About the Speaker

Jean Acevedo, Acevedo Consulting, has over 30 years of health care experience including a particular expertise in chart audits, compliance and education relative to hospice and palliative physician documentation and coding. Jean serves as a consultant to NHPCO and AAHPM when physician compliance, billing and coding issues arise. She was awarded a Presidential Citation by the AAHPM at the AAHPM/HPNA 2014 Annual Assembly in appreciation of her contributions to the field of hospice and palliative medicine in helping them understand the complexities of coding, reimbursement and regulatory compliance.

She is a workshop presenter for the AAPC, an instructor at Florida Atlantic University, and a member of several Coding Institute Editorial Advisory Boards. Jean has been a Participant in CMS' Medicare Provider Feedback Group, CMS Division of Provider Information Planning and Development since 2007 and is a member of the Jurisdiction 9 MAC's Provider Outreach and Education Advisory Group. She has co-authored a series of "Top 10" articles published in the Journal of Palliative Medicine on challenges in palliative care, and is co-creator of "Billing for Palliative Care Services," an online course of California State University. She is a frequently sought after speaker and works with hospice/palliative care clients across the country bringing the unique perspective of avoiding risk and liability while optimizing reimbursement in our highly regulated health care industry; providing practical solutions in a complex environment.

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Documentation & Coding of Physician Services in Palliative Care: Traditional Services

December 8, 2021

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"10 Iron Rules of Medicare"*

*Quote from Attorney Larry Oday; Modern Healthcare/June 19, 2000

1. Just because it has a code, that doesn't mean it's covered.
2. Just because it's covered, that doesn't mean you can bill for it.
3. Just because you can bill for it, that doesn't mean you'll get paid for it.
4. Just because you've been paid for it, that doesn't mean you can keep the money.
5. Just because you've been paid once, that doesn't mean you'll get paid again.
6. Just because your got paid in one state doesn't mean you'll get paid in another state.
7. You'll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There's always some schlemiel who doesn't get the message.
10. There's always some schmendrik (jerk) who gets the message and ignores it.

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Agenda

- Medical Necessity
- Typical Palliative Care Billable Services
  - E/M Services and the "3 Key Components"
  - Office/Clinic Based Visits: MDM or Time
- Advanced Care Planning

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MEDICAL NECESSITY

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Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"

CMS Glossary for Beneficiaries defines medical necessity as: "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

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Medical Necessity

(Pub 100-4, Medicare Claims Processing Manual, Ch. 12 §30.6)

"Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed."

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Medical Necessity & EMR Documentation

- Documentation software may facilitate carryovers and repetitive fill-ins of stored information
- Even when a “complete” note is generated, only medically necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E&M service
- Information not pertinent to patient’s condition at time of encounter cannot be counted
  - Patient seen in ‘routine’ follow-up of controlled chronic pain. History is “comprehensive” including past, family and social history. Was it “medically necessary” to repeat those history elements?

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HPI and Impression/Plan: The Most Important Documentation

- History of Present Illness
  - Description of the illness/problem from its onset or since the last time patient seen…
- Impression/Plan
  - Not only indicates what today’s findings and thought processes are, but substantiates future intervention!

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In Plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is "reasonable and necessary" or be one of the preventive benefits

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Noridian's Perspective on Medical Necessity

A vast majority of the documentation submitted to support claims billed with CPT® 99334–99337 fails to establish the medical necessity of the service. The documentation does not support any active issues or new injuries, and does not support any changes to the plan of care and/or medications. The documentation essentially supports a routine visit by the physician. The burden of proof for medical necessity of the service is that of the provider. Claims will be denied as not medically reasonable and necessary when the person who renders the service fails to document the medical necessity of the service.

**Based on Medical Review Level of Service findings performed by Noridian's Medical Review department.*

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Noridian's Perspective on Medical Necessity - cont.

