New Year, New Medicare and Lessons Learned from CMS Rules

Dr. Richard Soden

Welcome!

Host: Dr. Stephanie Woo

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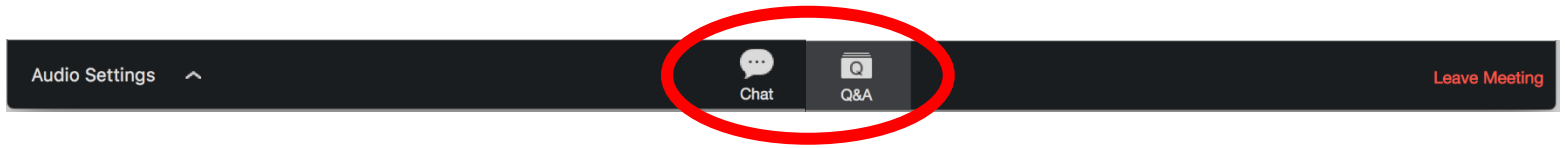
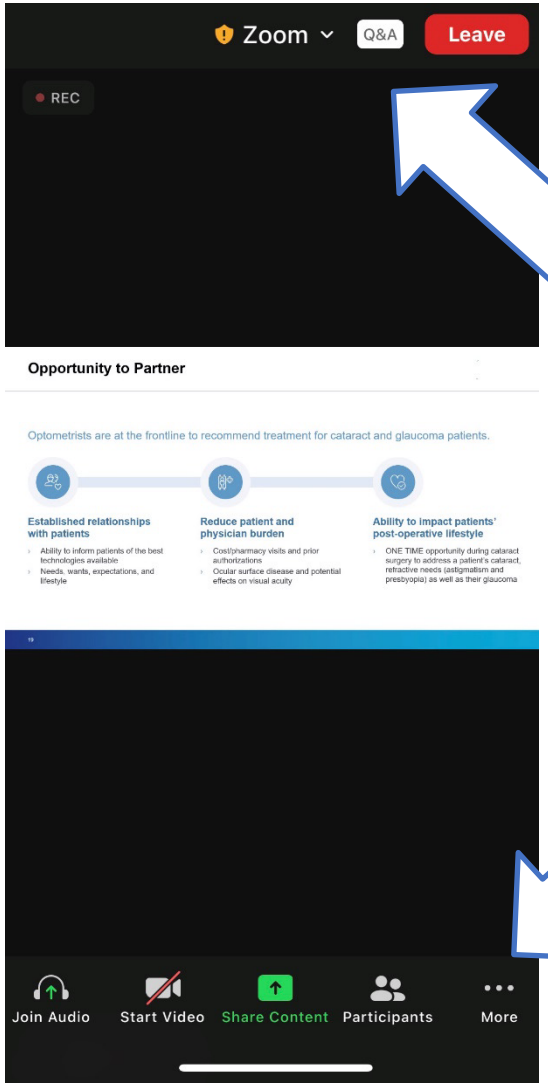
- For a COPE certificate, please fill out the survey link in the chat. Also, the survey link will appear when the webinar ends.
- CE certificates will be delivered by email and sent to ARBO with OE tracker numbers
- **CE certificates will be emailed within 4 weeks**
- Ask questions using the zoom on-screen floating panel




Zoom
Q&A
Leave
REC
Opportunity to Partner
Optometrists are at the frontline to recommend treatment for cataract and glaucoma patients.
Established relationships with patients
Ability to inform patients of the best technologies available
Needs, wants, expectations, and lifestyle
Reduce patient and physician burden
Cost/pharmacy visits and prior authorizations
Ocular surface disease and potential effects on visual acuity
Ability to impact patients' post-operative lifestyle
ONE TIME opportunity during cataract surgery to address a patient's cataract, refractive needs (astigmatism and presbyopia) as well as their glaucoma
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Speaker Bio

Richard M. Soden, O.D., F.A.A.O. is a Clinical Professor and currently the Director of Health Care Development At SUNY College of Optometry. Previously, he served as Vice President for Clinical Affairs at SUNY Optometry for 10 years. Dr. Soden graduated from SUNY college of Optometry in 1979. After graduation, he completed a residency program at the Northport VA Medical Center on Long Island. Dr. Soden remained at Northport VA for 26 years as the Associate Chief of Optometry Service. Dr. Soden was also a member of a large optometric practice in Lake Ronkonkoma, N.Y. In addition to primary care optometry, his special interests are in pediatrics, children with special needs and low vision rehabilitation for children and adults. He is recognized as a low vision specialist and has worked with the Commission for the Blind for his entire optometric career. After leaving the VA and private practice, Dr. Soden returned to SUNY College of Optometry as Vice President for Clinical Affairs.

Dr. Soden also serves as a third party consultant for the New York State Optometric Association and has lectured extensively in third party reimbursement and practice management. He is currently a member of the AOA's Coding Committee and prior to this, was a member of the Third Party Committee.

Financial Disclosures

- Nothing to Disclose

Objectives

- To thoroughly review the 2021 “E & M” changes with case examples and lessons learned during the past year
- New ICD-10 codes for 2022-2023
- Proposed Medicare changes 2022 and beyond
- New Benefit Package for Routine Vision Care – Not Included

“E & M” Outpatient Coding and Billing 2021

- In 2021, Medicare/CMS finalized the first major change for outpatient office billing and coding since the 1990’s
- Significant changes in “Evaluation and Management (E&M)” coding will start in January 2021
- CMS and AMA collaborated on this effort

CMS Reducing Provider Burden
Most extensive changes to “E&M” coding since their inception!

Goal: Reduce Administrative Burden on Clinicians
(EHR notes, Scribes, E/M inflation, etc.)
Goal: Increase Time Devoted to Patient Care

National Government Services

medicare university

Patients Over Paperwork – 2019 – Key Elements

- Simplifying documentation of history and exam for new and established patients E&M office/outpatient visits:
  - Clinicians can focus on what has changed since last visit
  - Clinicians can review and verify rather than re-enter a Chief Complaint, history or other historical information already recorded by ancillary staff or by patient; Practitioners may simply indicate in medical record that s/he reviewed and verified the information
  - No longer need to re-record defined list of required elements if there is evidence practitioner reviewed previous information and updated as needed
  - Practitioners should still review prior data, update as necessary, and indicate in medical record that they have done so

Proper Documentation

- Describes what the physician did and what was performed
- Identifies indications for treatment
- Demonstrates informed consent for treatment
- Shows adherence to clinical standards
- Supports medical necessity for a claim

2021 E&M Codes- Summary of Changes

1. Applies ONLY to office based E&M Codes; other E&M service locations remain the same (i.e. hospital, nursing homes, patient's home, etc.)
2. Deletion of code 99201
3. Revised codes 99202–99205, 99211–99215
4. Changed code selection components used to:

   Medical Decision Making (MDM) or Time

   (Instead of history, examination, MDM, and time)

5. Changed definition of MDM and time components
6. Added new and shorter prolonged services code
7. In is anticipated that there will be no change to the definitions of general ophthalmological services at this time!

2021 E&M Codes- Summary of Changes

- Office or other outpatient services include a medically appropriate history and/or physical examination, when performed
- The nature and extent of the history and/or physical examination is determined by the treating physician (Dilation required ???)
- The care team may collect information and the patient or caregiver may supply information directly (i.e., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional
- The extent of history and physical examination is not an element in selection of office or other outpatient services – Coding with based upon either MDM or Time!

Medically Appropriate History

- Reason for the visit (chief complaint)
  - What is important for the patient's care?
  - What do you need to know about the patient to properly care for him/her?
  - What information is not necessary to properly care for him/her? (Episodes that happened many years ago such as a broken arm 20+ years ago)
- Pertinent history of present illness (HPI)
    - When, what, where, why, how?
- Medical observations that address current health status and any contributory systemic diseases (ROS, PFSH)
- Think Medical-Legal, Think Standard of Care, Think Quality Reporting

Medical Decision Making (MDM)

- Four (4) Levels of MDM (unchanged from the current levels of MDM)
  - Straightforward
  - Low risk
  - Moderate
  - High

What is MDM?

- Medical decision making (MDM) refers to the complexity of establishing diagnose, assessing the status of a condition, and/or selecting a management option as measured by the following elements:
  - The number of possible diagnoses and/or the number of management options that must be considered
  - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and/or
  - The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

2021 E&M Code Changes

Why has 99201 been deleted?

- Both 99201 and 99202 had straightforward medical decision making
- Code ONLY differentiated ONLY by history and examination levels
- History and examination components no longer relevant to code choice
- Thus code 92201 was deleted

REVISED MDM TABLE

Levels of Medical Decision Making (MDM) (Effective January 1, 2021)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of MDM		
		Number and Complexity of Problems Addressed at the Encounter	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	**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

*Under the element "Amount and/or Complexity of Data to be Reviewed and Analyzed," each unique test, order, or document contributes to the combination of 2 or 3 components in the Category 1 listings

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

02-NP: 15-29
12-EP: 10-19

03-NP: 30-44
13-EP: 20-29

04-NP: 45-59
14-EP: 30-39

05-NP: 60-74
15-EP: 40-54

Note for 99211
NO time
NO physician work
Staff ONLY

2021 E&M Code Changes- MDM

- There will be a clearer definition of;
  - What constitutes a test ordered or reviewed
  - Independent interpretation of a test
  - Who is an independent historian
- MDM does not apply to 99211
  - Can be used by office staff
- Interpretation and Report requirements for separate codes are NOT part of MDM for E&M code selection (e.g. VF, Gonioscopy, OCT, Photography, etc.)

Medical Decision Making

- Modifications to the criteria for MDM
  - Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”)
  - Re-defined the Data MDM element to move away from simply counting tasks to focusing on tasks that affect the management of the patient

Three Elements of MDM

Let’s take a deep dive each of the elements

MDM Element 1:

Number and complexity of problem(s) that are addressed during encounter

- There are 5 levels for this element
  - N/A
  - Minimal
  - Low
  - Moderate
  - High

Element 1: Medical Decision Making (MDM) Element Criteria: Number and Complexity of Problems Addressed at Encounter

CPT Code	Level of MDM	Number and Complexity of Problems Addressed at Encounter Criteria
99211	N/A	N/A
99202 99212	Straightforward	Minimal 1 self-limited or minor problem
99203 99213	Low	Low 2 or more self-limited or minor problems or 1 stable chronic illness or 1 acute, uncomplicated illness or injury

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 undiagnosed new problem with uncertain prognosis or 1 acute illness with systemic symptoms or 1 acute complicated injury
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

Risk

- The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.
- Presenting problem risk -VS-Management Risk
- Essentially, AMA is stating that the presenting problem risk of the patient takes precedence over the management risk of the patient.
- In other words, Medical Necessity still controls the level of E&M service

Problems Addressed and Documentation

- A problem is addressed or managed when it is evaluated or treated at the encounter by the physician
- It can include the following:
  - Disease
  - Condition
  - Illness
  - Injury
  - Symptom
  - Sign
  - Finding
  - Complaint
  - Other issues noted at encounter
- This may be with or without a diagnosis being established at encounter

"Problem" Defined

Problem is *addressed or managed* when it is evaluated/ treated during visit by physician

Includes consideration of further testing or treatment that may not be chosen due to risk/benefit analysis or patient (parent/guardian/surrogate) choice

Problem NOT Addressed if:

- Note in record that problem managed by another professional without additional assessment or care coordination does not qualify as "*being addressed*" or *"managed"* by the clinician reporting the service
- Referral made without evaluation/treatment consideration for problem being documented
- Listing a diagnosis without consideration of test/treatment

Number and Complexity of Problems

- **Minimal (99202,99212)**
  - One self-limiting or minor problem
- **Low (99203, 99213)**
  - Two or more self-limiting or minor problems
  - One chronic or stable problem
  - One acute, uncomplicated illness or injury

Number and Complexity of Problems

- **Moderate (99204, 99214)**
  - One or more chronic problem with exacerbation, progress or treatment complications
  - Two or more stable chronic illness
  - One undiagnosed new problem with uncertain prognosis
  - One acute illness with systemic symptoms
  - One acute complicated illness
- **High (99205, 99215)**
  - One or more chronic problem with severe exacerbation, progress or treatment complications
  - One acute or chronic illness or injury that poses a threat to life or bodily function

Most examples are from AMA/CMS – very few pertain to eye care!

