2022 Evaluation and Management Services

Tri-State Cancer Summit

5/21/2022

Objective

Learn the documentation and billing changes for Evaluation and Management services

Agenda

- Office or Other Outpatient
- Split (shared) services
- Incident to
- Critical care
- Teaching physician services
- Infusion services

Time

- CPT for 2021 changed descriptions for the 99202 – 99215 procedure codes
- Description includes precise times
    - No longer typical time
- Count time spent on the calendar date of the visit by
    - Physician
    - Non-Physician Practitioner (NPP)
- Do not count time spent by
    - Ancillary staff
    - Clinical staff
    - Patient waiting for test results or other services
- Counseling/coordination of care not required
- Meet the lowest time listed in the code
- Includes both face-to-face and non-face-to-face services
- New Patient
    - 99202 – 15 – 29 minutes
    - 99203 – 30 – 44 minutes
    - 99204 – 45 – 59 minutes
    - 99205 – 60 – 74 minutes
- Subsequent Patient
    - 99212 – 10 – 19 minutes
    - 99213 – 20 – 29 minutes
    - 99214 – 30 – 39 minutes
    - 99215 – 40 – 54 minutes

Activities

- Face-to-face time with the patient
- Non-face-to-face time on the patient
    - Prepare to see the patient (e.g., review of tests)
    - Obtain and review separately obtained history
    - Perform a medically appropriate exam or evaluation
    - Counsel and educate patient/family/caregiver
    - Order drugs, tests, or procedures
    - Refer and share with other health care professionals (when not separately reported)
    - Record clinical data in the patient's medical record
    - Interpret results (not separately reported) and share results with the patient/family/caregiver
    - Care coordination (not separately reported)

Not Separately Reported

- Service for which there is a procedure code
    - Interprofessional consultations
    - The professional component of a test
        - Requires a distinct written and signed report
    - Care coordination
- When billing separately
    - Carve out the time spent on the service from the time for the E/M

Documentation

- Notate service
- Connect time spent on service
- Must support the code chosen

Common Questions

- Do I have to meet the mid-point of time in procedure code?
    - No
        - Codes have a range of times
        - Must meet the lowest time listed
        - Example – 99202 – must record at least 15 minutes
- Can I count time spent in the 24 hours prior to visit?
    - No
        - Count time spent on the calendar date of the visit
- Can I use time if the practitioner does not document on the date of the visit?
    - Yes
        - Count time on the date of the visit
        - Do not include the time spent on a different date
- How do we resolve one physician's standard time of 25 minutes with another's standard of 35 minutes?
    - Record must support the level of service chosen

Extended Care Service

- G2212 – Added time spent on the date of the patient visit

    - 15 minutes each unit
- Only applied
    - When choosing code based on time
    - Exceeds time for 99205 or 99215 by 15 minutes or more
    - 99205 – must record at least 89 minutes
    - 99215 – must record at least 69 minutes
- CPT code 99417 not valid for Medicare billing
    - CPT allows when time exceeds code time by one minute
- Do not use for time spent on a separate calendar date
- See the CMS Fact Sheet – Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits
    - https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

Common Questions

- Can we use the G2212 when choosing the level of service based on MDM?
    - No
    - Valid when using time to choose your level of service
    - Valid when exceeds 99205 or 99215 by 15 minutes or more
- Do we have to record at least 8 minutes to use?
    - No
    - Must record at least 89 minutes for new patient
    - Must record at least 69 minutes for established patient
- Do we have to record start and stop times?
    - No
    - CMS Internet-Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.15.D
        - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
    - CMS has not yet changed the IOM with the new rules

Other Prolonged Care Codes

- Cannot use other prolonged care with the 99202 – 99215
- 99354-99355
    - Face-to-face prolonged care
- 99358-99359
    - Non-face-to-face prolonged care
- 99415-99416
    - Prolonged supervision of clinical staff

Common Questions

- Can we submit the 99358 to account for time when the patient contacts the office 2 days later?
    - No
    - Pricing for E/M is for 3 days prior and 7 days after
    - Time and service during this period are part of the E/M allowed amount
- Can we submit the 99358 to show time when the patient contacts the office 15 days later?
    - No

    - Look for support for other codes such as
        - G2012 – Virtual check-in
        - 99421 – 99423 – On-line digital service
        - 99441 – 99443 – Telephone service (during the Public Health Emergency (PHE) only)
- Can we use the 99358 for time reviewing test results and changing the plan of care after the visit?
    - No
    - You cannot use the 99358/99359 to connect to an E/M service
- See the CMS Fact Sheet- Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits
    - https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation- and-management-em-visits-fact-sheet.pdf

Medical Decision-Making (MDM)

- Three elements
    - Number and complexity of problems addressed
    - Amount and complexity of data reviewed and analyzed
    - Risk of complications, morbidity, or mortality of patient management
- Four levels
    - Straightforward (99202) (99212)
    - Low (99203) (99213)
    - Moderate (99204) (99214)
    - High (99205) (99215)
- This is the same for both new and established patients
- Must meet or exceed two of the three elements

Number of Problems Addressed

- AMA definition
    - "Problem – A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter."
    - "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 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 health care professional reporting the service."

