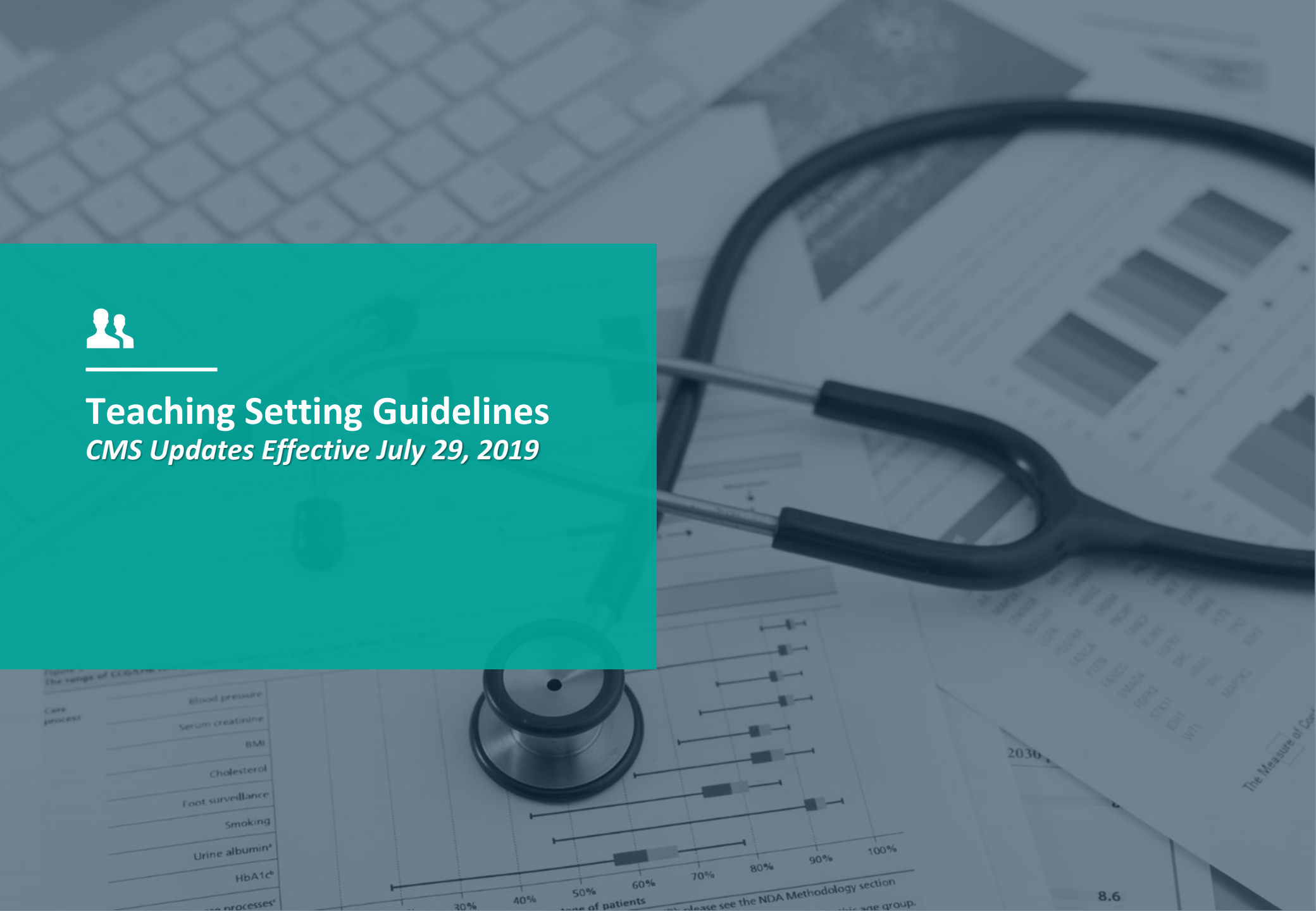
Consultation Services Require Documentation of “The 3 R’s”:

- ✓ **Request** for consultation service with reason to evaluate a specific problem

  “Patient seen at the request of Dr. _____ for the evaluation of _____.”