Self-Limited or Minor Problem (STRAIGHFORWARD MDM)

- Runs a defined and prescribed course
- Transient in nature
- Not likely to alter health status permanently

Sub- Conjunctival Heme

Glaucoma Patient Complaining of Itchy Eyes

Stable Chronic Illness: (LOW MDM)

- **Expected duration of 1 year or m**ore
- **Key Factors**
  - **Chronic**
    - Stable or Unstable
  - **Stable**
    - Varies-treatment goals for that patient
    - Not stable if not at goal
      - Even if no condition change
      - Even without short-term threat to life or function
      - Stable if at goal
  - **Risk of morbidity without treatment**

OPTOMETRY EXAMPLES: glaucoma, AMD, keratoconus, dry eye (depending on stability of patient's condition), cataract, ptosis

Examples of Stable Chronic Illness

Well controlled HTN

Well controlled DM

Acute Uncomplicated Illness or injury (LOW MDM)

- Recent or new short-term problem
- Low risk of morbidity
- Treatment considered
- Full recovery expected without treatment
- Typically self-limiting but not resolving as expected

Examples:

Cystitis

Allergic rhinitis

Simple sprain

OPTOMETRY EXAMPLES : bacterial conjunctivitis, hordeolum, corneal foreign body

Chronic Illness with exacerbation, progress or treatment side effect (MODERATE MDM)

- **Chronic Illness**
  - Worsening
  - Poorly controlled
  - Progressing with intent to control progression
  - Requiring additional supportive treatment
  - Requiring treatment for side effects
  - No consideration of hospital care

Asthma exacerbation

OPTOMETRY EXAMPLES: progressive glaucoma, progression to wet AMD

Undiagnosed new problem with uncertain progress (MODERATE MDM)

- New problem
- Differential diagnosis shows high risk of morbidity without treatment

Example:
Breast Lump

OPTOMETRY EXAMPLES: pseudopapilledema (e.g. elevated discs without known cause), high risk glaucoma suspect, suspicious choroidal nevus

Acute Illness with Systemic Symptoms (MODERATE MDM)

- Acute illness with systemic symptoms
- High risk or morbidity without treatment
- Systemic symptoms may be within a SINGLE system (do not have to be general symptoms)

NOTE: general symptoms like fever, body aches, fatigue that may be treated to lessen symptoms, shorten illness or reduce complications are considered minor or acute and uncomplicated illness or injury

Examples:

Pyelonephritis

Pneumonitis

Colitis

Retinal vasculitis, preseptal cellulitis, herpes keratitis

Acute Complicated Injury (MODERATE MDM)

- Injury requiring treatment
  - Needs evaluation of body systems not directly related to injury
- Injury extensive
- Multiple treatment options
- Treatment options associated with morbidity risk

Example:

Head injury with brief loss of consciousness

OPTOMETRY EXAMPLES: head trauma, blunt trauma to eye, Retinal detachment, laceration

Chronic Illness with severe exacerbation or progression or side effects of treatment (HIGH MDM)

- Chronic illness with severe exacerbation or progression
- Severe side effect of treatment with significant risk of morbidity
- May require hospital care

COPD exacerbation

OPTOMETRY EXAMPLES: Optic neuritis from MS, glaucoma with systemic side effect from Beta blocker

Acute or Chronic Illness or Injury with Threat to Life or Bodily Function (HIGH MDM)

- Acute illness with systemic symptoms
- Acute complicated injury
- Chronic illness with exacerbation or progression
- Chronic injury with exacerbation or progression
- Side effects of treatment with threat to life or bodily function in near term without treatment

Examples:

Acute myocardial infraction, Pulmonary embolus

Severe respiratory distress, Severe rheumatoid arthritis, Psychiatric illness with potential self threat

Psychiatric illness with potential threat to others, Peritonitis, Acute renal failure, Abrupt change in neurological status

OPTOMETRY EXAMPLES: GCA, CRAO, Orbital Cellulitis, Endopthalmitis, Shaken Baby Syndrome

Reminder

Underlying disease or comorbidities not consider for E&M level selection UNLESS they are:

1. Addressed in visit
2. Presence increase amount or complexity of data to be reviewed
3. Risk of complication, morbidity or mortality of patient management

Number and Complexity of Problems Addressed at the Encounter

- Multiple new or established conditions may be addressed at the same time and may affect medical decision making
- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition
- The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction

Number and Complexity of Problems Addressed at the Encounter

- “The term ”risk” as used in these definitions relates to risk from the condition
- While condition risk and management risk from often correlate, the risk from the condition is different from the risk of management”

Problems

Self-limited or minor problem (Straightforward MDM)	A problem that runs a definite and prescribed course, in transient in nature, and is not likely to permanently alter health status OPTOMETRY EXAMPLES: subconjunctival hemorrhage, allergic conjunctivitis; Glaucoma patient complaining of itchy eyes
Stable, chronic illness **(Low MDM)**	A problem with an expected duration of at least one year or until the death of the patient. "Stable" indicates consistently meeting treatment goal. Varies with treatment goals for the patient Chronic can be stable or unstable. Condition is not stable if not at goal; condition is stable if at goal Risk of morbidity without treatment OPTOMETRY EXAMPLES: glaucoma, AMD, keratoconus, dry eye (depending on stability of patient's condition), cataract
Acute, uncomplicated illness or injury **(Low MDM)**	A recent or new short-term problem with low risk of morbidity for which treatment is considered. Full recovery expected. Typically self-limiting but not resolving as expected OPTOMETRY EXAMPLES: bacterial conjunctivitis, hordeolum
Chronic illness with exacerbation, progression or side effects of tx **(Moderate MDM)**	A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or attention to treatment side effects. No consideration of hospital care. OPTOMETRY EXAMPLES: progressive glaucoma, progression to wet AMD
Undiagnosed new problem with uncertain prognosis **(Moderate MDM)**	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. OPTOMETRY EXAMPLES: pseudopapilledema (e.g. elevated discs without known cause), high risk glaucoma suspect, suspicious choroidal nevus

Problems

Acute, complicated injury with Systemic Symptoms **(Moderate MDM)**	Acute illness with systemic symptoms; systemic symptoms may be within a single system High risk or morbidity without treatment An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. OPTOMETRY EXAMPLES: Uncontrolled diabetes and/or uncontrolled HTN with ocular manifestations, head trauma,
Acute Complicated Injury **(Moderate MDM)**	Injury requiring treatment; needs evaluation of body symptoms not directly related to the injury Injury extensive; multiple treatment options Tx options associated with morbidity risk OPTOMETRY EXAMPLES: head trauma, blunt trauma to the eye
Chronic illness with severe exacerbation, progression or side effects of treatment **(High MDM)**	Significant risk of morbidity and may require hospitable level of care OPTOMETRY EXAMPLES: Optic neuritis from MS, glaucoma with systemic side effect from Beta blocker
Acute or chronic illness or injury that poses a threat to life of bodily function **(High MDM)**	An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment. OPTOMETRY EXAMPLES: GCA, CRAO, Orbital Cellulitis

MDM Element 2: Amount and/or Complexity of Data to be Reviewed and Analyzed

- This element was previously titled “Amount and/or Complexity of Data to be Reviewed.” This emphasis is expressed through the following 3 key changes:
  - An expanded definition of data: In the CPT E/M 2021 guidelines, “Data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.”
  - The introduction of criteria categories, each of which reflects a different type of data, and work required by the physician utilized in evaluating the patient
  - Reporting requirements that fulfill certain category criteria for a specific MDM level, providing flexibility to the physician or other QHP based on the needs of an individual patient

MDM Element 2:
Amount and/or Complexity of Data to be Reviewed and Analyzed

- There are 4 levels for this element
  - Minimal or None
  - Limited
  - Moderate
  - Extensive

Data

- Document review (not simply receipt)
    - External notes
    - External tests
- Provider orders for tests from other sources
- Essential comments by independent historian
- Provider discussion with an outside physician
- Interpretation of tests ordered/performed outside

Data

- Examples (Not So Good)
  - Patient brought in records from a referring physician
  - Patient brought in tests from referring physician
  - Patient to have blood work, ERG, genetic tests
  - Albino accompanied by parents
  - Refer patient to retinal specialist
  - Review blood work and MRI

- Preferred Documentation
  - Reviewed notes from referring physician today
  - Reviewed OCT and HVF from referring physician today
  - Ordered blood work, ERG and genetic tests from _____.
  - Albino patient seen today; parents expressed that their child has decreased vision OU and cannot tolerate bright lights
  - Called at spoke to retinal specialist
  - Interpretation of blood work shows _____; interpretation of MRI shows _____

Data

- **Data is divided into three (3) categories:**
  1. Tests, documents, orders, or independent historian(s)
     a. *Each* unique test, order, or document is counted to meet a threshold number
     b. Procedures with separate CPT Codes are not included for interpretation (e.g. VF, OC, Extended Ophthalmoscopy, etc.)
     c. Other Tests (Contrast, TBUT, Schrimer) not included as they are part of an eye examination
  2. Independent interpretation of tests performed by another physician/other QHP (not separately reported);
  3. Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

     (e.g. Talking to MD, OMD, OT, PT, Social Workers, Nurses, etc.)

2021 MDM – Data

Category 1: Tests and Documents, or Independent Historian

Amount and/or complexity of data to be reviewed and analyzed including:

a. Medical records

b. Interpretation of tests

c. Other information obtained, ordered, reviewed, and analyzed – not separately coded and collected during encounter itself including

1. Information obtained from multiple sources or interprofessional communications that are not separately reported
2. Interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter. Each unique test, order or document is counted to meet a threshold number
3. Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

TESTS: What tests do and do not count?

