CMS Final 2021 E/M Changes

2021 CMS Physician Fee Schedule

UCI Health Compliance & Privacy Office

UCI Health

2021 Medicare Physician Fee Schedule

- Changes effective January 1, 2021
- CMS is aligning their Evaluation and Management (E/M) guidelines with the American Medical Association Current Procedural Terminology (CPT)
- Most significant changes to E/M coding since 1997

Key Highlights

This alignment will:

- Retain the 5 levels of service for established office/outpatient visits, 99211-99215
- Reduce new patient services to 4 levels of office/outpatient visits, 99202-99205
- Coding will no longer be based on extent of history and physical exam documentation
- Providers can choose their level of service either by time spent in visit (both before, during and after on day of encounter) or complexity of medical decision making (MDM)
- Teaching Physician rules have not changed, at this time, but CMS may address the guidelines in the future

- ***All other E/M services that are defined by the 3 components (History, Exam, and MDM) will continue to use 1995 and/or 1997 Documentation Guidelines until further review has been completed***

Key Components to Remember

- You cannot forget the history and examination documentation just because the service is selected based on MDM

- You must document a medically appropriate history and/or exam when performed
  - Take into consideration what other clinicians will view when looking at the patient's chart

- Not documenting the history and/or exam could create a malpractice risk

Medical Decision Making

Medical Decision Making requires two of three elements:

1. Number and complexity of problems addressed at the encounter

2. Amount and/or complexity of data to be reviewed and analyzed

3. Risk of complications and/or morbidity or mortality of patient management

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
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**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
	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

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

Number and Complexity of Problems Addressed

Problem: Disease, condition, illness, injury, symptom, sign, finding, complaint

Problem addressed: Must be evaluated or treated during the visit with supporting documentation.

Example: Pt seen for HTN and there is a need to change medication. MD notes creatinine level and can't prescribe beta blocker due to CKD stage 3. Problem evaluated and treated.

Please note:

- *A notation of another physician managing the problem without additional assessment does not count*
- *Referral without evaluation does not count*

Amount and/or Complexity of Data Reviewed/Analyzed

Category 1: Based on each unique test, order, or document that contributes to a combination of 2 or 3 points in the new grid

Category 2: Requires independent interpretation of tests performed by another physician/provider.

Example: Reviewing outside tests and documenting your findings. However, if a test is performed/interpreted in the office and is separately billable you cannot count it in the category. It must be billed separately and not part of the E/M.

Category 3: Discussion of management or test interpretation with an external physician/provider and is not separately billable

Risk of Complications and/or Morbidity or Mortality of Patient Management

Straightforward: Minimal complexity, minimal data, minimal risk of morbidity

Examples: Cold; insect bite; tinea corporis

Low: Low complexity, limited data (at least 1 of the 2 categories), low risk of morbidity

Examples: Well controlled HTN; non insulin dependent DM; cataract; BPH; cystitis; allergic rhinitis; simple sprain

Moderate: Moderate complexity, moderate data (at least 1 of the 3 categories), moderate risk of morbidity

Examples: Chronic illness with mild exacerbation; undiagnosed new problem with uncertain prognosis; lump in breast; treated cancers under surveillance; pyelonephritis; pneumonitis; colitis; acute complicated injury, head injury with brief LOC

High: High complexity, extensive data (at least 2 of the 3 categories), high risk of morbidity

Examples: Chronic illness with severe exacerbation; current cancers; chronic illness posing threat to life, multiple trauma, acute MI, pulmonary embolus, severe RA, psychiatric illness with potential threat to self or others; abrupt change in neurologic status

Time Based Coding

When using time to choose a level of service the following attending physician activities can be counted:

- Preparing for the visit (ex reviewing test results)
- Obtain or review the patient history
- Performing a medically necessary exam
- Education for the patient, a family member, or caregiver
- Writing orders for tests, medicine, and/or additional services
- Refer or communicate with other health care professionals (when not separately reportable)
- Entering clinical information into the patient's record
- Interpreting and sharing test results with the patient
- Coordinating patient care

Time Based Coding

- Time for activities that are normally performed by clinical staff, such as vitals, *cannot* be counted
- Resident time cannot be counted until the Teaching Physician guidelines are addressed
- Per the AMA, documentation should support each activity and the total time that time was spent performing the activities

Time Based Coding

Example of Provider's time documented:

