2021 CPT® Evaluation and Management Office and Outpatient Services Code and Guideline Changes

Transcript from Live Session

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Quality Insights
Quality Payment Program Support Center

April Faulkner:

The Quality Insights QPP Support Center team welcomes you to today's webinar, 2021 CPT® Evaluation and Management Office and Outpatient Services Code and Guideline Changes. We will take just a few moments to review a few items before we begin the presentation. All participants entered today's webinar in listen only mode. Should you have a question during today's presentation, please type it into the chat or Q&A box at the bottom right of your screen. We will address questions at the end of the presentation as time permits. Today's webinar is being recorded. The recording along with the slide deck and a transcript of the webinar will be posted on the Quality Insights QPP Support Center website within the next week. These resources can also be found on the archived events page. We've posted a link to that webpage in the chat box.

April Faulkner:

I've also sent the slide deck and two handouts this morning to registrants. If you have not received those, they are available on our webpage at this time. Just click on that link in the chat box to access it. At this time, I'd like to introduce our presenter, Denise Walsh. Denise is a certified professional coder and has been working in the healthcare industry for over 25 years. As a consultant, her responsibilities range from assisting clients in the creation and implementation of compliance plans, designing and implementing charge capture, and coding systems that maximize reimbursements, and reviewing accounts receivable processes to strengthen revenue capture. She provides consulting support in the review and implementation of EHR and PM systems, ICD-10 and HIPAA privacy and security compliance plans for physician practices. Denise has extensive experience in guiding credentialing and payer contracting for new and established physicians, and practices, and lectures extensively on all of these topics. Denise has also served in the capacity of revenue cycle management director and practice administrator for several specialty practices. Denise received her BS degree in allied medicine from Ohio State University, and is a member of the American Academy of Professional Coders. Denise is also a certified HIPAA security professional. Now, I'll turn the presentation over to Denise to get us started.

Denise Walsh: (slide 2)

Thank you, April. I appreciate the introduction. I would like to welcome everyone to today's presentation, 2021 CPT Evaluation and Office and Outpatient Services Code and Guideline Changes. We'll start off with our typical disclaimer. This presentation is informational only. The information is accurate as of today's presentation, and it should not be considered legal advice. If you have any legal questions, you should consult legal professionals.

Denise Walsh: (slide 3)

During today's presentation, our objectives are, we're going to identify and describe the 2021 changes to E/M office and outpatient services. We'll also review the new criteria for time-based coding, identify and describe the new prolonged service code, and discuss the impact that the upcoming E/M guidelines will have on your practice and how to prepare for reimbursement changes.

Denise Walsh: (slide 4)

Effective January 1st, as it is every year, the AMA makes their annual CPT updates. This coming year, 2021, there are 329 changes to the 2021 code set. Among these changes are the revised E/M guidelines. CMS announced in 2019 Final Rule that changes to E/M services would be initiated in an attempt to alleviate the administrative burden that the current guidelines present to providers. So within six months of CMS' announcement, the AMA announced it would be revising the E/M code set 99201-99215 and the revision would go into effect January 1st, 2021. So now here we are, we're just counting down to the effective date.

Denise Walsh: (slide 5)

What is the purpose of these changes? Well, you're going to hear about this probably from now until next year. The purpose is to reduce provider burden and put patients over paperwork. That is the biggest stress here, putting patients over paperwork. CMS also wants to recognize the amount of time a provider spends with a patient. They realize that there's a lot more involved in a patient encounter than just the time that the provider spends in the exam room. Also, they want to make it easier for providers to be on the path towards value-based care.

Denise Walsh: (slide 6)

Why were these changes made? Well, the current guidelines haven't been updated for at least 30 years. The current 1995 and 1997 guidelines focused on charting and billing requirements more than clinical needs, meeting certain criteria, clicking the boxes. So, a lot of providers found these guidelines to be too complex and they didn’t give enough distinction between code levels, a little too ambiguous. So CMS decided it was time to update their E/M codes and update the descriptions.

Denise Walsh: (slide 7)

What do these revisions include? Well, first of all, I want to remind everybody that the 2021 E/M guideline revisions only apply to office and outpatient E/M codes. So these are the 99201-99215. They do not include hospital inpatient consults or a skilled nursing facility visit, only office outpatient E/Ms. So these revisions include established patients guidelines. Now, all five of the established patient codes, 99211-99215 will stay the same. Although for new patients, we are deleting 99201, and reducing the new patient E/M services to four levels, 99202-99205. The revisions include code definition and guidelines that have been revived. Hopefully these revisions will help give greater clarity to the medical decision-making level, the E/M level and give more specificity. So that should help not only providers, but help coders, auditors as well.

