SCAFP Summer Break Away and 73rd Annual Assembly

The 2021 Evaluation and Management Changes for the Ambulatory Space

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Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS Coding Guidelines rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.
- I disclose no other conflicts.

Objectives

- Know the definitions of the types of conditions that we use in our E&M services as well as how to define whether a patient is "new" or "established"
- Be able to correctly apply time-based coding in the ambulatory office practice setting
- Define the 2021 Medical Decision-Making components and be able to correctly apply them clinically

Changes….? What changes….?

- Massive overhaul in E/M in the outpatient office setting across all specialties
  - Designed to simplify code selection and decrease documentation burden
  - No longer 99201, still with 99202-99215 (so, 99211 still exists). No bundling.
- The 1995 and 1997 Guidelines are no longer to be used in ambulatory office setting
  - The "history" and "exam" are no longer "Key Components" to support billing
  - Document such now when "medically appropriate" and report when "reasonable and necessary and clinically appropriate"[1]
  - Code selection can be made based on Time or on Medical Decision Making (both defined differently in 2021)
- New codes for time related to prolonged service

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

Changes….? What changes….?

- Definitions[1] are placed in CPT for clarity
  - Time: can use to select level of E/M in the ambulatory space except for 99211 and 99201 – does not need to be >50% counseling/care coordination
    - Total time spent by the provider on a given day in clinical work related to a patient
      - Review of test(s), review of separately obtained history, performing an exam, ordering medications/tests/procedures, referring/communicating with other providers, documentation in the clinical record, independent interpretation of tests (not separately reported*), and communicating such to family/caregiver, care coordination (not separately reported*)

[1] CPT 2021 pp 5-17

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      - *Not separately reported: if you get paid to do this otherwise, then it is not MDM related time
    - For ambulatory office care, TIME does NOT have to constitute >50% of time spent in care coordination or counseling. In other E/M services, it does. Still not allowed in ED.

[1] CPT 2021 pp 5-17

Changes….? What changes….?

- Definitions of illnesses that are addressed/managed[1]:
  - Minimal: May not require the presence of a Provider, but care is delivered under their supervision (nurse collected BP check*)
  - Self-limited/minor: Problem that runs a definite course, is transient in nature, and not likely to permanently alter health status (contusion, superficial abrasion*)
  - Stable, chronic illness: Expected duration of at least one year, or until death. Risk of morbidity without treatment is significant. "Stable" is defined by the treatment goals and if not at goal, then is not stable. (controlled BP, stable DM w A1c 7, etc.*)
  - Chronic illness with exacerbation, progression, treatment side effects: A condition that is not at goal and needs management. Hospitalization is not considered. (*uncontrolled BP, diabetic with A1c 8, etc.**)
  - Chronic illness with severe exacerbation … : Severe exacerbation and hospitalization **is** considered. (AECOPD with in-office treatment, close f/u in lieu of hospitalization*)

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions

Changes….? What changes….?

- Definitions of illnesses that are addressed/managed[1]:
  - Acute, uncomplicated illness/injury: Low risk of morbidity where treatment is considered. Full recovery expected with treatment. (simple sprain, uncomplicated cystitis, allergic URI)*
  - Acute, complicated injury: This requires treatment with inclusion of evaluation of additional body systems not directly a part of the injured organ. (concussion with brief LOC, abdominal trauma with r/o splenic contusion)*
  - Acute illness with systemic symptoms: Symptoms are systemic or in a single system but there is a high risk of morbidity without treatment. (pyelonephritis[1], pneumonitis[1], colitis[1], COVID*, influenza*)
  - Acute/chronic illness/injury that poses a threat to life/bodily function: Self explanatory. (Angina in CAD patient, abdominal pain in colitis patient, AMS with UTI)*
  - Undiagnosed new problem with uncertain prognosis: The problem in the differential diagnosis representing the condition may result in a high risk of morbidity without treatment. (new adenopathy, new breast lump, NEW HTN, NEW DM)*
- A problem does NOT count in the billing of an encounter when documentation of your management is lacking (others manage and you just "list", or you see/refer without assessing)

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions

Changes….? What changes….?

