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Welcome to PMI's Webinar Presentation:

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E&M Guideline and Legislative Updates: What Practices Need to Know

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E&M Updates

Guidelines & Legislative Updates for Medical Offices

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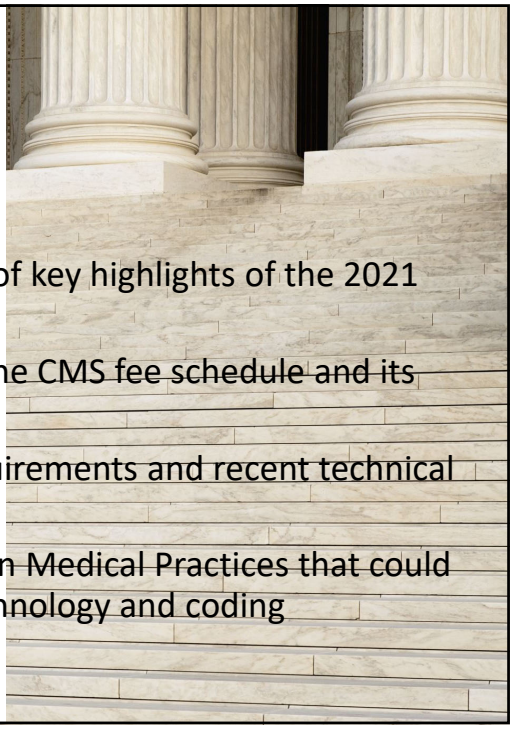
1

Learning Objectives



- Attendees will leave with an understanding of key highlights of the 2021 CMS PFS final rule
- Participants will be empowered to analyze the CMS fee schedule and its role in overall reimbursement oversight
- Explore Telehealth PHE Waivers, coding requirements and recent technical clarifications to CPT/HCPCS
- Identify strategies to analyze functions within Medical Practices that could be optimized based on new regulations, technology and coding clarifications

2

ABSTRACT

The 2021 CMS Final Physician Fee Schedule ushered in the most significant changes to the documentation of Evaluation and Management codes since 1997, RVU revaluations, significant reimbursement changes, telehealth billing changes and more.

Some changes are intended to last beyond the COVID Public Health Emergency (PHE) whereas others are projected to end when the PHE does.

This session will review the changes from the 2021 final rule.

3

Medicare Reimbursement Updates

4

2021 Conversion Factor

CONVERSION FACTOR (CF)					
2016	2017	2018	2019	2020	**2021**
$35.80	$35.89	$35.99	$36.04	$36.09	**$34.8931**
Increase	Increase	Increase	Increase	Increase	**DECREASE**

Anesthesia Conversion Factor	
2020	**2021**
$22.20	**$19.9631**

5

Medicare Physician Payment Formula

[(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF = Medicare Physician Payment

Work Relative Value Unit x Work Geographic Practice Cost Indices

+

Practice Expense Relative Value Unit x Practice Expense Geographic Practice Cost Indices

+

Malpractice Relative Value Unit x Malpractice Geographic Practice Cost Indices

x

Conversion Factor

÷

MIPS or AAPM

x

Sequestration

=

Medicare Physician Payment

6

CY 2021 Physician Fee Schedule Updates

- 3.75% overall reimbursement increase
- Reestablished the 1.0 floor on the work Geographic Practice Cost Index (GPCI) through 2023
- Suspended the 2% Sequestration cut through March 31, 2021
- Delayed institution until 2024 of G2211 Complexity Add on code for E/M Services

7

Sample Medicare Physician Fee Schedule (MPFS)

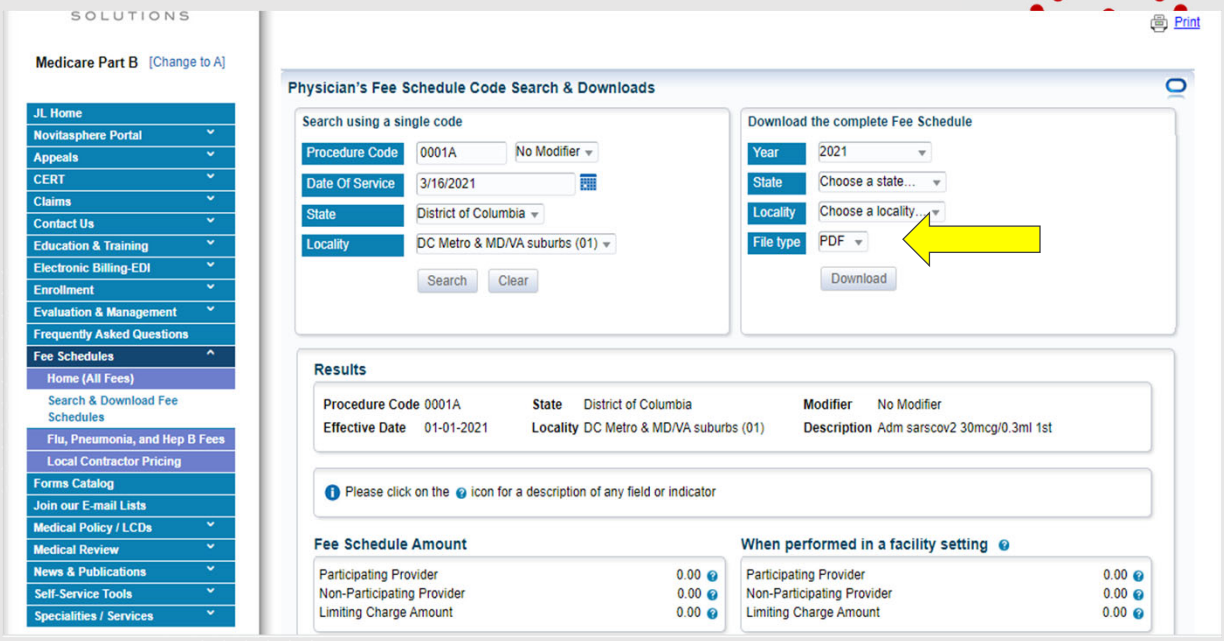
New patient	2018 Rate	2019 Rate	2020 Rate	2021 rate	Difference Between 2020 vs 2021
99201	$51.99	$47.70	$53.97	DELETED	
99202	$86.77	$79.38	$88.71	$79.99	($8.72)
99203	$124.43	$112.57	$124.97	$122.23	($2.74)
99204	$188.16	$170.64	$189.40	$182.60	($6.80)
99205	$236.10	$214.40	$238.67	$240.73	$2.06
Established patient	**2018 Rate**	**2019 Rate**	**2020 Rate**	**2021 rate**	**Difference Between 2020 vs 2021**
99211	$25.44	$23.69	$27.55	$26.20	($1.35)
99212	$51.11	$46.94	$53.53	$62.90	$9.37
99213	$83.92	$77.09	$87.12	$99.87	$12.75
99214	$123.44	$112.80	$125.75	$141.54	$15.79
99215	$166.00	$151.08	$168.31	$197.38	$29.07
	Source: Medicare Administrative Contractor – Novitas Solutions Jurisdiction L				