- Tests you perform in your office with their own CPT Codes – NO!
- Tests you perform as part of your examination that do not have their own CPT Codes such as contrast sensitivity, TBUT, Schrimers – NO!
- Tests you order from Labs: CT scans, MRI's, Blood Tests – YES!
- Tests performed by other offices and you interpreted or reviewed them – YES!
- Counting tests:
  - Each unique test – ordered and reviewed with previous tests = 1 test
    - If you ordered a test, it is assumed you also reviewed the test
  - Each unique test has its own CPT code
    - CBC is one test and not multiple ones
    - Cholesterol test = 1 test no matter how many separate times that test is performed
    - HA1C – 1 test no matter how many separate times the test is performed

Data Complexity

Example: Dr. Smith is seeing Debbie. He has reviewed and summarized medical records from general her PCP, ordered blood work and, obtained a detailed history from the parents of Debbie's health status

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)

Data

- This component includes the interpretation of tests that are not separately reported
  - If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making
  - Possible examples of Tests included in E/M:
    - Medical Testing:
      - TBUT, Schirmers, Amsler Grid, Contrast Sensitivity (NO)
      - Order an X-RAY, MRI, lab work etc. or send from other sources that you may need to review and interpret your self (YES)

Key Definitions and Reporting Considerations for Category 1

- ***Test, Documents, or Independent Historians.***
  - Category 1 outlines subgroups for tests, documents, and orders that may be performed for all MDM levels. For moderate and high levels of MDM, an option to assess a problem, illness, or injury that requires the participation of an independent historian is also included as a subgroup
  - Each unique test, order, or document contributes to the combination of 2 or 3 components in the Category 1 listing
  - However, to fulfill the requirements for Category 1, activities in a minimum of two different subgroups must be performed

Test, Documents, and Independent Historians: Terms and Definitions

Term	Definition
Test	Tests are services that result in imaging, laboratory, psychometric, or physiologic data. The differentiation between single and multiple unique tests is defined in accordance with the CPT code set. When a CPT code representing a clinical laboratory panel is reported (e.g., CPT code 80047, *Basic metabolic panel (Calcium, ionized)),* it is considered a single test.
External note(s)	External note(s) are record(s), communication(s), and/or test result(s) from an external physician/other QHPs facility or health care organization.
Independent historian(s)	An independent historian is an individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to the history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. Key to this definition is that the independent historian should provide additional information, and not merely restate information already provided by the patient. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the information

TESTS: What Test do and do not count?

- Tests you perform in your office with their own CPT Codes – NO!
- Tests you perform as part of your examination that do not have their own CPT Codes such as contrast sensitivity, TBUT, Schrimers – NO!
- Tests you order from Labs: CT scans, MRI's, Blood Tests – YES!
- Tests performed by other offices and you interpreted or reviewed them – YES!
- Counting tests:
  - Each unique test – ordered and reviewed with previous tests = 1 test
    - If you ordered a test, it is assumed you also reviewed the test
  - Each unique test has its own CPT code
    - CBC is one test and not multiple ones
    - Cholesterol test = 1 test no matter how many separate times that test is performed
    - HA1C – 1 test no matter how many separate times the test is performed

Tests and Independent Historian

- New key reporting considerations should be noted for tests and independent historians. The 2021 guidelines state, “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.”
- For independent historians, “In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met”
- In addition, within this element it is important to note that Category 1 criteria are considered met only when activities in at least two *different* subgroups are completed. For moderate and high MDM, activities in at least three different subgroups must be completed

Data

Category 2: Independent interpretation of tests

- Independent interpretation of a test performed by another physician/other QHP (not separately reported);

Key Definitions and Reporting Considerations for Category 2

- ***Independent Interpretation of Tests.*** This category addresses the work performed by a physician's independent interpretation of a test that has not been separately reported by another physician or other QHP, who performed the E/M service for the same patient at a different encounter. Key reporting considerations include the following:
- The test should be one for which there is a CPT code and an interpretation or report is customary
- A form of independent interpretation should be documented by the physician or other QHP but it does not have to conform to the usual standards of a complete report for the test
- If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM

Data

Category 3: Discussion of management or test interpretation

- Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

Discussion with an External Physician or other Qualified Health Care Provider

- An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency
- Discussion requires an interactive exchange
- The exchange must be direct and not through intermediaries (eg, clinical staff or trainees)
- Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange
- The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter
- It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two)

Key Definitions and Reporting Considerations for Category 3

- ***Data Element Category 3: Discussion of Management or Test Interpretation.*** This category recognizes the work performed by the physician or other QHP in discussion of management or test interpretation with an external physician or other QHP or appropriate source.

-

Discussion of Management or Test Interpretation: Definitions

Term	Definition
External physician or other qualified health care professional	An external physician or other qualified health care professional is one who is not in the same group practice or is a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be at a facility such as a hospital, nursing facility, or home health care agency.
Appropriate Source	In this element, an appropriate source includes professionals who are not health care professionals but may be involved in the evaluation and management of the patient's problem (e.g., lawyer, parole officer, case manager, teacher). It does *not* include discussion with family or informal caregivers. (Frequently performed with low vision patients)

MDM Element: Amount and/or Complexity of Data to be Reviewed and Analyzed

CPT Code	MDM Level	Amount and/or Complexity of Data to be Reviewed and Analyzed Criteria
99211	N/A	N/A
99202 99212	**Straightforward**	**Minimal or none**
99203 99213	**Low**	**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)

This is only a separate category for 99203 and 99213

99204 99214	**Moderate**	**Moderate** (Must meet the requirements of at least 1 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 QHP (not separately reported); *or* Category 3: Discussion of management or test interpretation •Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

99205 99215	**High**	**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 QHP (not separately reported); *or* Category 3: Discussion of management or test interpretation •Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

2021 Amount and/or Complexity of Data to be Reviewed & Analyzed

Category	99202 99212 Min/None	99203 99213 1 of 2	99204 99214 1 of 3	99205 99215 2 of 3
Category 1 – Tests & Documents	-	X	X	X
Category 2 – Independent Historian (E/M 3 only)	-	X		
Category 2 – Independent Interpretation of test (E/M 4, 5)			X	X
Category 3 – Discussion of Management or Test Interpretation			X	X

Data Complexity

- **<u>Minimal or None (99202, 99212)</u>**

- **<u>Limited</u> (Must complete one of two categories) (99203,99213)**

  Category 1 (complete any combination of two of following:

  1. Review of prior external notes from unique source
  2. Review results of each unique test
  3. Ordering of each unique test

  Category 2:
  Assessment requiring an independent historian

Data Complexity

- **<u>Moderate</u> (Meet at least 1 out of three categories) (99204, 99214)**

Category 1: Test documents or independent historian (any combination of three)

1. Review of prior external notes from unique source
2. Review results of each unique test
3. Ordering of each unique test
4. Assessment requiring an independent historian

Category 2: Independent interpretation of tests

Independent interpretation of test performed by another physician/QHP (not separately reported)

Category 3: Discussion of management or test Interpretation

Discussion of management or test interpretation with external physician/QHP – appropriate source (not reported separately)

What tests do and do NOT count as Data

- Tests you bill for in your office: OCT, VF, etc **NO!!**
- Tests you perform as a part of your examination: Contrast Sensitivity, TBUT, Schirmer's **NO!!**
- Tests you order from labs: CT scans, MRI, Blood Tests **YES!!**
- Tests performed by other offices and your interpret, review **YES!!**

How to count tests:

Each unique test – Ordered and reviewed long with 4 previous tests = **1 test**

If you order test, then assumed you also reviewed that test

Each unique test has own CPT code – CBC is one test not multiple

Cholesterol test = 1 test no matter how many separate tests

Ha1c = 1 test no matter how many separate tests

Data Complexity

- Example: Dr. Smith is seeing Debbie. He has reviewed and summarized medical records from general her PCP, ordered blood work and, obtained a detailed history from the parents of Debbie's health status

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)**

Data Complexity

- **<u>Extensive</u> (Meet at least 2 out of 3 categories) (99205, 99215)**

Category 1: Test documents or independent historian (any combination of three)

1. Review of prior external notes from unique source
2. Review results of each unique test (not reported elsewhere
3. Ordering of each unique test
4. Assessment requiring an independent historian

Category 2: Independent interpretation of tests

Independent interpretation of test performed by another physician/QHP (not separately reported)

Category 3: Discussion of management or test Interpretation

Discussion of management or test interpretation with external physician/QHP – appropriate source (not reported separately)

MDM Element 3: Risk of Complications and/or Morbidity or Mortality of Patient Management

- This element was previously titled “Risk of Complications and/or Morbidity or Mortality.” Guideline changes for this element in CPT 2021 E/M increased the emphasis on work performed by the physician or other QHP in addressing patient-management decisions made at the visit that would be associated with the patient’s problem(s), the diagnostic procedure(s), and/or treatment(s)
- It is important to note that this element encompasses the work of both the possible management options selected, as well as those considered but not selected, after sharing the MDM with the patient and/or family.
- Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining the risks and benefits of management options

MDM Element :3

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

- There are 4 levels for this element
  - Straightforward
  - Low
  - Moderate
  - High

Risk

- In the CPT 2021 E/M guidelines, *risk* is described as the probability and/or consequences of an event

  (Loss of visual function)

- The assessment of the level of risk is affected by the nature of the event under consideration. For example, a high-risk procedure may have a low probability of death whereas a low-risk treatment may have a high risk of a minor, self-limited adverse effect. Definitions of risk are based on the usual behavior and thought processes of a physician or other QHP in the same specialty
- For the purposes of MDM, the level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization

Risk

- The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.
- Presenting problem risk -VS-Management Risk
- Essentially, AMA is stating that the presenting problem risk of the patient takes precedence over the management risk of the patient.
- In other words, Medical Necessity still controls the level of E&M service

2021 MDM – Consists of Three (3) Elements

Risk Includes:

a) Complications, morbidity, and/or mortality of patient management decisions made at the visit
b) Associated patient's problem(s)
c) Diagnostic procedure(s) and treatment (s)
d) Possible management options selected and those considered, but not selected
e) Includes shared medical decision making with the patient and/or family

Appropriate risks should be addressed and documented

All risks should be explained to the patient and documented in the chart

Management

- Patient management decisions, made at the visit associated with the patient's problem(s), are graded based on the risk of complications, morbidity, and/or mortality. This includes possible management options selected and those considered but not selected after discussion with the patient and/or family
- Did you?
  - Identify treatment options?
  - Explain all options?
  - Note timing – urgent vs. emergent
  - Identify Risk factors
  - Give informed consent?

