SEE MORE PATIENTS MAKE MORE MONEY: TAKING ADVANTAGE OF THE NEW EVALUATION AND MANAGEMENT RULES

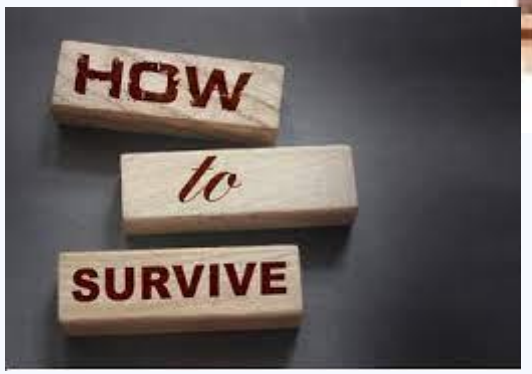
PRESENTED BY:

RENEE M. BROWN, ACS-EM, CHA, PRESIDENT

MEDICAL PRACTICE CONSULTANTS, INC.

405/848-8558

AUGUST 2023



AGENDA
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What are we going to learn about today?

2021 Evaluation & Management Codes

Why?

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DESCRIPTION , OBJECTIVES & SUBJECTS

Objectives

2021 brought new rules re: evaluation and management (E/M) CPT code services.

Physicians & providers can implement changes in their documentation practices to benefit from these changes.

Learn strategies that will allow you to spend more time with your patients as you lighten the administrative burden of documentation and coding while also protecting yourself from billing audits.

Additionally, a snapshot of the 2023 changes will also be presented.

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DESCRIPTION , OBJECTIVES & SUBJECTS

OBJECTIVES

- Discuss AMA's 2021 changes to clinical E/M codes and understand the benefits of proper E/M documentation Rules (2021)
- Identify opportunities to lighten the administrative burden by decreasing unnecessary documentation.
- Provide a snapshot of the 2023 changes to some of the outpatient E/M services.

DESCRIPTION , OBJECTIVES & SUBJECTS

Subjects

- Lighter documentation burden
- More time with patients
- No longer “bloating” of records
- Decrease unnecessary documentation.
- Reduce administrative burden of documentation & coding.

DESCRIPTION , OBJECTIVES & SUBJECTS

Subjects

- Reduce the need for audits.
- Protect yourself from audits
- Protect yourself from audits ‘Make it simple, practical and clinically relevant.”
- Stopped bullet system and changed to “Medically Appropriate” and “Medically Necessary

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….. **Just the Facts**

Evaluation & Management Rules Changed in 2021 for clinical codes

99202 - 99215

….. Just the Why

Because the AMA (American Medical Association) said so

Because the CMS (Centers of Medicare & Medicaid Services) said so

&

All other insurance plans had no other options

& It makes sense, if used correctly will make documentation easier.

FIRST DECISION
WHICH WAY DO YOU WANT TO GO?

There are two rules that will break or make the clinical CPT E/M code billed, and therefore determine if the appropriate code will be denied or paid that started on January 1, 2021.

- You can pick to bill based on time or based on MMM.

In an audit, it does not matter on a case-to-case basis which rule you use. But you must be able to prove that the physician performed one of the two options. It cannot be performed by anyone but the physician, and the time frame cannot be shared with any other provider.

LIGHTER DOCUMENTATION BURDEN

No more bullet counting!

If you want to spend time with your patient, you can spend more time with them, and bill based on time only.

If you want to perform key elements of the patient's history and exam, which needs to be relevant, that is up to you.

No more "bloat" in your records.

Decrease unnecessary documentation.

Reduce administrative burden of documentation & coding.

ESTABLISHED CPT CODE DESCRIPTORS - 2021

99211 –
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (NO Time)

99212 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter. (Straight Forward Complexity)

99213 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter. (Low Complexity)

ESTABLISHED CPT CODE DESCRIPTORS - 2021

99214 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. (Moderate Complexity)

99215 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (High Complexity)

Let's Understand The Time Documentation/Billing

Time Used Correctly

1. The organization must put systems in place if a "clock" system is used.
2. Verify with each new year if there have been changes in the CPT codes "time".
3. Take advantage of using time when it seems best; just understand other staff members may be billing as well.
4. AMA has further stated: It is important to remember that E/M codes can be based on time (Example: time supported the level 99214 = 30-39 minutes. If the time is supported the service passes.) However, to approve the time, you must verify that the billing provider performed the time based on the code requirements, and that another provider has not identified that they have performed services during the same time frame. If they do not personally perform the required time, the service is not approved.

Time Used Incorrectly

Example

(example: Dr. Smith said it took between 1300 – 1400 to take care of the patient, so 60 minutes. But another document states that a staff member performed another service on the same patient from 1330 – 1430. This would create a conflict for the time element of 1330- 1400. This would require the auditor to fail both services using time.