- Definitions that touch other aspects of our care[1]:
  - Test: Imaging, laboratory, psychometric, or physiologic data. Single vs multiple definitions follow CPT code set. A basic metabolic panel (80047) is ONE test, not seven…..
  - Independent historian(s): An individual who provides MDM history in addition to a history provided by the patient or who gives because the patient is unable to provide the information. Document reason historian needed…developmental stage, dementia, or psychosis prohibits adequate collection. (caregiver of a demented patient, *mother of an infant*)*
  - Independent interpretation: Interpreting a test with a CPT code and a report is customary. Documentation does not need to conform to the standards of a complete report. If compensated for the interpretation (professional component) already, then this cannot weigh into the MDM of the encounter (no double-dipping)
  - Drug therapy requiring intensive monitoring for toxicity: Monitoring provided for assessment of adverse effects and not primarily for assessment of therapeutic efficacy. Less than quarterly and not routine. (BMET 2 wks after starting combination ACE/Diuretic → yes; BMET yearly for a BP pt → no)*

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions

Changes….? What changes….?

- Definitions that touch other aspects of our care[1]:
  - Social Determinants of Health (NEW)
    - Economic and social conditions that influence the health of people and communities. Correct documentation includes the addition of the ICD-10 codes. (job loss, food insecurity, homeless state)*
    - Adding SDOH data to current risk prediction models increases accuracy for predictive modeling in costs of care
    - SDOH alone in one model predicted health outcomes and costs as well as one based on clinical comorbid conditions[2]

[1] CPT 2021 pp 5-17
*Dr. Ulmer's suggestions
[2] *Circ Cardiovasc Qual Outcomes.* June 2020, pp290-298 (AHA journal).

Billing Basis: Time-based

- Specific for codes 99202-99205, 99212-99215
  - Time can be assigned based on TOTAL TIME rendered by a Provider in a CALENDAR DAY.
    - Review of test(s), review of separately obtained history, performing an exam, ordering medications/tests/procedures, referring/communicating with other providers, documentation in the clinical record, independent interpretation of tests (not separately reported*), and communicating such to family/caregiver, care coordination (not separately reported*)
    - *Not separately reported: if you get paid to do this otherwise, then it is not MDM related time
    - With split/shared visits (physician and other qualified health care professional(s) both deliver care), only count the times spent together once.
    - Staff time does NOT count in this total time calculation
    - DOCUMENT TIME IN THE NOTE to support the billing level IF time is the driver of charge

CPT 2021 Professional Edition pp5-17

Time-based Calculation 2020 vs 2021

New Patient E/M Code	Typical Time (2020)	TOTAL Time (2021)
~~99201~~	~~10 minutes~~	~~DELETED~~
99202	20 minutes	**15+** minutes
99203	30 minutes	**30+** minutes
99204	45 minutes	**45+** minutes
99205	60 minutes	**60+** minutes

So, remember for 99202-99205: 15 – 30 – 45 – 60 as the minimum total time thresholds

Time-based Calculation 2020 vs 2021

Est. Patient E/M Code	Typical Time (2020)	TOTAL Time (2021)
99211	5 minutes	Time Threshold Removed
99212	10 minutes	**10+** minutes
99213	15 minutes	**20+** minutes
99214	25 minutes	**30+** minutes
99215	40 minutes	**40+** minutes

Remember for 99212-99215: 10 – 20 – 30 – 40 as the minimum total time thresholds

Prolonged Care Code for Time-based coding (2021)

- G2212 (Medicare patients)
  - Use this for prolonged care associated with the highest new and established office visit codes 99205 and 99215 ONLY
  - Use instead of 99358 (1st hr non-FTF), 99359 (ea. 30 min more), 99417 (Commercial)
  - Add-on code for 15+ minutes spent in addition to the UPPER TIME THRESHOLD for these codes
    - 99205 (60-74 minutes) add G2212 when more than 15' (74+15= **89**) minutes total time
    - 99215 (40-54 minutes) add G2212 when more than 15' (54+15= **69**) minutes total time
      - 0.61 RVU
      - For EACH additional 15+ minutes, then add the G2212 code
  - Document the TOTAL TIME to support the billing
- 99417:
  - Add-on code for prolonged care, but the threshold is on the LOWER time (60' and 40')
  - Commercial payors: often to each his own, so ask how they define it.

