

Quality, Payments – Internal Reviews
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2021 E/M Changes –
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Introduction

- ▶ Electronic Health Records (EHRs) have impacted the ways clinicians document and often results in "note bloat" and reduces the usefulness of encounter documents to effectively communicate the care provided, the patient's response to care and care planning/changes
- ▶ Quality of care has always been a discussion; however, the system is moving toward paying for quality
- ▶ This is NOT the first attempt to change E/M coding rules....1995...1997

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Impacts to compliance and audit function

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COMPLIANCE OFFICER, ADULT ENTERPRISE

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Why do we have medical record documentation?

- ▶ Support clinical care
 - ▶ Should be clear and concise
 - ▶ Report the care provided chronologically
 - ▶ Report pertinent facts, findings and observations
 - ▶ Assists in treating the patient's immediate needs as well as providing care over time (continuity of care)
- ▶ Support Billed Services
- ▶ Support Research Endeavors

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What do we really have with medical record documentation?

- ▶ Lots of clicks and templated phrases – many of which cause errors in documentation
- ▶ Note Bloat
- ▶ Clinicians who document to meet coding requirements
- ▶ Notes that do not support patient care or continuity of care for various providers and specialties
- ▶ Teaching Physician Rules and EHR Templates

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Effective Compliance Programs

1. Implementing written policies, procedures and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. **Conducting internal monitoring and auditing**
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

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How are
outpatient
(clinic)
encounters
coded?

Clinician-Coded?

Professionally-Coded?

Mix?

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E/M Audits /PROFESSIONAL CODING ACTIVIITES Today

- ▶ Focus on reading the documentation from the clinician to support
 - ▶ E/M Level Billing
 - ▶ History
 - ▶ Exam
 - ▶ Medical Decision Making (MDM)
 - ▶ Time can be used for largely counseling and/or coordination of care
 - ▶ CPT Billing
 - ▶ ICD-10 Diagnosis Coding

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E/M Coding - Today

- ▶ 5 levels of E/M Office/Outpatient Visits with payments increasing with each level
- ▶ Code set regarding as clinically outdated; not reflecting patient complexity and care
- ▶ Documentation is to support the code, not necessarily facilitate good patient care
 - ▶ With EHR copy/paste/templates there is an increase in volume in many notes but often not substance to facilitate patient care

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Remainder of 2020

- ▶ For Outpatient (clinic) E/M coding – things stay the same
- ▶ We plan to continue auditing and educating our clinicians and helping them improve their documentation, coding and billing
- ▶ 2021 Lots of Changes are Coming...

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E/M Coding – New (2021)

- ▶ Established patient visits, when relevant information exists in the medical record, the documentation can focus on changes since the last visit or pertinent items with no change and no requirement to re-record the list of required elements if there is evidence the practitioner reviewed the previous information and updated as needed
- ▶ New and established visits no longer require re-entry of the chief complaint and history entered by ancillary staff or the patient
- ▶ Remove potentially duplicative requirements that may have been entered by Residents or other members of the medical team

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MPFS2020: Payment for Evaluation and Management Visits

Background: CMS recently announced substantial changes to requirements for new and established E/M visits in office and outpatient settings. Revised approach to take effect on 1/1/2021. Expected to reduce clinician burden and be more consistent with current practice.

Current State: Level determined by 3 components: 1) history; 2) exam; and 3) MDM. Clinicians may use 1995 or 1997 version of E/M Documentation Guidelines.

Future State: Level based on one of two elements: 1) total time; OR 2) level of MDM. 1995/1997 Guidelines no longer apply to E/M office and outpatient visits.