- Another trend noted by Part B MR is the MDM does not correlate to the chief complaint. One such example would be the HPI supports a follow-up visit for renal functions tests, hypertension, and reflux. The medical management of that patient is then a Physical Therapy referral for low back pain, with no mention of medical management of the issues that brought the patient to the clinic. The documentation did not support complaints of low back pain. Part B MR has also noted that the plan of care simply lists the medical diagnoses of the patient, with no mention of changes to the plan of care if any, or continuation of current treatment regimens. It is difficult to determine the medical necessity of a visit when the documentation lacks important information, or when the documentation does not support medical management of the patient's chief complaint.

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Palliative Care "Physician" Services

- Traditional Palliative Care Services
  - Evaluation & Management
  - Advanced Care Planning

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Historical Palliative Care Billing Codes

- Initial Hospital 99221-99223
- Subsequent Hospital 99231-99233
- Initial Nursing Facility Assessment 99304-99306
- Subsequent Nursing Facility Care 99307-99310
- New Patient Rest Home (Domiciliary/Rest Home/ALF) 99234-99328
- Established Patient Rest Home 99334-99337
- New Patient Home 99341-99345
- Established Patient Home 99347-99350
- New Patient Office 99202-99205
- Established Patient Office 99212-99215

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E&M Services

- Billable encounters/visits
  - Medically necessary
  - Face-to-face
    - Some exceptions during the PHE
- Code sets by type of service and/or place of service
  - New patient vs. established patient
    - Home visits
    - ALF, domiciliary, rest home visits
    - Office/Clinic visits
  - Initial care vs. subsequent care
    - Inpatient hospital
    - SNF/NF

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E&M Services – Choosing the Right Code

- Once the right "type" is identified
  - Location of the patient
  - New vs. Established
  - Initial vs. Subsequent
- Must chose the right "level" of service*
  - Home/ALF/SNF/NF/Hospital: 3, 4 or 5 levels
    - Based on documentation of 3 Key Components **or**
    - Time and counseling and/or coordination of care when that dominates the encounter
  - Office/Clinic Visits: 4 levels
    - Medical Decision Making (MDM), or
    - Total time on the date of the visit

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Home, ALF, SNF/NF or Hospital Visits

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Seven Components Define E&M Services:

- Key Components in selection of level
  - History
  - Examination
  - Medical Decision Making
- Ancillary elements in selection of level
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity)
  - Time

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Requirements of the 3 Key Components

- "Key Components"
  1. History
  2. Physical Exam
  3. Medical Decision Making
- Documentation of all three key components must meet the code's definition for
  - "New patient" visits
  - "Initial" patient visits
- Documentation of two of the three key components must meet the code's definition for
  - "Established patient" visits
  - "Subsequent" visits

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Coding Based on
3 Key Components

#1: Documentation of History

- Based on 4 Types
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- History Elements
  - Chief Complaint (CC)
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past, family and/or social history (PFSH)

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Chief Complaint

- Concise statement describing symptoms, problems, condition, physician recommended return, or other factor that is the reason for the encounter.
- Chief complaint must be explicitly stated or easily inferred from documentation:
  - "Severe abdominal pain for past 8 hours" (explicit)
  - "Less agitation since adding Ativan" (inference is that visit is to follow-up on medication change)

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Generic Chief Complaint

- "To assist with symptom management and to further clarify goals of care."
  - When family has already decided, who is the clarification for?
- CC: "Symptom control"
  - What symptom?
- CC: "Follow up"
  - Ok, but of what? All patients who have been seen before are seen in follow up.
- CC: "Evaluate patient's response to treatment care plan"
  - What aspect of the treatment plan?

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History of Present Illness

History of Present Illness elements

No E&M code requires more than 4 HPI elements.

1. Location – body area (abdomen)
2. Quality – sharp, burning, deep
3. Severity – intensity of illness (9 on a scale of 1-10)
4. Duration – how long symptoms last (past 8 hours)
5. Timing – relation to events (constant)
6. Context – what the patient was doing
7. Modifying factors – precipitating or alleviating factors (relieved by pain medications)
8. Associated signs (objective evidence) or symptoms (subjective evidence) (e.g., nausea)

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Review of Systems

A series of questions about past/present <u>symptoms</u>

- Constitutional symptoms; e.g. fever
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/ Immunologic

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Past, Family and/or Social History Consists of:

- Past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- Social history (an age appropriate review of past and current activities).