Medical Decision Making (MDM) Element Criteria: Risk of Complications and/or Morbidity or Mortality of Patient Management

CPT Code	Overall MDM Level	Criteria
99211	N/A	N/A
99202 99212	**Straight-forward**	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	**Low**	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	**Moderate**	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 THESE ARE ONLY EXAMPLES

99205 99215	**High**	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 (Retinal Detachment??) -Decision regarding hospitalization -Decision not to resuscitate or to de-escalate care because of poor prognosis

THESE ARE ONLY EXAMPLES

Surgery (minor or major, elective, emergency, procedure or patient risk):

- **Surgery–Minor or Major:**
  - The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.”
  - These terms are not defined by a surgical package classification
- **Surgery–Elective or Emergency:**
  - Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition
  - An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization
  - Both elective and emergent procedures may be minor or major procedures
- **Surgery–Risk Factors, Patient or Procedure:**
  - Risk factors are those that are relevant to the patient and procedure
  - Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk

MDM: Risk of Complications and/or Morbidity or Mortality

- **Minimal Risk** - from treatment (including no treatment) – essentially no risk from additional diagnostic testing or treatment
- **Low risk** – very low risk of anything bad from additional diagnostic testing or treatment

Risk Levels Defined

- **<u>Moderate Risk</u> of mortality by additional diagnostic testing or treatment**
  - **Examples:**

    Prescription drug management

    Decision-minor surgery with patient/procedure risk factors identified

    Decision-major surgery with patient/procedure risk factors identified

    Diagnosis or treatment significantly limited by social determinants of health

Risk Levels Defined

- **<u>High Risk</u> of mortality from additional diagnostic testing or treatment**
  - **Examples:**

    Drug therapy requiring intensive monitoring for toxicity

    Decision-elective major surgery with patient/procedure risk factors identified

    Decision-emergency major surgery

    Decision regarding hospitalization

    Decision to Not resuscitate or de-escalate care due to poor prognosis

Morbidity and Social Determinants of Health

- Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment (Ocular Disease)
  - **Illness/functional impairment expected to be of substantial duration and function is limited**
  - **Quality of life is impaired**
  - **Organ damage may not be transient even with treatment**

- Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity
  - Use ICD-10 Z codes to document that care may be limited as a result of social determinants of health

FIGURE 1

Social determinants of health encompass a wide range of factors

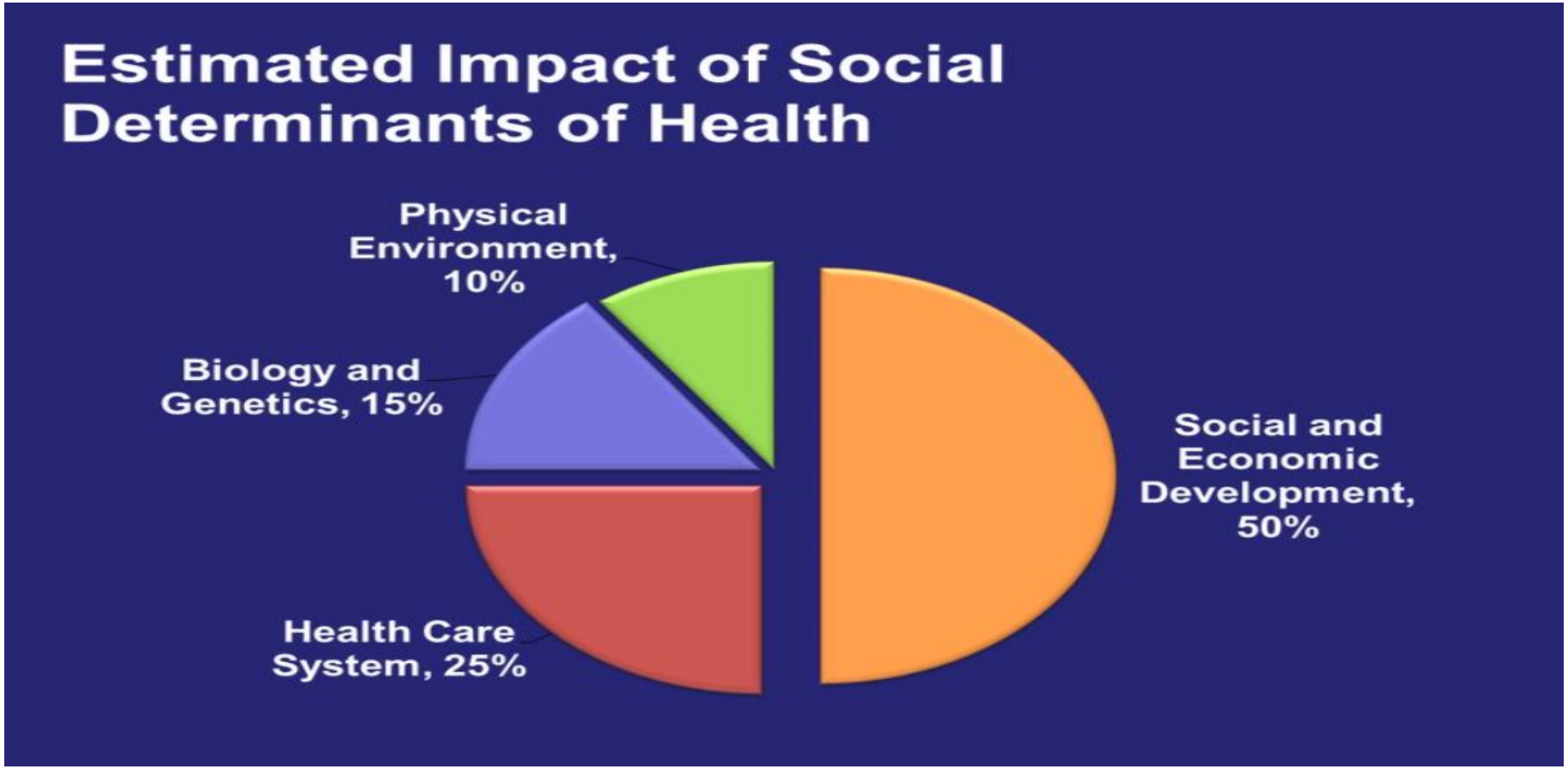
Source: Deloitte analysis.

ECONOMIC STABILITY	NEIGHBORHOOD AND PHYSICAL ENVIRONMENT	EDUCATION	FOOD	COMMUNITY AND SOCIAL CONTEXT	HEALTH CARE SYSTEM
Employment	Housing	Literacy	Hunger	Social Integration	Health Provider Availability
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Linguistic and Cultural Competency
Expenses	Safety	Early Childhood Education		Community Engagement	Quality of Care
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education			
Support	Walkability				

What are Social Determinants of Health (SDoH)?

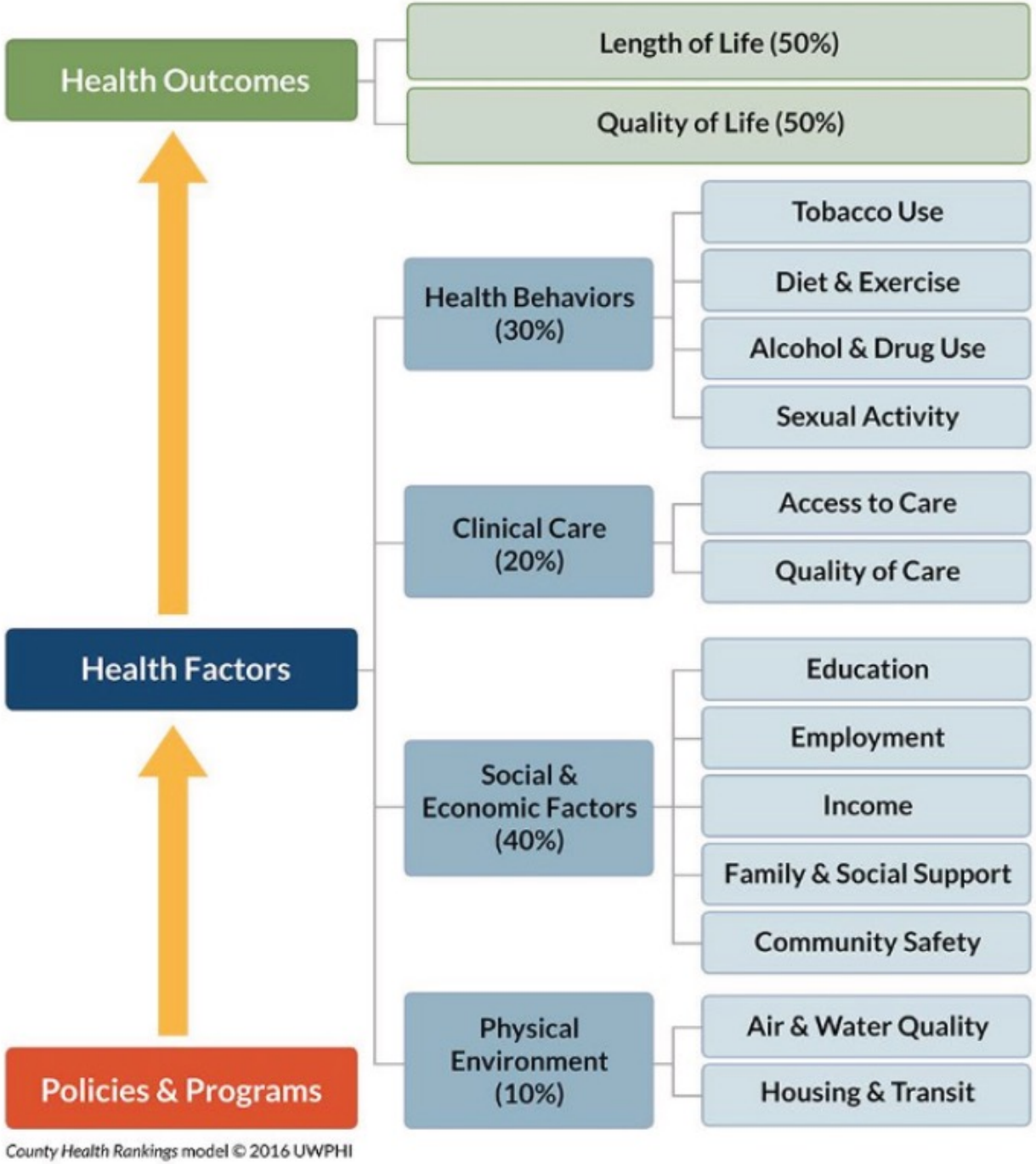
***It also includes* lack of insurance, lack of access to medications, etc.**

SDoH Impact



- *Social factors account for 25-60 percent of deaths in the United States in any given year according to various meta-analyses. (Hieman & Artiga, 2015)*

- *Up to 70 percent of a person's overall health is driven by these social and environmental factors and the behaviors influenced by them. (Schroeder, 2007)*



Eye Care Practices can impact all of these areas with a small effort

Social Determinants of Health 101 for Health Care: Five plus Five Sanne Magnan, MD, PhD, HealthPartners Institute; University of Minnesota.October 9, 2017

Reporting Social Determinants of Health – "Z" Codes

- Z55 – Problems related to education and literacy
  - Illiteracy/low-level, schooling availability, failing school, underachievement, discord with teachers
- Z56 – Problems related to employment and unemployment
  - Changing of job, losing job, no job, stressful work schedule, discord w boss/co-workers, bad working conditions
- Z57 – Occupational exposure to risk factors
  - Noise, radiation, dust, other air contaminants, tobacco, toxic agents in farming, extreme temperatures, vibration, others
- Z59 – Problems related to housing and economic circumstances
  - Homeless, inadequate housing, discord with neighbors/landlord, problems w residential living, lack of adequate food/safe drinking water, poverty, low income, insufficient social insurance/welfare support
- Z60 – Problems related to social environment
  - Adjustment to life-cycle transitions, living alone, cultural differences, social exclusion and rejection, discrimination/persecution
- Z62 – Problems related to upbringing
  - Inadequate parental supervision/control, parental overprotection, upbringing away from parents, child in custody, institutional upbringing (orphan or group home), hostility towards child, inappropriate/excessive parental pressure, child abuse including history of (physical and/or sexual), neglect, forced labor, child-parent conflict
- Z63 – Other problems related to primary support group, include family circumstances
  - Spousal conflict, in-law conflict, absence of family member (death, divorce, deployment), dependent relative needing care, family alcoholism/drug addiction, isolated family
- Z64 – Problems related to certain psychosocial circumstances
  - Unwanted pregnancy, multiparity, discord with counselors
- Z65 – Problems related to other psychosocial circumstances
  - Civil/criminal convictions, incarceration, problems after release from prison, victim of crime, exposure to disaster/war, religious persecution

Morbidity and Social Determinants of Health

- Social determinants of health may become a significant component of the MDM puzzle in January
- If a clinician has to rethink his/her treatment options for a patient because of a social determinant of health and it's a significant rearrangement of their planning, that's actually considered a component to support moderate complexity MDM
- In the past that social determinants of health have never been mentioned, even though accountable care organizations are ensuring we are documenting and reporting them

Social Determinants of Health

- Components to consider:
  - Is the patient unable to go to the pharmacy and get the prescribed Rx (or see their medication bottles)?
  - Does the patient have a support system?
  - Is patient capable of remembering the take the medication?
  - Is they patient anxious or upset? Is the patient taking care of him or herself ?
  - Is the patient homeless?
  - Is the patient having any adverse effect of the recommended treatment and cannot continue with the treatment?
- Document why treatment plan did not or could not happen!