8

Obtaining your Locality for your CMS Jurisdiction

Locality #	State	Fee Schedule Area	Counties
01	DC	DC + MD/VA Suburbs	District of Columbia, Alexandria City, Arlington
01	MD	Baltimore / Surrounding Counties	Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard
99	MD	Rest of State	All Other Counties EXCEPT Montgomery and Prince George's

9



10

MIPS 2021 Program Changes

MIPS Measure Categories

- **Quality**: 40%
- **Improvement Activities**: 15%
- **Promoting Interoperability**: 25%
- **Cost**: 20%

Complex Patient Bonus = 5 points

www.qpp.cms.gov

11

MIPS Performance Measures

	2017	2018	2019	2020	2021
Performance Threshold Points (avoid penalty)	3	15	30	**45**	**60**
Except. Performance Threshold (bonus) points	70	70	75	**85**	**85**
Quality Category	60%	50%	45%	45%	40%
Cost Category	0	10%	15	15%	20%

12

MIPS APM 2021 Program Changes

MIPS APM Measure Categories

- **Quality**: 50%
- **Improvement Activities**: 20%
- **Promoting Interoperability**: 30%

www.qpp.cms.gov/apms/overview

13

Advanced Alternative Payment Models

Specialty Specific APMs	Accountable Care Organizations	Advanced Care Models
• Comprehensive Care for Joint Replacement • Comprehensive ESRD Care • Radiation Oncology Model (Effective 2022)	• Medicare Shared Savings Program (MSSP) Tracks 1-3 • Medicare Shared Savings Program (MSSP) Basic Track E & Enhanced Track • Next Generation ACO	• Comprehensive Primary Care Plus (CPC+) • Bundled Payments for Care Improvement (BPCI)