When History is Unobtainable:

The documentation must clearly reflect:

- The components that were unobtainable (HPI, ROS and/or PFSH)
- Circumstances that preclude obtaining the HPI, ROS, and PFSH (dementia, sedated on a vent, etc.). When using 'poor' historian the documentation must support why (e.g. dementia).
- Attempt to obtain from other resources:
  - A family member, spouse, nurse etc. was not present or was unable to provide additional information
  - The medical record (chart, ambulance run sheet, etc.) did not contain the information needed
- If patient or family can provide information at a later time, the provider may add an addendum containing this information

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When History is Unobtainable- Examples

- "Family History: Unobtainable." (yet family is at the bedside)

"No further ROS or family history obtainable; chart reviewed, no family present."

What history elements could the physician/nurse practitioner get "credit" for?

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Selecting* Level of History

HPI	ROS	PFSH	Level
Brief (1-3 elements)	N/A	N/A	**Problem Focused** 99341, 99347 99231
Brief (1-3 elements)	Problem Pertinent (system directly related to problem identified in HPI)	N/A	**Expanded Problem Focused** 99342, 99348 99232
Extended (4 or more elements)	Extended (system directly related to problem identified in HPI and a limited number of additional systems 2-9 total)	Pertinent (at least 1 specific item from 1 of the PFSH)	**Detailed** 99343, 99349 99221, 99233
Extended (4 or more elements)	Complete (system directly related to problem identified in HPI plus all additional systems or a minimum of 10 systems)	Complete (2 or all 3 of the PFSH depending on E&M category)	**Comprehensive** 99344, 99345, 99350 99222, 99223

*To qualify for a given level of history, **all 3 elements** in the history table must be met

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#2: Documentation of Exam (1995 DG)

Body Areas

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

Organ Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/ immunologic

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Documentation of Exam

Problem Focused 99231, 99341, 99347	A limited exam of the affected body area or organ system (1+BA/OS)
Expanded Problem Focused 99232, 99342, 99348	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/systems(s) (2-7 BA/OS)
Detailed 99233, 99221, 99343, 99349	An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) (2-7 BA/OS)
Comprehensive 99222, 99223 99344, 99345, 99350	General multi-system (8+ OS) or complete single organ system exam

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#3 Medical Decision Making (2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests and/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or possible management options

Each variable can be one of four levels: from minimal to low to moderate to extensive/high

Number of Diagnosis/Management Options

Number of Diagnosis/Management Options	#	x Points	= total
Self limited or minor (stable, improved or worsening) – Maximum of 2 points in this category		1	
Established problem (to examining M.D.); stable or improved		1	
Established problem (to examining M.D.); worsening.		2	
New problem (to examining M.D.); no additional work up planned – maximum of 1 in this category		3	
New problem (to examining M.D.); additional work up planned (e.g., tests, admit/transfer)		4	
Total			

Legend for #Dx and Amt of Data:
Straightforward = 1 pt
Low = 2 pts
Moderate = 3 pts
High = 4 pts

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Amount/Complexity of Data

Amount and/or Complexity of Data Reviewed	Points
Review and/or order clinical lab tests (regardless of number ordered)	1
Review and/or order tests in the radiology section of CPT (nuclear medicine and all imaging except echocardiography and cardiac cath)	1
Review and/or order of tests in the medicine section of CPT (EEG, EKG, echocardiography, cardiac cath, non-invasive studies, pulmonary function studies)	1
Discussion of tests results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Independent review of image, tracing or specimen (not simply review of report)	2
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion with other healthcare provider	2
Total	

Legend for #Dx and Amt of Data:
Straightforward = 1 pt
Low = 2 pts
Moderate = 3 pts
High = 4 pts