Definitions You Need to Know

Drug therapy requiring intense monitoring for toxicity

- Therapeutic agent with potential to cause serious mortality or morbidity or death
- Monitoring for adverse effects not therapeutic efficacy
- Generally medically accepted monitoring-short term
- Long term monitoring at least quarterly required
  - Lab tests
  - Physiological tests
  - Imaging

Monitoring not qualified:

IDDM: Glucose monitoring

Annual renal function/electrolytes for diuretic use

Monitoring qualified:

Cytopenia with antineoplastic agent between dosing cycle

Short-term intense monitoring of renal function/electrolytes for diuretic use

History/examination monitoring does not qualify

Putting It All Together – Use the Table

Medical Decision Making Table

To qualify for a particular level of medical decision making, <u>two of the three</u> elements for that level of decision making must be met or exceeded **(concept unchanged from current guidelines)**.

Eliminates the methodological distinction between new and established patients – same 2 of 3 rule for both

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	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

Number and Complexity of Problems	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management	MDM Type
Minimal	Minimal or None	Minimal	Straightforward
Low	Limited	Low	Low
Moderate	Moderate	Moderate	Moderate
High	Extensive	High	High

Drop the lowest component and bill the lowest of the remaining components

Medical Decision Making New or Established Patient

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

Code

Code				

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
				
				All risks and benefits explained to the patient and documented

*Under the element "Amount and/or Complexity of Data to be Reviewed and Analyzed," each unique test, order, or document contributes to the combination of 2 or 3 components in the Category 1 listings

The MDM levels are defined as follows:

- Straightforward – the E/M service has addressed a self-limited problem
- Low- the E/M service has addressed a stable, uncomplicated, simple problem
- Moderate- the E/M service has addressed multiple problems or the patient is significantly ill with a singular problem
- High- the E/M service has addressed singular or multiple problems for a patient who is very ill

These factors impact the MDM level as follows:

- Straightforward- review and analysis of data is minimal or none
- Low- two documents are reviewed and analyzed **OR** the provider elicits history from an independent historian, due to the patient's inability to provide history
- Moderate- **select one** of the following scenarios:
  - the provider reviews two documents **and** elicits history from an independent historian
  - the provider interprets document(s) prepared by another provider(s), e.g., diagnostic reports
  - the provider confers with another provider relative to the patient's problem
- High- same concepts as at the Moderate level but **applied to two** of the scenarios defined above

Risk is assigned relative to each of the levels as follows:

- Straightforward- no treatment is prescribed or there is minimal risk associated with the prescribed treatment or testing plan
- Low- problem(s) are associated with low risk and require minimal discussion and/or patient consent
- Moderate- the provider would review a moderately serious problem with the patient/surrogate, obtain necessary consent and monitor the outcome of the treatment plan. This would also apply in situations where complex social factors may impact patient management
- High- the provider would discuss potential higher risk problems that will require ongoing monitoring

Summary of Each Level - MDM

Code	MDM	Problems	Data	Risk
99211	NA	NA	NA	NA
99202	Straightforward	Minimal	Minimal/None	Minimal
99212	Straightforward	Minimal	Minimal/None	Minimal
99203	Low	Low	Limited (1/2)	Low
99213	Low	Low	Limited (1/2)	Low
99204	Moderate	Moderate	Moderate (1/3)	Moderate
99214	Moderate	Moderate	Moderate (1/3)	Moderate
99205	High	High	Extensive (2/3)	High
99215	High	High	Extensive (2/3)	High

Type of Decision Making

# Diagnoses/ Management Options	Amount/ Complexity Data Reviewed	Risk : Complications Morbidity Mortality	Decision Making type
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

Quick Overview of Coding "RULES"

Redefined levels of MDM:

1. Straightforward
2. Low
3. Moderate
4. High

MDM does not apply to 99211

3 Elements of MDM

1. Number/complexity of problem(s)
2. Amount and/or complexity of data reviewed and analyzed
3. Risk

Must meet 2 of 3 elements for code level

Problems (addressed/managed)

a) Disease
b) Condition
c) Illness
d) Injury
e) Symptom
f) Sign
g) Finding
h) Complaint
i) Other issues noted at encounter
j) Maybe with or without diagnosis being established at encounter

Risk

a) Complications, morbidity, mortality of patient management decisions made at visit
b) Associated patient's problem(s)
c) Diagnostic procedure(s) and treatment(s)
d) Possible management options selected and those considered, but not selected
e) Includes shared medical decision making with the patient and/or family

Data

Category 1: Test documents independent historian

a) Review of prior external notes from unique source
b) Review results of each unique test
c) Ordering of each unique test
d) Assessment requiring an independent historian

Category 2: Independent interpretation of tests

Independent interpretation of test performed by another physician/QHP (not separately reported)

Category 3: Discussion of management or test Interpretation

Discussion of management or test interpretation with external physician/QHP – appropriate source (not reported separately)

Coding Scenario – MDM Only

- **New patient referred for cataract evaluation**
  - Medically appropriate complaint/history
  - Appropriate examination
- MDM
- Addressed problems (Two or more stable conditions)(Moderate)
  - Cataract: recommend surgery
  - Eyes Itch: recommend artificial tears
- Data reviewed (Limited)
  - Review referring doctor records

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)

- Risk (Decision regarding elective major surgery without identified patient or procedure risk factors) (Moderate)
  - Recommend major Elective surgery
  - Discussed with patient and documented

Coding Scenario – MDM Only

Problems Addressed	Amount or Complexity of Data	Risk of Complications	E/M Code New & Est
Minimal	Minimal/None	Minimal	99202/99212
Low	Limited	Low	99203/99213
Moderate	Moderate	Moderate	99204/99214
High	Extensive	High	99205/99215

2 of 3 components of Medical Decision Making must be met or exceeded.

Drop the lowest component and bill the lowest of the remaining components

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

O2-NP: 15-29
12-EP: 10-19

3-NP: 30-44
3-EP: 20-29

4-NP: 45-59
4-EP: 30-39

05-NP: 60-74
15-EP: 40-54

Note for 99211
NO time
NO physician work
Staff ONLY

Examples: POAG Follow-up Glaucoma

- Well Controlled (At Treatment Goal):
  - Continue Xalatan drops
  - Code 99213

- Worsening (Not at Treatment Goal):
  - Continue Xalatan drops
  - Start Alphagan P
  - Code 99214

- In both visits, diagnosis of POAG is used and plan includes prescription medications.

- Difference in Medical Decision Making is a result of the differing clinical complexity of problem addressed: chronic, stable illness vs. chronic illness with exacerbation

Examples: POAG Follow-up Anterior Uveitis

- Anterior uveitis patient
  - Diagnosis:
    - Anterior uveitis - acute illness with systemic symptoms
    - Moderate
  - Tests:
    - Lab Ordering
    - Ordering HLA B27, ACE, Syphilis panel
    - Moderate
      - If uveitis patient has a history of RA and you discuss the case with the patient's rheumatologist, this increases this category
  - Risk:
    - Prescription medication management
    - Generating a prescription for Pred Forte
    - Moderate
- Coding: 99204 (moderate, moderate, moderate)
    - Moderate

Morbidity and Social Determinants of Health

- Social determinants of health may become a significant component of the MDM puzzle in January
- If a clinician has to rethink his/her treatment options for a patient because of a social determinant of health and it's a significant rearrangement of their planning, that's actually considered a component to support moderate complexity MDM
- In the past that social determinants of health have never been mentioned, even though accountable care organizations are ensuring we are documenting and reporting them

Social Determinants of Health

- Components to consider:
  - Is the patient unable to go to the pharmacy and get the prescribed Rx (or see their medication bottles)?
  - Does the patient have a support system?
  - Is patient capable of remembering the take the medication?
  - Is they patient anxious or upset? Is the patient taking care of him or herself ?
  - Is the patient homeless?
  - Is the patient having any adverse effect of the recommended treatment and cannot continue with the treatment?
- Document why treatment plan did not or could not happen!

Let’s Talk About Time

Time

- 2020:
  - When counseling and/or coordination of care dominates (over 50%), the encounter with the patient and/or family, time shall be the key or controlling factor to qualify for a particular level of E/M service
  - Only face-to-face counted
- 2021:
  - Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service
  - Includes face-to-face and some non-face-to-face

Time

- For coding purposes, time is the total time on the date of the encounter
- It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff)
- Ranges for total time (face-to-face and non-face-to-face) expended by the billing clinician in caring for a patient on the date of the patient's office visit are given for each code, replacing the typical face-to-face times previously provide
- If you are going to code based upon time, you must document the time in your record
- Teaching institutions. ???

Time

- Time:
  - Recognizes the importance of non face-to-face activities
  - Removes “midpoint” vs. “threshold” by giving exact ranges
  - There is no required minimum amount of time when using MDM for code selection
  - Clinical staff time (technician) is not counted as time for selection of an E/M code! – If the visit is only with a technician, use 99211

Time – Physician time includes the following activities, when performed:

- preparing to see the patient (e.g., reviewing records, review of previous tests, etc.)
- 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 (not separately reported)

Time

Time is calculated only for time spent on the day of the E/M encounter (not the day before or days following, even if additional services are provided on those days).

According to the AMA, the E/M work expense value already takes into consideration time spent caring for the patient (e.g., phone calls, prescriptions, questions, calling patient with test) for the three days prior to and seven days following the actual E/M service, so if time spent performing these services was counted in addition to the time spent on the actual date of the encounter, this would be considered double dipping.

Time – What does it not include?

- Time spent by clinical staff will *not* be included in the calculation of total time for the purposes of code selection because part of practice expense
  - If provider time is **only** spent in clinical staff supervision and clinical staff perform service➔ use 99211
- Charting after day of encounter
- Travel
- Communication with patient/family after day of encounter
- Time spent performing or interpreting test results billed separately on the same day (e.g. VF billed separately includes interpretation and report)
- Intern time (???)

Separately Reported Services

- Services with a specific CPT code are Not included in Total Time
- Such as Diagnostic Tests

Time

OD Time Spent – Example (Incorrect)

- Patient dilating in the waiting room - 15 min
- Examine patient - 10 min
- Refraction - 10 min
- Discussion with family members 5 min
- Total time spent 40 min
- Established patient: 99215 (40-54 minutes)

OD Time Spent – Example (Correct)

- ~~Patient dilating in the waiting room 15 min~~
- Examine patient 10 min
- ~~Refraction – 10 min~~
- Discussion with family members 5 min
- Total physician time spent 15 min - Instead of 40 minutes
- Established patient: 99212 (10-19 minutes)

2021 E&M Code Changes -TIME

Code	Time
99211	Not application
99202	15-29 minutes
99212	10-19 minutes
99203	30-44 minutes
99213	20-29 minutes
99204	45-59 minutes
99214	30-39 minutes
99205	60-74 minutes
99215	40-52 minutes

There is now a range of times instead of a single time!