- ✓ **Render** and document recommendation and findings based on evaluation

- ✓ **Report** in a shared EMR, there is no need to send a letter/report back to the referring physician. However, if there is no shared EMR, a letter/report must be sent to the requesting provider



Teaching Setting Guidelines

CMS Updates Effective July 29, 2019

Type of Service	Teaching Physician Criteria	Attestation Statement*
E/M Service – Sees patient concurrently	• TP performed the service or was physically present during the key or critical portions of the service when performed by the resident • TP participates in the management of the patient	"I saw and evaluated the patient with the resident. See resident's note for details. I agree with the findings and plan of care as outlined in the resident's note." (***this statement may also include any modification(s) to the resident's note***)
E/M Service – Sees patient separately	• TP performed the service • TP participates in the management of the patient (Residents admits patient late at night and TP does not see patient until later, including the next calendar day)	"I saw and evaluated the patient separately from the resident. See the resident's note for details. I agree with the findings and plan of care as outlined by the resident." (***this statement may also include any modification(s) to the resident's note***)
Procedures/Endoscopy/ Single surgery (present the entire procedure)	TP present the entire procedure	"I was present along with the resident for the entire procedure."
Anesthesia/Two overlapping surgeries/ Single surgery (not present the entire procedure)	TP present during the critical or key portions	"I was present with the resident for the critical or key portions of the procedure." [Include free text of the critical or key portions.]
Interpretation of diagnostic radiology and other diagnostic tests	TP performed the interpretation or reviewed the resident's interpretation	"I personally reviewed the images and the resident's findings. I agree with this report."

Teaching Physician Linkage – Best Practices

In an effort to advise providers on the optimal way to document, rather than teaching to a minimal standard, we ***highly recommend*** that the linkage statement fully supports the Teaching Physician's participation in the visit, by including observations or decisions specific to the particular encounter

"I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs"*

National Government Services, 2017

Scribe Services

Utilizing Scribes

Appropriate Attestation

Documentation of scribed services should indicate who performed the service and who recorded the service. The scribe's note should include:

- The name and title of the scribe
- The name of the practitioner providing the service

Sample Scribe Attestation:

"Entered by _____, acting as scribe for Dr./PA/NP _____."
Signature _____ Date _____ Time _____

NOTE: CMS does not require the scribe to sign/date the documentation.

The Practitioner's Note Should Indicate:

- Affirmation the practitioner personally performed the services documented.
- Confirmation he/she reviewed and confirmed the accuracy of the information in the medical record.
- Acceptable practitioner signature:

Sample Practitioner Attestation:

"The documentation recorded by the scribe, in my presence, accurately reflects the service I personally performed, and the decisions made by me with my edits as appropriate."
Signature _____ Date _____ Time _____

Advanced Practice Provider (APP) Services Understanding the Rules

Key Incident-To Elements

Elements of the following four (4) key criteria must be met in order to bill Medicare for an incident-to service:

- ✓ **Site of Service**
- ✓ **Type of Personnel**
- ✓ **Type of Service**
- ✓ **Level of Physician Involvement**

Initial Service

"There must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the APP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her continuing active participation in and management of the course of treatment"

Established Plan of Care

The individual providing the incident-to service should:

- Document the "link" between their face-to-face encounter with the patient and the physician's preceding service to which their service is incidental
- Reference by date and location the precedent providers' service that supports the active involvement of the physician
- Clearly note the supervising physician for the encounter

Medicare Requirements

- MD must be in office suite
- MD must maintain direct supervision
- MD does not have to see patient
- APP can see only **established** patients (not new patient or new problem, no change to the POC) for "incident to"

Documentation Evidence of "incident to" service may include

A co-signature or name and credentials of both the practitioner who provided the service and the supervising physician in the patient's chart

- While co-signature of the supervising physician is not required, it is a best practice suggestion as a means of verifying the physician's availability for oversight.

Some indication of the supervising physician's involvement with the patient's care. The indication could be satisfied by:

- Notation of supervising physician's involvement within the text of the associated medical record entry
- Documentation from other dates of service (ex: initial visit) establishing the link to the previously documented physician plan of care

EKGs, Flu Shot, Laboratory Tests, Venipuncture, or X-Rays

“These services have their own statutory benefit categories and are subject to the rules applicable to their specific category.
They are not "incident to" services and the "incident to" rules do not apply.”

Independent

MD

MD
MD sees patient (new or established E&M visit or procedure visit) independently *(All documentation by MD).*

MD bills for the service under the MD NPI.

APP

APP
APP initiates patient encounter for all visit types independently *(All documentation by APP).*

APP bills for the service under the APP NPI.

Scribe

MD/APP

APP
APP initiates patient encounter for all visit types and independently obtains and documents history (CC/HPI/ ROS/PFSH).