Table of Risk

Level of Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
Minimal **Level I - II**	* One self-limited problem, e.g., cold, insect bite, tinea corporis	* Lab tests requiring venipuncture * Chest X-rays * Urinalysis * Ultrasound [e.g., echocardiography] * KOH prep	* Rest * Gargles * Elastic Bandages * Superficial Dressings
Low **Level III**	* Two or more self-limited or minor problems * One stable chronic illness [e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH] * Acute uncomplicated illness or injury [e.g., cystitis, allergic rhinitis, simple sprain	* Physiologic tests not under stress [e.g., pulmonary function tests] * Non-cardiovascular imaging studies with contrast [e.g., barium enema] * Superficial needle biopsies * Clinical lab tests requiring arterial puncture * Skin biopsies	* Over-the-counter drugs * Minor surgery with no identified risk factors * Physical therapy * Occupational therapy * IV fluids without additives
Moderate **Level IV**	* One or more chronic illnesses with mild exacerbation, progression or side effects of treatment * Two or more stable chronic illnesses * Undiagnosed new problem with uncertain prognosis [e.g., lump in breast] * Acute illness with systemic symptoms [e.g., pyelonephritis, pneumonitis, colitis] * Acute uncomplicated injury [e.g., head injury with brief loss of consciousness]	* Physiologic tests under stress [e.g., 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 [e.g., arteriogram, cardiac catheterization] * Obtain fluid from body cavity [e.g., 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 **Level V**	* One or more chronic illnesses with severe exacerbation, progression or side effects of treatment * Acute or chronic illnesses or injuries that may pose a threat to life or bodily function [e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure * An abrupt change in neurologic status [e.g., seizure, TIA, weakness or sensory loss]	* Cardiovascular imaging studies with contrast with identified risk factors * Cardiac electrophysiologic tests * Diagnostic electrophysiologic tests * Diagnostic endoscopies with identified risk factors * Discography	* Elective major surgery [open, percutaneous or endoscopic] with identified risk factors * Emergency major surgery [open, percutaneous 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

The one criteria with the highest degree of risk, is the overall risk for the patient.

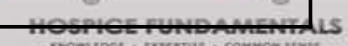

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Table of Risk, excerpted

Level of Risk	Presenting Problems	Management Options Selected
Moderate **Level IV**	* One or more chronic illnesses with mild exacerbation, progression or side effects of treatment * Two or more stable chronic illnesses * Undiagnosed new problem with uncertain prognosis [e.g., lump in breast] * Acute illness with systemic symptoms [e.g., pyelonephritis, pneumonitis, colitis] * Acute uncomplicated injury [e.g., head injury with brief loss of consciousness]	* 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 **Level V**	* One or more chronic illnesses with severe exacerbation, progression or side effects of treatment * Acute or chronic illnesses or injuries that may pose a threat to life or bodily function [e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure * An abrupt change in neurologic status [e.g., seizure, TIA, weakness or sensory loss]	* Elective major surgery [open, percutaneous or endoscopic] with identified risk factors * Emergency major surgery [open, percutaneous 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

The one criteria with the highest degree of risk, is the overall risk for the patient

Determining MDM

Putting these elements together:

Medical Decision Making Elements	**Straight-forward**	**Low**	**Moderate**	**High**
Number of Diagnoses or Management Options	< 1	2	3	4 or more
Amount and Complexity of Data	< 1	2	3	4 or more
Overall Risk	Minimal	Low	Moderate	High

MDM: ______________________________

Two out of three elements of medical decision making (2 of the 3 tables) must meet or exceed to qualify for a given level of MDM.

Which equates to from an MDM perspective:

Straightforward	99341, 99201/2, 99212
Low	99221, 99231, 99342, 99348
Moderate	99222, 99232, 99344, 99349
High	99223, 99233, 99345, 99350

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Sample Patient – Visit 1

- A new patient is evaluated for intractable pain. A CXR and lab results from a previous hospital admission are reviewed. History is obtained from the husband and the decision is made to start the patient on IV morphine.
  - # of diagnoses and management options = 3 or moderate
    (new problem to examining MD; no additional work up planned)
  - Amount and complexity of data = 4 or high
    (review lab and CXR; obtain history from someone other than the patient)
  - Level of risk = 4 or high
    (parenteral controlled substance)