In the new revisions for 2021, history and exam are no longer a part of the equation to determine the E/M label. A history and exam needs to be documented for a medically appropriate encounter. So whatever the condition may be, a medically appropriate history and exam should be documented. The criteria for time and medical decision-making have both been revised, and now clinicians will be able to choose whether they want to determine the level of the E/M visit by medical decision-making or by time. The criteria for time now includes not only face-to-face, but non face-to-face time spent by a physician or qualified healthcare professional on the day of the encounter. This does not include

ancillary staff. This is only the rendering provider. I can't stress to you enough, this is time that is spent only on the day of the encounter. We'll go over that a little bit more in the presentation.

Denise Walsh: (slide 8)

History and physical exam, as I said, are no longer elements in selecting the overall level. But as I said, the E/M visit should always include a medically appropriate history and physical exam. When documenting the encounter, chief complaint is always necessary. You remember that the chief complaint and the history elements help define medical necessity. Medical necessity is the overarching criteria for payment, and must always be supported. The nature and extent of the history or physical exam is now determined by the rendering physician. It doesn't need to meet a certain criteria per level three, four, five, of your E/M. The other important change with history and physical exam is that in the history component, the HPI can now be documented by ancillary staff, any member of your care team, and then can be reviewed by the provider. Previously, this was not acceptable. It had to be the rendering provider who took the HPI, documented the HPI for that encounter.

Denise Walsh: (slide 9)

As I said, when selecting the appropriate level of E/M service, you can decide whether you want to use medical decision-making or you want to use the total time of the visit to determine the overall level.

Denise Walsh: (slide 10)

If you're going to use medical decision-making, there are four levels. These levels have not changed. They are still straightforward, low, moderate and high. But modifications have been made to the criteria to each one of these levels. The levels themselves have not changed.

Denise Walsh: (slide 11)

There are three elements to medical decision making. These three elements are similar to the previous, but again, they are more clearly defined. So initially, we have the number and complexity of problems addressed. Previously, this was just diagnosis management. We have the amount and/or complexity of data reviewed and analyzed. Then we have the risk of complications, morbidity, and/or mortality. Those two are pretty similar to the previous medical decision-making elements. A few things that have changed, they have removed ambiguous terms, such as mild, important terms, such as independent historian have now been more clearly defined. There are other elements in the data analysis that focus on the tasks that affect the management of the patients. So, it really does clearly outline medical decision-making more so than it did in the past. The other thing is that the criteria for medical decision-making has not changed. So, you still need to meet or exceed the level in two out of three of these elements to determine the overall medical decision-making level.

Denise Walsh: (slide 12)

The first area or the first element of medical decision-making is the number and complexity of problems addressed. A problem addressed is defined as a condition that is evaluated or treated at the encounter. This includes consideration of further testing or treatments that may not be elected by virtue of risk,

benefit of analysis, or patient's choice. The mere presence of a condition listed in the patient's record or managed by another provider does not qualify as being addressed. So even though it's a chronic condition that you may put in your assessment, if you are not taking care of that condition because you are not managing it or it is managed by a specialist or another provider, it does not count towards the complexity of problems addressed during that encounter.

AMA guidelines indicate that only diagnosing documented as active treatment during that encounter will be credited for scoring purposes. As we look at the terminology for diagnoses, some of the terminology has changed, or I should say have been revised. When you look at the term stable chronic illness, it is now defined as a problem with an expected duration of at least a year or until death of the patient, and the patient is at their treatment goal. So, it is not just stable because it is unchanged, it is only stable if the patient is at their treatment goal. So that is something to consider, especially when you're dealing with maybe hypertension issues, other things like that, diabetes, where, yes, they are stable, but are they at their treatment goal? If not, they're not considered stable.

Denise Walsh: (slide 13)

This is a portion of the AMA's new medical decision-making table. This is the criteria for selecting the complexity of problems addressed. Under the complexity of problems addressed, it now eliminates the diagnosis criteria additional workup. It also eliminates the term new diagnosis to the provider. That is a really big change. So, you are no longer looking if a patient comes and it is a new condition to the provider as a moderate complexity diagnosis. Now, it's either considered whatever the diagnosis is, an acute, uncomplicated problem, or maybe an undiagnosed new problem, but the consideration of new to the provider is no longer an option.