Documentation

- *“CPT based on physician time spent:*
- *I spent __##__ minutes with this patient today, reviewing charts from outside physician, doing a medical evaluation, discussing with family members, coordinating care with an outside physician, ordering diagnostic tests from other facilities, and/or documenting in the electronic medical record.”*

Documentation of Time

- CPT provides code selection, not documentation standards
- However, all time-based coding requires a statement of time spent with enough specificity to meet code requirement
  - Example: Total time on the date of the encounter spent is 22 minutes
- How about time spent discussing the recent fishing trip?
  - Unless the fishing trip is relevant to the Evaluation and Management service, it is not counted!
- What about a clinician who is slow on the EMR?
  - There is no time adjustment for being slow or fast. Lack of efficiency for any reason is not rewarded in the new time methodology

Documentation of Time

- MEDICAL REVIEW WHEN PRACTITIONERS USE TIME TO SELECT VISIT LEVEL
  - Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.

Source: CMS Fact Sheet February 2021

Coding Scenario – TIME Only

- **Established patient returned complaining of double vision after an accident (Fell down a flight of steps and hit her head)**
  - Medically appropriate complaint/history
  - Appropriate examination
  - Exam start at 10:30 AM – Ended at 11:05 (35 minutes)
    - Long discussion regarding diplopia causes related to trauma and advised patient to wait one month before recommending prism or therapy to resolve double vision over time.

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

Exam starts at 10:30 AM – Ended at 11:05 AM (35 Minutes)

Code: 99214 (30-39 Minutes)

New Prolonged Service Codes

- **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, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (added to 99205 and 99215 only

CMS Final Rule Comments

Prolonged Services: 99417 and CMS replacement G2212

CMS replaced 99417 with G2212 due to time dispute with CPT

(ONLY CMS)

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

(Addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)
(Do not report G2212 for any time unit less than 15 minutes)

CMS Final Rule Comments

CMS replaced 99417 with G2212 due to time dispute with CPT (ONLY CMS)

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

(Addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)
(Do not report G2212 for any time unit less than 15 minutes)

Prolonged Services

Codes 99417 & G2212 are only used when the office visit has been selected using time alone as the basis and only after the total time of the highest-level services has been exceeded (i.e. 99205, 99215)

This MEANS 99205 or 99215 time has been exceeded by 15 minutes

To report a unit of 99417 or G2212 15 minutes of additional time must have been attained (not < than 15)

Do not report 99417 or G2212 for any additional time increment of less than 15 minutes

Prolonged Service Coding

Visit MUST last at least 75 minutes before you can use 99417

▶Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes

Only charge again once you have spent another 15 minute interval

Prolonged Service Coding

Visit MUST last at least 55 minutes before you can use 99417

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

Only charge again once you have spent another 15 minute interval

CMS Final Rule Comments

Total Time New Patient 99205 Prolonged Service Coding		
less than 75 minutes	60-74	Not reported separately
75-89 minutes	89-103	99205 X 1 and 99417 X 1
90-104 minutes	104-118	99205 X 1 and 99417 X 2
105 minutes or more	>119	99205 X 1 and 99417 X 3 or more for each additional 15 minutes

Total Time Established Patient 99215 Prolonged Service Coding		
less than 55 minutes	40-54	Not reported separately
55-69 minutes	69-83	99215 X 1 and 99417 X 1
70-84 minutes	84-98	99215 X 1 and 99417 X 2
85 minutes or more	>99	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

CMS Prolonged Services Required Times G2212 (Blue box)
vs
CPT Required Times (Green) 99417

AMA vs. CMS for Prolonged Services

Codes	Time range	CPT: times to add on 99417	CMS: times to add on G2212
99205	60-74 min.	75-89 min.	89-103 min.
99215	40-54 min.	55-69 min.	69-83 min.

Loss of Vision

- A neuro-ophthalmologist sees a 45 y/o new patient referred for evaluation and management of slow loss of vision with unexplained etiology
- The patient brings a copy of the complete medical record from the referring physician and ophthalmologist reviewed today
- Exam performed and findings discussed with patient. 90 minutes spent with patient, reviewing records from outside physician, performing exam, and documenting in medical record.

OD Time Spent

- Reviewing patient records today 15 min
  - Examine patient 45 min
  - Discussion with family members 10 min
  - Documenting in patient's record 20 min
  - Total physician time spent 90 min
- New patient: 99205 + 99417 x 2 (90-104 minutes)
- Alternate: 99205 + G2212 x 1 (89-103 minutes)

CPT: NP Prolonged Services

- **Duration of NP**

Office Visit	Code(s) Use with 99205
<75 mins	Not reported separately
75-89 mins	99205 and 99417 X 1
90-104 mins	99205 and 99417 X 2
≥105 mins	99205 and 99417 X 3 or more for each added 15 mins

- Do not report 99417 for any time unit less than 15 minutes

CMS: NP Prolonged Services

Duration of NP Office Visit	**Code(s) Use with 99205**
< 88 mins	Only 99205
89 - 103 mins	99205 and G2212 X 1
104 - 118 mins	99205 and G2212 X 2
119 - 133 mins	99205 and G2212 X 3

- Do not report G2212 for any time unit less than 15 minutes

Some Initial Thoughts Regarding "E & M" Changes

- Documentation – one of the purposes of proper documentation is to chronicle the patient's health history, telling the patient's specific story about their presenting problem
  - Each encounter will still be expected to chronical the patient's plan of care for each presenting problem for which the provider assumes care
  - Documentation of each encounter will still have an obligation to explain the **WHY** of each service rendered and the **COMPLEXITY** of each patient encounter
  - "Medical Necessity" is based completely on the documentation of each patient encounter
  - The more complex the patient is, the more physical/mental work is involved, and the more documentation is needed to communicate this
  - Reduced duplicative, extraneous notes

Some Initial Thoughts Regarding “E & M” Changes

- **Questions providers may be asking include:**
  - Can the patient wait for additional testing and results before receiving treatment?
  - What kind of treatment is required?
  - Are more conservative measures appropriate (e.g., rest, over-the-counter medications) or do they require a prescription medication to recover?
  - If a prescription is required, what are the risks associated with it and is it contraindicated with any other prescription medications or supplements the patient is already taking to treat another condition?
  - What are the other conditions (chronic or co-morbid) the patient has and how might the recommended treatment for the current problem exacerbate them? Will the patient require a minor, major, or emergency surgical procedure and if so, what risks, if any, are associated with the recommended procedure?
  - Is there a risk to an organ syste m, bodily function, or even the patient's life if they go without treatment (e.g., DNR, pal liative care) or if they choose to complete the treatment?

Documentation Considerations

- **Ensure Unique Documentation**
  - One issue that every clinician should consider double-checking is whether they're carrying forward information in their electronic health records using copy/pasting techniques without adding details about the current encounter
  - "If you're seeing a patient on follow up and you want to pull forward that old information, that's okay — but you should document how the patient has been doing since the last encounter
  - "There should be a unique story for each new visit and copy/pasting often gets in the way of that significantly"

Documentation Considerations

- How hard did you have to work and think?
- Did you document your thoughts
  - Example: I would consider glaucoma surgery in the future if drops do not work
  - Example: Should I refer a macular degeneration for cataract surgery?
- Indicate the tests that are being ordered and why
- Include documentation for interpretation when being performed
- Continue to document clinically appropriate history and examination
- Communicate the complexity of the conditions(s)

92002; 92012; 92004; 92014

- Initially, there was going to be a synchronization of eye codes and E/M codes with RVU's
- However, now CMS is proposing not to revalue these services because they are not sufficiently analogous or connected to the office/outpatient E/M visit codes
- These codes will be reviewed by CPT and RUC (time uncertain)

92000 vs 99000

- When reporting services related to an optometric or ophthalmologic office visit, it is important to closely review the CPT definitions and ensure that all criteria are met for the code used
- Unless you signed a managed care contract that specified when to use a specific set, you have a choice to use either the 92000 or 99000 codes for office visits

99000 vs. 92000

- How to decide?
  - When using “E&M” codes, all payers let you bill these codes as often as medically necessary; 92000 codes may have limitations on frequency
  - Record more clearly supports one or other
  - Patient’s insurer requires using one set or other

92OOO Series Exam Requirements

- History not defined other than must have CC
- There are 11 elements of an ophthalmogical examination, including:
  - 1. Test visual acuity (does not include determination of refractive error)
  - 2. Gross visual fields
  - 3. Eyelids and adnexae
  - 4. Ocular motility
  - 5. Pupils/iris
  - 6. Cornea
  - 7. Anterior chamber
  - 8. Lens
  - 9. Intraocular pressure
  - 10. Retina (vitreous, macula, periphery, and vessels)
  - 11. Optic disk

Requirements of Comprehensive Ophthalmological Service 92004/92014

- Payers may develop their own interpretations of a CPT definition
- The elements that are required by the CPT definition are:
  - 1. General evaluation of the complete visual system
  - 2. History
  - 3. General medical observation
  - 4. External examination
  - 5. Ophthalmoscopic examination (with or without cycloplegia or mydriasis)
  - 6. Gross visual fields
  - 7. Basic sensorimotor examination
  - 8. Initiation of diagnostic and treatment program
  - 9. Greater than 8 examination elements (carrier-specific)

  - Does this mean that if one (or more) of these elements is missing, the visit cannot be coded as comprehensive ophthalmological service?

- You bet it does!

Requirements of An Intermediate Ophthalmological Service 92002/92012

- Payers may develop their own interpretations of a CPT definition - the following elements are included in the CPT definition:
  - History
  - General medical observation
  - External ocular/adnexal examination
  - Other diagnostic procedures as indicated
  - Initiation or continuation of a diagnostic and treatment program
  - 1 to 7 (or possibly 8) examination elements (carrier-specific)

- Does this mean that if one (or more) of these elements is missing, the visit cannot be coded as an intermediate ophthalmological service?

- You bet it does!

Wording creating confusion Get the FACTS!

1. CPT® is **ONLY** official definition for codes
2. CPT® code wording is **ONLY** official definition for codes
3. CPT® code **introductions are NOT official definitions-** only to further explain code use

• **92012: Official Code Wording – established patients**

Ophthalmological services: medical examination and evaluation, with **initiation or continuation** of diagnostic and treatment program

• **92012: Introduction to Code Wording – established patients**

Evaluation of new/existing condition ***complicated by new diagnostic/management problem*** not necessarily related to primary diagnosis

Documentation Rules

If it’s not in the chart, it did not happen and even if it did happen, and the documentation was incomplete, untimely or otherwise improper, you shouldn’t be paid for it!

Coverage of eye examination is based on purpose of exam, not on the findings

Without complaint, not billable to Medicare and most carriers

For example: "no change since last visit," "here for annual exam," "here for follow-up," "no problems"

- Even if pathology found, exam not billable to Medicare

May be chronic illness being followed

For example: "here for 4 mo. f/up POAG OU," "Cataract check," "Yearly diabetes eval."

