Medicare 2021 Physician Fee Schedule Final Rule (Part 1 of 2)

Questions & Answers from the Live Session

Wednesday, January 6, 2021

1. H & P provider must review, what does that mean? I'm sure him reading the HPI is not enough to say he reviewed. He signs the chart. How should this be documented?

The new E/M guidelines no longer use History or Exam to determine the overall E/M level. As such, it is no longer required that the HPI be documented only by the rendering provider. The HPI, as well as the other history elements, can be documented by ancillary staff. This information can also be imported into the EMR from forms completed by the patient through the patient portal. The rendering provider's signature on the encounter note signifies that he has reviewed and confirmed the information.

2. Would you kindly list the scoring tool resources that were just mentioned? (aapc.com, ama.com, amga.com)

- Codify by AAPC - https://www.apc.com/codes/em-calculator-2021
- AMA - CPT E/M Office Revisions | AMA (ama-assn.org)
- MGMA - 2021 E/M Coding, Billing and Auditing Toolkit (mgma.com)

3. Can you go over time documentation and how physicians should enter their notes?

There are no specific documentation requirements for time-based coding, except to state the entire time of the encounter. It is suggested that a provider document the services performed during the encounter that equates to the 60 minute visit. Remember that time is both face-to-face and non-face-to-face. The following activities performed by the rendering provider can be counted towards the overall amount of encounter time:

- Preparing to see the patient
- 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 healthcare 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)

Example: Patient presents with HTN. Medical records were reviewed. Blood pressure is not adequately controlled with medications. Time is spent discussing ongoing treatment, medication, lifestyle modifications and preventive healthcare. The overall time of the visit is 42 minutes.

4. Our physician interprets a sleep study and discusses results and recommendations at the office visit. Can that discussion time count toward the visit?

Any test or interpretation of a test that is separately billed by the practice cannot be used to determine the level of Medical Decision Making (MDM).

5. Are E&M codes 99211-99215 a permanent telehealth service? What about Medicare Annual Wellness Visits G0403, G0438, G0439. Are they permanent or expiring when the PHE ends?

CPT codes 99202 – 99205 and 99212 – 99215 are permanently telehealth eligible. 99211, G0403, G0438 and G0439 have been added to the expanded telehealth list during the PHE. It is uncertain if this code will become a permanent telehealth eligible service.

CMS has also created a third temporary category of criteria for adding services to the list of Medicare telehealth services. Category 3 describes services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic (COVID-19 PHE) that will remain on the list through the calendar year in which the PHE ends.

Please refer to the approved CMS list of telehealth services. Also, refer to the 2021 CPT Coding Manual – all CPT codes that are telemedicine eligible are denoted by a star.

6. My doctor is questioning how to document. Also, since the doctor is the coder, he only codes for our specialty and does not code comorbidities even though he manages the patient's diabetic, heart and blood pressure medications prior to an outpatient procedure. Should he also add DM, HTN and a-fib to the diagnosis codes for the office visit?

Under the new 2021 E/M guidelines, only problems addressed during the encounter can used to determine the level of MDM. So, if these comorbidities are not being addressed or managed, then **NO**, they should not be coded or used toward the level of MDM.

The AMA definition of "Problems Addressed" is *a problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented **does not** qualify as being 'addressed' or managed by the provider reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment **does not** qualify as being addressed or managed by the provider reporting the service.*

7. Can you bill telephone visits during the PHE? We have elderly patients that can only use the phone.

Medicare is covering telephone services (99441 – 99443) during the **PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

8. So we can't bill for 99441-99443 in 2021? Did CMS stop that at the end of 2020?

Medicare is covering telephone services (99441 – 99443) **during the PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

9. When did CMS terminate the 99441-99443 codes?

Medicare is covering telephone services (99441 – 99443) **during the PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

10. We were paid for 99442-3 by CMS. We were under the impression that this is extended until the public health emergency is not in effect.

Medicare is covering telephone services (99441 – 99443) **during the PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

11. You said 99441-99443 are not recognized by CMS---when did this stop? Can we no longer do telephone visits for telehealth?

Medicare is covering telephone services (99441 – 99443) **during the PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

12. You had mentioned from slide 14 that Medicare was not paying for 99441 - 99443. We are being paid and thought this was part of the PHE? Mine was released on 12/28 but it was taken back down.

Medicare is covering telephone services (99441 – 99443) **during the PHE**. Medicare is not expected to continue reimbursing for these services once the PHE has ended.

13. Has the fee schedule been released for 2021?

The 2021 fee schedule has been released by CMS; however, each Medicare Administrative Contractor (MAC) publishes their own jurisdiction's fee schedules. It is recommended that you check with your MAC for regional fee schedule updates.

- DE, NJ, PA – Novitas Solutions Inc
- WV – Palmetto GBA LLC

14. Are these amounts the full reimbursement or only Medicare's share?

Fees posted are total Medicare allowables for each code. Physician reimbursement will be less any patient responsibility.

15. Are these amounts the 80% Medicare pays or the full amount providers should receive?

Fees posted are total Medicare allowables for each code. Physician reimbursement will be less any patient responsibility.

16. What do you mean that Medicare will pay PAs directly? That they will no longer pay at 85% rate or that they no longer need direct supervision?

Enactment of the PA Direct Payment Act will place PAs on equal footing with other Medicare providers who can be directly paid for services provided to Medicare patients. Current Medicare policy requires that the employer of a PA be paid for services provided to Medicare patients.

Authorizing PAs to be paid directly by Medicare will ensure they can reassign their payments in a manner and be able to receive direct payment from the Medicare program. The inability to be paid directly hinders PAs from fully participating in the increasing number of emerging models of healthcare delivery.

The PA Direct Payment Act (S.596/H.R. 1052) was included in the omnibus and will take effect **January 1, 2022.** The PA Direct Payment Act **DOES NOT** affect the rate at which PAs are paid, nor does it affect the supervision requirements.

17. Will these E/M changes affect 99304-99310?

NO, the revised 2021 E/M guidelines will only affect Office and Outpatient services 99202 – 99215.

18. Can you explain the 2% cut starting in March of this year? What is this adjustment and will it continue through the year?

Medicare sequestration is a penalty created during The Budget Control Act of 2011. Physicians' payments are reduced under Medicare sequestration. Under these budget cuts, any claim received by Medicare after April 1, 2013 was subject to a 2 percent payment cut. Due to the PHE, the 2% sequestration decrease has been delayed until March 31st, 2021.

19. If a provider is basing their level on time, does the time need to be documented in the office Master IM? We have a finalization page where you can document time that will then generate your level based on the time entered. Is the time in that area acceptable or should it be in both places?

NO, the total amount of time MUST be documented in the encounter note. It is unacceptable to just populate the total encounter time into an EMR field to generate the E/M level. See answer to question #3.

20. For determining the MDM of a level, does the level of decision making/complexity need to be marked or documented as well or is the note enough information to show how the level was determined?

You do not need to state "the level of MDM is moderate" in the encounter note. The level of MDM complexity is inferred by the provider's documentation of the problems addressed, data reviewed and risk and management of complications, morbidities and mortalities.

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support Center for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-020221