Level of MDM = High

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Sample Patient – Visit 2

- A follow up visit is made and the patient's pain is now controlled but she has new onset of nausea and vomiting. There is no data reviewed during this visit. The decision is made to titrate the IV morphine.
  - # of diagnoses and management options = 4 or high
    (1 stable problem; new problem to examining MD; no additional work up planned)
  - Amount and complexity of data = 0
  - Level of risk = 4 or high
    (parenteral controlled substance)

Level of MDM = High

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Sample Patient – Visit 3

- A follow up visit is made and the patient's pain continues to be controlled; nausea and vomiting is now resolved. The nurse reports that no PRNs were required overnight. The amount of IV morphine administered over the past 24 hours is reviewed and the decision is made to keep the dosage the same.
  - # of diagnoses and management options = 2 or low
    (2 stable or controlled problems)
  - Amount and complexity of data = 2 or low
    (history obtained from someone other than the patient)
  - Level of risk = 4 or high
    (parenteral controlled substance)

Level of MDM = Low

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Let's discuss the E&M documentation requirements for choosing the code based on time…

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What the E&M Documentation Guidelines say about Time

"The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E&M services. An exception to this rule is the case of visits which consists predominantly of counseling and/or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E&M service."

E&M Documentation Guidelines and Time

"In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E&M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the records should describe the counseling and/or activities to coordinate care."*

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Counseling and/or Coordination of Care

- The physician need not complete a history and exam to select the level of service. The time spent in counseling and/or coordination of care and medical decision making will determine the level of service billed
- Code selection based on total time of face-to-face or (in the inpatient setting) floor time, not just the counseling time
- Medical record must be documented in sufficient detail to justify the selection of the specific code
  - The reasonable person standard

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Counseling and/or Coordination of Care Office/Outpatient

- Face-to-face time refers to patient time with the physician only
  - Counseling by other staff does not count.
- Time spent after you leave the patient does not count.
- Duration of counseling and/or coordination of care may be estimated but must be recorded
- Total duration of the visit also documented

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Counseling and/or Coordination of Care – Inpatient Setting

- Counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor/unit
- Time spent in counseling and/or coordination of care after the physician has left the floor or begun care for another patient does not count
- Duration of counseling and/or coordination of care may be estimated, but must be recorded
- Total duration of the visit also documented

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Examples of Documenting Time

- Discussing a patient's diagnosis, treatment plan and prognosis with a patient/family members/caregivers
- Reviewing and discussing a patient's medication indications, dosages and interactions
- Discussing plan and reasons for admitting the patient to a facility

Remember, these discussions must be medically necessary.

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Initial Hospital Care

Code	History	Physical Exam	Decision Complexity *	Counseling/ Coordination of Care – Visit Time
99221 Detailed Hx & Exam	CC; HPI (4+); ROS (2-9); PFSH (1:3)	Extended exam 2-7 Body areas/Organ systems in more detail	Straightforward or low	30 minutes
99222 Comprehensive Hx & Exam	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l Multisystem 8+ Organ Systems	Moderate	50 minutes
99223 Comprehensive Hx & Exam	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l Multisystem 8+ Organ Systems	High	70 minutes

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Subsequent Hospital Visits

Code	History	Physical Exam [3]	Decision Complexity [1]	Counseling/ Coordination of Care – Visit Time[2]
99231 Problem Focused Hx & Exam	CC; HPI (1-3)	Limited exam of 1+ Body Areas/Organ Systems	Straightforward or low	15 minutes
99232 Expanded Problem Focused Interval Hx & Exam	CC; HPI (1-3); ROS (1)	Limited exam of 2-7 Body Areas/Organ Systems	Moderate	25 minutes
99233 Detailed Interval Hx & Exam	CC; HPI (4+); ROS (2-9);	Extended exam 2-7 Body areas/Organ systems in more detail	High	35 minutes

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Office/Clinic Visits as of 1/1/2021