Problem Level Minimal or Low

- Minimal
    - 1 self-limited or minor problem
- Low

- 2 or more self-limited or minor problems
  - Runs a definitive course
  - Transient in nature
  - Not likely to permanently alter health
- 1 stable chronic illness
  - Expected duration of at least a year or until death
  - Patient meets or exceeds decided goal
  - Risk of morbidity **without** treatment is significant
- 1 acute, uncomplicated illness or injury
  - Recent or short-term problem with low risk of morbidity
  - Treatment considered
  - Self-limited or minor but not clearing up

Problem Level Moderate

- 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
  - Acutely worsening
  - Poor control
  - Progressing with intent to control progression
  - Requiring additional supportive care
  - Requires actions to treat side effects
  - Does not need thought of hospital level of care
- 2 or more stable chronic illnesses
- 1 Undiagnosed new problem with uncertain prognosis
  - Problem in differential diagnosis indicates an illness or injury likely to result in high risk of morbidity without treatment
    - Note this does not state new problem to practitioner
- 1 Acute illness with systemic symptoms
  - Systemic symptoms
  - High risk of morbidity without treatment
  - Can be a single system
- 1 Acute complicated injury
  - Assess body systems not directly part of injured organ
  - Injury is extensive
  - Treatment options are multiple
  - Risk of morbidity

Problem Level High

- 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment
  - Documentation would show "severe"
  - Severe side effects of treatment
  - May need hospital level of care
- 1 acute or chronic illness or injury that poses a threat to life or bodily function
  - Poses a threat to life or bodily function in the near term
  - Systemic symptoms
  - Acute complicated injury
  - Chronic illness or injury with exacerbation or progression
  - Side effects of treatment

Amount and Complexity of Data to be Reviewed and Analyzed

Categories

- Requires mixtures of two or three categories
  - Each level of service requires certain records
  - Items may change based on the level of service
- Category 1 – Tests and documents
  - Review of prior external notes (each unique source)
  - Review of result(s) of each unique test
  - Order of each unique test
- Category 2
  - Assessment requiring independent historian (low level)
    - This item moves to Category 1 for moderate or high MDM
  - Independent interpretation of tests
    - Moderate or high level
- Category 3
  - Discussion of management or test interpretation

Minimal

- Minimal or none

Limited

- Must meet the requirements of 1 of 2 categories
- Category 1 – Tests and documents
  - Need any mixture of 2 of the following:
  - Review of external notes
    - Each unique source
  - Review of unique test
    - Test – imaging, laboratory, psychometric, or physiologic data
    - Unique based on CPT code description
    - Professional service not reported separately
  - Order of unique test

▪ Count order and review of same test once

- Category 2 – Assessment requiring independent historian
  - Patient is unable to provide complete or accurate history
  - Another person provides history in addition to patient
  - Requires a confirmatory history
  - No need to obtain in-person

Moderate

- Must meet requirements of 1 out of the 3 categories
- Independent historian moves to Category 1
- Category 1 now requires 3 elements
- Category 2 - Independent interpretation of tests
  - This is the professional service
  - Requires report
  - Does not have to meet standard of normal interpreting physician

    - Not billing separately
- Category 3 – Discussion of management or test interpretation
    - Real-time communication
        - Interactive exchange
    - Professional involved in patient care
- External
    - Not same office
    - Not same specialty
- Includes
    - Facilities
    - Other professionals
- Does not include
    - Family or informal caregivers
    - Discussions between physician, NPP, or ancillary staff in the same practice
- When would I use the "review" bullet?
    - Reviewing tests ordered by an external source
    - The order not counted before
- Can I count a Medicare non-covered test?
    - Yes
    - AMA instructions do not require a Medicare covered test
    - Document medical necessity for test
- Would the review of a letter or response from a consult count as discussion?
    - No
        - This could be review of external notes
    - Discussion is real-time interaction between the two parties