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

If not Time, then Medical Decision Making (MDM)

- Similarities to the 2020 version of MDM: 3 components, different verbiage
  - **Diagnoses** managed (number and type) → Number and Complexity of **Problems**
  - **Data** reviewed to manage diagnoses of visit → Amount/Complexity of **Data** Reviewed/Analyzed
  - **Risk** associated with the management plan → **Risk** of Complications and/or Morbidity/Mortality of Patient Management
- Similarities to the 2020 version of MDM: 2 of 3 needed to meet MDM
- Similarities to the 2020 version of MDM: A Very Busy Chart …… !!!!

2021 Outpatient Medical Decision Making (MDM) – 2 of 3 Needed

E/M LEVEL and MDM (99201 deleted, 99211 N/A; MDM based on 2 of 3)	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (*Each unique test, order, or document reviewed counts in Category 1)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99202 (15-29 min) 99212 (10-19 min) Straightforward MDM	MINIMAL NUMBER AND COMPLEXITY • One self-limited or minor prob. (abrasion)	Minimal but usually none	Minimal risk of morbidity from additional diagnostic testing. Consider: Rest, superficial dressings, labs, EKG, EEG, etc.
99203 (30-44 min) 99213 (20-29 min) Low MDM	LOW NUMBER AND COMPLEXITY • 2 or more self-limited or minor prob. ***OR*** • 1 chronic stable illness (HTN) ***OR*** • 1 Acute, uncomplicated illness/injury (UTI)	**(Must Meet 1 of 2 Categories)** Category 1: Tests and documents (any 2) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test ***OR*** Category 2: Assessment requiring an independent historian	Low risk for undergoing additional management Consider: OTC drugs, non-contrast imaging, PT/OT, skin bx, minor surgery

Clinical Example

- 66yo in for establish with PCP for HTN. BP at home are all below 140/80. No significant history of concern. BMET and CBC are normal in labs done at last PCP 2 months ago. Exam benign.
- A/P:
  - HTN: Continue ACEI. Lifestyle modifications. Reck 6 months

Clinical Example

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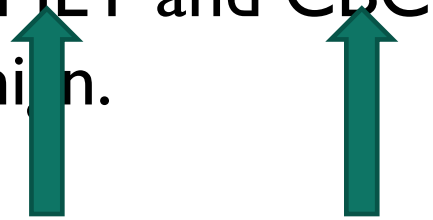

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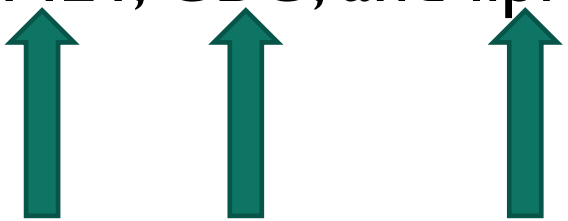
99203 (30-44 min) **99213 (20- min)** **Low M M**	LOW NUMBER AND COMPLEXITY • 2 or more self-limited or minor prob. ***OR*** • *1* ***chronic stable illness (HTN)*** ***OR*** • 1 Acute, uncomplicated illness/injury (UTI)	**(Must Meet 1 of 2 Categories)** Category 1: Tests and documents (**any 2**) 1. *Review of prior external note(s) from EACH unique source 2. ****Review results of EACH unique test*** 3. *Order of EACH unique test ***OR*** Category 2: Assessment requiring an independent historian	Low risk for undergoing additional management Consider: OTC drugs, non-contrast imaging, PT/OT, skin bx, minor surgery