Talking to the patient's PCP

Reviewing the patient's history

Examining the patient

Discussing treatment options

Writing a prescription

Ordering diagnostic tests

Updating the patient record

Total time: **38 minutes (total time required)**

CPT code	New Patient	99203
	Established Patient	99214

Time Based Coding

Guideline	2020	2021
Visit time is calculated based on pre-, intra- and post-encounter services on day of visit	No	Yes
Separately reported services may also be counted towards time	No	No
To report based on time counseling/coordination of care must dominate the visit	Yes	No
Time is include in the descriptor for 99211	Yes	No
Physicians and other qualified health care professionals may share a time-based visit	N/A	Yes
Prolonged service with direct patient contact (99354-99359) may be reported with an office visit	Yes	No
Prolonged service without direct patient contact (99358-99359) may be reported with an office visit	Yes	No
Prolonged service by clinical staff (99414-99416) may be reported with an office visit	Yes	Yes

Source: CPT 2020 Professional Edition: www.ama-assn.org/sysem/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Time Based Coding

Times for Codes 99202-99205 and 99212-99215		Work RVUs for Office/Outpatient E/M Codes	
New patient	**Minutes**	2020 Work RVU	2021 Work RVU
99202	15-29	0.93	0.93
99203	30-44	1.42	1.60
99204	45-59	2.43	2.60
99205	60-74	3.17	3.50
Established patient	**Minutes**		
99211	N/A	0.18	0.18
99212	10-19	0.48	0.70
99213	20-29	0.97	1.30
99214	30-39	1.50	1.92
99215	40-54	2.11	2.80

Prolonged E/M Visit - 99417
wRVU = 0.61

- Used when total time exceeds level 5 visit by 15 min

Time Based Coding

Possible Timing Errors

- **Insufficient Documentation**

  Documentation states that 25 minutes was spent performing face to face and non face to face services but there was no detail to support what was done

- **Record Completion**
  - If the provider waits until the next day to enter clinical documentation into the patient's record***, that time cannot be counted in the visit as it did not occur on the same date as the encounter***

- **Double-Dipping**

  Time spent in services that are separately reported cannot be counted

Time Based Coding

Shared Visit with APP

- When the APP and the physician perform a shared visit, the time that each provider spends can be counted and added together to get the level of service for the visit.

- Time that the APP and the physician spend together can only be counted once.

Time Based Coding

Shared Visit Example:

The APP reviews the intake form done by the patient	**5 minutes**
The APP interviews the patient to get the history and performs an exam	**5 minutes**
The physician performs an additional exam with the APP present, discusses the case, they order diagnostic testing, and complete the case.	**13 minutes**

Total time: **23 minutes**

CPT code:	**New Patient**	**99202**
	Established Patient	**99213**

New Prolonged Services Code

CPT created a new prolonged care code, **99417**, for each additional 15 minutes of time spent on the calendar day of service, for use with CPT codes 99205 or 99215. CMS will require G2212 to bill prolonged services for Medicare patients.

This prolonged services code is used to report total time, both with and without direct patient contact, after the time threshold for 99205 or 99215 is met.

If time is spent performing other services that are identified by a CPT code, you may not include that time in the office visit or prolonged care service. The total time of 15 minutes must be met to report 99417, not the midpoint time.

Cannot use with other prolonged services codes 99354-99359, 99415-99416.

Prolonged Service

CPT Code(s)	AMA Total Time Required for Reporting*	CPT Code(s)	CMS Total Time Required for Reporting*
99205	60-74 minutes	99205	60-74 minutes
99205 x 1 and 99417 x 1	75-89 minutes	99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and 99417 x 2	90-104 minutes	99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes	105 or more	99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Prolonged Service

CPT Code(s)	AMA Total Time Required for Reporting*	CPT Code(s)	CMS Total Time Required for Reporting*
99215	40-54 minutes	99215	40-54 minutes
99215 x 1 and 99417 x 1	55-69 minutes	99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and 99417 x 2	70-84 minutes	99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and 99417 x 3 or more for each additional 15 minutes	85 or more	99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