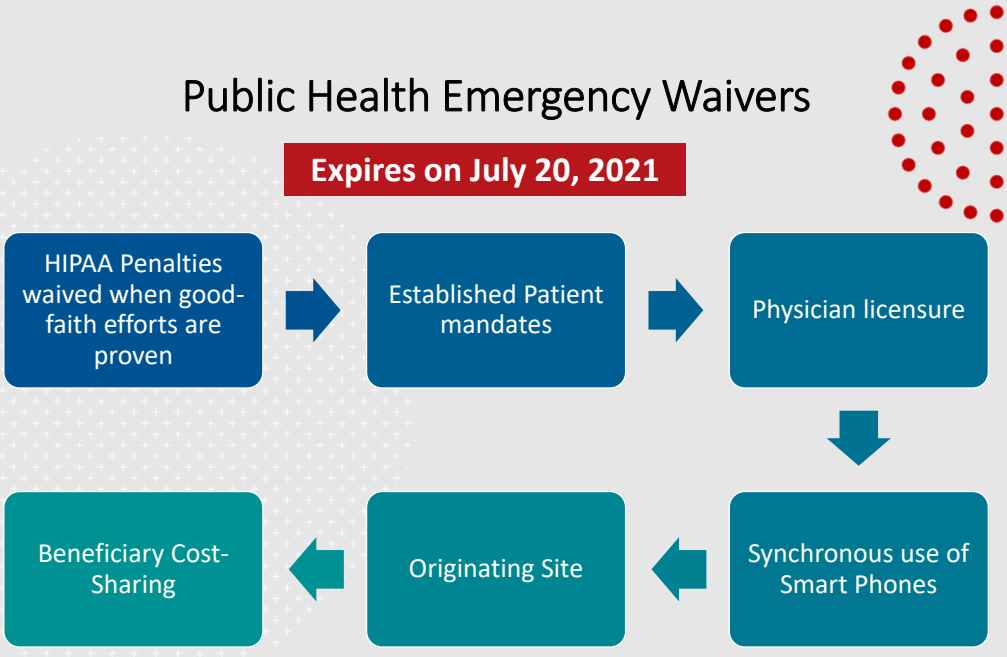
14

Key Legislative Updates

15

Public Health Emergency Waivers

Expires on July 20, 2021



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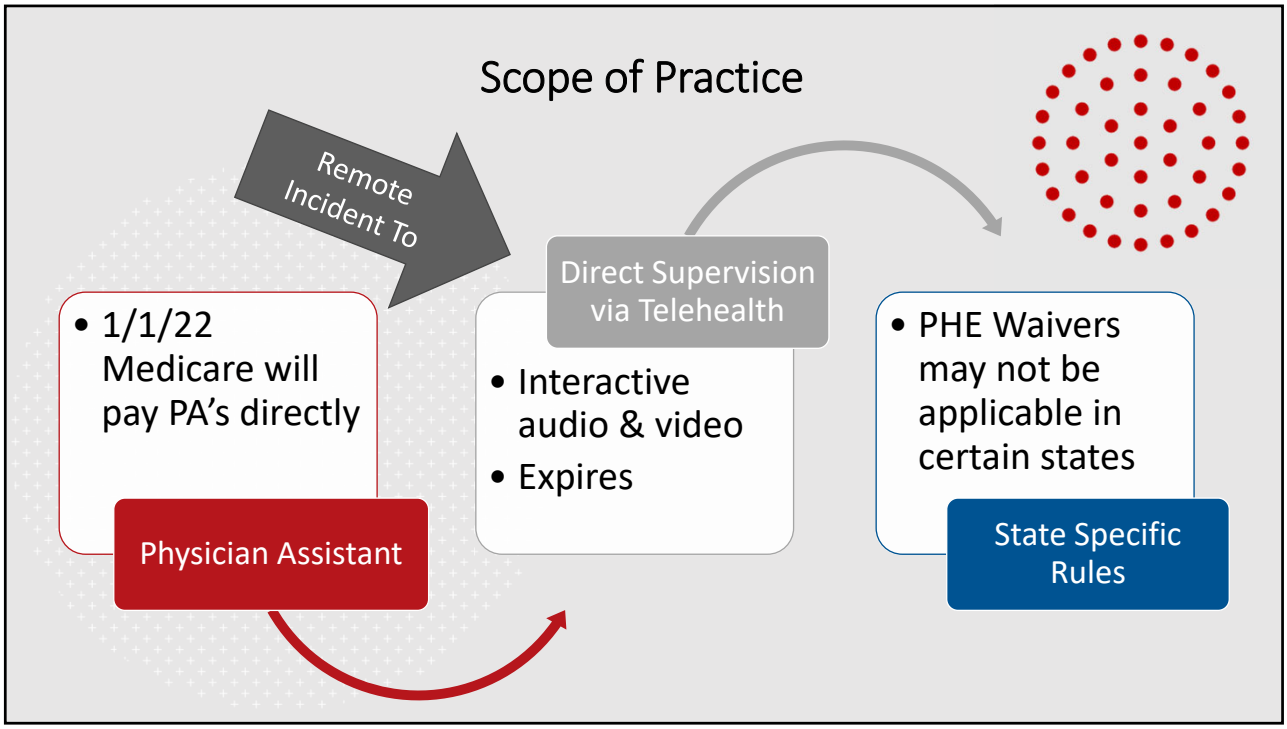
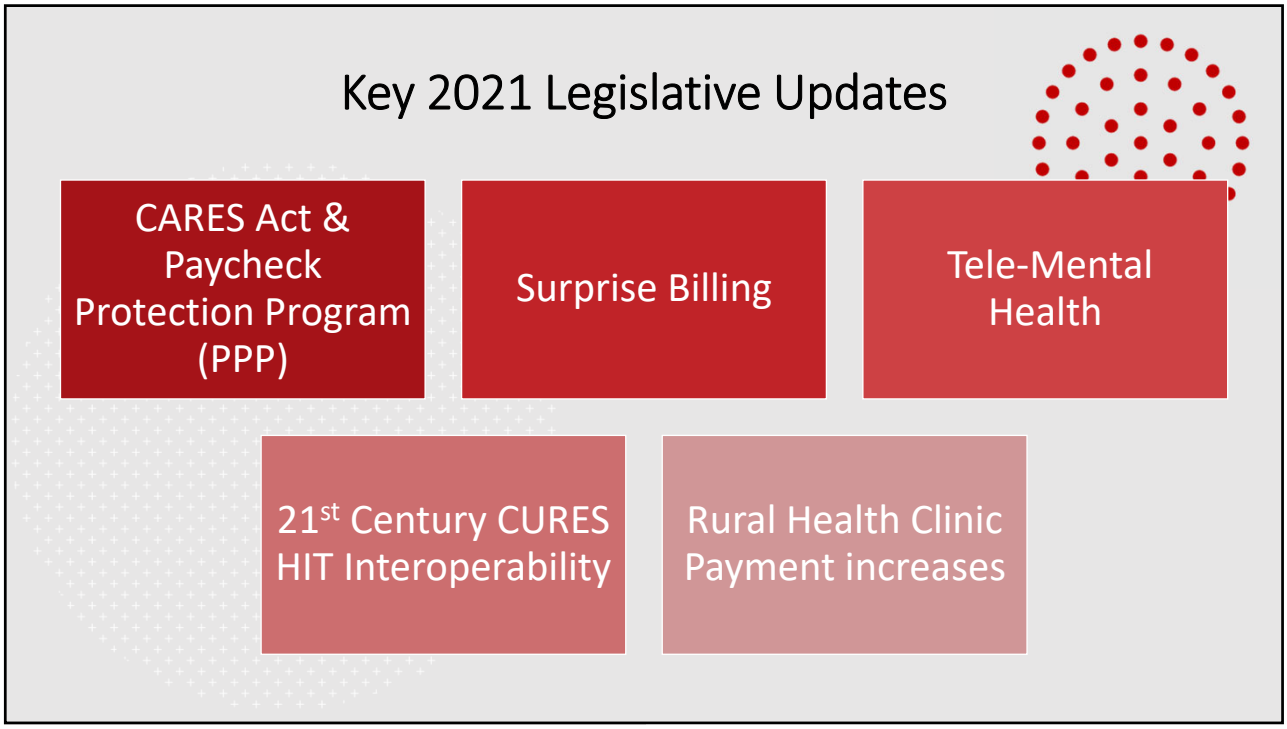
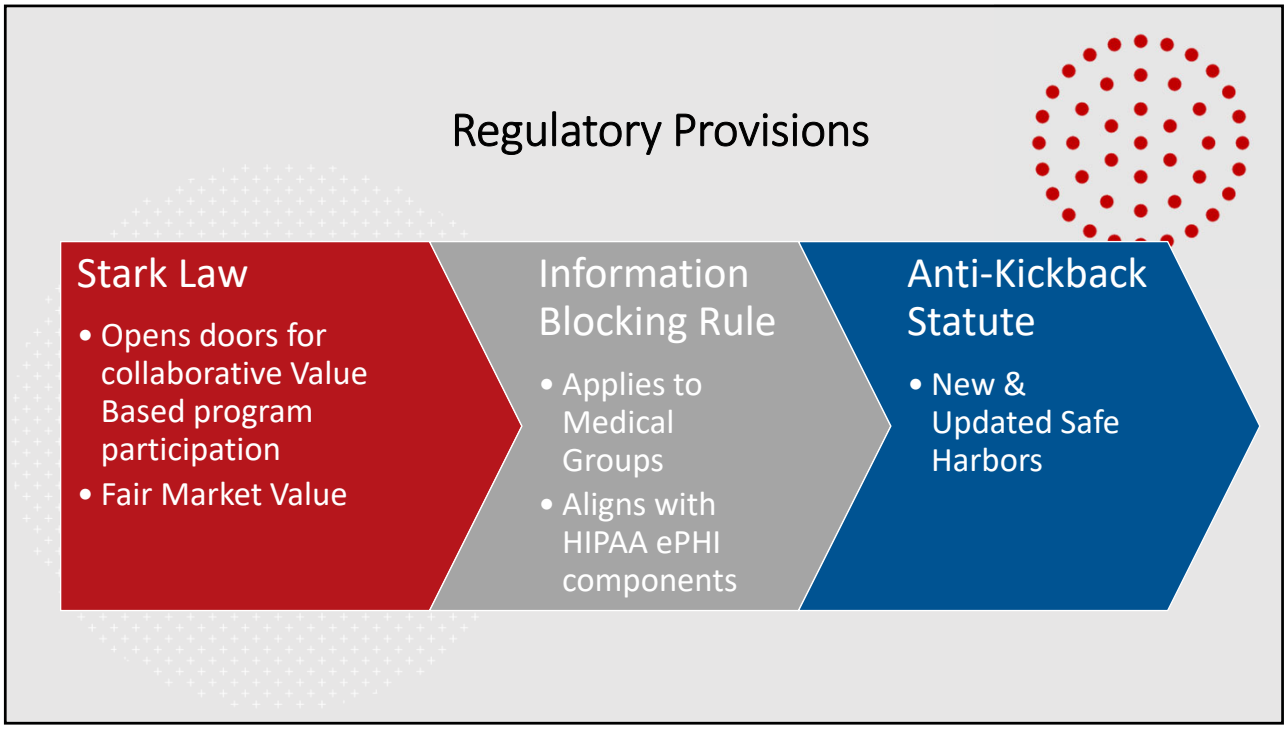

