NATIONAL RURAL HEALTH RESOURCE CENTER

Revenue Cycle Improvement Webinar Series

Sessions: 11:00am – 12:00pm CST

1. CMS 2021 Coding Updates – Tuesday, January 12, 2021
2. Telehealth Coding and Billing to Maximize Reimbursement – Thursday, January 14, 2021
3. Charge Capture Improvement and Best Practices – Tuesday, January 19, 2021
4. Front-end Revenue Cycle Improvement: Patient Registration – Thursday, January 21, 2021

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Revenue Cycle Resources

- Billing and Coding Bootcamp Webinar Series - Three-part coding and billing training to build staff skills that improve coding and billing processes with the goal to increase reimbursement and enhance financial stability.

- Best Practice Concepts in Revenue Cycle Management Guide - Guide providing generally accepted best practice concepts in revenue cycle management so that they may consider opportunities for performance improvement within their own hospitals and individual departments.

- 2020 Revenue Cycle Improvement Bootcamp - Five-part webinar series that provides staff development on revenue cycle best practices to support performance improvements with front and back end revenue cycle processes as demonstrated by increased cash collection, improved charge capture, and a reduction in denials.

- Revenue Cycle Management and Business Office Processes - Compilation of tools to assist leaders with improving revenue cycle processes and increasing business office efficiency, which results in positive financial benefits due to quick course correction, increased reimbursement and clean claims to ensure money is not left on the table.

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CMS 2021 Coding Updates

January 12, 2021

Your Presenter

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Managing Consultant

Continuing Education

- **This program has been approved for 1.0 continuing education unit(s) for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA). Granting prior approval from AHIMA does not constitute endorsement of the program content or its program sponsor.**

- **An excel report should be submitted to BKD with first name, last name and email address of each attendee completing the webinar. BKD will issue the certificates post broadcast (within 15 business days) by email.**

Key Learning Objectives

1. High level overview of 2021 E/M documentation and coding changes
2. Prolonged service codes and Principal Care Management
3. Review fee-for-service adjustments and RHC encounter rate updates

Polling Question 1

Will my professional staff use different criteria for selecting office visit E/M codes in CY2021?

A. Yes
B. No
C. Not sure

Overview – Evaluation and Management Changes

E/M Revisions – Effective 1/1/21

- Apply only to Office or Other Outpatient Service codes
  - Established patient - 99212-99215
  - New patient - 99202-99205
- New patient CPT 99201 deleted
- Clinically relevant history & examination elements must still be obtained/performed & documented, but will not be used in the determination of the level of service
- Levels of service would be determined *by one of the following criteria*
  - Level of medical decision making defined for each service; *or*
  - Total amount of time for E/M services performed by the rendering provider on the date of the visit


TIME

Determining Level Based on “Time”

- New CPT definition of “time”
  - Counseling &/or coordination of care is not required to dominate the visit in order to use “time” as the determining element
  - The amount of time allotted to visit levels was revised from “typical time” to “time ranges”
  - Includes the total time spent by the physician or other qualified health care professional who is eligible to bill an E/M service, *e.g.*, PA, NP
    - Includes face-to-face & nonface-to-face time personally spent by the rendering provider on the encounter date of service
    - Does NOT include time spent by ancillary staff

Activities Included in Total Time

- Preparing to see the patient, *e.g.*, review of tests
- Obtaining &/or reviewing separately obtained history
- Performing a medically appropriate examination &/or evaluation
- Counseling & educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring & communicating with other health care professionals
- Documenting clinical information in the EMR/medical record
- Independently interpreting results (not separately reported) & communicating results
- Care coordination (not separately reported)

Source: AMA, "CPT E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes"

NOT Included in Total Time

- When calculating the total time, carve out any time spent on a separately reported or ineligible service
  - Ancillary staff time (i.e., rooming patient)
  - Minor office procedures, *e.g.*, lesion removal, joint injection
  - Diagnostic services, *e.g.*, PFTs, EKG
  - Explaining risks & benefits of surgical procedures, obtaining surgical consent, etc.