The levels for complexity are, minimal, which would be a limited or minor problem. You have low complexity, which would be two or more self-limited minor problems, one stable chronic illness, or one acute uncomplicated illness or injury. For moderate complexity, you are looking at one or more chronic illnesses with exacerbation or two or more stable chronic illnesses, or one undiagnosed new problem with uncertain prognosis or one acute illness with systemic symptoms, or one acute complicated problem. Then for high complexity, you are looking at one chronic illness with severe exacerbation or an acute or chronic illness that poses threat to life or bodily functions. So a lot of these terms for diagnosis management, the complexity of problems addressed are very similar to the previous diagnosis table with only a few minor revisions.

Denise Walsh: (slide 14)

The next element is data. We are assessing or reviewing data. The AMA has taken most of the elements from the Marshfield chart of data and complexity and incorporated it into these new guidelines. Changes include, new requirements for specific combinations of different work elements to support a specific level of service. The data is divided into three categories. You have testing, independent interpretations and then discussions with external physicians. A lot of it is similar to the previous data review, but you are given a lot more credit for the work and the analysis of the work you do with this new medical decision-making chart.

Denise Walsh: (slide 15)

Data includes medical records, tests, and any other information that must be obtained, ordered, reviewed, and analyzed during the encounter. Tests include each unique test ordered. This is a big change from the previous criteria. Previously, you could order five lab tests and you still just got credit for one. So now, each individual test ordered, you get credit for. It counts as one data element review. You cannot count interpretations of tests that you bill for, those services, separately. An example of that is if you are ordering an EKG and that EKG is done in house, you can count the EKG being ordered. But if you were billing for that EKG and the interpretation of that EKG, you can't separately count it as a data element that's being reviewed. Also, another change here is if you order labs or diagnostic testing, you get credit for ordering those on the day of the encounter. But if the patient comes back on a subsequent visit and you are reviewing those results on a follow-up encounter, you cannot count the review of those tests on that follow-up encounter. So, it is one-time that you count for ordering it, but not reviewing it on the subsequent encounter. Now, if you are reviewing tests that were ordered from another physician, then you get credit for reviewing those tests on the follow-up visit. But not if you already took credit for ordering them on the previous visit.

Denise Walsh: (slide 16)

When you're selecting the data complexity, the first level is minimal. So that would be minimal or no data that has been reviewed or ordered. The next level is limited. So this is a little confusing, or at least I find it confusing. They switched the terminology. Instead of sticking with minimal, low, moderate and high, they've switched low to limited. It can be a little confusing, but just look at the limited complexity as low complexity. The low complexity or limited complexity, is category one. It's a combination of any two of the following: you are reviewing external notes or any external tests that are ordered. You are reviewing test results of any unique test, or you are ordering a unique test. When you say unique test, it is a separate CPT code. That's how you define a unique test. So if you are ordering two lab tests during this encounter, that would count as two from category one. If you happen to review a specialist note and make a notation in the encounter and order one lab test that is two from category one.

Category two is an assessment requiring an independent historian. So whether you are a pediatric practice and you have a parent or a guardian that gives a history, or whether you have a caretaker or maybe this is an elderly patient and their son or daughter's giving the history, if you have an independent historian, that counts separately as well. So, any combination of two of those counts for limited complexity.

Denise Walsh: (slide 17)

We move on to moderate complexity. For moderate complexity, you must meet the requirements of one of these three categories. Now, this is interesting because we have a little bit of a change here. So in category one, you still have review of external notes, review of results of unique testing, ordering of unique testing, but the assessment requiring an independent historian moves from category two into category one. So now it is part of category one. Category two becomes independent interpretation of tests. Then you have category three, which is a discussion with an external provider.

To meet moderate complexity, you must meet the requirements of one of the three categories: a combination of any two from category one, category two, or something from category three. You must meet the requirements at least one of those categories.

Denise Walsh: (slide 18)

Then for extensive, the only difference between moderate complexity for data reviewed and extensive complexity is that the requirement is now you must meet two of the three requirements. Not just one, but two of the three requirements of the categories. So you must either have two combinations of tests, independent historians, two things from category one, and at least meet the criteria from something in two and/or three.