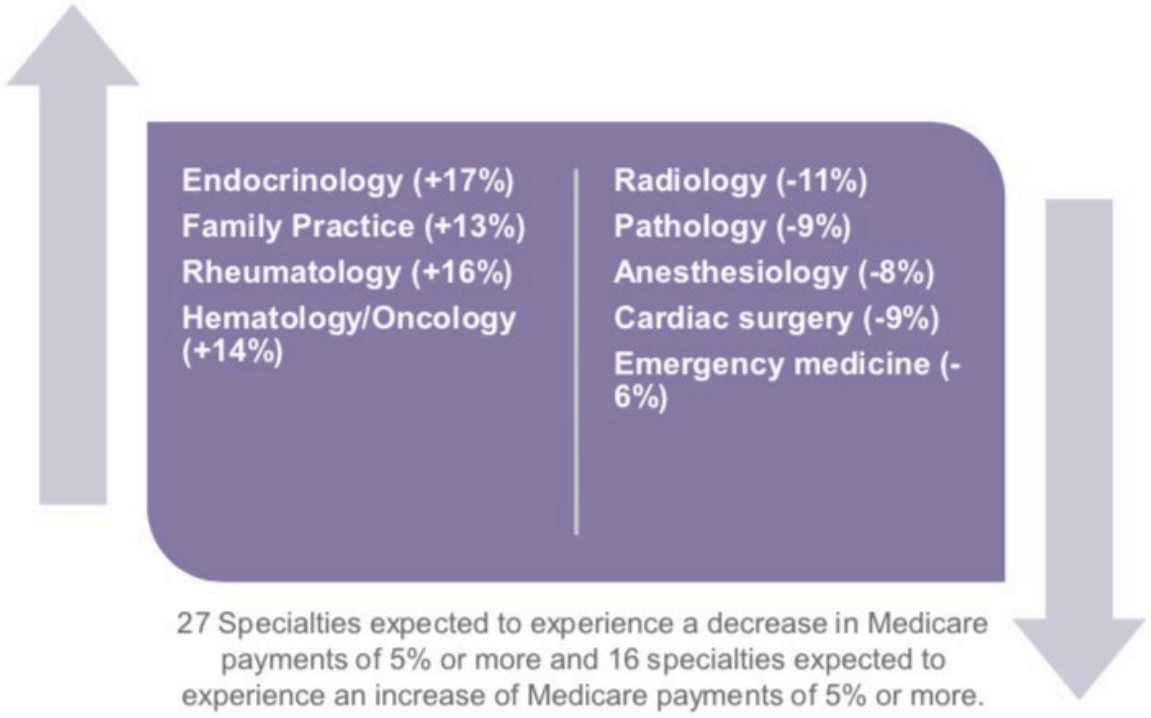
Budget Neutrality

- Budget neutrality – total Medicare spend stays unchanged year to year

- Payment = Conversion factor (CF) * Geographic factor (GF) * RVU
  - CY 2019 CF = $36.04
  - CY 2020 CF = $36.09
  - CY 2021 CF = $34.89 (updated 01/12/21)
- In addition, wRVUs for many CPT codes have been recalculated and a new patient fee schedule created

- Because more wRVUs are allocated to office visits, less attributed to other procedures

Impact of 2021 Changes: CMS Estimates



References

CMS 2021 Physician Fee Schedule Final Rule
https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1?mkt_tok=eyJpIjoiTVRsaVpHRTNaamxsTnpobCIsInQiOiJcLzZXTUZZWkxsNEdGOGZWM1FaclVtSmxrQ1Bsc1l4U21YS2tpMVZNNE02NVJSbmhTSERYMzY5dlk0aktpZVNnRk5iWmgzckFkWVRJb0ZsUTVTb00xXC9OdEkzSlFCOG9hOUlrRU5LV1RPd05Xcm0xSWxJMTJ2V2lzRU4rR3cxMjFMIn0%3D

2021 Medicare Physician Fee Schedule Proposed Final Rule
https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

AMA – E/M Office Visit Changes on Track for 2021: What Doctors Must Know
https://www.ama-assn.org/practice-management/cpt/em-office-visit-changes-track-2021-what-doctors-must-know

PBSC – Medicare Physician Fee Schedule Proposed Rule
CPSC PFS PR webinar Aug 2020.public.pdf

Next Steps

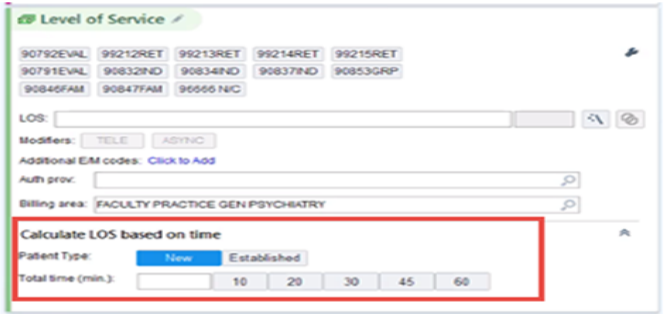
- Assign physician champions to work with Compliance to lead the transition
- Develop on demand resources and training materials and provide on Compliance & Privacy Office website
- Deliver ad hoc in-person provider education to departments
- Encourage practices to develop workflow for both the classic and new E/M guidelines
- Seek clarity from private payers to get full understanding on how time will be reimbursed
- Establish a baseline with a coding and documentation audit to ensure correct implementation after CMS finalizes proposed rule on December 1, 2020