Risk of Complications, Morbidity, or Mortality of Patient Management

Risk

- Probability and/or effects of an event
- Level affected by the nature of event under consideration
- Based on usual behavior and thought processes of practitioner
- Base on effects of problem(s) addressed at encounter when appropriately treated
- Includes MDM related to starting or foregoing further testing, treatment, or hospitalization
- Includes treatments adopted and those thought about but not put in place

Minimal or Low

- Minimal – Minimal risk of morbidity from other diagnostic testing or treatment
- Low – Low risk of morbidity from other diagnostic testing or treatment
    - The AMA does not provide examples

Common Question

- Can we use examples in the 1995 or 1997 Documentation Guidelines?
    - The 2021 AMA instruction does not provide examples for minimal or low
    - Record must support definitions listed above

Moderate Risk

- AMA MDM grid provides examples

- Meeting an example does not always mean meeting the level
- Prescription drug management
    - Managing the patient's prescription medications
    - Not medication management
        - Includes over the counter and supplements
    - Does not require
        - New medication
        - Change in dosage
        - Stopping a medication
- Surgery
    - Minor with
        - Known patient or procedure risk
    - Elective major without
        - Known patient or procedure risk
- Social determinants of health
    - Diagnosis or treatment severely limited by
        - Economic and social conditions that affect health
        - Food or housing insecurity

High Risk

- Drug therapy requiring intensive monitoring
    - Potential to cause serious morbidity or mortality
    - To assess adverse effects
    - Not for efficacy
    - May be long or short-term
        - Long-term is not less than quarterly
    - Lab test, physiologic test, or imaging
        - History or exam does not count
    - Affects the level of MDM for the visit
- Elective major surgery
    - With known patient or procedure risk
- Emergency major surgery
- Patient needs hospitalization
- Determine patient is do not resuscitate (DNR)
- Decision to deescalate care due to poor prognosis

Surgery

- Major or minor
    - Clinical decision based on patient
- Elective or emergency
    - Timing of procedure when timing related to patient condition
        - Elective – Planned in advance
        - Emergency – Performed immediately
    - May be major or minor
- Risk factors
    - Relevant to patient and procedure
    - Evidence-based risk calculators not required

Common Questions

- Can we count level of risk when physician decides, but patient declines certain care?
  - Yes
  - This is the decision even if patient declines to follow the advice
- Would a sample prescription count as prescription drug management?
  - Yes
  - Practitioner is making prescription drug choices
- How does Medicare define major or minor surgery?
  - Record practitioner's judgement in patient medical record
- Can we count an over-the-counter medication when management is to decide appropriateness with patient's prescription drugs?
  - Yes
  - This is managing patient's prescription drug

Split (shared) Services

- Definition
  - Evaluation and Management (E/M) service
  - Facility setting
  - Physician and non-physician practitioner (NPP) provide services
  - In the same group
  - Either could perform and submit the service
  - Submit under the practitioner who performs the substantive portion of the service
- Facility Setting
  - Institutional setting in which Medicare does not pay for services and supplies furnished incident to
    - Hospital
    - Skilled Nursing Facility
- Physician and NPP
  - Allowed by Medicare rule and state law to perform the service
- Same group
  - CMS does not define group
  - Billing and performing professionals will determine if they are part of the same group
  - Keep records of how you are defining group
- Perform and submit the service
  - Both professionals can perform the E/M service independently
  - Both professionals can receive payment from Medicare
- Substantive Portion
  - Effective January 1, 2023
    - More than half the total time of the encounter
  - Effective January 1, 2022 - Transitional Period
    - Time
      - More than half the total time of the encounter
      - Sum the total time of the encounter
      - Determine who provided the most time
      - Add the time practitioners meeting once to the time for the encounter
      - Add the meeting time to the billing practitioner

        - Qualifying time
            - Does not assist in choosing the procedure code
            - Can assist to determine billing practitioner
            - Preparing to see the patient (for example, review of tests)
            - Obtaining and/or reviewing separately obtained history
            - Performing a medically needed 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 (not separately reported)
        - History
        - Exam
        - Medical Decision-Making
            - Billing practitioner must perform a component in its entirety
            - Billing practitioner documentation must support the component that chooses the level of service
            - Would not count the other practitioner services for that component to choose the level of service
- Face-to-Face
    - One practitioner must have face-to-face with patient
    - Does not have to be billing practitioner
- Prolonged Care
    - January 1, 2023
        - Practitioner providing substantive portion submits the prolonged care
    - January 1, 2022
        - Practitioner billing the service submits the prolonged care when documentation supports
        - Outpatient – G2212
        - Other – Correct prolonged code
        - Does not apply to
            - Emergency
            - Critical Care
- Patient status
    - Applies to
        - New and established
        - Initial and subsequent
- Documentation
    - Both parties document their service
    - Signature and date of signature by the person providing the substantive service and submitting the service
- Claim Submission
    - Include Modifier FS