Scope of Practice
Remote Incident To
• 1/1/22 Medicare will pay PA's directly
Physician Assistant
Direct Supervision via Telehealth
• Interactive audio & video
• Expires
• PHE Waivers may not be applicable in certain states
State Specific Rules

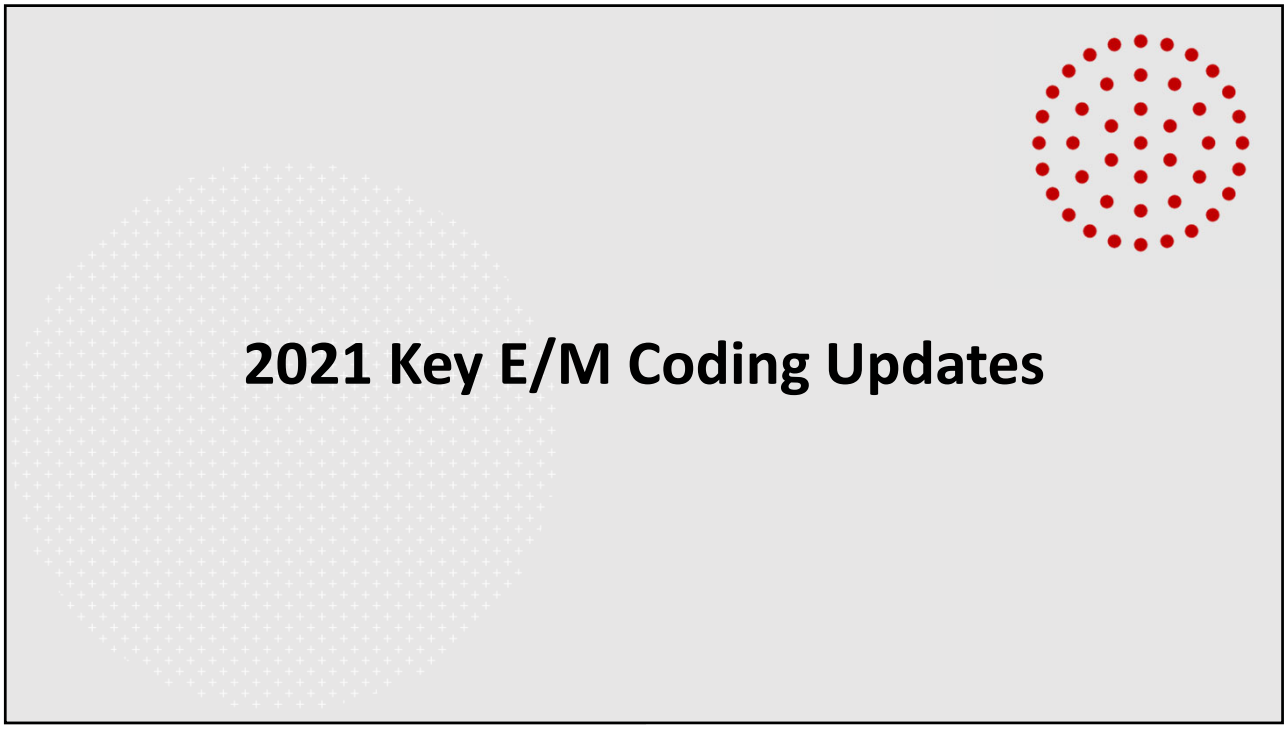
17


Key 2021 Legislative Updates
CARES Act & Paycheck Protection Program (PPP)
Surprise Billing
Tele-Mental Health
21st Century CURES HIT Interoperability
Rural Health Clinic Payment increases

18

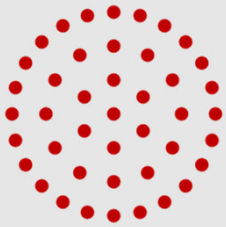

Regulatory Provisions
Stark Law
• Opens doors for collaborative Value Based program participation
• Fair Market Value
Information Blocking Rule
• Applies to Medical Groups
• Aligns with HIPAA ePHI components
Anti-Kickback Statute
• New & Updated Safe Harbors

19


2021 Key E/M Coding Updates

20

COVID-19 ICD-10-CM Codes



U07.1 – Confirmed Test for COVID-19

Pneumonia due to the coronavirus (COVID-19)

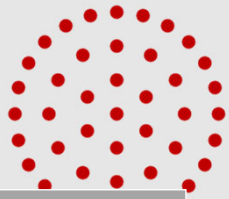
- Assign code **U07.1** confirmed Covid-19 (Primary DX) **AND**
- **J12.89** Other viral pneumonia (Secondary DX)

Patients presenting with signs / symptoms (such as fever, etc.) and where a definitive diagnosis has **NOT** been established