Denise Walsh: (slide 19)

The last medical decision-making element is risk. This is risk of complication, morbidity, or mortality of patient management decisions made at the visit. This is associated with the patient's problems, diagnostic procedures, and treatments. This includes possible management results as well. Even though you may not be the manager or you may not be doing the procedure, as long as it is an option, and you discuss those options and what the possible risks of those options are, and it is all documented, then it goes towards the complexity of the risk. For example, the decision about hospitalization may include consideration of alternative levels of care. Those management options are documented and added to the complexity of risk. So, there are many different options here. As long as those risks options are identified and documented, they count towards the complexity of the risks.

Denise Walsh: (slide 20)

This is the old AMA table of risk and it has been eliminated. They are consolidating the last column, the “management options selected” column into the new medical decision-making table. This is the column that they will use to determine the treatment of risk options. Again, you're looking at minimal level options of rest, gargles, elastic bandages and superficial dressing. Low level options include over the encounter medications and possibly physical therapy and moderate level includes prescription drug management and minor surgeries with identified risks. Then you come down to high level, which is emergency major surgery, decisions not to resuscitate or de-escalate due to poor prognosis. So those are examples of the risk management.

Denise Walsh: (slide 21)

When we're selecting the risk complexity, again, we have the same as before minimal, low, moderate, and high options. Again, the criteria for minimal and low have not changed. They fall in line with the old table of risk. Now, this is interesting, moderate complexity has added additional risk elements. This includes, social determinants of health. Now this is really important because the key to the complexity of this is your documentation. So you really need to, as a provider, make sure that you are documenting this well, to show the complexity of this risk. The CDC definition of social determinants of health is life enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and healthcare, who's just distribution across populations effectively determines length and

quality of life. Again, as a coder and documentation specialist, it is my responsibility to educate providers on the importance of complete and accurate documentation, and to make sure they capture the patient's story with documentation and reflect the two true complexity of this encounter. Hopefully, moving forward, that you will be able to use these social determinants of health to properly indicate the complexity of the patients. The new ICD-10 book for 2021 has, in chapter 21, diagnosis codes for social determinants of health. These are Z category or status codes. These will go to persons with potential health hazards related to socioeconomic and physio-social circumstances. Remember that if you are looking for diagnoses to help describe this, it's chapter 21 of your ICD-10 book.

Denise Walsh: (slide 22)

Selecting your high risk options of complexity includes decisions for elective surgery with identified risks, and decisions for emergency surgery. What's important when you are documenting surgery, and the potential risk for surgery, is that you should not only be documenting the potential risk of the patient but also the patient's comorbidities. Not just what are their risks during the surgery, but what are the identified risks of the surgery itself? Both of those count towards the complexity of this risk. Again, documentation is key. It really will help you to spell out the patient's condition and really help determine the overall level of risk.

Denise Walsh: (slide 23)

Let's put all this together now. We have looked at the diagnoses, the problems addressed, the complexity of the data, and the risks. So we're putting this all together. Again, the criteria for the level of MDM has changed a little bit. But the criteria to meet that level, you still need two of the three categories, meet or exceed the level in two of the three categories, to determine the overall level. As a reminder, 99211 does not require medical decision-making. They have eliminated 99201. The reason being is 99201 was straightforward medical decision-making the same as level two, so it was a bit confusing. The only difference were the documentation requirements for history and exam. So since those requirements have been eliminated, the level one 99201 has been eliminated. Again, two out of the three medical decision-making elements are required to come to the overall level of either straightforward, low complexity, moderate complexity, or high complexity.

Denise Walsh: (slide 24)

I know this is a little difficult to read, but I want you to see the AMA medical decision-making chart in its entirety. This is a great cheat sheet that will help you understand all of these 2021 revision. We have included this sheet with your handout for this presentation. I think this is a really good guide for you as you go into 2021, looking at these revisions. If you have any questions, this is really spelled it out for you. So I do recommend printing these off, maybe even laminating them, keeping them with you just to get a good indication of how the medical decision-making has changed and helped you determine the level. Again, when you are calculating the medical decision-making, I want to show you this table and break it down. As I said, the overall grid is very difficult to see. So, let's look at each level a little closer.

Denise Walsh: (slide 25)

Again, 99211 does not require medical decision-making. Then we have level two, let's put it that way, level two includes 99202 and 99212. That is straightforward medical decision-making. So that is minimal problems addressed, minimal data, minimal risks. Again, you can see on this slide, I've included the link to the AMA grid just for your reference as well.