UCI EPIC News

2021 Code Updates

CMS changes for 2021 involve new documentation and coding methodology in multiple care settings, most prominently affecting outpatient care. New 2021 LOS codes align with Epic LOS charging options and with a new Epic LOS Calculator (see below). When closing encounters for 2020 dates of service, please be sure to adhere to 2020 LOS codes. If a provider choses a 2021 code for a 2020 DOS or a 2020 code for a 2021 DOS, a special alert will communicate to the provider that the code selection is not valid:

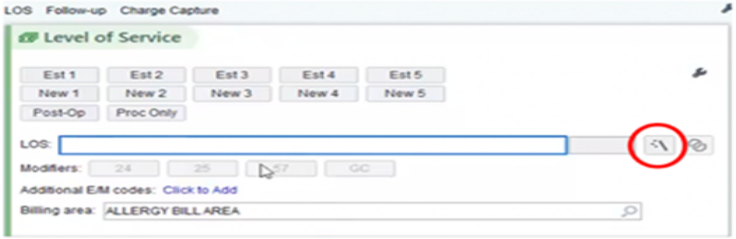
The LOS section in Wrap-Up will show Time Spent quick buttons to assist providers with the appropriate code selection for all encounter types in ambulatory except Telemedicine. For Telemedicine, providers should continue to use the ".UCITELEMED" SmartPhrase.



UCI EPIC News

Ambulatory: 2021 LOS Calculator

As of January 1st, our Level of Service (LOS) Calculator has been updated to 2021 rules. Providers who would like assistance with billing for E&M can access the LOS Calculator by clicking on the “wand” symbol to the right of the LOS search bar. The LOS Calculator suggests the appropriate LOS charge based on either Medical Decision Making or Time Spent. Providers must select New or Established care.



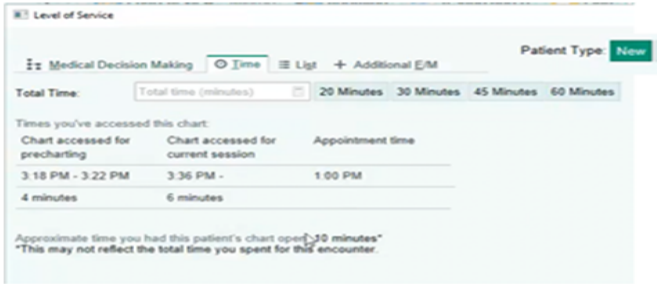
For Medical Decision Making, Epic prompts the provider to enter the number and complexity of problems addressed and the overall healtl risk.

UCI EPIC News

Ambulatory: 2021 LOS Calculator

For Time Spent, the LOS Calculator will show the time spent with the Epic chart open on that day. Prior chart review or time spent on prior preparatory work will not show. The approximate time of the chart open will be indicated (10 minutes as demonstrated in the example below) but may not reflect the total time spent for the encounter. Providers can choose the most appropriate total time spent to be used for billing purposes.

Time Spent:



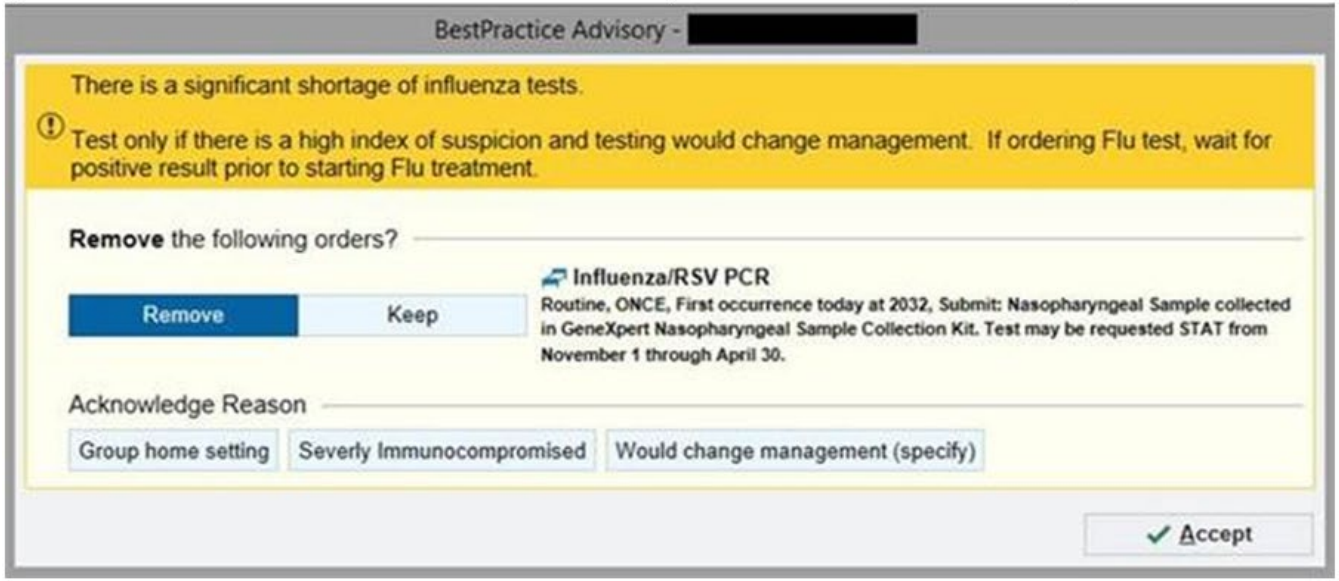
If Medical Decision Making and Time Spent result in different LOS codes, Epic will advise the higher level of service.

Providers should be careful not use the new LOS Calculator on any 2020 DOS charges as the 2021 LOS Calculator will generate incorrect charges for any 2020 DOS.

UCI EPIC News

COVID PCR and Influenza Orders Changes

The order options available for COVID PCR testing have been updated to allow for sufficient availability of limited STAT tests per recommendations from HICS. Similarly, the ability to order influenza testing will also be restricted due to limited test supplies. The guidelines from UCI Infection Control recommend empiric treatment if influenza is suspected.



UCI EPIC News

Medication Alert Acknowledgement Reasons--Update

The most common reasons to override medication alerts have been updated to improve alert optimization. Click here for details.

Did you know that a multidisciplinary team of clinical informatics physicians, pharmacists, and analysts meets regularly to continuously optimize medication alerts in the EHR? Data is routinely gathered about alert frequency, who was alerted, whether the recommended action was accepted, and if not, what was the reason for overriding the clinical decision support alert. The Medication Alerts Optimization Committee evaluates this data to improve the alert quality for better clinical decision support. Accurate responses help this team to optimize alerts and the updated override reasons will allow this team to better adjust the quality and frequency of medication alerts.

UCI EPIC News

Doximity (unsupported application)

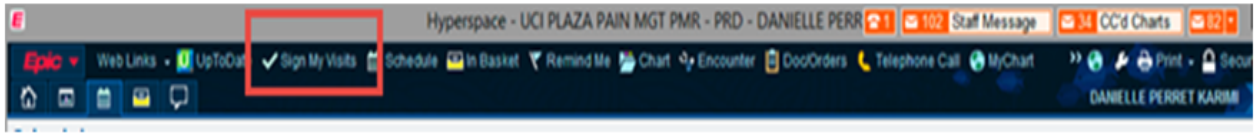
Doximity recently e-mailed many of you about their shifting business plan to time-based limitations for providers and a charge for non-providers. UC Irvine and our sister UC schools are not pursuing Doximity given we have an integrated solution with Epic (via MyChart/Zoom) and high cost for Doximity's paid version. Our primary method for Virtual Care remains our Epic-integrated MyChart Zoom visit. If clinicians are unable to reach patients some alternatives for video connections include Skype, non-MyChart based Zoom, or Facetime, as well as an audio-only call. If you want to mask your own number, some options include "*67" and connecting through the hospital operator. Reportedly Doximity will continue to offer the number masking for providers. We actively are looking for an alternative to offer improved number masking.