- Assign the appropriate code(s) for each of the presenting signs and symptoms

21

2021 Evaluation & Management Highlights



Removals

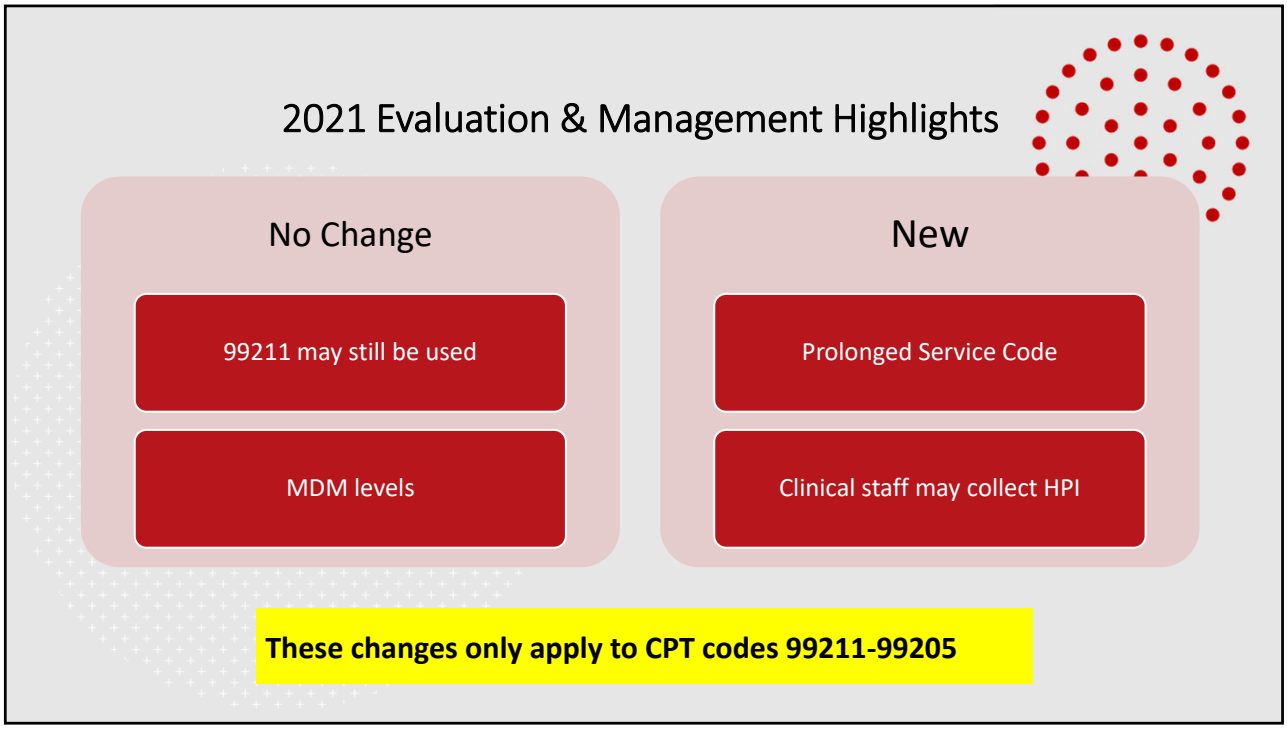
- 99201 Deleted
- History & Exam excluded from CPT scoring level
- > Than 50% of F2F Time spent on counseling and/or coordination of care

Revisions

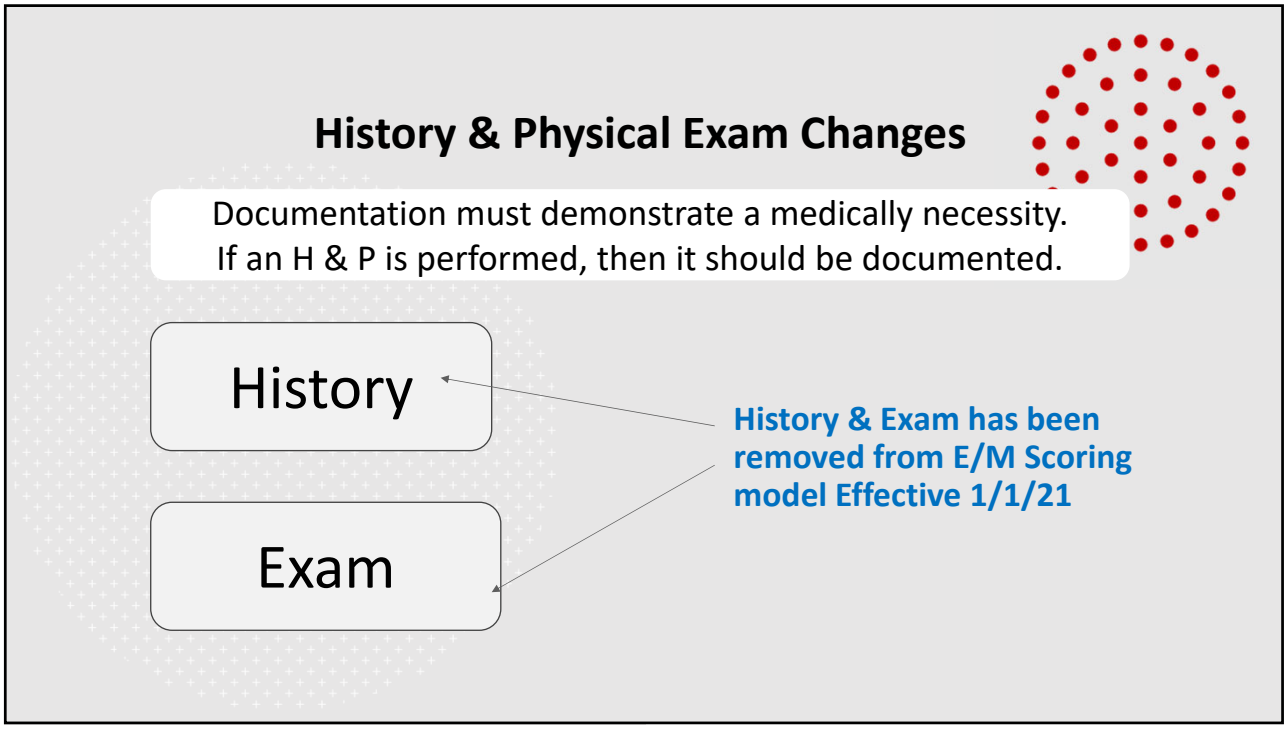
- Time criteria
- MDM process
- Code Definitions & Guidelines
- HPI may be documented by care team members