Revised E/M Time Ranges

New	Minutes
99202	15–29
99203	30–44
99204	45–59
99205	60–74

Established	Minutes
99212	10–19
99213	20–29
99214	30–39
99215	40–54

Documentation of Time

- CMS Medical Review recommends:
  - Only time spent on the calendar date of the visit may be counted
  - Document actual time and the activities or work personally performed by the rendering physician or non-physician practitioner.
  - Include actual time spent by ancillary staff that must be carved out
    - Nursing time to room patient, take vitals, take initial history
    - Procedure time (i.e., drug administration, in-office procedures)
    - Diagnostic testing or therapeutic procedures (i.e., EKG, pulmonary function testing, breathing treatments)
    - Avoid inserting a “cloned” or “formatted” statement containing the CPT code description of time frame
    - Documentation must support the amount of time mapped to the level of service assigned and be reasonable based on content of the chart note

Documentation of Time, Continued

- AMA –
  - Acceptable to document total time and describe the activities and work that were done.
    - "I spent 30 minutes caring for this patient today, reviewing labs from date of service XXXXXX, reviewing records from (name of hospital) where patient was discharged on Tuesday, December 15, 2020, assessing and examining the patient, documenting in the medical record and ordering lab work (describe in orders) and imaging (describe in orders)."
- Medicare –
  - Would prefer to see increments of time spent during visit or on date of service supporting the time personally spent by rendering provider
    - "Nursing time- 2 minutes rooming patient, taking vitals and history. Physician time – 5 minutes taking history and performing examination, 3 minutes reviewing prior hospital discharge records before seeing patient on (DOS), 5 minutes entering orders, documenting in medical record. – total time spent on DOS 13 minutes"

Additional Rationale – Shared Visits

- If a shared visit, where the non-physician practitioner and physician both see the patient and perform work to jointly determine management of the patient, the total time of the professional time can be counted. Time may not overlap. If so, only one provider's time is counted.
- If the physician only comes by to review the documentation, agree with the course of treatment and authenticate the note, the physician time is not counted.
- *CMS will be issuing additional guidance on this topic soon*

Medical Decision Making (MDM)

Medical Decision Making (MDM)

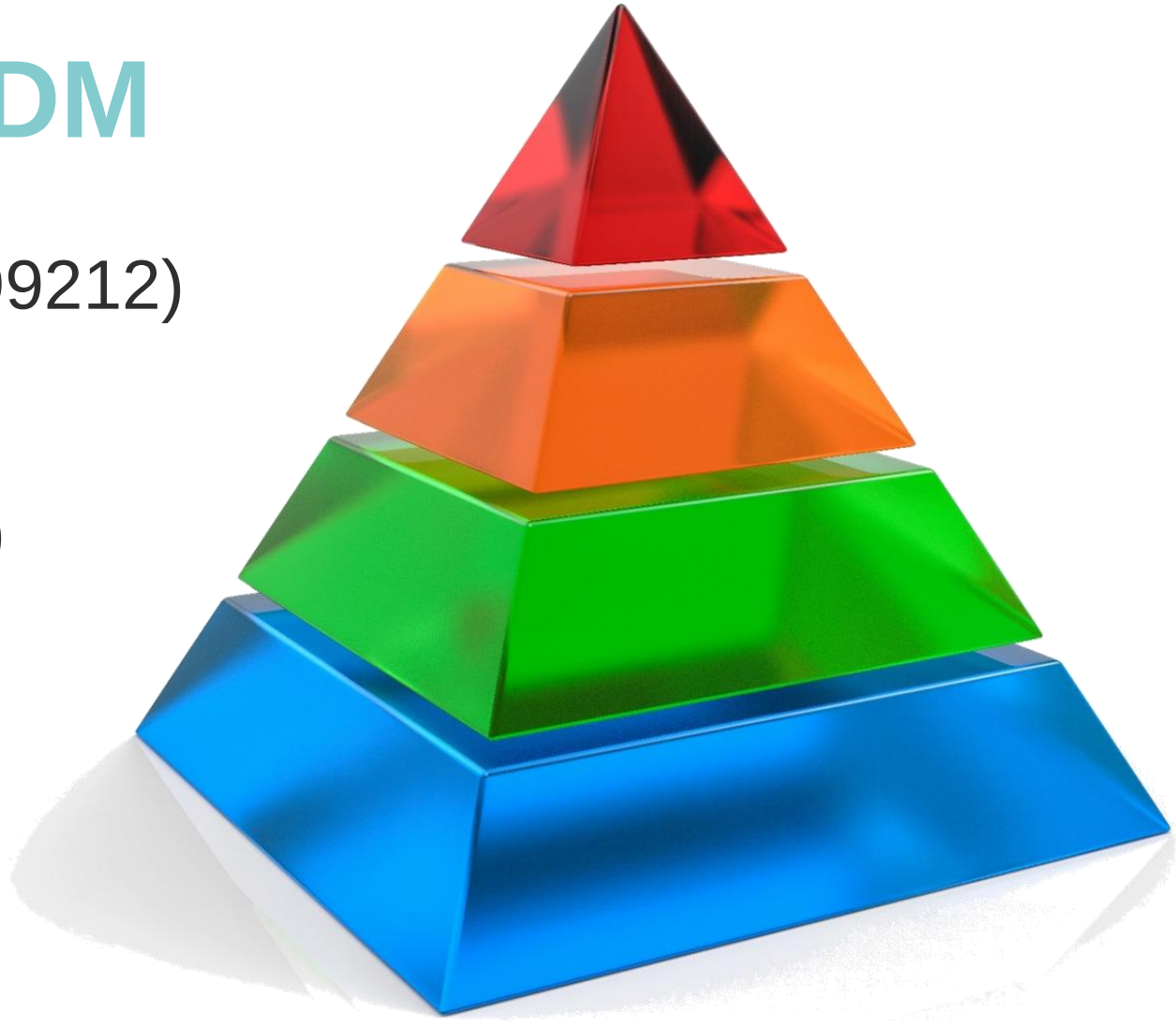
- Three components
  - Number of complexity of problem(s) addressed during the encounter
    - Stable, chronic illness
    - Acute, uncomplicated illness or injury
  - Amount/complexity of data to be reviewed ***& analyzed***
    - Tests, documents, orders or independent historian(s). Each unique test, document or order would be counted toward the threshold ***if not billed separately***
    - Independent interpretation of tests
    - Discussion of management or test interpretations with external physician or other qualified health care professional
  - Risk of complications, morbidity/mortality of patient management decisions made at the visit