UCI EPIC News

Tip of the Month:

Ambulatory: Use "Sign My Visits" Function to Find & Sign Open Encounters

You work off the schedule to close your ambulatory encounters but you still have open encounters! Often patients are "checked in" (telemedicine) but the visit never occurs, patients may leave before being seen or an addendum is unsigned... You can find all these (potentially hidden) open encounters (and any others) using a special tool in Epic. Using the **Sign My Visits** function, clinicians can review and sign all their outstanding visits in one place. If any items need additional follow-up, jump to the appropriate place in the patient's chart while keeping the **Sign Visits** activity open in the sidebar. You also access Sign My Visits function via the Epic (drop-down) toolbar > Patient Care.

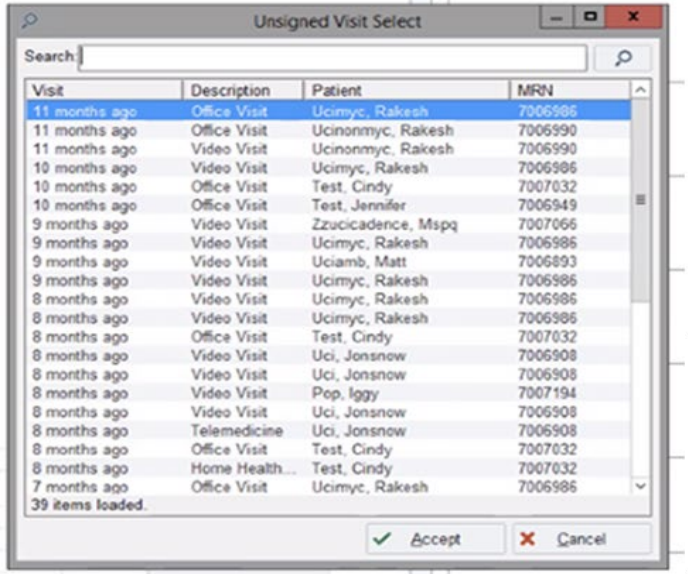


UCI EPIC News

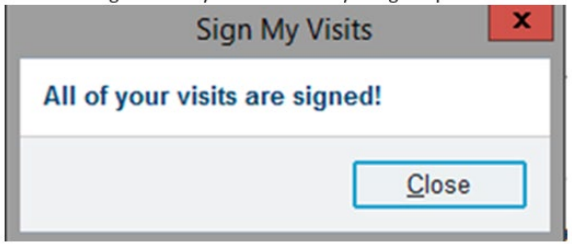
Tip of the Month:

Ambulatory: Use "Sign My Visits" Function to Find & Sign Open Encounters

Click and complete tasks in each open chart. To see a full list of open encounters assigned to you, click on the number in the bottom right to open a new window with a table including patient name, MRN, and encounter information.



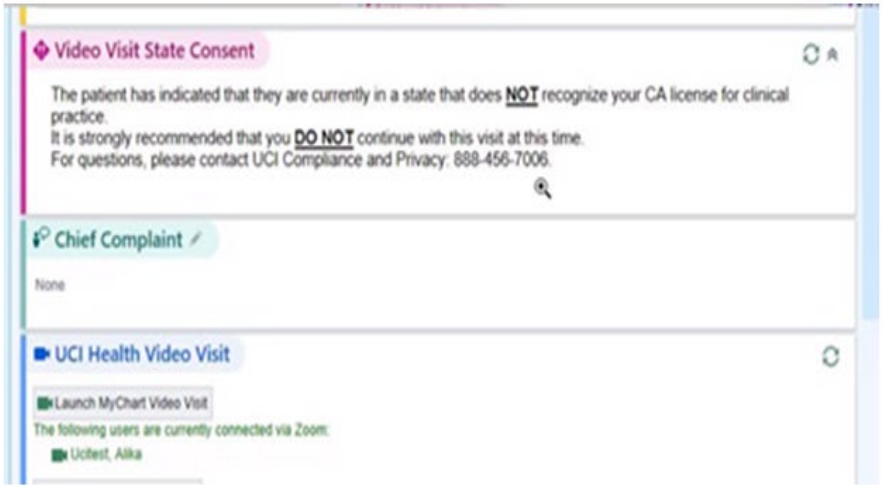
This message means you are officially caught up:



UCI EPIC News

Ambulatory: Update to the Video Visit Consent for Patients

Patients will now consent that they will be in the state of California for the duration of their MyChart Video Visit. Care outside the state of California is contingent upon state-by-state telehealth regulations. If the patient's location, by state, does not allow for such services (red box; Wisconsin in the example below), per Compliance, providers will receive a notification advising against telehealth care services.



Questions

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