Biggest E/M CPT® Changes in >20 Years

- Only office or other outpatient visits are impacted
  - 99202- 99205
  - 99212-99215

    Just these 8 codes
  - Consultations, Hospital, SNF/NF, Home, ALF Visits are not included in these code changes
    - 3 Key Components continue to determine code selection for now
- Level of service is now chosen based on time or medical decision making
    - How time is computed changed dramatically
    - Determining medical decision making is more definitive
    - Medically appropriate history and/or physical exam

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What has and hasn't changed

- All medical necessity requirements remain in place whether choosing 99202-99215 based on time or medical decision making.
  - The documented Chief Complaint/Reason for Today's Visit and the narrative History of Present Illness (HPI) will set the stage for determining the complexity of MDM.
- Rules for modifiers (e.g., -25) have not changed
  - Office visit plus Advanced Care Planning
- Previously nebulous terms such as "stable chronic illness," or when a "problem" can be counted in determining MDM are now defined.

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Time Based Office Visits

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Time: Countable Activities

Physician/other qualified health care professional time includes the following activities, **<u>when performed on the date of the OV:</u>** [emphasis added]

- 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
  - But only on the date of the visit
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Time: Office Visits in 2021

E/M Code	2021 Time
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99211	N/A (no time listed)
99212	10-19
99213	20-29
99214	30-39
99215	40-54

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Documenting Time Spent

- It is reasonable to require documentation of the actual activities and the total amount of time spent.
- We do not recommend use of an all-encompassing macro that memorializes activities that may be counted towards time whether all of them were actually performed.

Sample: *A total of 35 minutes was spent on this visit, reviewing previous note and outside cardiology notes, counseling the patient on the importance of compliance with medications, and documenting the findings in the EMR.*

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Well Documented 99205 – *Is it bullet proof?*

“70 minutes spent preparing to see the patient, reviewing external medical records, performing a medically appropriate examination and/or evaluation, counseling and educating the patient regarding above, ordering tests, coordinating care, answering patient's questions, and documenting clinical information in the electronic record.”

  – Complex case, multiple problems, COVID-19 reaction to vaccine, multiple issues preventing starting preferred drug treatment, etc.

- Except….”performing a medically appropriate examination and/or evaluation,,”
  – Which was it? Performing the exam AND evaluating the patient?
    Just examining the patient?
    Only evaluating the patient but no exam?

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Well Documented 99215 – *Is it bullet proof?*

Yes, yes it is.

"Spent 45 minutes with the patient today reviewing outside radiographs, reviewing recent laboratory results, examining the patient, counseling, discussing, reviewing treatment plans together and making sure that she verbalized her understanding given that instructions had to be translated in Spanish."

- Patient specific
- Overall note shows progression of the patient's chronic conditions, complexity of MDM, and the impact of SDoH:
  "s/p Prolia sq 10/2017 but too costly for pt. Fall precautions reviewed. Cont with ca/vit d. She cannot afford any parenteral meds. "

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Coding Office Visits on Medical Decision Making

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Complexity of Medical Decision Making

3 Elements -2021 Office/Other OP Visits

1. Number and Complexity of Problems Addressed
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Risk of Complications and/or Morbidity and Mortality of Patient Management

2:3 Elements of MDM must meet or exceed to qualify for a given level of service.

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MDM Definitions

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

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Element #1. Number and Complexity of Problems Addressed

- ***Stable, chronic illness:*** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia. [emphasis added]

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Element #2. Amount and/or Complexity of Data to be Reviewed and Analyzed

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- Confusion existed as to what tests could/could not be counted towards the Data element if you performed the test and billed for it.
  - As of 3/9/21: tests without a professional component can be included in Element 2/Amount and/or complexity of data
    - Clinical lab

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Element #3: Risk of Complications and/or Morbidity and Mortality of Patient Management

MODERATE RISK

- Prescription drug management
- Decision regarding minor surgery w/identified pt. or procedure risk factors
- Decision regarding ele[...] surgery w/o identified [...] risk factors
- Diagnosis or treatmen[...] impacted by social det[...] health.