MD and APP
MD is provided patient update by APP.
MD sees and examines patient with APP acting as Scribe.
MD reviews and updates, as needed, history components obtained by APP and performs Physical Exam and MDM.
Visit ends and MD reviews/edits encounter note, enters/signs orders, electronically signs note, and performs visit wrap-up.
Scribe attestation statements are added.
MD Bills for service under MD NPI

Shared/Split

MD

MD
MD sees patient (new/ established initial/subsequent, ER, OBS, discharge E&M visit) independently or collaboratively with APP.
***(MD personally documents** his/her portion of the visit).*

APP

APP
APP sees patient (new/ established initial/subsequent, ER, OBS, discharge E&M visit) independently or collaboratively with MD.
***(APP personally documents** his/her portion of the visit).*

Visit may be shared by MD/APP based on either MDM or time when all the components of the service are documented as such.
Either provider can bill for the service.

Incident-to

APP

APP
APP independently sees and examines **ESTABLISHED** patient. MD is immediately available in office suite but does not need to see patient.

APP
APP provides services based on MD's Plan of Care (POC).
The problem(s) is established, with no new problem(s) or change in POC.
MD reviews the APP's note and adds comments (as appropriate) and co-signature.
MD Bills for service under MD NPI

If new patient, established patient with new problem or change in POC, MD must see patient and document visit
OR
APP independently bills for service under his/her NPI

Preventive Services: Medicare

AWV Elements

G0438: First Annual Wellness Visit including PPPS

- Establishment of an individual's medical/family history
- Review beneficiary's potential risk factors for depression
- Review beneficiary's functional ability and level of safety
- An examination, obtain the following measurements:
  - Height, weight, BMI (or waist circumference, if appropriate), blood pressure; and
  - Other routine measurements as deemed appropriate based on medical and family history
- Establishment of a list of current providers and suppliers
- Detection of any cognitive impairment that the beneficiary may have
- Establishment of a written screening schedule for the beneficiary for the next 5-10 years as appropriate
- Establishment of a list of risk factors and conditions of which the primary, secondary and tertiary interventions are recommended or underway
- Furnishing of personalized health advice to the beneficiary and referrals as appropriate

SWV Elements

G0439: Subsequent Annual Wellness Visit including PPPS

- Update of beneficiary's medical/family history
- An examination
- Update of the list of current providers
- Detection of any cognitive impairments
- Update to screening schedule
- Update to list of risk factors and conditions from initial AWV
- Furnishing of personalized health advice to the beneficiary and referrals as appropriate

AWV/SWV & Counseling Services

As part of a wellness visit, the provider furnishes personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling service or programs

Referrals to programs are aimed at:

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
- Fall prevention
- Nutrition
- Physical activity
- Tobacco-use cessation
- Weight loss

Expanded Care

Counseling Services	
Code	**Description**
G0444	Annual depression screening, *15 minutes* **(allowed only with G0439)**
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); *approximately 15 minutes*
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); *approximately 30 minutes*
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); *approximately 45 minutes*
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); *approximately 60 minutes*

Change Interventions	
Code	**Description**
99406	Smoking and tobacco use cessation counseling visit; intermediate, *greater than 3 minutes up to 10 minutes*
99407	Smoking and tobacco use cessation counseling visit; intensive, *greater than 10 minutes*
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; *15 to 30 minutes*
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; *greater than 30 minutes*

Advanced Care Planning

Advanced Care Planning

CPT 99497
Advance Care Planning (ACP), first 30 minutes

CPT 99498
Each additional 30 minutes (list in addition to 99497)

- Effective, January 1, 2017 Medicare will pay for Advance Care Planning
- Advance Care Planning (ACP) involves a face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to their medical treatment at a future time should the patient lack decisional capacity at that time.
- The counseling can take place during an annual wellness visit or during a routine office visit and at various stages of health

Advanced Care Planning

According to the AMA, the following guidelines should be followed

- Encourage all patients, regardless of age or health status to:
  - Think about their values and the type of care they would like to have if faced with a life-threatening illness or injury
  - Identify someone that would make decisions on their behalf if they did not have decision-making capacity
  - Inform their loved ones of their views and decisions
- Be prepared to answer questions about ACP and assist patients in formulating their views and articulating their preferences for care
- Utilize advance directives as a tool to help guide treatment decisions
- Incorporate notes from ACP discussion in the medical record
- Include a copy of advance directive documents in patients' records
- Periodically review ACP with patient and update changes that reflect the patient's current wishes