No Medical Necessity = No Reimbursement

Telehealth

- Proposal to continue certain services:
  - Home visits for established patients
- Proposal to eliminate certain services:
  - Home visits for new patients
  - Therapy Services, Physical and Occupational Therapy, All levels

Telehealth

- In response to the public health emergency (PHE) for the COVID 19 pandemic, CMS temporarily waived a number of these restrictions and adopted regulatory changes to expand access to Medicare telehealth
- Before the PHE, only 14,000 patients received a Medicare telehealth service in a week
- During the PHE, over 10.1 million patients received a Medicare telehealth service from mid-March through early-July

Reminders for Telehealth Services

- On/after 3/1/2020 and for duration of PHE:
  - Bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site)
  - POS equal to what it would have been (if were performed FTF) in the absence of a PHE
  - **CR modifier not required on telehealth services**
  - Telehealth services are professional services billed as distant site
  - Teaching physician may use audio/video telecommunications during key portions of service

Services Added to the Medicare Telehealth List on a Category 1 Basis

- For CY 2021, CMS is finalizing the addition of the following list of services to the Medicare telehealth list:
  - Group Psychotherapy - 90853
  - Psychological and Neuropsychological Testing- 96121
  - Domiciliary, Rest Home, or Custodial Care services - 99334-99335
  - Home Visits - 99347-99348
  - Cognitive Assessment and Care Planning Services - 99483
  - Visit Complexity Inherent to Certain Office/Outpatient E/M - G2211
  - Prolonged Services - G2212
- Category 1 means permanent Telehealth services

Addition of Services to the Medicare Telehealth List on a Category 3 Basis

- Category 3 - services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic (COVID-19 PHE) that will remain on the list through the calendar year in which the PHE ends:
  - Domiciliary, Rest Home, or Custodial Care services - 99336-99337
  - Home Visits - 99349-99350
  - Emergency Department Visits - 99281-99285
  - Nursing facilities discharge day management - 99315-99316
  - Psychological & Neuropsychological Testing- 96130-96133; 96136-96139

Addition of Services to the Medicare Telehealth list on a Category 3 Basis

- Therapy Services, Physical and Occupational Therapy - 97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
- Hospital discharge day management - 99238-99239
- Inpatient Neonatal and Pediatric Critical Care - 99469, 99472, 99476
- Continuing Neonatal Intensive Care Services - 99478-99480
- Critical Care Services - 99291-99292
- End-Stage Renal Disease Monthly Capitation Payment - 90952, 90953, 90956, 90959, 90962
- Subsequent Observation and Observation Discharge Day Management - 99217; 99224-99226

Originating Site

- Definition: Where the patient is located during telehealth service
  - Geographic restrictions waived
  - Originating site now includes patient home
  - No originating Part B site fee payable when patient is at home

Distant Site Services

- Distant site practitioners bill Part B Medicare for professional services furnished via telehealth:
  - Submit appropriate CPT/HCPCS code
  - Modifier 95 mandatory on all telehealth claims during PHE
    - Indicates service rendered via telehealth
  - Use POS as would apply if seeing the patient face to face (e.g., POS 11, 21, 23)
  - No reduction in payment under MPFS

Telephone Services

- 99441-99443
  - Physicians (including Osteopaths, Podiatrists, and Optometrists), Dentists, Non-Physician Practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife) and Maxillofacial Surgeon
  - Telephone E/M service by practitioner or qualified health care professional
  - **4/30/2020 added to telehealth services; use modifier 95**
- 98966-98968
  - Clinical Psychologists, PT/OT/SLP, Optometrists, Non-Physician practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife), LCSWs, Registered Dietitians (RDs) and Nutrition Professionals (NPs)
  - Telephone assessment & management service
  - **Not on the CMS list of telehealth codes**

New CMS Place Of Service Code: Telehealth

POS 02: Telehealth Provided Other than in Patient's Home Descriptor:

The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provided in Patient's Home Descriptor:

The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care

Medicare hasn't identified a need for new POS code 10.
MACs will instruct their providers to continue to use the Medicare billing instructions for Telehealth claims in Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 190.

https://www.cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf

Telemedicine

- **Telemedicine – Synchronous Audio-Visual**
  - **99201-99205**
  - **99212-99215**
- **Telephone Services – Synchronous Audio only**
  - **99441** Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  - **99442 ;**11-20 minutes of medical discussion
  - **99443 ;**21-30 minutes of medical discussion
- **Virtual Check In – Asynchronous Electronic**
  - **G2012:** Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  - **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
- **E-visits -Asynchronous Electronic Portal**
  - **99421:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
  - **99422:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11– 20 minutes
  - **99423:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- **Remote Physiological Monitoring**
- **Remote Therapeutic Monitoring**

Telehealth Documentation

- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with:
  - Patient location
  - Provider location
  - Names of all persons participating in the telemedicine service and their role in the encounter
- Time-based services, document start/stop time or total time
- Teaching physician may use audio/video telecommunications during key portions of service

CPT Changes 2020 – Extended Ophthalmoscopy

- Routine ophthalmoscopy is part of the general and special ophthalmological service whenever indicated. It is a non-itemized service and is not reported separately
- New Codes:
  - 92201 – Ophthalmoscopy; extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g. for retina tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
  - 92202 – Ophthalmoscopy, extended with drawing of optic nerve or macular (e.g.. For glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
- Do not report 92X18, 92X19 in conjunction with 92250 ???

Ophthalmoscopy

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

● **92201** Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral

CPT Changes: An Insider's View 2020

● **92202** with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral

CPT Changes: An Insider's View 2020

►(Do not report 92201, 92202 in conjunction with 92250)◄

►(92225, 92226 have been deleted. To report, see 92201, 92202)◄

ICD-10 Changes – October1, 2001 to September 30, 2022

- Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)
  - No Change Z55 Problems related to education and literacy
  - Add Z58.6 Inadequate drinking-water supply
  - Add Z59.00 Homelessness unspecified
  - Add Living in a shelter such as: motel, scattered site housing, temporary or transitional living situation
  - Revise from Z59.4 Lack of adequate food and safe drinking water
    - Revise to Z59.4 Lack of adequate food
    - Add Excludes2: deprivation of food (T73.0)
    - Add effects of hunger (T73.0)
    - Add inappropriate diet or eating habits (Z72.4)
    - Add malnutrition (E40-E46)
    - Add Z59.41 Food insecurity

Z79.4 Long term (current) use of insulin

Excludes1: long term (current) use of oral antidiabetic drugs (Z79.84) **Deleted**
long term (current) use of oral hypoglycemic drugs (Z79.84) **Deleted**

Excludes2: long term (current) use of oral hypoglycemic drugs (Z79.84) **ADDED**
long term (current) use of oral antidiabetic drugs (Z79.84) **ADDED**

New ICD-CM-10 Guideline for Diabetic medication coding

- **Injectable non-insulin antidiabetic**
- **Use Z79.899**

- **Oral antidiabetic**
- **Use Z79.84**

- **Insulin**
- **Use Z79.4**

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned. **Additional** code**(s)** should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, **or injectable non-insulin antidiabetic, as follows:**

If the patient is treated with both oral medications and insulin, **both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs,** should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.899, Other long term (current) drug therapy.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Page 38 of 2022 ICD-10-CM Guidelines

Medicare Guidance Change – Glaucoma Screening

We cover high-risk patients' annual glaucoma screenings in at least 1 of these groups:

- Patients with diabetes mellitus
- Patients with family history of glaucoma
- African-Americans aged 50 and older
- Hispanic-Americans aged 65 and older

A covered glaucoma screening includes:

- Dilated eye exam with intraocular pressure measurement
- Direct ophthalmoscopy exam, or slit-lamp bio microscopic exam

We pay glaucoma screening exams by, or under the direct supervision in the office of, an ophthalmologist or optometrist legally authorized under state law. Medical record documentation must show the patient's high-risk group.

Use diagnosis code Z13.5—Encounter for screening for eye and ear disorders, to bill glaucoma screening claims.

Z13.5 Encounter for screening for eye and ear disorders

Excludes2: encounter for general hearing examination (Z01.1-)
encounter for general vision examination (Z01.0-)

While glaucoma screening is a Medicare-covered preventive service, apply patients' copayment or coinsurance, and deductible.

Not new
Z13.5 is glaucoma screening diagnosis code

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/VisionServices_FactSheet_ICN907165.pdf

CPT Changes – January 2022

92065 Orthoptic ~~and/or pleoptic~~ training, ~~with continuing medical direction and evaluation~~

Rationale

- **92065** - revised To delete terms “and/or pleoptic” and “with continuing medical direction and evaluation” to Better reflect current medical practice

only used to report orthoptic training

Orthoptics = broad term for visually based oculomotor tasks or vision training designed to improve the function of eye muscles or binocular vision.
These procedures are useful in the treatment of disorders such as binocular vision disorders including convergence insufficiency, some forms of strabismus, such as esotropia and exotropia, and other eye movement disorders.

Pleoptics = treatments designed to improve impaired vision especially from amblyopia by using a light source to dazzle parts of the retina allowing adjacent areas to begin to function. Technique is no longer in wide spread use, the descriptor was revised to reflect current medical practice.

68841 NEW CODE

68840 Probing of lacrimal canaliculi, with or without irrigation

● 68841 Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each **New**

►(For placement of drug-eluting ocular insert under the eyelid[s], see 0444T, 0445T)◄
►(Report drug-eluting implant separately with 99070 or appropriate supply code)◄

0699T NEW CODE

0699T Injection, posterior chamber of eye, medication **New**

►The anterior segment of the eye includes the cornea, lens, iris, and aqueous.
The aqueous is divided into anterior and posterior chambers.

The anterior chamber is by far the larger, including all of the aqueous in front of the lens and iris and behind the cornea.