MDM – Revised Guidelines

- History & exam – will be required for documentation, but not scored for level of service
  - Documentation establishes medical necessity for service
  - Clinically relevant
- Diagnoses & management options – document in the impression, and give credit for, only those diagnosis(es) actively assessed and/or treated during the encounter
  - “Additional work-up” option was removed from leveling criteria
- Data & complexity – new guidelines require combinations of elements of work to score MDM (see AMA tool)
- Table of risk – removed multiple columns, uses only treatment options

Four Levels of MDM

- Straightforward (99202 or 99212)
- Low (99203 or 99213)
- Moderate (99204 or 99214)
- High (99205 or 99215)



99212/99202 – Straightforward MDM

- Documentation must support MDM based on two of the following three elements
  1. ***Straightforward*** complexity: one self-limited or minor problem
     1. Self-limited is defined as: "a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status." (Source: *AMA*)
  2. Data to review: ***minimal or no data*** to be reviewed/analyzed
  3. Risk: ***minimal risk of morbidity*** from additional diagnostic testing or treatment

99213/99203 – Low MDM

- Documentation must support MDM based on two of the following three elements
  1. ***Low*** complexity: two or more self-limited or minor problem(s) OR one stable chronic illness OR one acute, uncomplicated illness or injury
     1. Acute, uncomplicated illness or injury is defined as: “a recent or new short-term problem with low risk of morbidity for which treatment is considered. Little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course. Examples: cystitis, allergic rhinitis, or a simple sprain.” (Source: *AMA*)
  2. Data to review (***must meet one of the two categories***): ***limited***
     - ***I.*** ***Category 1***: tests & documents
       - ***Any combination of two from the following-***
         - Review of prior external note(s) from each unique source
         - Review of results of each unique test
     - ***II.*** ***Category 2:*** assessment requiring an independent historian
  3. Risk: ***low*** risk of morbidity from additional diagnostic testing or treatment

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and 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

99204
99214
	Moderate	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

99214/99204 – Moderate MDM

- Documentation must support MDM based on two of following three elements

99215/99205 – High MDM

› Documentation must support MDM based on two of following three elements

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and 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

99205
99215
	High	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

Additional Rationale - Medication

- ***Prescription medication*** is still listed under “moderate” risk
- ***OTC medication*** are assumed to be in the “straightforward” risk category but could also be moderate or high. The decision is left to the rendering provider to determine the level of risk based on the clinical judgement and the context. Recommendation is to not automatically assign the risk level based on whether OTC medications or prescription medications are part of the decision making.
  - Example: A patient who is on an anticoagulant with a history of congestive heart failure (CHF) and chronic kidney disease (CKD) from hypertensive heart disease would fall under a moderate or high risk if OTC NSAID was prescribed
- Documentation of a medication list (counted toward past history) is not automatically assigned to medical decision making. If documentation supports a treatment plan of medication management, the medication and a mapping to the condition treated, then it can be captured.
- A ***drug that requires “intensive monitoring”*** is not one that is assessed for therapeutic efficacy (i.e., levels). Rather, the monitoring is for adverse effects of a medication that has the “potential to cause serious morbidity or death.” Monitoring should be within accepted practice, not less than quarterly for long-term monitoring, and may be accomplished by lab test(s), physiologic test or imaging.