Denise Walsh: (slide 26)

Then we move on to level three. This is new patient and established patient level three. The criteria, you must meet a low level of medical decision making. So this would be low problems addressed, limited data, low risk. Again, for data, you need to meet the requirements of one of the two categories. For overall level of low complexity, two of the three elements, problems addressed, data risk, two of those three must be at a low level.

Denise Walsh: (slide 27)

Then we have level four, CPT codes 99204 and 99214. That would equate to a moderate level of medical decision-making. Again, we have our moderate level for problems addressed, data and risk. Two of the three of these criteria must be met. For data for moderate complexity it is the criteria for one of the three categories must be met to meet the moderate level of complexity for data.

Denise Walsh: (slide 28)

Then we have high, again, this is our level five visits. You must meet the level of high complexity for level five. This is high for problems address, data and risk. Two of those three categories must meet or exceed the high complexity level. For data, it is two out of those three categories. The criteria must be met to get to the extensive level of data for high medical decision-making.

Denise Walsh: (slide 29)

Again, just reviewing as we put this all together again: level two, new and established patients, is straightforward, level three is low complexity, level four is moderate complexity, and level five is high complexity.

Denise Walsh: (slide 30)

Let's move on now to time based coding. The limitations on the use of time have now been deleted. So therefore we no longer have the requirements that a visit must be dominated by counseling or coordination of care. Time spent now includes the rendering providers' total time spent on the day of the encounter. This includes non-face-to-face time, as well as face-to-face time with the patient. Criteria and the amount of time has changed. As you can see here, again, we no longer use the criteria that 50% of the face-to-face time has to be spent counseling or coordination of care, that has been eliminated. There is no time criteria for a 99211 that has minimal presenting problems, so there are no requirements.

Denise Walsh: (slide 31)

You can see here with this chart, this spells out the new time requirement for new patient levels, as well as established patient levels. Again, when using the criteria for time, this is face-to-face as well as non-face-to-face, but only on the day of the encounter. This time does not include time spent by ancillary staff. This is only time that is spent by the rendering physician.

Denise Walsh: (slide 32)

What's included in this time? Well, here are the activities that the AMA now lets you count as total time seeing the patient. It is preparing to see the patient. It is reviewing medical records or anything that you need to do prior to walking into that exam room, obtaining and reviewing separately obtained histories, performing medically appropriate exams, counseling, educating the patient or family caregiver, ordering medications, tests, or procedures, and referring and communicating with other health professionals, when not separately reported. It also includes documenting clinical information in the EMR. Now, that being said, yes, this does include documenting in the EMR, but let's say that you are notoriously slow documenting, such as an older physician that isn't as well adept in using their laptop to document in the EMR and they are very slow. You cannot use that excessive time. Or if you're changing EMRs and you are just getting used to the new system and it takes you longer to document, you cannot take that excessive time and add it to your time of the encounter. It also includes, independently interpreted results, if you were not billing for those separately and care coordination.

Now, there's a few things that I do want to bring up as we look at this list. If you are a physician, a provider who documents regularly and completes their documentation by the end of the day, this will not be an issue for you. So, you can make sure that you have calculated the total time that you've spent on that patient encounter within that day. But there are some providers, and we all know some, who may not finish their documentation by the end of the day or they may not finish their documentation by the end of the week. You cannot use that time to base the time for this encounter. It is only the time spent on the day of the encounter, no more. So, it's very important to make sure that you realize that.

The other thing is, if you are going to use time as the basis for your E/M level, and you are track, you've got to figure out a way for your practice to not only record, but track these times. So, it may be not only the time that you spent in the exam room, but maybe time after lunch that you spent on the phone with a specialist or coordinating care, or maybe you received test results and you're documenting those into the chart at the end of the evening. This is cumulative time, so it's not straight time all together. So, it is very important to figure out for the practice, for the provider, how you are going to track and document the overall time, if that's the way you want to determine the overall level of your visit.

Denise Walsh: (slide 33)

There is a new prolonged service code for 2021. This is an add-on code. This new code is 99417. You may see in some publications, the code 99XXX, this has been used as a place holder until they determined what the new prolonged service code was going to be. In the ninth and the new 2021 CPT manuals, that code has been replaced by 99417. Again, 99417 is an add-on code, it cannot be used as a primary code. It must be added on to a level five E/M. It can only be used if you are using time as a basis for the level of E/M and that you have exceeded the amount of time in a level five visits. So, you can bill

the 99417 in increments of 15 minutes. But again, it's only after you have exceeded the time for a level five visit.