HIGH RISK

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding elective major surgery [...]rocedure risk factors
- [...]emergency major
- [...]ospitalization
- [...]scitate or to de-[...]se of poor prognosis.

Low Risk (L3): *"Low risk of morbidity from additional diagnostic testing or treatment."*
That's it….no examples.
OTC?
PT/OT?
Order MRI?

Element #1: *Number/Complexity of Problems Addressed*

- **Level 3**
  - 2+ self-limited or minor problems
  - 1 stable chronic illness
  - 1 acute uncomplicated illness or injury

- **Level 4**
  - 1+ Chronic illness w/ exacerbation, progression, or side effects of treatment
  - 2+ Stable chronic illnesses
  - 1 Undiagnosed new problem w/ uncertain prognosis
  - 1 Acute illness w/ systemic symptoms
  - 1 Acute complicated injury

- **Level 5**
  - 1+ Chronic illnesses w/ severe exacerbation, progression, or side effects of treatment
  - 1 Acute or chronic illness or injury that poses a threat to life or bodily function

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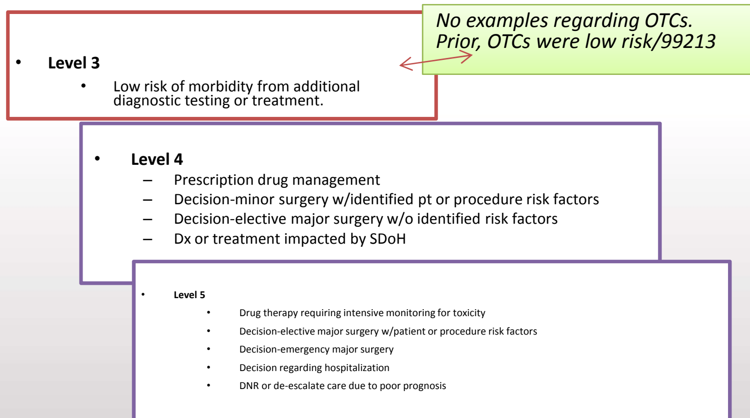
Element #3: *Risk of Patient Management*



Clinical Example of the 3 Elements

1. #/Complexity of the Problems Addressed
   – Doing well. No joint pain or swelling. Tolerating meds
2. Amount/Complexity of the Data to be Reviewed/Analyzed
   – Plan Orders: CRP, Sed Rate, CBC w/diff, CMP
3. Risk of Complications of Patient Management
   – Included in the Plan: Methotrexate 15 mg (6 tabs) weekly, folic acid 1 mg daily,

1 stable chronic illness: Low/99213

3 Unique tests: Moderate/99214

Rx Mgmt: Moderate/99214

What code level do you think this is and why?

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Example of the 3 Elements

1. #/Complexity of the Problems Addressec
   - COPD still with shortness of breath
2. Amount/Complexity of the Data to be Rev
   Analyzed
   - None
3. Risk of Complications of Patient Managem
   - Continue bronchodilator and O2 as needed

1 unstable stable chronic illness: Moderate/99214

0 data: Minimal/99212

Rx Mgmt: Moderate/99214

What code level do you think this is and why?

Example of the 3 Elements

1. #/Complexity of the Problems Addressed
   - Osteoporosis will be treated now that BMD has reduced significantly and FRAX is elevated
2. Amount/Complexity of the Data to be Reviewed/
   Analyzed
   - Bone density. Reviewed Vitamin D level and calcium level
3. Risk of Complications of Patient Management
   - continue calcium and vitamin D 2000 IU per day
   - restart Prolia w/rheumatologist

1+ unstable chronic illness: Moderate/99214

3 tests ordered: Moderate/99214

Rx management: Moderate/99214

What code level do you think this is and why?

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2021 E/M Practically Speaking

- Chief complaint/reason for the visit still required
- A descriptive HPI is more important than ever
  - Best way for an objective reader to determine if acute, stable chronic, unstable chronic, chronic w/sever exacerbation/progression, etc.
- Cloning and Copy & Pasting remains a risk area
  - If carrying forward, must ensure what you did "today" is unequivocal
- To support the complexity of MDM, a good narrative is critical for proper coding

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Remember….