Additional Rationale – “Unique Test”

- A “unique” test is one that is mapped to a distinct CPT or HCPCS code
  - Documentation tip: identify distinct tests that are ordered. Avoid internal “panels” or “standing orders”. Indicate what reports are reviewed versus tests that are interpreted by the provider and eligible for separate billing (i.e., EKG interpretation)
- The definition of “unique” would also be met if a provider reviews distinct reports from the same test performed bilaterally. For example, x-rays of the RT and LT knee would be assigned the same CPT code, but be distinct to the RT and LT anatomical sites. If the provider documents review of both, points would be captured for each.

Additional Rationale – “Order and Review”

- Per AMA, “ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.”
- “If you order a diagnostic test (i.e., CBC) during a patient visit but do not review the results until three days later, credit is not given for the review. Only count the order.
- If you bill separately for a diagnostic test, the provider may not count MDM for the order and review of the same diagnostic test. That work is included in the billing for the diagnostic test.
  - AMA states “The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately.”
- If you are in the same specialty of another provider who has ordered the test, and you are reviewing separately, you are all considered the “same provider”. The review would not be counted again.

Sources: Coding Intel, “FAQ: Scoring the elements in the new E/M guidelines for 2021,: Betsy Nicoletti, December 9, 2021
Novitas,

Additional Rationale – “Discussion”

- Documentation of an email communication with an outside provider would not meet criteria for “discussion of management” with another physician or qualified health care professional
- Discussion must be real-time, interactive communication between the two providers or appropriate source

Additional Rationale – “External”

- “External source” or “External Documents”
  - Defined as a source not in the same group practice or is a different specialty or subspecialty
  - Defined as documentation that is housed outside the practice EMR system (i.e., hospital documentation, outside physician records)
  - Review of the provider’s own past documentation does not meet criteria of “external”

Additional Rationale – “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.”
  - Consideration of further testing or treatment although it may not be the final management choice after a risk/benefit analysis or patient choice is made
  - Notation in the medical record that another provider is managing the problem without personally performing additional assessment or care coordination does not meet criteria as “addressing” a problem.
  - A referral without personally evaluating (by history, examination, or diagnostic study(ies) or consideration of treatment) does not meet criteria

Additional Documentation Tips

- Document a SOAP note as you always have, reflecting clinically relevant information for the date of service.
- Avoid internal abbreviations, or have on file a list of common abbreviations and acronyms used by professional staff to mitigate risk of misinterpretation
- Document only those conditions, signs or symptoms addressed in the encounter
  - Removes the need to document every diagnosis a patient has received (i.e., auto-populating from problem list)
- Reduce “cut and paste” by eliminating the need to document information that is irrelevant or ancillary to the purpose of the visit
- Document if a social determinant will impact the management plan
  - Patient with diabetic ulcer requiring wound care, but is homeless and may not make it to follow-up visits for dressing changes and monitoring
  - A patient who does not have reliable transportation for their scheduled follow-up visits

Prolonged E/M Service - Medicare

- **Pending confirmation:**
  - CMS has not confirmed whether FQHCs will be eligible to report prolonged services to Medicare under the definition outlined in the 2021 MPFS Final Rule
- **HCPCS code G2212**
  - "Prolonged office or other outpatient evaluation and management service(s) **beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact"
- Eligible only for 99205 or 99215
- Prolonged time of <15 minutes is not reported

Prolonged Service – Other Payers

- RHCs will be eligible to report prolonged services to other payers under the AMA definition
- **CPT code 99417**
  - "Prolonged office or other outpatient evaluation and management service(s) **beyond the minimum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact"
- Eligible only for 99205 or 99215
- Prolonged time of <15 minutes is not reported

CPT Code(s)	Total Time Required for Reporting
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes.	119 or more

CPT Code(s)	Total Time Required for Reporting
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

Source: CMS, 2021 MPFS Final Rule

TIMELINE							
NEW	1-14	15-29	30-44	45-59	60-74	75-89	90-104
	Do not use time (99202 by MDM)	99202	99203	99204	99205	99205+ 99417	99205+2 units 99417
ESTABLISHED	1-9	10-19	20-29	30-39	40-54	55-69	70-84
	Do not use time (99212 by MDM)	99212	99213	99214	99215	99215+ 99417	99215+2 units 99417