2021 Outpatient MDM (cont.) – 2 of 3 Needed

E/M LEVEL and MDM (99201 deleted, 99211 N/A; MDM based on 2 of 3)	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (*Each unique test, order, or document reviewed counts in Category 1)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99204 (45-59 min) 99214 (30-39 min) Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects (AECOPD) • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis (breast lump) • Acute illness with systemic symptoms (flu) • Acute complicated injury (concussion)	**(Must Meet 1 of 3 Categories)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. ***OR*** Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) ***OR*** Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed)	Moderate risk of morbidity from additional tests/treatment Consider: Rx mgmt., Discussion regarding minor surgery w/ patient or procedure risk factors Discussion regarding elective major surgery w/o risk factors Diagnosis or treatment significantly limited by social determinants of health
99205 (60-74 min) 99215 (40-54 min) High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects (AECOPD w hypoxia) • Acute/chronic illness that may pose threat to life or bodily f(x) – (acute abd pain → ED)	**Must Meet** **2 of 3 Categories Above**	High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care, Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog

Clinical Example

- 71-year-old with f/u **HTN** and **hyperlipidemia**. BP well controlled and no S/E from statins. Benign history and exam. CMET, CBC, and lipids reviewed with patient today.



- A/P:
  - HTN: ACEI, Diuretic continue. F/U 6 mo.
  - Hyperlipidemia: Statins continue.

Clinical Example: COPD

- 66 YO with COPD. Med compliant. Symptoms x 4d. Worse sputum, discolored. No other complaints. Happens each year.
- VSS except sat is 88% on exertion, 91% at rest (RA).
- Nebs in office, sats 92 on ambulation. You recommend hospitalization. He refuses due to care issues with wife at home.
- You treat OP with close f/u tomorrow.

E/M Complexity Add-On Code (2021)

- G2211
  - "*Visit complexity inherent* *associated with medical care services what serve as* *ed health care services and/or with medical care se* *part of ongoing* *to a patient's single, serious, or complex conditi*
  - Established or n
  - Focus is on cor care del continuous of time
  - Team based car to be a par olistic, p entered, integrated around the illne he patient's ne ordi f specialty care
  - Include patient e goal-setting, sha g. ("care plan")
    - Add-on of G221 cumentation sho eing delivered
    - RVU 0.33 ($10.69)

[1] CMS Transmittal 10505, 12/04/2020, CR 12071

Time take-aways

- Total time for THAT DAY…finish notes "after midnight"…not included
- Staff time does NOT count, only provider time related to ONE patient
- ALL time counts – including dictation of notes (be reasonable), review of labs, talking to family or other providers. Add it up and make a note in record.
- Waiting on the phone for a consultant or auth # is NOT countable
- The time it takes for you to read an EKG or CXR IS countable if you are billing based on TIME….unless you are getting paid to read the EKG or CXR, etc.*
- I see time trumping MDM when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

MDM take-aways

- 2+ chronic problems that are stable on Rx → Mod MDM (level 4, new or established)
- 1 New problem w uncertain prognosis/1 chronic exacerbation + Rx → level 4
  - Patient-specific problem, not provider specific, unlike 2020
  - Work-up or not is the same, unlike 2020
- If you have someone clinically unstable enough to mention "hospital care" (ED, in house), then they need close f/u (if they refuse) and a "story" that shows illness … and level 5 for your MDM work – even if the time spent was minimal
- If you own your machine, don't take credit for MDM for that test (EKG, CXR)* interpretation, but you can get credit ORDERING that test
- Talk to a parent of a 5-year-old = Low MDM for DATA
- Social Determinants of Health = Moderate MDM for RISK
- I see MDM trumping time most often EXCEPT when I get side-barred or need to speak to other physicians about a complex problem because I can add dictation time into mix

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Telehealth Coding for 2021

E. G. "Nick" Ulmer, Jr., MD CPC FAAFP
VP, Clinical Integration and Medical Director, Case Mgmt, SRHS
Chief Medical Officer, Regional HealthPlus PHO

Objectives

- Know how the Public Health Emergency (PHE) impacts telehealth services
- Define "Telehealth" and know where to find the active file for telehealth services covered by Medicare and the most recent updates and additions
- Be able to state the various Telehealth applications in primary care and best practice billing processes

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - Virtual Check-ins
  - On-line digital Management (E-visits)
  - Telephone encounters and other waivers

Telemedicine

- Medicare telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider who is at a separate location using an interactive 2-way telecommunications system (like real-time audio and video).
- These services were previously only available in rural areas, under certain conditions, for ESTABLISHED patients located at one of these places:
  - A doctor's office
  - A hospital
  - A Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)
  - A skilled nursing facility
  - A community mental health center (if substance use disorder or co-occurring mental health disorder, can get from home)
  - A dialysis clinic and with home dialysis (after 1x/mo in-person visits, then q 3 mo in-person)

Telehealth waivers from CMS

- Temporary policy changes during the Coronavirus pandemic
- CMS has issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 Public Health Emergency.
- Some of these changes allow providers to:
  - Conduct telehealth with patients located in their homes and outside of designated rural areas
  - Practice remote care, even across state lines, through telehealth
  - Deliver care to both established and new patients through telehealth
  - Bill for telehealth services (both video and audio-only) as if they were provided in person
  - Include RHC in telehealth expansion
- Current PHE goes until July 21, 2021 (some services are covered until EOY of PHE) https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telemedicine

- Prior to waiver, all needed to be HIPAA compliant
  - This is a real-time concurrent session where interactive Q/A and medical decision-making occur just like in the standard face-to-face (FTF) office visit.
  - Since waiver, HIPAA violations will be waived to increase access and other "everyday communications technologies" are allowed. Documentation in your record needs to note method and other info as if standard FTF encounter performed.
    - May use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk during the COVID-19 PHE.
    - Notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
    - Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should <u>not</u> be used

Telemedicine Coding

- The same E/M CPT codes are used with the same reimbursement; co-pay/deductibles apply
  - 99202-99215; G0245-G0247 (ED/IP consults); G0406-G0408 (f/u IP consults hospital/SNF); preventive and other services
- Documentation is still accountable, exam will be hindered without advanced technology (follow 2021 E&M Guidelines)
- Modifiers and Place of Service (POS) codes – main ones:
  - CS: Waives cost sharing. Use only in ov where COVID test/labs ordered
  - -95 Modifier: Denotes video visit for Telemedicine
  - See Resource handouts and grab a billing staffer to follow the links…
    - Some for Part B, for Part A, for both, for RHC/FQHC (or optional) and most only for PHE ….

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - **Virtual Check-ins: not Telehealth. "Technology-based"**
  - On-line digital Management (E-visits)
  - Telephone encounters, and other waivers

Virtual Check-in

- "Check-in" with provider using a phone, integrated audio/video system, or captured video image
- Provider can respond using:
  - Phone
  - Audio/video visit
  - Secure text messages or Email
  - Use of a patient portal
- Standard Part B pricing (co-pay/deductible applied until waiver)

Virtual Video/Image Sharing: G2010 and G2250

- G2010: Remote evaluation of recorded video/image submitted by an established patient (including interpretation with f/u with the patient within 24 hours). (0.18 wRVUs/~$12)
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Need consent. Co-insurance not waived. Professional who **CAN** bill E&M
- G2250: Remote evaluation of recorded video/image submitted by an established patient (including interpretation with f/u with the patient within 24 hours). (0.18 wRVUs/~$12)
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Need consent. Co-insurance not waived. Professional can**NOT** bill E&M (not MNT or audiology)

Virtual Check-ins: G2012, G2251, and G 2252

- G2012: A brief (5-10 min) check-in with provider via telephone or other telecommunications device to decide whether an office visit or other service is needed (0.25 wRVUs/~$14)
  - Initiated from an established patient. Need consent. Not co-insurance waived. Provider **CAN** bill for E&M
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Document content of conversation, plan. Include TIME duration of call.
- G2251 A brief (5-10 min) check-in by a qualified healthcare provider (who **can NOT** bill E&M) via telephone or other telecommunications device to decide whether an office visit or other service is needed (0.25 wRVUs/~$14)
  - Initiated from an established patient. Need consent. Not co-insurance waived
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Document content of conversation, plan. Include TIME duration of call.
- G2252 …. 11-20 minute check-in by a provider who **CAN** bill E&M ($26/0.50wRVU)

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - Virtual Check-ins
  - **On-line digital Management (E-visits)**
  - Telephone encounters, and other waivers

Evaluation and Management: On-line Digital Services

- CPT developed 3 new codes for physicians and NPPs (NPs, PAs, CNSs)
  - Takes the place of former code 99444 (…on-line E/M service by …) never paid by CMS, others
  - Brief, on-line E/M services when using a secure platform and initiated by established patient
  - Timed, specific to work done by providers who can bill for E/M services. Staff time does not count
  - Time is counted during a 7-day period
    - Starts when patient-initiated service is reviewed, evaluated, and managed by PROVIDER
      - Questions addressed, chart review, management plans developed, subsequent communication (email, call, digitally supported contact)
  - Also: document in permanent record, if FTF w/in 7d then it is bundled in (no bill for this), if < 7 days after FTF then no bill, not in global surgical period if surgeon billing, and only once in 7d.

CPT Professional Edition, 2020. AMA, p. 68.

99421-99423 On-line Digital Management

- 99421
  - 5-10 minutes of cumulative time
  - 0.25 wRVUs ($15)
- 99422
  - 11-20 minutes of cumulative time
  - 0.50 wRVUs ($31)
- 99423
  - > 20 minutes of cumulative time
  - 0.80 wRVUs ($50)
- Problem: tracking of time, cross-over of service delivery, marketing

Non-Provider On-line Digital Services

- CMS developed 3 new HCPCS codes for NON-providers in 2020, updated '21
  - Brief, on-line "assessments" when using a secure platform and initiated by established patient
  - Timed, specific to work done by qualified nonphysician healthcare professionals who CANNOT bill for E/M services. These are ASSESSMENTS.
    - Dietitians, Social Workers, PTs, OTs, SLPs, etc.
  - Time is counted during a 7-day period
    - Starts when patient-initiated service is reviewed, assessed by QNHP
      - Questions addressed, chart review, management plans developed, subsequent communication (email, call, digitally supported contact)
  - Also: document in permanent record, if FTF w/in 7d then it is bundled in (no bill for this), if < 7 days after FTF then no bill, not in global surgical period if surgeon billing, and only once in 7d and no double-dipping with other services (CCM, etc.)

CPT Professional Edition, 2021. AMA, p.811-812

98970-98972 On-line Digital Management

- ~~G2061~~ 98970
  - 5-10 minutes of cumulative time
  - 0.25 wRVUs ($12)
- ~~G2062~~ 98971
  - 11-20 minutes of cumulative time
  - 0.44 wRVUs ($21)
- ~~G2063~~ 98972
  - > 20 minutes of cumulative time
  - 0.69 wRVUs ($33)
- Problem: tracking of time, cross-over of service delivery, marketing

On-line Digital Management/Assessment

- Do not bundle with other billable codes that cross over
  - *NEW CODES, so be wary.*
  - *Yearly consent – verbal OK, but note in chart.*
  - *Looks OK for TCM (but I would not go there)*
  - *Worry about CCM and CPO (so, I would not go there either)*
  - *7d before …. 7d after do not use or will lose the E/M of the office visit or other encounter (payors usually pay the lesser code billed together)*
- These are generally asynchronous communications from patients, telemedicine is real-time
- Example ……

Examples of Digital Management Encounter

- Acute complaint sent to your NPP, and email is addressed with review of record, reply of email and send in meds to pharmacy (5 min). Patient replies back tomorrow with f/u and new complaint. NPP addresses and add another med. (4 min). Total time is 9 minutes.
  - Bill 99421 (5-10 min) ….. Or hold in que for now until 7d later, then bill → $15
- RD counseling issue. Review of food log, exercise plan. Return email with several interchanges to address patient's questions (12 minutes). Tomorrow, new issues arise re diet plan and there is a to/fro email exchange with the patient (13 min). Total time = 25 minutes.
  - Bill 98972 (+21 min) ….. Or hold in que for now until 7d later, then bill → $33
- **NOT** co-pay/deductible waived…..so educate before you deploy! Consent.

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - Virtual Check-ins
  - On-line digital Management (E-visits)
  - **Telephone encounters, and other waivers**

Telephone Assessments for Providers in PHE

- CMS is now paying for Telephone calls for assessments. Previously non-covered. Not coinsurance waived. IS deemed telehealth (so, -95)
  - Rates have been changed to mirror 99212-99214 and are time-based
  - Established patient
  - Call is initiated by the patient
  - Not used if seen w/in 7d prior or to be seen in the next 24h, or "soonest available"
- 99441: Telephone evaluation and management by provider who can report E//M services. 5-10 minutes (total time) ($46/0.48wRVU) "99212"
- 99442: Telephone evaluation …. 11-20 minutes ($76/0.97wRVU) "99213"
- 99443: Telephone evaluation … >21 minutes ($110/1.50wRVU). "99214"

Telephone Assessments for QNPHP[1]

- Telephone assessment as "sometimes therapy" codes effective for the duration of the PHE for COVID-19. Coinsurance applies.
  - QNPHP: Registered dietitians, social workers, speech language pathologists and physical and occupational therapists use these codes
- CPT 98966 - Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion ($13).
- CPT 98967 - Telephone assessment and management service… (11-20 min. - $27)
- CPT 98968 - Telephone assessment and management service… (21-30 min. - $40)

MLN Matters: MM12126; 12/2020.

WHAT TO DO TODAY…..?

- E-visits we are good with and without E&M providers w CMS (commercial…?)
- Virtual image sharing
  - G2010 (E&M providers) and G2250 (non-E&M providers)
    - Remote evaluation of recorded video/image submitted by an established patient … (0.18 wRVUs/~$12)
- Virtual Communication Technology-based Check-ins
  - G2012: A brief (5-10 min) check-in with provider **who CAN** bill (0.25 wRVUs/~$14)
  - G2251 A brief (5-10 min) check-in by a QHCP (who **can NOT** bill E&M) (0.25 wRVUs/~$14)
  - G2252 …. 11-20 minute check-in by a provider who **CAN** bill E&M ($26/0.50wRVU)
- Telephone Encounters
  - 99441-99443 for E&M providers (5-10/11-20/20+ min for $46/$76/$110 in PHE)
  - 98966-98968 for non-E&M providers (same time intervals for $13/$27/$40)

Telehealth/TelePHONE Flexibility in Pandemic

- Several services during the PHE (through April 21, 2021 at a minimum)
- Of Note, PHONE ONLY allowed for…
  - The Initial or Subsequent Annual Wellness Visit is eligible to be done by PHONE only
    - Flexibilities regarding vitals, still perform PHQ2/9, GAD-7, MMSE (Sweet 16) and the STEADI for falls risk
    - The IPPE is still **FACE-TO-FACE ONLY** (not video visit either)
  - Advance Care Planning (both codes)
  - Intensive Behavioral Therapy: obesity, CV screening, or STD screening
  - Annual alcohol screening, Brief alcohol misuse counseling
  - Annual depression screening (subsequent AWV only)
  - Tobacco cessation 3-10 min and >10 min
  - DM for individual, group
  - Visit to determine LDCT eligibility for lung CA screening

Remember…..TCM Revenue Value

Check the boxes, document the checks

- 99495: 2.78 wRVU (increased in 2020 and 2021)
  - Moderate MDM
  - < 14 days to be seen
- 99496: 3.79 wRVU (increased in 2020 and 2021)
  - High MDM
  - < 7 days to be seen (best practice for all hospital f/u care)
- 30-day code cross-over relaxed in 2020 and 2021, but caution with those codes
  - CCM (99490/491/493, 99487/89, and CPO (G0181, G0182) are allowed if medically necessary
- Don't forget code 1111F to show med reconciliation in the 3rd and 4th week (<30d)
- During the PHE is TeleHEALTH (not PHONE) allowed…be clinically correct here!

Transition Care Management (99495, 99496)

- For 2021 CMS has reduced the restrictions to billing, now OK to bill with
  - Non-Complex (99490) and Complex Case Management (99487, 99489)
  - Care Plan Oversight (G0181-G0182)
  - ESRD services for patients over 20 years of age (90960-90962, 90966, 90970)
  - Prolonged Services without direct patient contact (99358-99359)
  - Home and OP INR monitoring (93792-93793)
  - Interpretation of physiologic data (99091)

Closing…

- Check with your insurance carriers – especially after 07/20 for guidance on PHE waivers

- Now, on to questions…..

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