EXAMPLE USING TIME (E/M CODE 99214)

- "When billing outpatient E/M on the basis of time, the provider may now use the total time on the date of the patient encounter, not just the face-to-face time." This total time must be indicated in the medical record. Time spent on activities, for the date of encounter, can include:
  - Preparing to see the patient (e.g., review of tests, records)
  - Obtaining and/or reviewing a separately obtained history
  - Performing a medically necessary exam and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests or procedures
  - Referring and communicating with other healthcare professionals (when not reported separately)
  - Documenting clinical information in the electronic or paper health record
  - Independently interpreting results of tests/labs and communication of results to the family or caregiver
  - Care coordination (when not reported separately)

- NOTE: No other provider can claim they have performed a service during this time frame if they are part of the same group same specialty.

MMM AMA GUIDELINES
HISTORY AND/OR EXAMINATION

1. Office or other outpatient services include a medically appropriate history and/or physical examination, when performed.

2. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.

3. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.

4. The extent of history and physical examination is not an element in selection of office or other outpatient services.

M.M.M.
(ANOTHER NAME FOR MEDICAL NECESSITY)

Medically Appropriate* History	Medically Appropriate* Exam	Medical Decision Making
Reviewed, but not audited	**Reviewed, but not audited**	**AUDITED! Drives the Code Selection**

Medically appropriate means at the provider's discretion

Remember: Even though the history and exam won't count toward the E/M level, medical necessity dictates that providers will still have to perform a condition-appropriate history and exam for each patient they see. The 'counting of elements' or completing a template is no longer the focus.

Final Point To Consider

M.M.M. means the provider performed a history and/or exam that was appropriate in detail/content for the patient's presenting problem in their opinion. Even with the relaxed history and exam criteria, it still comes down to standard of care when evaluating and treating patients. If what's documented doesn't meet that standard of care, the provider hasn't met the code criteria.

These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care.

Select the appropriate level of E/M services based on the following two options:
1.) The level of the MMM as defined for each service, or
2.) The total time for E/M services performed on the date of the encounter.

Designed by:
Renee Brown, Owner and President
Medical Practice Consults, Inc.

Medical Decision Making Guide New & Established Patients Effective (1/1/2021)					
CPT Code	**Time Requirement (minutes)**	**Level of MDM (Based on 2 out of 3 Elements of MDM)**	**Number & Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	NA	**NA**	NA	NA	NA
99202 **99212**	15-29 10-19	**SF**	**Minimal** ·1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	30-44 20-29	**L**	**Low** ·2 or more self-limited or minor problems; or ·1 stable chronic illness; or ·1 acute, uncomplicated illness or injury	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** **·Any combination of 2 from the following:** ·Review of prior external note(s) from each unique source*; ·Review of the result(s) of each unique test*; ·Ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 **99214**	45-59 30-39	**M**	**Moderate** ·1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or ·2 or more stable chronic illnesses; or ·1 undiagnosed new problem with uncertain prognosis; or ·1 acute illness with systemic symptoms; or ·1 acute complicated injury	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** **·Any combination of 3 from the following:** ·Review of prior external note(s) from each unique source*; ·Review of the result(s) of each unique test*; ·Ordering of each unique test*; ·Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** ·Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** ·Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: ·Prescription drug management ·Decision regarding minor surgery with identified patient or procedure risk factors ·Decision regarding elective major surgery without identified patient or procedure risk factors ·Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	60-74 40-54	**H**	**High** ·1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or ·1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** **·Any combination of 3 from the following:** ·Review of prior external note(s) from each unique source*; ·Review of the result(s) of each unique test*; ·Ordering of each unique test*; ·Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** ·Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** ·Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: ·Drug therapy requiring intensive monitoring for toxicity ·Decision regarding elective major surgery with identified patient or procedure risk factors ·Decision regarding emergency major surgery ·Decision regarding hospitalization ·Decision not to resuscitate or to de-escalate care because of poor prognosis
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AMA 2023
CHANGES EVALUATION & MANAGEMENT
CPT CODES SNAPSHOT

Snapshot To Name A Few

Changes for the Evaluation and Management codes as they relate to Inpatient and/or Outpatient only. Things to be aware of:

1. Consolidation of inpatient and Observation E/M code when reporting 99221: Changes in coding & billing for services in observation – the place of service will be the status of the patient either inpatient or outpatient.
2. Inpatient E/M – Time reporting: Time is based on total time both face-to-face time and non face-to face
3. Consultation codes (99252 – 99255) are back in play. “For non-Medicare patients, if the consultation is done after the patient is admitted to the hospital, consultation services may be reported with the inpatient consultation codes (99251– 99255).”

AMA 2023
CHANGES EVALUATION & MANAGEMENT
CPT CODES SNAPSHOT

Snapshot To Name A Few

Changes for the Evaluation and Management codes as they relate to Inpatient and/or Outpatient only. Things to be aware of:

1. AMA stated to learn the rules for the following code sets that have significant changes: Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242- 99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350

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Presenter

Medical Practice Consultants, Inc.

Renee M. Brown, President

(405/848-8558)

renee@mpcinc.biz