ACP - CMS Guidelines

Payable in both facility and non-facility settings

NOT limited to particular physician specialties. May be rendered by a physician or other qualified health professional

Incident-To rules apply to ACP services

ACP services may be furnished in person or via telehealth (audio + video or audio only during the PHE)

Per CPT, there are no limits on the number of times ACP can be reported in a given time period

CMS has not established any frequency limits and is currently following CPT guidelines

When ACP service is billed multiple times for a given beneficiary, it is expected that there is a documented change in the beneficiary's health status and/or wishes regarding his/her end-of-life care

2022 Compliance Strategies

Medicare

Medicare/CMS tracking

- Bell Curve - Level of Service Distribution

Prepayment Reviews

Recovery Audit Contractors (RACs)

Targeted Probe and Educate (TPE)

Zone Program Integrity Contractor (ZPIC)

Patient Reporting

- Complaints made by patients

Employee Reporting under Qui Tam

- Disgruntled employees
- Employees concerned about “what is right”
- Financial incentives

2021-2022 OIG Work Plan

- Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid
- Follow-up Review on Medicare Claims for Outpatient Services Provided During Inpatient Stays
- ***Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks***
- COVID-19 Testing Data From Federal Programs
- ***Medicaid—Telehealth Expansion During COVID-19 Emergency***
- ***Advanced Care Planning Services: Compliance With Medicare Requirements***
- ***Medicare Part B Payments to Physicians for Co-Surgery Procedures***
- ***Medicare Part B Payments for Speech-Language Pathology***
- Review of Medicare Part B Urine Drug Testing Services
- Review of Medicare Facet Joint Procedures
- ***Medicare Part B Payments for Podiatry and Ancillary Services***
- ***Physicians Billing for Critical Care Evaluation and Management Services***
- Medicare Part B Payments for End-Stage Renal Disease Dialysis Services
- ***Medicare Payments for Chronic Care Management***
- ***Medicare Payments for Transitional Care Management***
- Sleep Disorder Clinics - High Use of Sleep-Testing Procedures
- Hospice Home Care - Frequency of Nurse On-Site Visits to Assess Quality of Care and Services
- Risk Adjustment Data - Sufficiency of Documentation Supporting Diagnoses
- ***Review of Post-Operative Services Provided in the Global Surgery Period***
- Review of Medicare Payments for Bariatric Surgeries

NOTE: In order to enhance transparency around OIG's continuous work planning efforts, OIG updates its' Work Plan website monthly. The above-listed projects only highlight some of the various projects in the 2021 OIG Work Plan.

For a complete list of active work plan items, please visit:
https://oig.hhs.gov/reports-and-publications/workplan/index.asp

2022 Medicare Physician Fee Schedule Proposed Rule

Split (or Shared) E/M Visits

- Defines the split (shared) visit as evaluation and management (E&M) visits provided *in the facility setting by a physician and an NPP in the same group*;
- Changes proposed include a shift in which provider bills the visit, to the practitioner who provides the more substantive portion of the visit (>50%);
- Split (or shared) visits could be reported for both ***new*** and established patients and ***initial*** and subsequent patients; and
- Requires reporting a modifier on the claim, documentation in the medical record identifying all providers who performed the visit, and a date and signature by the practitioner performing the substantive portion.

Physician Assistant (PA) Services

- Reimburses physician assistants (PAs) directly for their services and permits them to reassign their payments as other non-physician providers (NPPs) (currently, PAs are reimbursed through their employer or supervising physician).

Critical Care Services

- Allows critical care services to be furnished to the same patient on the same day by more than one practitioner representing more than one specialty, but not with other E&M visits.
- Critical care services can be furnished as a split/shared service.