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MPFS2020: Payment for E/M Visits

Option 1: Time

Includes face-to-face and non-face-to-face time personally spent by the clinician on day of encounter, including time spent:

- Preparing to see patient (e.g., review of tests)
- Obtaining/reviewing separately obtained history
- Performing medically appropriate exam/evaluation
- Counseling and educating
- Ordering meds, tests, or procedures
- Referring/communicating with other health care professionals
- Documenting clinical info
- Interpreting results
- Care coordination

OFFICE OF OTHER OUTPATIENT VISITS: NEW PATIENTS

| Code | Time (min) | MDM |
|-------|------------|-----------------|
| 99202 | 15-29 | Straightforward |
| 99203 | 30-44 | Low |
| 99204 | 45-59 | Moderate |
| 99205 | 60-74 | High |
| 99XXX | 75+ | High |

OFFICE OF OTHER OUTPATIENT VISITS: ESTABLISHED PATIENTS

| Code | Time (min) | MDM |
|-------|------------------------------|-------------------------------|
| 99211 | MD/APP presence not required | Presenting problem is minimal |
| 99212 | 10-19 | Straightforward |
| 99213 | 20-29 | Low |
| 99214 | 30-39 | Moderate |
| 99215 | 40-54 | High |
| 99XXX | 55+ | High |

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MPFS2020: Payment for E/M Visits

Option 2: MDM

Includes establishing diagnoses, assessing status of condition, and/or selecting management option.

- Four levels of MDM: 1) straightforward; 2) low; 3) moderate; and 4) high.
- Appropriate level defined by:
 1. Number and complexity of problems addressed during encounter
 2. Amount and/or complexity of data to be reviewed and analyzed (i.e., medical records, tests)
 3. Risk of complications, morbidity, and/or mortality of patient management decisions made at visit

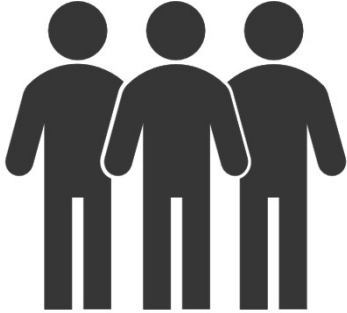
| Code | MDM | Problem Complexity | Data Complexity | Risk of Complications |
|----------------|-----------------|--------------------|-----------------|-----------------------|
| 99211 | N/A | N/A | N/A | N/A |
| 99202 99212 | Straightforward | Minimal | Minimal or none | Minimal |
| 99203 99213 | Low | Low | Limited | Low |
| 99204 99214 | Moderate | Moderate | Moderate | Moderate |
| 99205 99215 | High | High | Extensive | High |

Note: To qualify for a particular level of MDM, two of three elements for that level of MDM must be met or exceeded.

Additional Resources: [Level of Medical Decision Making Table](#) and [AMA E/M Guidelines](#).

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Compliance Team Focus



- ▶ Policy Development
 - ▶ What do we as an organization expect of the documentation in our medical records?
- ▶ Educate, Educate, Educate
 - ▶ What do these rule changes really mean?
 - ▶ How do we ensure patient care is the priority?

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Strategy
Today



Engage Physician
Leadership



Develop Training and
Educational Information



Assist with Template
Changes

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Change is Coming Be prepared

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Patients over Paperwork Initiative

**Preparing for 2021 CPT
Evaluation & Management Changes
Impacting
Documentation, Coding, & Clinical
Practice Workflows**

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Objectives today.....

- ▶ Discuss implementation of 2021 Evaluation and Management Guidance

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2021 CPT & CMS Final Rule

- ▶ E/M guidelines for new and established patients Only
 - ▶ 99202 - 99215
 - ▶ Removes the history and exam as a key component for coding purposes only!
- ▶ Code descriptor still includes: “which requires a medically appropriate history and/or exam”

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Read the CPT Code Descriptors

- ▶ Currently 99203 code descriptor includes the phrase “requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity.”
- ▶ In 2021, the descriptor for 99203 will instead state the code “requires a medically appropriate history and/or examination and low level of medical decision making.”

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2021 E/M Guideline Changes

- ▶ Time
 - ▶ Redefined from face-to-face time to total time spent on the DAY of the encounter
- ▶ CPT has also defined:
 - ▶ Total Time
 - ▶ Added a guideline for clarity when more than one provider is involved in the patients care

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Change in Training - Challenge!