- Only Office/Other Outpatient E/M services impacted by these changes:
  - Choose the level of E/M service based solely on MDM or time.
    - Your choice
    - Only a "clinically appropriate" history and/or exam will be expected
    - Applies only to 99202-99205 and 99212-99215
      - Just these 8 codes
    - 99201 is deleted and 99211 is not impacted
    - All payers – not just Medicare
    - Effective January 1, 2021
  - The 1995 and 1997 E/M Documentation Guidelines remain in place for all other consultation and E/M codes.
    - For now!

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Key References

AMA's CPT E/M OV Guidelines, revised 03/09/21

- www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

CMS's E/M Services Guide; revised February 2021

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

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Advanced Care Planning

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Advance Care Planning Defined

Codes 99497, 99498 are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and 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 his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will and Medical Orders for Life-Sustaining Treatment (MOLST)

*AMA – *CPT® Changes 2017*

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Advance Care Planning (ACP) - the Codes

CPT® Code	Description
99497 Medicare allowable ~$89 OP	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
+99498 Medicare allowable ~$77 OP	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Codes 99497 and 99498 are time-based codes with code 99497 reported for the first 30 minutes and add-on code 99498 reported for each additional 30 minutes but only if a total of more than 45 minutes is spent.

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CPT® on "Time"

- "A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed."*
- The above only applies where no code-range-specific instructions exist.
  - For example, CPT® instructions for E&M coding tell us to only choose a level of service if the "typical time" associated with an E&M code has been met or exceeded.

**CPT® 2020 Introduction*

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ACP Services Guidelines

- There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. When the service is billed multiple times for a given beneficiary, a change in the beneficiary's health status and/or wishes regarding his or her end-of-life care should be documented. [emphasis added]
- There are no place of service limitations on the ACP codes.
- Only physicians and NPPs may report CPT codes 99497 or 99498.
- CPT codes 99497 and 99498 can only be reported for time spent with the beneficiary, family members, and/or surrogate. If the beneficiary is not present, you should document that the beneficiary is impaired and unable to participate effectively and that ACP was instead conducted face-to-face with family or other legal surrogate(s).
- ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services. The beneficiary should be notified that Part B cost sharing will apply as it does for other physicians' services

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ACP Documentation

Examples of appropriate documentation would include:
- An account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter;
- Documentation indicating the explanation of advance directives (along with completion of those forms, when performed);
- Who was present; and
- The time spent in the face-to-face encounter.

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Billing for ACP Services

- Time spent in ACP cannot also be counted towards time spent in C/CC during the same encounter.
- CPT codes 99497 and 99498 **may** be billed on the same day or a different day as most other E&M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods. Some MACs may require modifier -25 be appended to the E&M code when billed with an ACP code.
- No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary.
- The usual Part B deductible and coinsurance apply except when ACP is furnished as an optional element of the AWV (Annual Wellness Visit).

Modifier -25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

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ACP in Summary

- Two CPT time-based codes
  - 99497 for the 1st 30 minutes
    - 16 or more minutes face-to-face
  - 99498 for each additional 30 minutes
    - A total of 46 minutes or more for 99498 to be reported in addition to 99497
  - Only Face-to-face service time counts
  - May be reported in addition to other visit codes as ACP does not include any treatment or medical management
    - Modifier -25
- May be provided by a physician or other qualified health care professional
  - Nurse practitioner, physician assistant, clinical nurse specialist
  - The service must be medically necessary.

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ACP During the COVID-19 PHE

- Advance Care Planning codes are on the current list of payable Telehealth services.
- Bill with modifier -95 when provided via telehealth
- Telehealth requirement updated 4/30/20 to allow audio only
- No requirement to do so, but best practice…
  - Document method of service delivery
    - "Patient unable to use audio/video application, discussion held via audio only telephone with……"
    - "Advance care planning discussion via (FaceTime) (Skype) (Zoom) (other)….with….."

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