Telehealth Services Under the PFS

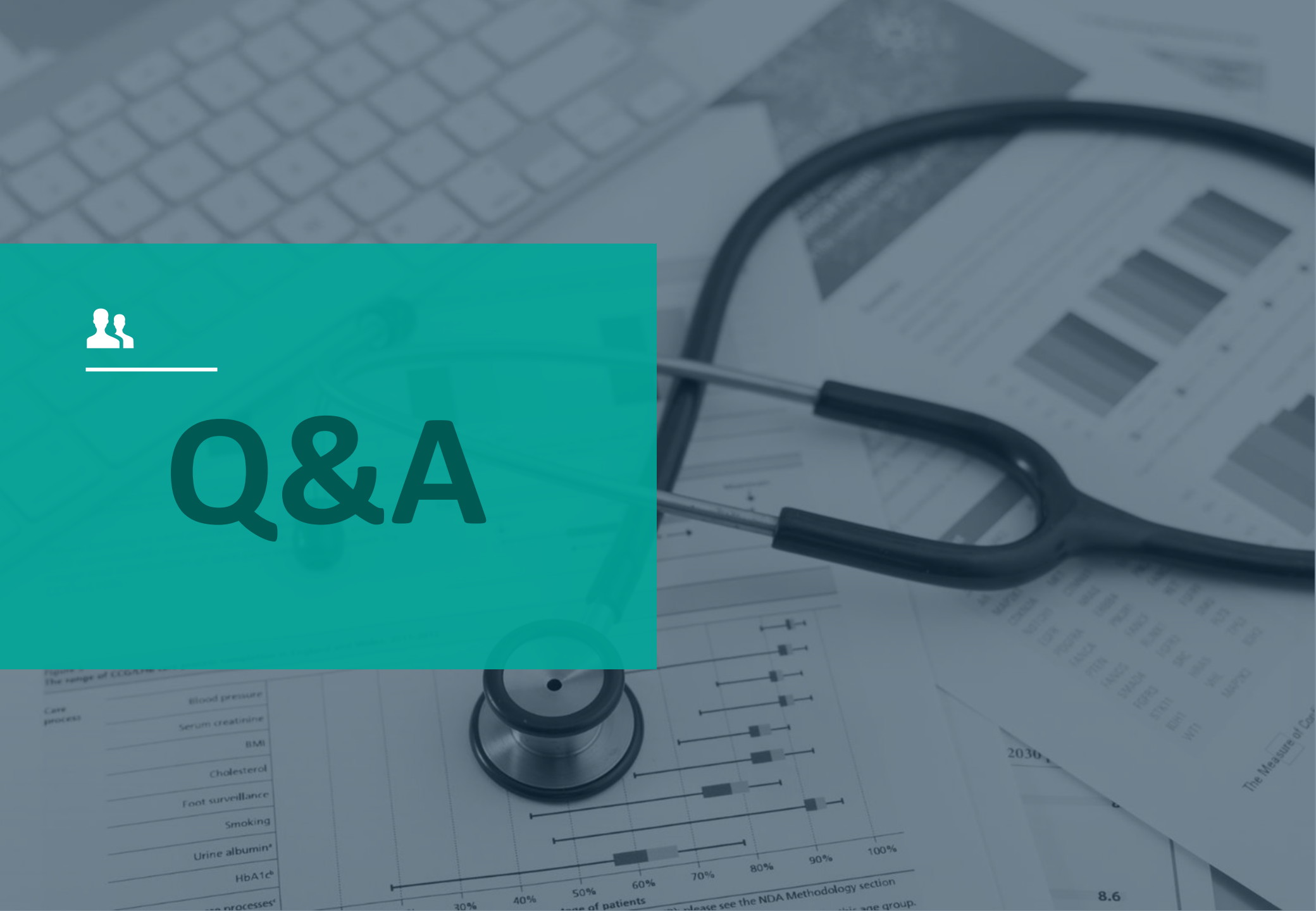
- Allows certain services added to the Medicare telehealth list to remain on the list to the end of December 31, 2023 (currently set to expire with the PHE); and
- Changes to the provision of mental health services including loosened geographic restrictions, allowing patients to be served from their home location, and the use of audio-only communications in some instances (as opposed to requiring two-way audio-visual requirements).

Therapy Services

- Reimburses physical therapy and occupational therapy services furnished by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) at 85% of the fee schedule using two new modifiers (CQ and CO); and
- Revises the *de minimis* policy to allow a timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care along with a physical therapist or occupational therapist (PT/OT), and the PT/OT still meets the necessary Medicare billing requirements for the timed service without counting the minutes furnished by the PTA/OTA by providing more than the 15-minute midpoint

Teaching Physician Services

- CMS is proposing to clarify that the time when the teaching physician was present can be included when determining E/M visit level. Under the primary care exception specifically, only MDM would be used to select the visit level to guard against the possibility of inappropriate coding that reflects residents' inefficiencies rather than a measure of the time required to furnish the services.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WE VALUE HEALTHCARE

Contact us:

(631) 231-0505

pam.dapuzzo@vmghealth.com
debra.rossi@vmghealth.com

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