Prolonged Services – AMA Tables

CY2021 Principal Care Management

- New category in chronic care management
- For a single chronic illness that meets the definition
- RHCs will report to Medicare under G0511
- Medicare will calculate an adjusted fee schedule payment utilizing the additional new HCPCS codes G2064/G2065 (Part B eligible) in the average
  - 2021 fee schedule rate has not been released

Reimbursement Updates – CY 2021

2021 MPFS Conversion Factor

- CMS adjusted the conversion factor to reflect a 3.325% decrease, much less than the decrease of 10.2% initial released
- The Consolidated Appropriations Act allowed for change in impact, with a final 3.75% increase in MPFS payments for CY2021
  - Conversion Factor 34.8931
- 2% payment adjustment for sequestration is suspended through March 31, 2021
- Delayed implementation of an inherent complexity add-on code for E/M services until CY2024 (HCPCS G2211)

Polling Question 2

Was there a negative or positive change in the fee-for-service conversion factor for CY2021?

A. Negative

B. Positive

RHC Payment Cap Rules

Prior to April 1, 2021

- Freestanding RHCs or RHCs that were provider-based to a hospital with 50 or more beds subject to a reimbursement cap of $87.52 (effective 1/1/2021)
- RHCs that were provider-based to a hospital with less than 50 beds received full cost-based reimbursement

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After April 1, 2021…

- All RHCs certified after December 31, 2019, will now be subject to a cost-based reimbursement cap, regardless of provider-based or freestanding status
  - The National Association of RHCs (NARHC) working with Congress to change this date to December 31, 2020, so RHCs with effective dates in 2020 that expected no cap in cost-based reimbursement are not negatively impacted
  - Would be included in Technical Corrections Bill & details TBD
- Reimbursement caps to begin at $100 per visit in 2021 & increase to $190 per visit by 2028
  - RHCs to be reimbursed the lesser of their cost per visit & the reimbursement cap in any given year
- Medicare Economic Index (MEI) increases annually beginning in 2029

After April 1, 2021… Continued

- RHCs provider-based to hospitals with less than 50 beds & effective prior to December 31, 2019, will be grandfathered

Will retain existing cost-based reimbursement amounts

Future increases will be at the MEI rate

Reimbursement Caps by Year

Beginning	Ending	Rate
1/1/2021	3/31/2021	$87.52
4/1/2021	12/31/2021	$100.00
1/1/2022	12/31/2022	$113.00
1/1/2023	12/31/2023	$126.00
1/1/2024	12/31/2024	$139.00
1/1/2025	12/31/2025	$152.00
1/1/2026	12/31/2026	$165.00
1/1/2027	12/31/2027	$178.00
1/1/2028	12/31/2028	$190.00
1/1/2029	12/31/2029	$190 + MEI

Next Steps…

Existing RHCs:

- Review cost report for accurate cost allocations
- Evaluate financial impact of changes to reimbursement caps

Potential RHCs:

- Update financial analyses to include new reimbursement caps to estimate benefit
- Evaluate if benefits to provider-based status exist

Thank You!

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References

- *American Academy of Professional Coders (AAPC),* "What Happens When E/M Guidelines Change," Renee Dustman, BS, Executive Editor
- *American Medical Association (AMA),* "10 Tips to Prepare Your Practice for E/M Office Visit Changes"
- *AMA,* "CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes", Effective January 1, 2021

References, Continued

- *AMA*, "CPT E/M Office Revisions Level of Medical Decision Making (MDM)" tool
- *AMA*, CDI Strategies, "AMA Issues Checklist for Transitioning to 2021 E/M Coding Guidelines," Volume 14, Issue 3, January 16, 2020
- AMA, "Evaluation and Management Office Visits," Peter Hollmann, MD, and Barbara Levy, MD
- *HCPro*, Revenue Cycle Updates, "Q&A: Preparing Hospitals for the 2021 E/M Overhaul," Valerie Rinkle, MPA & Jugna Shah MPH

References, Final

- *Centers for Medicare & Medicaid Services (CMS),* 42 CFR Parts 400, 410, 414, 415, 423, and 425, "CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule"
  - https://public-inspection.federalregister.gov/2020-26815.pdf
- *National Association of Rural Health Clinics (NARHC),* "2021 Physician Fee Schedule Final Rules Released," 12/3/2020, Nathan Baugh, Director of Government Affairs
- *CMS*, "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021," 12/1/2020