These changes only apply to CPT codes 99211-99205

22


2021 Evaluation & Management Highlights
No Change
99211 may still be used
MDM levels
New
Prolonged Service Code
Clinical staff may collect HPI
These changes only apply to CPT codes 99211-99205

23


History & Physical Exam Changes
Documentation must demonstrate a medically necessity.
If an H & P is performed, then it should be documented.
History
Exam
History & Exam has been removed from E/M Scoring model Effective 1/1/21

24

Selecting the Level of E/M Service

Choose the Evaluation and Management Level based on:

MEDICAL DECISION MAKING

OR

TOTAL TIME ON DOS

25

2021 Time Calculations on the Date of Service

- 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
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (that is not separately reported)

26

Exclusions from Counting Time

Posted on March 9, 2021 by AMA – Effective January 1, 2021

- Performing other services that may be reported separately
- Travel Time
- General teaching discussion with Care Team that is not required for the management of a specific patient

27

Medical Decision Making

Elements that make up MDM

- Number and complexity of problems addressed
- Amount and/or complexity of data and analyzed
- Risk of Complications, morbidity and/or mortality

Levels have not been modified

Straightforward Complexity	Low Complexity
Moderate Complexity	High Complexity

28

Recent MDM Clarifications

PRESENTING PROBLEMS & RISK

- Presenting problems and Co-morbidities may drive MDM even when the diagnosis doesn't have a high morbidity
- The "RISK" relates to the risk from the condition. The risk of the condition is distinct from the risk of the management

ANALYZED

- Tests ordered are considered analyzed when those results are reported; so when tests are ordered during an encounter, they are counted at that encounter
- When tests are ordered outside of an encounter, they should be counted during the encounter in which they are analyzed.

UNIQUE TEST

- When there is a review of all materials from a unique source, it counts as one element toward MDM.
- Basically - tests that have overlapping elements are NOT unique (even if they have distinct CPT codes.

ORDERING TESTS

- Reporting a test that is CONSIDERED but not selected after shared decision making
- Ordering a test is within the category of Test Results
- A patient may want to rule out a condition and request diagnostic imaging that may not be medically necessary. The provider having a discussion about the absence of benefits for this imaging may be required.

29

Recent MDM Clarifications

DISCUSSION

- The discussion must be an interactive exchange. It must be direct and not second hand through liaisons like staff.
- The discussion doesn't need to happen on the DOS but it's only counted when it's used in the decision making of the DOS.
- The discussion may only be counted one time.
- The discussion may be "asynchronous" - so it can be virtual and not real-time.
- The discussion must occur within a short period of time like within a day or two of the DOS

INDEPENDENT HISTORIAN

- Who is an Independent Historian?
- Why use an Independent Historian?
- An independent history doesn't need to be obtained in person but it does need to be obtained directly from the source giving the independent information

SDOH

- When there is a review of all materials from a unique source, it counts as one element toward MDM.
- Basically - tests that have overlapping elements are NOT unique (even if they have distinct CPT codes.

30

2021 Revised Time Based Coding Table

CPT CODE	TIME
99202	15 – 29 minutes
99203	30 – 44 minutes
99204	45 – 59 minutes
99205	60 – 74 minutes
99211	May not require the presence of a MD/DO. No time requirement.
99212	10 – 19 minutes
99213	20 – 29 minutes
99214	30 – 39 minutes
99215	40 – 54 minutes

31

New Add-on Codes for 2021

99417 Prolonged Service with or without Direct Patient Contact on DOS

- Non-Medicare Payers
- Use AFTER total time of 99205 & 99215 is exceeded

G2211 Visit Complexity (CMS payment delayed Implementation)

- Use in addition to E/M
- Same guidelines as 99417

G2212 Prolonged Service (In Person & Telehealth)

- Use for Medicare only
- Same guidelines as 99417

32

2021 Key Telehealth Services

Permanent

- 90853 – Group Psychotherapy
- 99483 – Cognitive Assessment & Care Planning
- 99347 - 99348 Home Visits