Denise Walsh: (slide 34)

This chart shows you the new revised times and how you would bill this prolonged service code. For a new patient, anything less than 75 minutes, you would not bill prolonged service. But 75 to 89 minutes, you would bill your level five new patient with one increment of 99417. 90 minutes to 104, it would be two increments of the prolonged service code. 105 and above, it would be three or more, depending upon, again, every 15 minutes. The same below for the established patient codes. Anything less than 55 minutes, you would not report the prolonged service. But 55 to 69, you could use one unit. 70 to 84, it would be two. Anything 85 and above, it would be three or more.

Denise Walsh: (slide 35)

The existing prolonged service codes 99354, 99354 and 99356 have been revised to restrict reporting these with E/M codes. So you can no longer use these codes with 99202-99215. These prolonged service codes must be listed separately in addition to the primary service codes, but they can be used with psychotherapy and consultations. Home health services can be used with inpatient psychotherapy, inpatient and observation E/M services and inpatient consultations and skilled nursing visits. You can still use these prolonged service codes, but you can no longer use them with the outpatient E/M codes.

Denise Walsh: (slide 36)

I know we just went through an awful lot of information. I hope that you found it useful. I think sometimes the best way to really look at some of this stuff is if you put it to use. We thought we would do a few case scenarios so that you can see how these changes will reflect in CPT coding.

Denise Walsh: (slide 37)

The first case, we have a new patient and the patient complains of fever, body aches, cough, minor sore throat, and headache, exposed to flu at home. A detailed exam is performed. We have rest, fluids, over the counter drugs and then prescription medications. The diagnosis is fever, cough, and influenza. Orders include influenza testing, chest x-ray, which was negative, and medications. Again, lab results say positive for the flu. With that information, given that information, how would you bill this E/M level?

Denise Walsh: (slide 38)

If you were to bill this E/M level, this would be a 99203. The rationale for that is the patient presents with symptoms that lead the provider to determine it was influenza. So the other symptoms are symptoms that are part of the influenza and not addressed separately. They are all part of the primary diagnosis. So, the number of complexity of problems addressed is considered low for one acute uncomplicated illness or injury. The amount of data to be reviewed would be also limited because one test was ordered, and then the prescription drug would be your moderate risk. That gives you an overall medical decision-making of a level three, so this would be a 99203.

Denise Walsh: (slide 39)

We'll go to the next case. You have a new patient who presents to establish care for management of chronic conditions, stable hypertension, controlled type two diabetes, and poorly controlled hyperlipidemia. Medical records were reviewed from the previous PCP. Comprehensive exam was performed. On assessment and plan, we have benign hypertension, type two diabetes, mixed hyperlipidemia. Labs were ordered, three different lab tests and medications were ordered. So looking at this, what would you consider the level of E/M?

Denise Walsh: (slide 40)

Looking at the patient's condition is the fact that there are multiple chronic issues, so that would be a moderate complexity for number of chronic problems addressed. The amount of data, they have four points for data for each individual test that is being reviewed as well as information or medical records that were reviewed that supports moderate complexity for data. Then the patient has two medications prescribed, which falls under moderate risks. This would meet the criteria for a level four, 99204.

Denise Walsh: (slide 41)

The next case, this is an established patient who's had an allergic reaction. Patient broke out into an itchy rash yesterday, no dysphagia or shortness of breath. Patient does have a throbbing headache. Recently finished Sulfa for UTI prescribed by Dr. Bailey. Looks like a limited exam performed, and then the assessment and plan. We have severe hives with headache. Injection of Depo Medrol given, and prednisone. Over the counter medications, Benadryl, for side effects and treatment options were discussed. They spent 55 minutes obtaining records from Dr. Bailey, evaluating patient and discussing treatment options. 55 minutes with that patient, what level would you think that this visit is?

Denise Walsh: (slide 42)

This is a 99215 because you've spent 55 minutes with the patient. They probably would have come to moderate complexity using medical decision-making, but using time, this is a level five 55 minutes, which equates to a level five.