Different guidelines will apply for documentation if you or your group provides care in settings other than office/outpatient. Documentation supports more than just the E/M code:

- ▶ MIPS reporting
- ▶ HCC coding
- ▶ Quality scores

Transitioning to these changes will be challenging!
Try and think of your documentation holistically



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Time Facts for 2021 E/M Outpatient

Time can be used to select a code level in office or other outpatient services **whether** counseling and/or coordination of care dominates the service. In other words face-to-face and non-face-to-face time the provider personally spent on the patients care.

When using time as the basis for choosing your E/M – Providers can now count the time they spend performing activities on the **DAY** of the patient encounter including:

- ▶ Updating clinical information
- ▶ Prep for visit – reviewing tests
- ▶ Performance of exam as appropriate
- ▶ Updating, ordering procedures, meds, tests, consults, etc.



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Proposed Time Chart 2021

Comparison for providers to consider when thinking about workflow and daily patient projections for 2021.

| E/M Code | Current typical time | 2021 Proposed time |
|----------|----------------------|--------------------|
| 99201 | 10 | N/A |
| 99202 | 20 | 15 - 29 |
| 99203 | 30 | 30 - 44 |
| 99204 | 45 | 45 - 59 |
| 99205 | 60 | 60 - 74 |
| 99211 | 5 | No time listed |
| 99212 | 10 | 10 - 19 |
| 99213 | 15 | 20 - 29 |
| 99214 | 25 | 30 - 39 |
| 99215 | 40 | 40 - 54 |

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Polling Question

Understanding how to track your time under the new 2021 E/M changes.

- ▶ Does Clinical Staff Time count towards the physician time for determining an E/M service?

YES or NO

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Using the NEW
MDM Table in
2021

Revision of MDM definitions

- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient management

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Number &
complexity of
Problems

- ▶ “Comorbidities/underlying diseases, in and of themselves are not considered in selection of a level of E/M services unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.”

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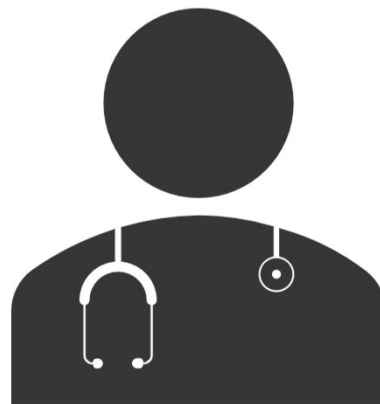
What's addressed mean?

- ▶ “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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Attention to Definitions

- ▶ Pay particular attention to the definitions included in the new MDM guidelines!
- ▶ The definitions for acute and chronic illnesses, will help you use the MDM table correctly.



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2021 Definitions Examples

- ▶ Independent historian (s):
- ▶ An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

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2021 Definitions Examples

- ▶ Independent Interpretation:
- ▶ The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.

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2021 Definitions Examples

- ▶ Risk:
- ▶ The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. Level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

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2021 Definitions

- ▶ **Determinants of Health:**
- ▶ Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- ▶ Coding in ICD-10-CM
 - ▶ **Z55-Z65**

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2021 Definitions

Drug Therapy – Intensive Monitoring - toxicity

- ▶ Adverse effects not therapeutic efficacy
- ▶ Generally accepted practice for the agent, but may be patient specific in some cases
- ▶ Long-term or short term monitoring
 - ▶ Long-term intensive monitoring is not less than quarterly
 - ▶ Monitoring: lab test, a physiologic test or imaging, does not mean monitoring by history or exam.

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Challenges or Roadblocks - Implementing 2021 Changes



Largest E/M guideline change since 1997

1995 & 1997 still in use for other E/M codes



EHR readiness



Communication internal/external

Payers



Resources

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Start preparation for changes now!

Consider using tools provided by the AMA!

Review your current office documentation practices

Will your current EHR E/M format need to be modified to accommodate the 2021 changes?

If EHR revisions are not made will provider time be increased?

EHR formats may need to be changed to meet the E/M format and not the insurance claim format.

• Without change – note bloat will continue and provider documentation time will not decrease

Assess for possible financial impacts

Update practice protocols

UPDATE YOUR COMPLIANCE & AUDITING PROTOCOLS & PLAN

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Sources

AMA

- ▶ <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

CMS

- ▶ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F>



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