        - Shows the split (shared) service
        - Include regardless of who submits the service
    - Modifier 52 not appropriate
        - Medicare does not pay for a partial E/M service
- Payment
    - Physician submitted
        - Allowed at 100% of the Physician Fee Schedule
    - NPP submitted
        - Allowed at 85% of the Physician Fee Schedule

Incident to

- CMS Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy, Chapter 15, Section 60 contains instructions
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Applies to locations other than hospital or skilled nursing facility
- Must meet all requirements
    - Location
        - Other than hospital or skilled nursing facility
    - An integral, although incidental, part of the physician's professional service (section 60.1)
    - Commonly rendered without charge or included in the physician's bill (section 60.1A)
    - Of a type that are commonly furnished in physician's offices or clinics (section 60.1A)
    - Furnished by the physician or by auxiliary personnel under the physician's direct supervision (section 60.1B)

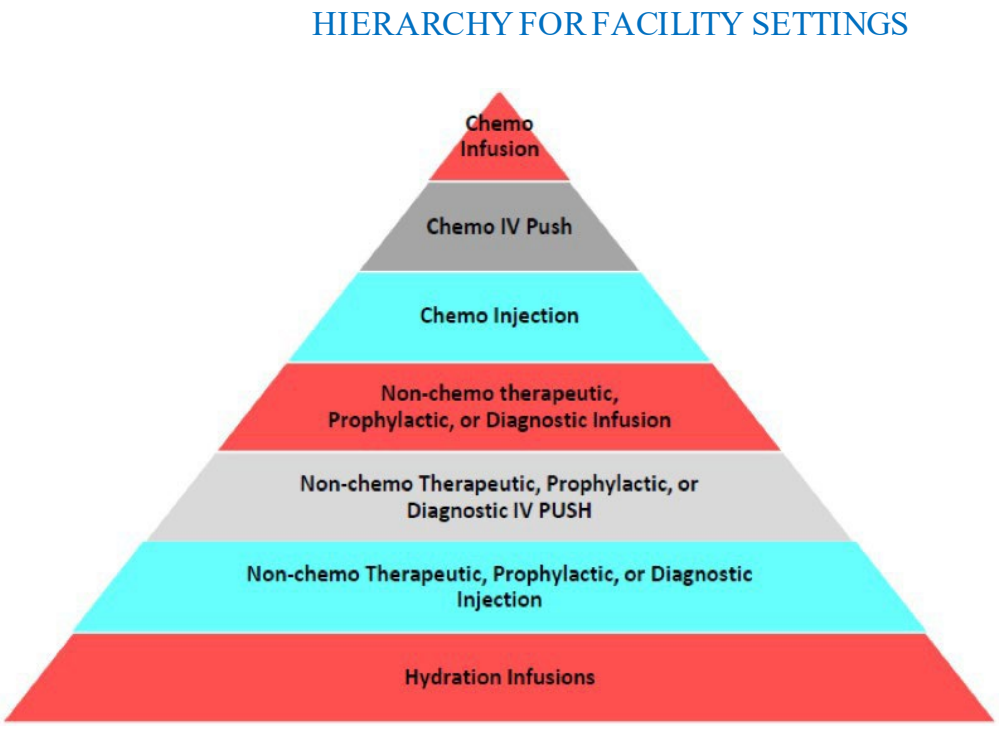
Critical Care

- Location
    - Typically
        - Critical care unit
        - Emergency room
        - Not restricted to those locations
- Definition
    - CPT Codebook definition
    - Direct delivery of care
    - Critically ill or injured patient
        - Acute impairment of one or more vital organ systems
        - Probability of imminent or life-threatening deterioration of patient condition
        - High complexity medical decision-making
        - At the time of the service
    - Full attention of practitioner
        - Cannot provide service to other patients during the same time
        - Face-to-face
        - Floor or unit
- Bundled care
    - Interpretation of cardiac output measurements
    - Chest x-ray