Denise Walsh: (slide 43)

We'll now go to our last case scenario. An established patient presents for follow-up appointment with their oncologist to discuss the results of recent diagnostic tests. The physician meets with the patient and spouse for 60 minutes to discuss findings, and a new malignancy diagnosis. After initial discussion, physician leaves the room and spends 30 minutes on the phone with another provider and facility coordinating care, each of the urgent need and progression of disease. Following the phone call, the physician spends an additional 30 minutes discussing the disease process and plan of care with the patient. So for a total time of 120 minutes. With 120 minutes, what level E/M would you bill?

Denise Walsh: (slide 44)

Looking at this rationale, the total physician time is 120 minutes, so you would bill the 99215 with five units of 99417 (99215 + 99417 x 5). I hope that makes sense to you - If you refer to the time criteria

chart for established patients, you bill 99215 + 99417 x 3 units for 85 minutes. You still have an additional 35 minutes of billable time in this encounter, you would then need to add-on two more 15-minute units. So, to bill 120 minutes encounter, you would code 99215 and 99417 x 5 units.

Denise Walsh: (slide 45)

Now, I would like to introduce, Kem Tolliver, who is the President of Medical Revenue Cycle Specialists. She's going to give you a brief synopsis on RVUs and conversion factors, and how these will tie into the revised 2021 CPT codes. Kem, it's all yours.

Kem Tolliver: (slide 45)

Thanks so much, Denise. Hi, everyone. Denise, that was a ton of really, really valuable information. I'm really excited to look at the handouts that you've sent out so that we can really start putting this into practice. But I wanted to very briefly just talk about RVUs and tying relative value units to compensation. It's an industry standard, which is why it's important for us to understand when RVU fluctuations occur so that we can be better equipped to understand how it's going to impact our providers' compensation, and our reimbursement from Medicare.

Medicare really is the industry standard for benchmarking, so most payer reimbursements rely on Medicare's guidance for the conversion factor and for relative value units. Now, one thing that I noticed is that most or many organizations who internally leverage RVU for physician compensation, they typically rely on some type of software to calculate their RVU formulas. As you'll see from this table, we expect quite a few CPT codes to get an increase in the work RVU for 2021. So as you look at 99203, 99204, 99205, those work RVUs are going up. Then 99212, 99213 and 99214 are going up as well.

As we consider the 2021 proposed RVUs, it's also important to be aware of the proposed adjustments to the 2021 conversion factor. So the conversion factor, it essentially converts the value expressed by RVUs into dollars, which is then applied to all of the services and procedures. The proposed 2021 conversion factor is projected to be around $32.26. The current conversion factor is $36.90, so we're looking at a $3.83 overall decrease for the 2021 conversion factor. This roughly equates to about an 11% overall decrease. The proposed 2021 anesthesia conversion factor is a $2.24 decrease from the current anesthesia conversion factor.

Looking at the conversion factor and RVUs, as both being important components of the overall Medicare physician methodology for reimbursement, we would really like it if you guys can join us for our upcoming program when we're going to do a deeper dive into the Medicare final rule. That's going to take place on Wednesday, January 6th at 1:00 PM. There will be more information coming out from Quality Insights about that program. In that webinar, we're going to talk about the conversion factor and highlights from the Medicare Physician Fee Schedule Final Rule. We'll talk about telehealth, CPT updates, and the scope of practice updates for NPs and midwives. Then we'll talk about the MIPS value pathways delay for further down the road. Denise, I'll go ahead and kick it back over to you.

Denise Walsh: (slide 46)

Thanks, Kem. Now that we've gone over all of these updates and revisions for 2021, what do you need to do to prepare yourself? Well, let's start. The first thing I recommend that you do is take a look at the

new requirements. Determine if there are any gaps in your documentation. So look at current documentation, compare your CPT coding and see if it will match up to the new guidelines. If not, what documentation gaps are there? What do you need to make sure that you are supporting the same level? If it doesn't support the same level, then at least you know where the complexity of that type of visit now lies. So it gives you a good indication.

Do a compare and contrast where you currently are now and what your documentation looks like. What do you need to make sure that you document to get to the level three, level four, whatever it might be? Look at the current documentation and see what it supports, what level E/M it supports with the 2021 guidelines. Then look at the financial impact that this may have on your practice. As Kem just said, we are looking at changes with the RVU. How do you do this? You typically run a few of your revenue cycle reports, maybe productivity, profitability reports see your overall levels of E/M and where things may differ. Take a look at that and see if there are some reductions in the RVUs once that comes out. How will that affect your practice looking at what the previous history of productivity is?

We recommend starting immediately. Of course, this webinar is a good start, but educating providers and staff on these new guidelines is important. It's not just providers, but this is billers, coders, everyone should make sure that they are educated. There are a lot of resources out there. I mean, we can provide individual provider training, specialty specific, but there are also websites that have a ton of resources out there. As I mentioned before, the AMA, the AAPC, CMS, they all have a lot of good information and a lot of resource tools to help you with this transition.

If you haven't done so yet, I would contact your EMR vendor. A lot of EMRs have built-in encoders. These encoders are set with algorithms. A lot of the times they are set by clicks, depending upon your history and your exam. A lot of times they expect the physician to determine his own level of medical decision-making to determine if they're using the encounter, what that level will be. So, all of that has to change. So contact your vendors, see if they have updates that are coming out for your EMR. When do they expect the updates to take place? Will those updates have any consequences on documentation or your current templates? I would make sure to find out, if you are using a built-in encoder, how that encoder will now work.

I would also, as we talked about this earlier, test the time element and see if it is feasible for your practice. Figure out how your practice will calculate track document, the overall time that is spent on a patient in a given day. I think that's a very important. It may be something that you can do within the EMR, it may not be. But you need to make sure that's a feasible option for your practice.

Then I always recommend that somebody in your practice, whether it be your practice administrator, one of the billers, maybe somebody on your clinical staff, is the gatherer of information to make sure that they follow-up with your local Medicare contractor, the AMA, all of your payers, make sure that they're getting updates. See if these updates are relevant to your practice, to your specialty, and make sure that they disseminate that information to those in the practice. So, keep updated, make sure that you are keeping educated.

Denise Walsh: (slide 47)

As I said, here's some additional resources from the AMA, CMS, the AAPC, the Maryland MGMA and AAP for Pediatrics. They have a ton of resources on their websites and some useful tools that we highly recommend you all use.

Now, I would like to turn this over for questions. If you have questions, please put them in the chat box at this time. I know this is a long presentation and we only have a couple of minutes, but we'll try to get to a couple of them. And any questions that we haven't gotten to today, we will respond to in writing and post them on the website. So again, if you have any questions, please put them in the chat box now.

April Faulkner:

All right. Thank you, Denise. Thank you, Kem. I have gotten a lot of questions for you. I think that's an accurate statement that we will collect them, so feel free to enter questions. We will gather them and put them together in a Q&A document, but I will go ahead and start with some that we've received already. "We have a CLIA certified lab, and most labs are done in house. If the provider orders labs to be done in three months, is this counted at that office visit?" Then they have a second part to the question, and that is "When the patient returns in three months for follow-up, does the provider get credit then?" If you need me to repeat that, just let me know because it was a long question in two parts.

Denise Walsh:

No, I totally got it. They get time when they are ordering those tests, not when they review them on the subsequent visit. They get credit for ordering those tests at the time of the visit. They can't get credit for both. I know a lot of practices, especially maybe it's an internal medicine practice and they go ahead and they give orders out for three months because the patient's coming back in three months for their physical. Again, you can't take credit for those now and then take credit for them three months from now when you review them. So, you can only get credit once, it's either one or the other. So if you're taking credit now when you order them, you cannot take credit when you review them in three months.

April Faulkner:

Okay. Thank you. How about one more? This question came in when you were talking about calculating MDM. Denise, they asked "Did they do away with 99211?"

Denise Walsh:

No, 99211 is still there. It is still considered a nurse visit. It does not require a physician to see the patient. 99211 just does not have any medical decision-making requirements. So, it is still your nurses. So if somebody comes in, you may have protocols in place for your nurse visits. That is a 5 to 10 minute visit where the nurse documents the reason for the visit, the necessity for the patient to be there. Maybe there are, again, protocols in place that the doctor has already set up. The doctor does not see the patients. So really there is no medical decision-making involved, but that code is unchanged.

April Faulkner:

All right. Seeing how we are at the top of the hour, we will close out very soon. But again, continue to put those questions in the chat and Q&A boxes. We will collect them, and we will get back to you with the answers. I will alert attendees as to when that Q&A document is available and posted on our website.

Thank you so much, Denise and Kem. Thank you, everyone, for joining us today. Just a quick reminder, when you close out of today's session, you will automatically be directed to a very brief evaluation. Please take just a moment to complete it. We greatly appreciate your feedback and comments. Thank you again for joining us. Have a great rest of the day. The session has now concluded.

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