Expires w/PHE

- 99281-99285 ER Visit
- 99291-99292 Critical Care
- Therapy Services

CPT ® ★ = Telemedicine

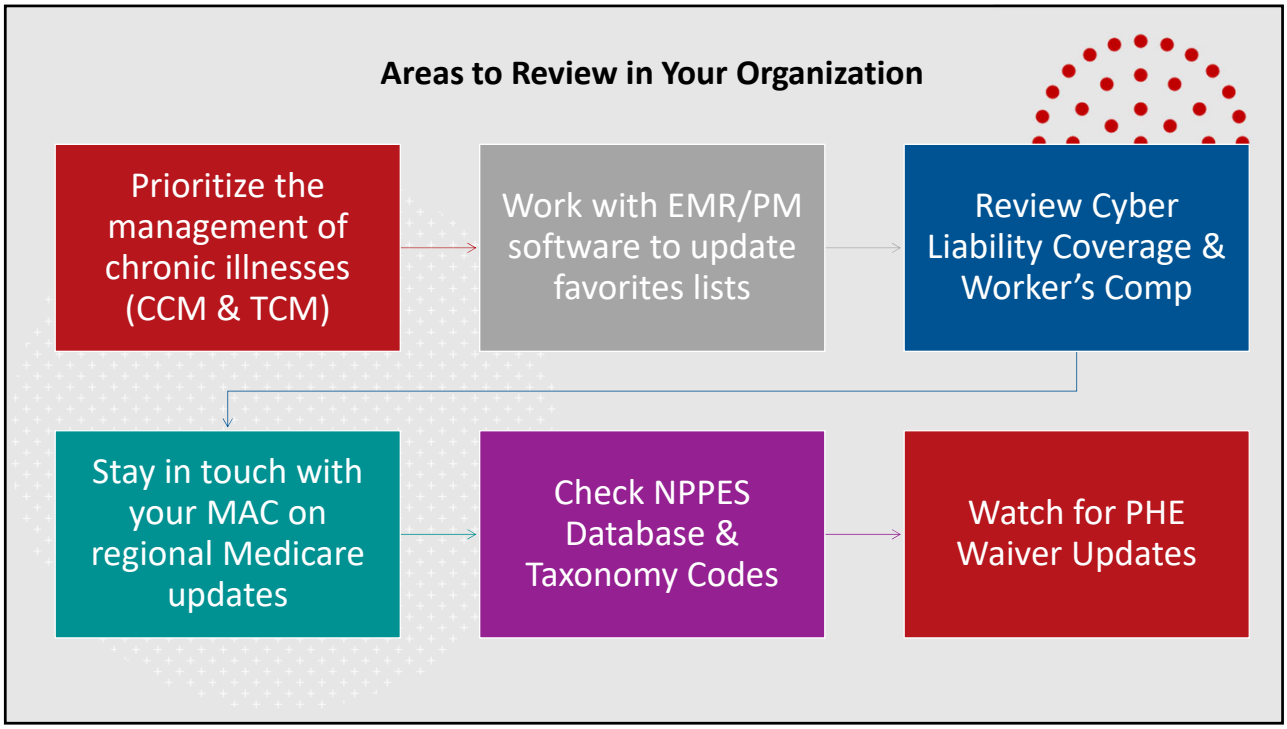
Audio Only

- G2252 (Same billing requirements as G2012): Virtual Check In
- 99441-99443: Telephone Services are recognized by CMS during the PHE

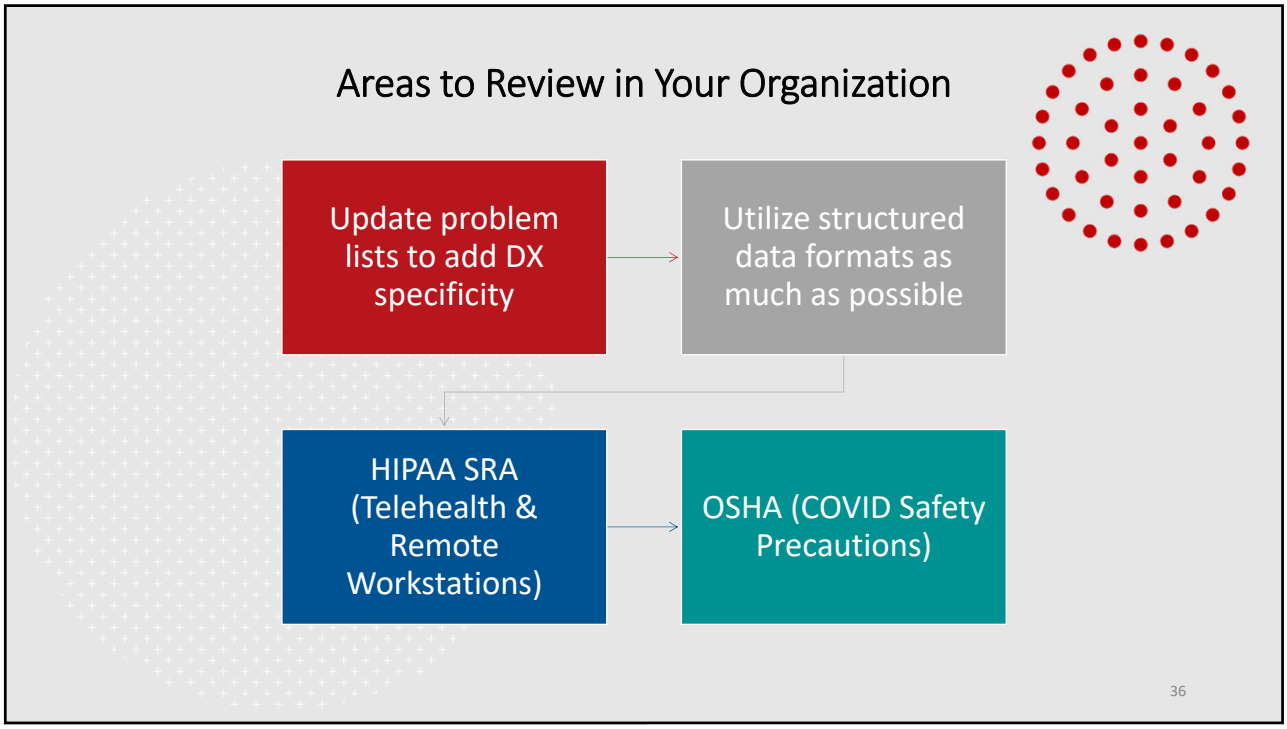
33

Practice Analysis & Enhancements

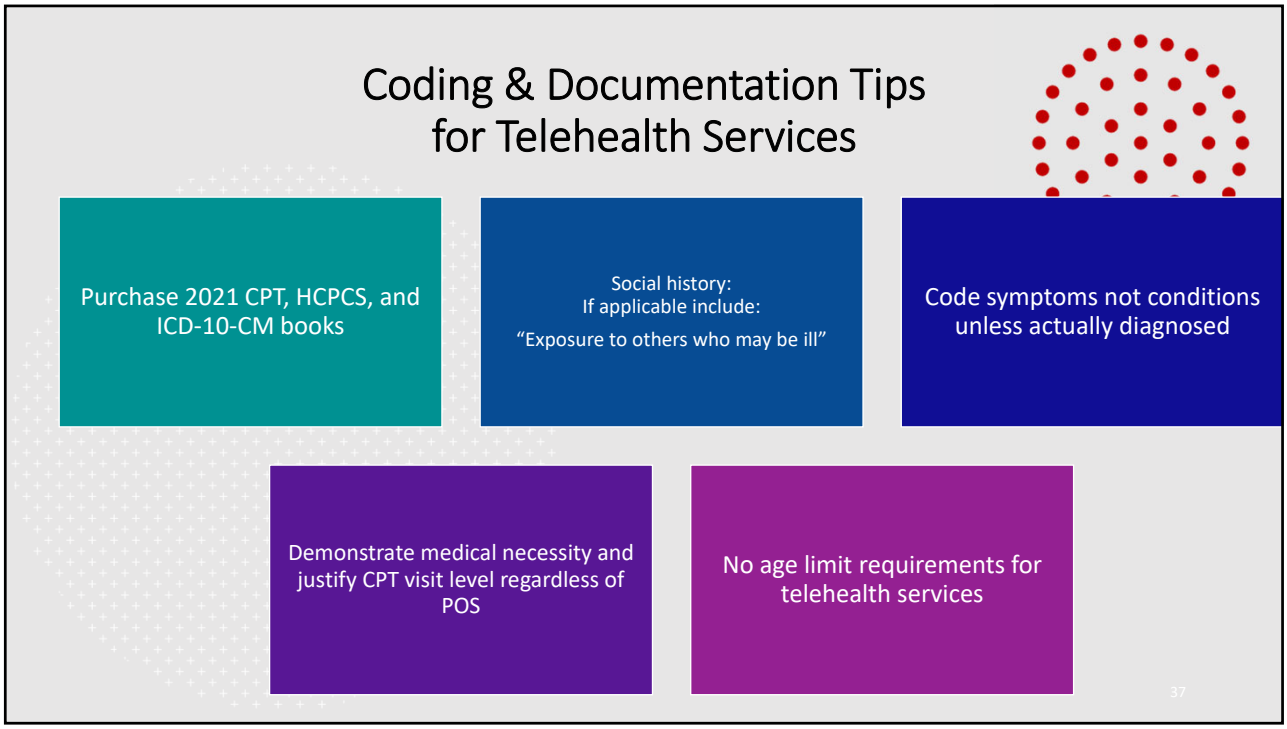
34


Areas to Review in Your Organization
Prioritize the management of chronic illnesses (CCM & TCM)
Work with EMR/PM software to update favorites lists
Review Cyber Liability Coverage & Worker's Comp
Stay in touch with your MAC on regional Medicare updates
Check NPPES Database & Taxonomy Codes
Watch for PHE Waiver Updates

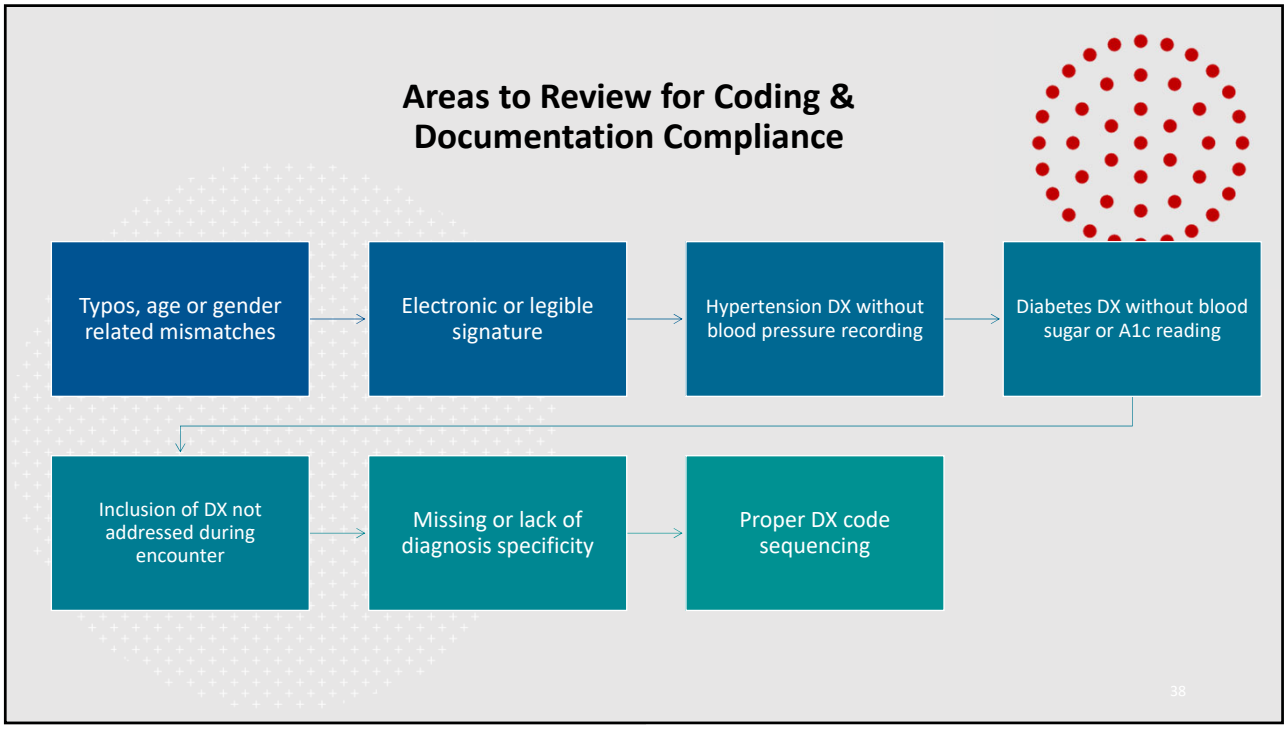
35


Areas to Review in Your Organization
Update problem lists to add DX specificity
Utilize structured data formats as much as possible
HIPAA SRA (Telehealth & Remote Workstations)
OSHA (COVID Safety Precautions)
36

36


Coding & Documentation Tips for Telehealth Services
Purchase 2021 CPT, HCPCS, and ICD-10-CM books
Social history:
If applicable include:
"Exposure to others who may be ill"
Code symptoms not conditions unless actually diagnosed
Demonstrate medical necessity and justify CPT visit level regardless of POS
No age limit requirements for telehealth services
37

37


Areas to Review for Coding & Documentation Compliance
Typos, age or gender related mismatches
Electronic or legible signature
Hypertension DX without blood pressure recording
Diabetes DX without blood sugar or A1c reading
Inclusion of DX not addressed during encounter
Missing or lack of diagnosis specificity
Proper DX code sequencing
38

38

Areas to Review for Coding & Documentation Compliance

- Ordering testing without documented intention in the assessment & plan
- Impression, findings, patient status not clearly stated in assessment & Plan
- Encounter cloning resulting in errors or inconsistencies
- Medication management, new RX prescribing
- Addressing chief complain during the encounter
- Adherence to prolonged, preventative and time-based service guidelines

39

39

Resource Alert

www.mgma.com/RCM

REVDIVE w/ Taya & Kem

www.sliceofhealthcare.com/revdive

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40

Don't be a stranger... Give us a shout!

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41

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