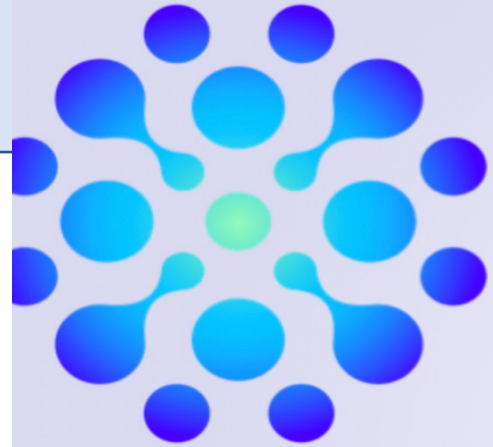
The posterior chamber includes the narrow area behind the iris and in front of the peripheral portion of the lens and lens zonules.◄

AMBLYOPIA TREATMENT #1

0687T Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session **New**

0688T assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month **New**

►(Do not report 0687T, 0688T in conjunction with 92065, when performed on the same day)◄



The average improvement experienced in RevitalVision's amblyopia treatment for adults is a 2.5-line advancement on the eye chart & 100% in contrast sensitivity

AMBLYOIA TREATMENT #2

0704T-Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment **New**

0705T- Surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days **New**

0706T-Interpretation and report by physician or other qualified health care professional, per calendar month **New**

►(Do not report 0704T, 0705T, 0706T in conjunction with 92065, when performed on the same day)◄

►(Do not report 0704T, 0705T, 0706T in conjunction with 0687T, 0688T when reported during the same period)◄

E&M UPDATE

★▲ 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. ~~Usually, the presenting problem(s) are minimal.~~
Revised to add telehealth use

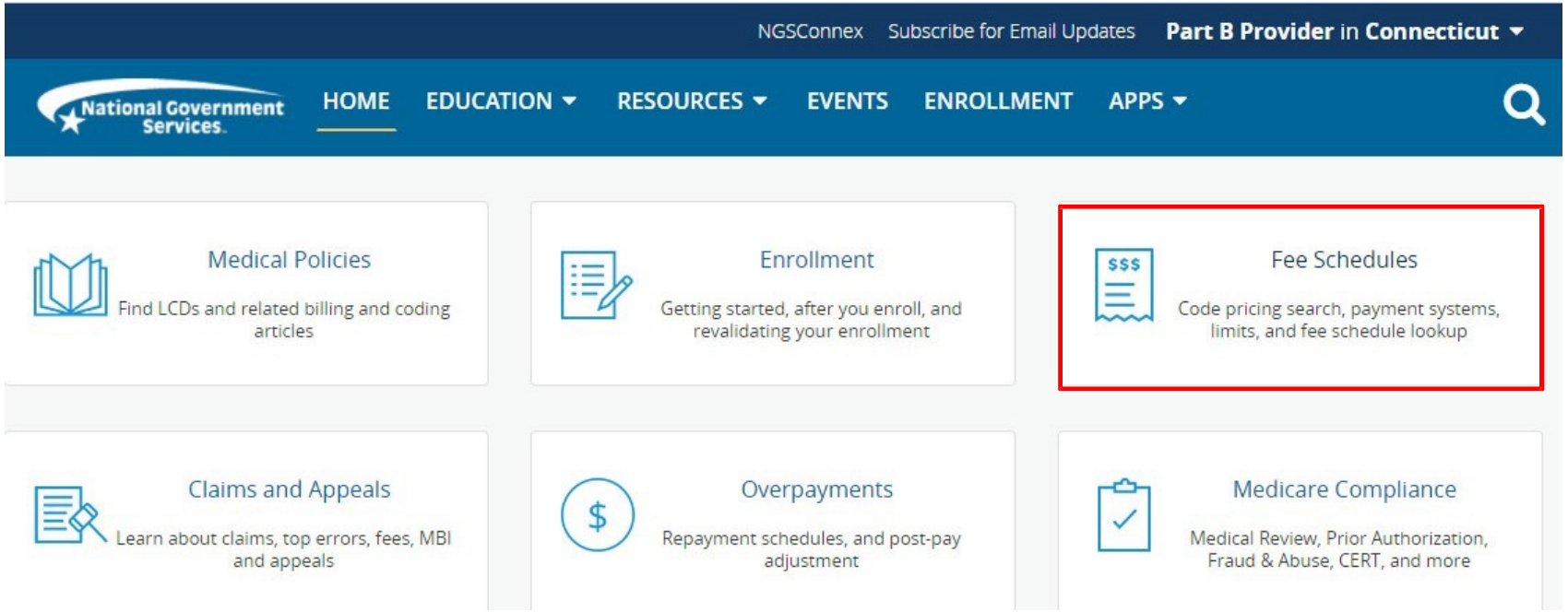
Edited

Rationale:

- Code 99211 has been editorially revised for 2022 with the removal of the statement that the presenting problems are usually minimal
- Prior to 2021, the descriptors of the Office and Other Outpatient codes (99202-99215) included a description of the patient's presenting problem(s). Effective 2021, many revisions were made to the Office or Other Outpatient Services codes. Among the revisions was the removal of this description of the patient's presenting problem(s).
- The description was inadvertently left in the descriptor of code 99211.

For 2022, code 99211 has been revised with the removal of the presenting problem description for consistency with the rest of the Office or Other Outpatient codes.
This revision does not change the way code 99211 is reported.

Fee Schedules



2022 Physician Fee Schedule (PFS) Ratesetting and Conversion Factor

- 2022 PFS conversion factor is $33.59
- A decrease of $1.30 from the 2021 PFS conversion factor of $34.89
  - ON HOLD
- The 2% Sequestration of Medicare payments will resume latter in 2022.

2022 Medicare Premium and Deductibles

2022 Premium and Deductibles	Amounts
Monthly Part B Premium *Individual income above $91,000 up to $114,000 pay higher part B Premium	$170.10 (+21.60) *$238.10
Part B Deductible	$233 (+30)
Part B Coinsurance	20%
Mental Health Services	80%
Part A IH Deductible (first 60 days)	$1,556 (+72)
Days 61st -90th Days	$389 (+81)
Lifetime reserve day	$778 (+36)
Skilled Nursing Facilities (21st-100th days)	$194.50 (+9)

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

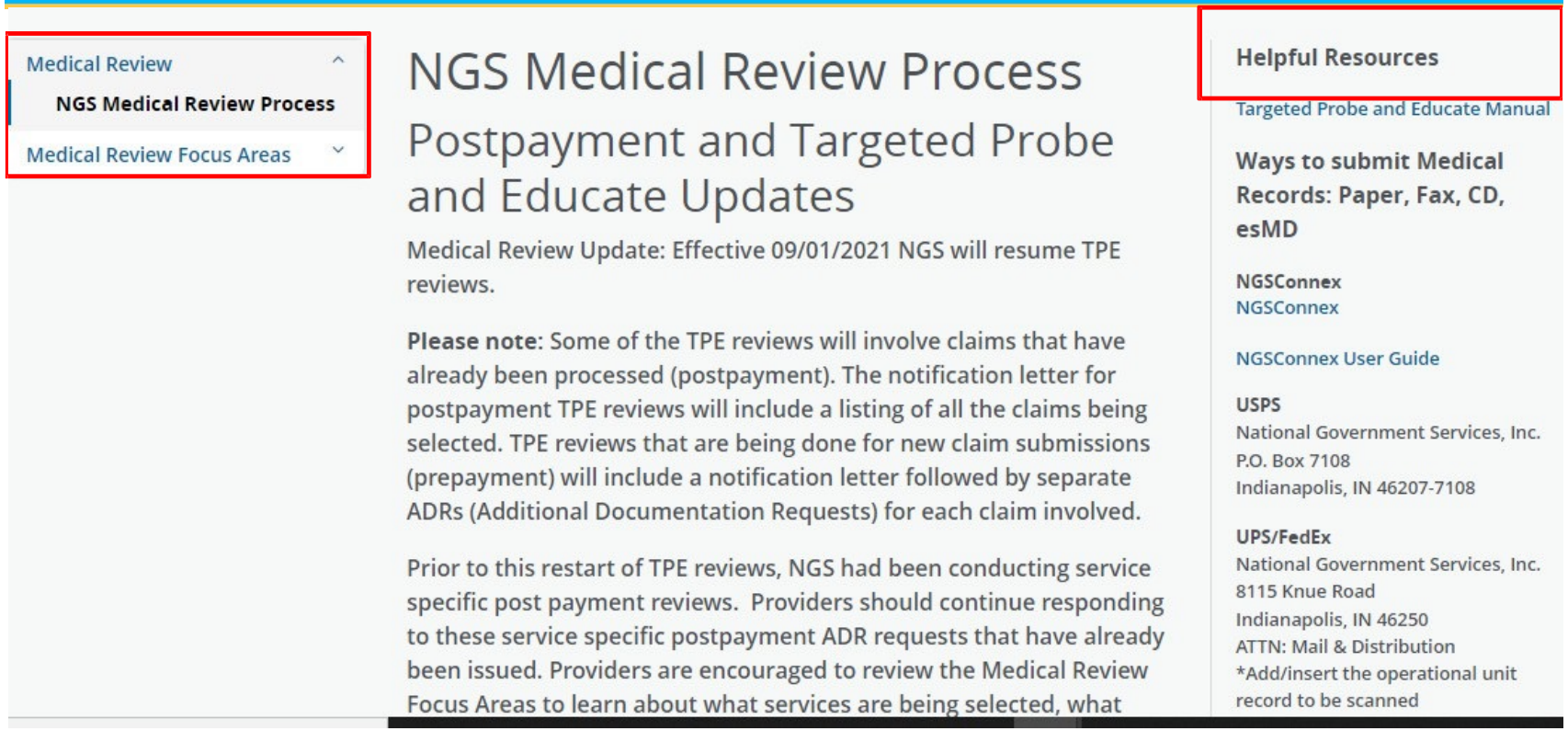
Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | **Medical Policy Articles**

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880

Medical Review



National Government Services

medicare university

Medical Review Target Probe and Educate (TPE)

- Effective September 01, 2021, NGS resumed TPE reviews
- TPE reviews may involve claims that have already been processed (post payment)
  - Notification letter will include a listing of all the claims being selected
- New claim submissions (prepayment)
  - Includes a notification letter followed by separate ADRs for each claim

Comprehensive Error Rate Testing (CERT) program

- Effective August 11, 2020, CMS resumed **CERT** program activities that were temporarily suspended in response to the PHE
- Improper payments represent payments that do not meet program requirements whether intentional or otherwise and contribute to inaccurate spending of Americans' tax dollars
- Overall Improper payment rate:
  - 2018 – 8.12 percent
  - 2019 – 7.25 percent
  - 2020 – 6.27 percent
  - 2021 – 6.25 percent

Comprehensive Error Rate Testing (CERT) program

- CERT Documentation Center Customer Service
- CERT contractor can assist with questions related to medical records requests, review status, etc.
  - Email: CERTmail@nciinc.com (Providers are encouraged to password protect their documentation, passwords should be submitted in a separate email)
  - 888-779-7477
- Documentation request:
  - CERT Documentation Center 1510 East Parham Road Henrico, VA 23228
  - Fax: 804-261-8100
- CERT Program

Quality Payment Program Resources

- For More Information:
  - Quality Payment Program website
  - Resource Library webpage
  - Email: QPP@cms.hhs.gov or
  - Call: 866-288-8292
  - Speaking Engagement Request Form

Medicare 2022 – Possible Changes

- **Merit Based Incentive Payment System (MIPS)**
  - CMS had planned to move towards implementing the new version of MIPS, the "MIPS Value Pathways" starting in 2022. CMS has indicated they are postponing that transition until 2023 and are seeking feedback on when they should sunset the traditional MIPS participation process and require use of MVPs.
- **Diabetes Eye Exam Measure:** CMS is revising the language for the quality measure related to the provision of an eye exam for patients with diabetes. CMS is proposing to update the guidance for the measure to allow for the use of artificial intelligence. The measure guidance is being proposed to read: "Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. **The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation**."

Medicare Expansion

- Expansion to include:
  - Routine Vision, Dental, Audiology
  - Not in current bill except for audiology
- Maybe Next Year!

Resources

- AMA CPT Evaluation and Management ama-assn.org/cpt-office-visits
- Access the Module
- CPT® E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes
- The above PDF includes the official E/M CPT guidelines effective January 1, 2021.
- CPT® E/M Office Revisions Level of Medical Decision Making (MDM)
- Revisions to reporting CPT E/M office visits: Time
- Revisions to reporting CPT E/M office visits: MDM
- E/M health plan webinar: Overview of changes proposed for 2021
- Videos to guide you step-by-step
- 10 tips to prepare your practice for E/M office visit changes

Resources

- Final Rule
- Physician Fee Schedule Final Rule
  - fact sheet
- Quality Payment Program Final Rule
  - fact sheet and FAQs
- Medicare Diabetes Prevention Program
  - fact sheet

Thank you!

Questions