    - Pulse oximetry
    - Blood gases
    - Collection and interpretation of physiological data
    - Gastric intubation
    - Temporary transcutaneous pacing
    - Ventilator management
    - Vascular access procedures
    - Specific procedure codes
        - National Correct Coding Initiative
            - https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits
        - Procedure to Procedure (PTP) edits
- Time
    - Count time practitioner spent on bundled services
    - Do not count time on procedures billed separately
    - Count time spent directly providing care to the patient
    - When the patient is critically ill or injured
    - Does not have to be continuous or contiguous
    - Going over a midnight
        - Count toward the date started
        - If a break in care, start a new calendar date
    - 99291 – first 30 to 74 minutes
    - 99292 – each additional 30 minutes (can bill when reach 104 minutes)
- Multiple Providers
    - Different specialties
        - Active role in patient treatment
        - Patient has multiple conditions
        - Must be medically necessary
        - Must not be duplicative of other practitioners
        - Must be critical care (not consultations)
            - Consultations billed as initial or subsequent hospital visits
        - Bill the 99291 and 99292 as time and service permits
    - Same specialties/Same group
        - One physician bills the 99291
        - One physician does not need to meet the entire time
        - Bill under the physician who has the most time
            - The first 30 to 74 minutes of critical care service
        - If more time, submit the 99292
            - Meeting time and service requirements
    - Non-physician practitioner (NPP) is a separate specialty from a physician
        - NPP provides independent service
            - Normal critical care rules apply
        - NPP provides follow-up or split (share) care to a physician
            - Both critical care and split (shared) rules apply
            - Submit under the practitioner with the substantive portion of time
            - Submit using Modifier FS
- Global Period
    - Applies to same day and within the global period of the procedure

    - Service is does not relate to the procedure performed
    - Patient requires critical care
    - Care is above and beyond care related to the procedure
    - Append Modifier FT
    - Surgeon transfers post-op care to another
        - Surgeon submits surgical code with Modifier 54
        - Other practitioner submits surgical code with Modifier 55 and FT
        - Care is unrelated
- Multiple Services
    - Another E/M provided on the same date
    - Prior to the critical care
    - Patient did not need critical care at the time of the first service
    - Services separate and distinct from the critical care and not duplicative
    - Medically necessary
    - Use Modifier 25 on the critical care service
- Documentation
    - Support patient is critically ill or injured
    - Show medical necessity for the practitioner's service
    - Support any concurrent care
    - Support the time spent by the practitioner
    - If split (shared), show time of both practitioners and who provided the substantive portion

Hierarchy



Infusion Time Requirements:

Infusion Time Requirements

Infusion Time for Chemo and Non-Chemo Drugs	Coding Guideline
15 minutes or less	Any administration lasting 15 minutes or less is not an infusion and is appropriately coded as an IV push
16-90 minutes	Billed with a code representing the first hour of an infusion
91-150 minutes 151-210 minutes Etc.	Bill 1 unit of an additional hour code Bill 2 units of an additional hour code Etc.
Infusion Time for Hydration	**Coding Guideline**
30 minutes or less	Cannot be billed as hydration
31-90 minutes	Billed as the first hour of hydration
91-150 minutes 151-210 minutes Etc.	Bill 1 unit of the additional hour code Bill 2 units of the additional hour code Etc.

WPS GOVERNMENT HEALTH ADMINISTRATORS

Resources

- CMS MM 12543 - Internet-Only Manual Updates (IOM) for Critical Care, Split/Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants
    - https://www.cms.gov/files/document/mm12543-internet-only-manual-updates-iom-critical-care-split-shared-evaluation-and-management-visits.pdf
- CMS MM 12550 - Internet-Only Manual Updates for Critical Care Evaluation and Management Services
    - https://www.cms.gov/files/document/mm12550-internet-only-manual-updates-critical-care-evaluation-and-management-services.pdf
- Code of Federal Regulations – 42CFR410.26 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.26
- CMS IOM Publication 100-02, Medicare Benefits Policy, Chapter 15, Section 60
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- CMS Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing, Chapter 12, Section 30.6
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
        - Not all information pertains to office and other outpatient
- CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.4
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- CMS Fact Sheet – Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) visits

    - https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf
- CMS Evaluation and Management Guide
    - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- CMS News Release – Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021
    - https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
- American Medical Association Evaluation and Management Office or Other Outpatient (99202 – 99215) and Prolonger Services (99354, 99355, 99356, and 99417) Code and Guideline Changes
    - https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- WPS Infusion Services Resource Guide:
    - https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/infusion-services/
- CMS IOM Publication 100-08, Chapter 3 , Section 3.6.2.4
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
- CMS IOM Publication 100-04, Chapter 12, Section 30.5(D and E)
    - https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- WPS Local Coverage Article (LCA) A58544 – Billing and Coding: Complex Drug Administration Coding
    - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=5854
- Targeted Probe and Educate Topics
    - https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/targeted-probe-and-educate-topics/
- Medical Review Calculator
    - https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/medical-review-calculator/
- Use the Portal to Submit Prepayment/Post Payment Review Documentation
    - https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/infusion-services/

Notes: