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2022 NGS Medicare Spring Virtual Conference

Medicare for You

Introduction to Evaluation and Management Services

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- To provide an overview of evaluation and management types of service and provide instruction on selecting the correct level of service.
- **Note:** As a Medicare Administrative Contractor, we cannot code a providers service.
- We can advise of the steps providers must take to get to the correct code.

Agenda

- Define E/M
- Differentiate between a new and established patient
- Identify service location and type
- Understand requirements for levels of service
- Learn how to properly level an E/M service

ICD-10-CM Coding

- Principle diagnosis
  - Reason for the visit (chief complaint)
- Signs and symptoms
  - Report all if no definitive diagnosis is stated
  - Report any symptom not routinely associated with the definitive diagnosis
  - Not reported if symptom is associated with definitive diagnosis

What Is Evaluation and Management

- Inspection and observation
- Palpation – examination by touch
- Auscultation – listening to body sounds
- Percussion – creating sounds from tapping on body areas
- Collection of history
- Medical decision making based on all information

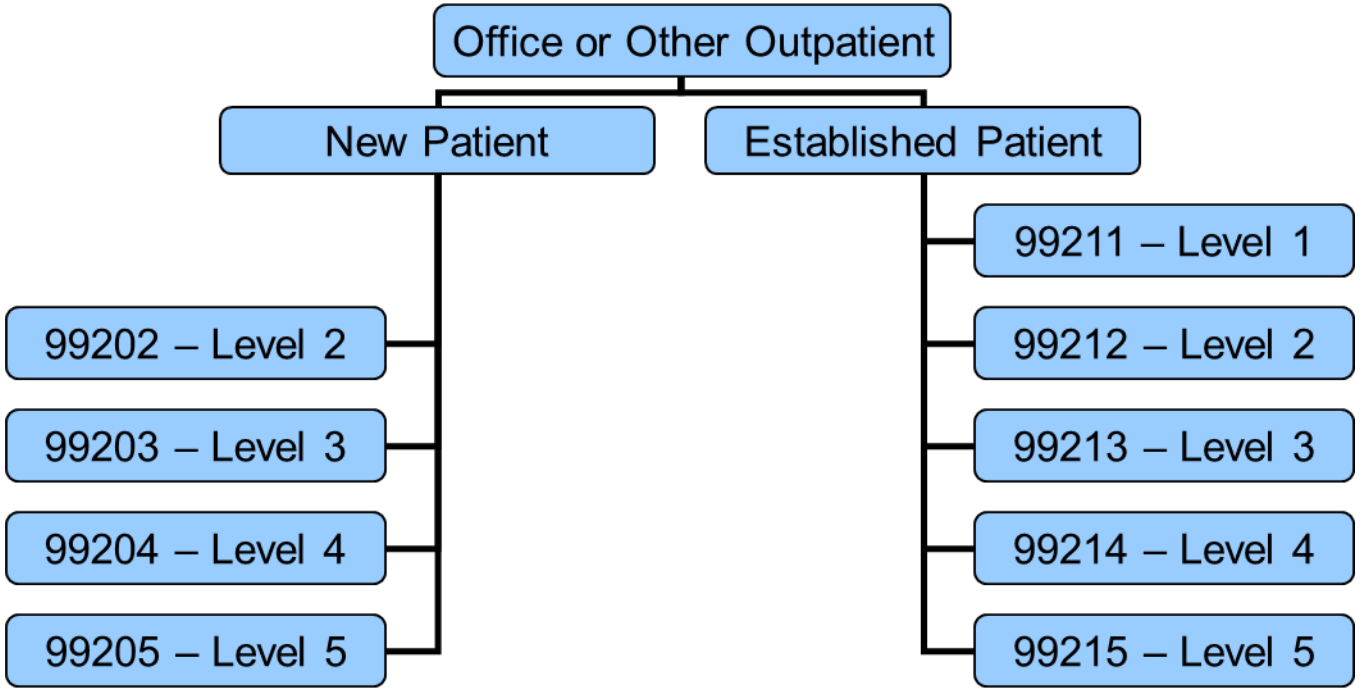
CPT Coding (Office or Other Outpatient)

1. Select the category or subcategory of service and review the guidelines.
2. Review the level of E/M service descriptors and examples.
3. Determine medically necessary level of history.
4. Determine medically necessary level of exam.
5. Determine the level of medical decision making, or, determine total time on date of encounter.
6. Select the appropriate level of E/M service.

CPT Coding

1. Select the category or subcategory of service and review the guidelines.
2. Review level of E/M service descriptors and examples.
3. Determine the level of history.
4. Determine the level of exam.
5. Determine the level of medical decision making, or determine if greater than 50% of time is counseling and/or coordination of care.
6. Select the appropriate level of E/M service.

Category/Subcategory



New Versus Established

- New – not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years
- Established – has received face-to-face services in the last three years
- CMS IOM Publication100-04, *Medicare Claims Processing Manual*, Chapter 12, 30.6.7 (A)

Office or Other Outpatient Services

- Provided in an office or other outpatient clinic or ambulatory facility
- New patient
- Established patient

Outpatient Hospital Observation

- Initial observation services (99218-99220)
  - Patient is designated or admitted to observation status in the outpatient hospital
  - No CPT® guideline on length of observation stay
- Observation care discharge services (99217)
  - If discharge is other than date admitted to observation
- Subsequent observation care (99224-99226)
  - Patient is seen on a date other than the date of admit or discharge to observation

Outpatient Hospital Observation Discharge

- 9 p.m. patient seen in ED with concussion and evaluated
- 10 p.m. patient placed in observation status
  - Remains in observation for 12 hours
- 10 a.m. following date (day) discharged from observation status
- Two separate dates for observation admission and discharge
  - Report observation care discharge code for services provided on discharge date

Initial Inpatient Hospital Observation

- Use code from this group when provider initially chooses to place patient into observation
- Admitted/discharged same date see 99234-99236
- If admitted to observation status in the course of another service, all other services are included in the observation status
- Codes may not be used for post-op recovery

Hospital Inpatient Services

- Codes used for inpatient facility and partial hospitalization (99221-99223)
- Use codes 99234-99236 for admit/discharge on same date
- Subsequent hospital care codes used for subsequent visits while admitted (99231-99233)
  - Includes reviewing medical record, test results, etc.

Inpatient Admit/ Discharge Same Day

- Patient presents to ER in morning
- Admitted to observation at 2 a.m.
- Patient feeling better by 8 a.m.
- Lab work is okay; situation resolved
- Patient discharged
- Select from codes 99234-99236
- Discharge code would not be used

Inpatient Hospital Discharge Services

- Codes are based on time
  - 30 minutes or less
  - 31 minutes or more
  - Includes time spent with the final exam, paper work, writing prescriptions, talking with patient's family, etc.
- Parenthetical notes
  - How to code for concurrent care on the discharge date

Consultations for Medicare

- Office consultations
  - Report with new and established patient codes
- Inpatient consultations
  - Report with initial hospital care codes for the first encounter regardless if performed by the admitting physician
  - Use modifier AI for the principal physician of record

Emergency Department

- Does not distinguish between new/established
- Facility must be hospital-based and available 24 hours a day
- Physician direction of EMS emergency care, advanced life support

Critical Care Services

- Critically ill or injured
  - Acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient condition
  - Services included in critical care described in critical care sub-guidelines
  - Services provided in critical care unit to patient who is not considered critically ill are reported with other E/M codes
  - Critical care and other E/M services may be reported on same date by the same provider

Critical Care Services

- Guidelines list services inclusive to critical care
  - May not be reported separately
  - Refer back to list to avoid unbundling services
  - Beneficial to highlight each of the CPT® codes listed in the guidelines

Critical Care Services

- Codes are in time increments
  - < 30 minutes, use appropriate E/M instead of critical care codes
  - First 30-74 minutes code 99291
  - Each additional full 30 minutes use 99292
- Total time spent by provider(s) on that DOS
  - Doesn't need to be continuous time
  - Reviewing records/tests, time with family members
- Time spent off the floor not included

Nursing Facility Services

- Nursing facility services
  - Nursing facility
  - Psychiatric residential treatment center
  - Divided into initial and subsequent
- Nursing facility discharge 99315 and 99316
  - Similar to hospital discharge – instructions for care, prescriptions, etc.
- Annual assessment – 99318
  - Annual assessment required by law

Domiciliary, Rest Home or Custodial Care Services

- Also includes assisted living
- Physician sees patient in one of these types of facilities
  - No medical component
- Either new patient or established patient

Domiciliary, Rest Home or Home Care Plan Oversight Services

- Physician or other qualified health care professional provides oversight of the patient's care plan
- Review the case management plan
- Write new orders
- Make a new care plan

Home Services and Prolonged Services

- Home services
  - Seen in home by physician or other qualified health care professional
  - Separated by new and established patient
- Prolonged services
  - Direct patient contact or without direct patient contact
  - Settings are office/outpatient and inpatient
  - Most are add-on codes
    - Exception is physician standby code

Prolonged Services (Other than Office/Other Outpatient Services)

- Prolonged service with direct face-to-face contact beyond usual service
- Must be at least 30 minutes over visit time
- Reported in addition to other services
- Report total duration of face-to-face time; even if time is not continuous
  - Similar to critical care in this manner
- 99358-99359 are used for prolonged service without patient contact (Not for use with 99205, 99215)
  - The initial code is stand alone

Prolonged Services – Office/Other Outpatient Services

- G2212
- 15 minutes of elapsed time must be met to bill
- Additional unit for each 15 minutes of time
- Only billable if time is the billing factor

Care Plan Oversight Services

- Home health agency
- Hospice
- Nursing facility
  - Billed on a monthly basis
  - For the amount of time physician spends overseeing care of patient
  - Billed by time
    - 15-29 minutes
    - 30 minutes

Chronic Care Management

- Two or more chronic illnesses requiring coordination of care among multiple disciplines
- Reported by the provider overseeing the care plan and coordination
- Reported only once per month
- Code selection
  - Time spent overseeing
  - Whether a face-to-face encounter occurs

Principal Care Management

- Single high risk disease with
  - One complex chronic condition
  - Require development/monitoring/revision of care plan
  - Frequent adjustments in medication regimen
  - Ongoing communication and care coordination
- Reported by the overseeing practitioner
- Reported only once per month
- Code selection
  - Time spent overseeing
  - Whether a face-to-face encounter occurs

Advance Care Planning

- Advance care planning codes report face-to-face discussion of advance directives
- Based on time
  - Health care proxy
  - Durable power of attorney for health care
  - Living will
  - Medical orders for life-sustaining treatment

Transitional Care Management Services

- Transitional care intent is to prevent repeat admissions
- Codes reported once per 30-day period
- Code selection
  - Level of medical decision making (discussed later)
  - When the first encounter occurs after discharge

Cognitive Assessment

- CPT 99483
  - 50 minutes face-to-face with the patient and Independent Historian
    - Definition of Independent Historian is provided by the AMA on page 15 of 2022 CPT manual
- Cognitive Assessment and Care Plan Services
- CMS' YouTube Video
  - Medicare Coverage and Payment of Cognitive Assessment & Care Plan Services

Psychiatric Collaborative Care Management

- Initial code 99492
  - Requires 70 minutes in first calendar month
  - Outreach to and engagement in treatment of a patient
  - Initial assessment administration of validated rating scales with individual plan development
  - Review by the psychiatric consultant with plan modification
  - Entering patient in registry and tracking patient follow up and progress using registry
  - Provision of brief interventions using evidence-based techniques

Psychiatric Collaborative Care Management

- Subsequent code 99493
  - Requires 60 minutes in subsequent calendar month
  - Tracking patient follow up and progress using registry
  - Participate in weekly caseload consultation with psychiatric consultant
  - Ongoing collaboration with and coordination of patients MHC with treating physicians or other qualified professional
  - Provision of brief interventions using evidence-based techniques
  - Monitoring of patient outcomes using validated rating scales
  - Relapse prevention planning with patient as remission is achieved and/or other treatment goals with plan for discharge from active treatment

Psychiatric Collaborative Care Management

- Prolonged time add on code 99484
  - Each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure
  - (Use in conjunction with 99492 or 99493)
- Care management service for behavioral health conditions “Clinical Staff Time”
  - At least 20 minutes spent
  - Initial assessment or f/u monitoring, included applicable validated rating scales
  - Care planning in relation to psychiatric health problems, including revision for non progression or status change
  - Facilitation and coordinating treatment
  - Continuity of care with designated member of the care team

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E/M Resources

- 1995 Documentation Guidelines for E/M Services
- 1997 Documentation Guidelines for E/M Services
- MLN® Booklet: *Evaluation and Management Services Guide*
- NGS Medicare Part B 101 Manual Evaluation and Management Services
- NGS Evaluation and Management FAQs
- 2022 CPT page five – Evaluation and Management Guidelines

Split/Shared E/M Visits

- In the CY 2022 PFS final rule, CMS is establishing the following
  - Definition of split (or shared) E/M visits as E/M visits provided in the **facility setting** by a physician and an NPP in the same group
  - The visit is billed by the physician or practitioner who provides the **substantive** portion of the visit
  - **Effective 1/1/2022, Modifier FS required on all E/M services that have been performed on a split/shared basis**
  - Modifier FS applies to split/shared E/M service codes used in the **inpatient** and **outpatient *facility*** setting

Split/Shared E/M Visits

- **For 2022**
  - The substantive portion can be history, physical exam, medical decision-making, or more than half of the total time
  - When using time to assess the substantive portion of the service, the provider who spent and documented the most time is considered the billing provider
- **By 2023**
  - The substantive portion of the visit will be defined only as more than half of the total time spent
  - As above, the provider who spent and documented the most time will be considered the billing provider

Split/Shared Options

- Split/shared rules in the **facility** setting (inpatient and outpatient) apply to
  - **New and established** care for outpatients and for initial and subsequent care for inpatients
  - **Observation** services
  - **Prolonged** services
  - **Consultative** services
  - **Admission and discharge** services
  - **Critical care** services (see later slides)
  - **Emergency Department** services

Split/Shared Documentation

- Documentation in the medical record must identify the two individuals who performed the visit
- **The individual providing the substantive portion must sign and date the medical record**
- Each provider must document his/her contribution to the service and, if applicable, the specific time that he/she spent on the service

Split/Shared Observation Services

- Observation occurs in an **outpatient facility** setting
- Observation codes (99218-99220, 99224-99226) are used **only** by the **primary physician** who is responsible for care
- During the observation period, **consultative providers** bill services using outpatient codes 99202-99205 and 99211-99215

Split/Shared Observation Services

- Attending physicians and consultants may perform split/shared services in the observation setting
- **For 2022**: split/shared observation services may be level-set based on service components (history, exam, MDM) ***or*** on cumulative time spent by both providers
- **For 2023**: split/shared observation services will be level-set based on cumulative time only

Critical Care Basics

- Critical care includes multiple other services that are not separately payable
  - These services are defined in the AMA 2022 CPT Manual, referenced in the CMS 2022 Final Rule
- When medically necessary, critical care may be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty

Critical Care Same Day as Other E/M

- Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty
  - The practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care
  - Both services are medically necessary and are separate and distinct, with no duplicative elements from the critical care service provided later in the day
  - Practitioners must report modifier 25 on the claim when reporting these critical care services

Critical Care Split/Shared

- **As of 1/1/2022, critical care services may be furnished as split (or shared) visits**
- **Physician and NPP** members of the same group may split/share critical care service over a full DOS
- Service may be billed based **only on cumulative time spent by both providers**
- Substantive (billing) provider = spent and documented >50% total time

Critical Care In the Global Period

- Critical care by the performing surgeon may be payable in the global period, only when it is **unrelated** to the surgery
- **Modifier FT**: appended to claims for critical care in the global period by the **performing surgeon**, for a clinical situation **unrelated** to the surgery

Resources

- MLN Matters® *M12519 Revised: Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List*
- MLN Matters® *MM12543 Revised: Internet-Only Manual Updates (IOM) for Critical Care, Split/Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants*
- MLN Matters® *MM12549: Telehealth Update Medicare Physician Fee Schedule*
- Change Request 12550: Internet-Only Manual Updates for Critical Care Evaluation and Management Services
- MLN Matters® MM12613: *An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage*

NGS Initiative

- NGS goal: reduce unnecessary provider burden
- Claim data analysis demonstrates high rate of denials and appeals for
  - **Multiple same date of service** E/M claims submitted by group NPPs
  - **Multiple new patient visit** E/M claims by group NPPs within a three-year period

E/M Golden Rule and Facts

- CMS permits one E/M service per beneficiary per date of service for each provider specialty
- NPs (Specialty 50) and PAs (Specialty 97) are only assigned a single specialty, but they work in full scope of sub-specialty groups
- NPPs working in a physician group: considered as working in exact same specialty or subspecialty as physicians in the group

NPP E/M Billing Issue

- Issue
  - NPP E/M claims are denied when more than one same-specialty NPP service is billed by a group on a single DOS
  - NPP “new patient” claims are denied when a second new visit is submitted by a group NPP within a three-year period
  - High rate of denial, frequently overturned with documentation of both services on appeal
  - Denials and appeal process is burdensome and costly to both the providers and NGS

Solution

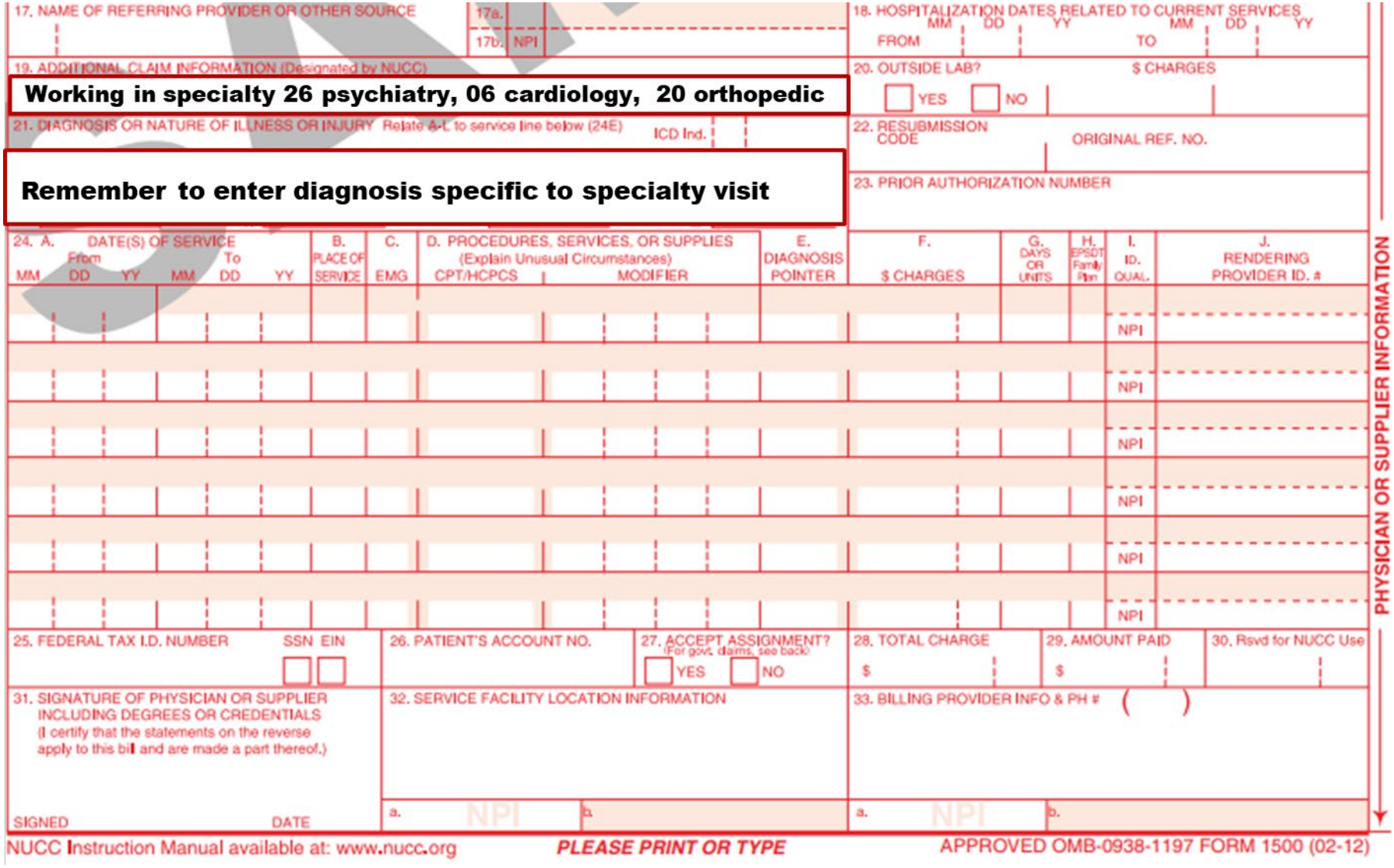
- Applies to **all** NPP E/M claims
- NPP is still the **rendering** provider
- NPPs add specialty of the group in which the service was rendered (e.g., Cardiology Spec 06, Psychiatry Spec 26) – info added to loop 2400 NTE segment (or Box 19 paper)
- Repeat claims for same day and new patient services will suspend for comparison with paid claims in history
- NGS claim examiners compare specialty information with paid history claim(s); claims may be allowed when both **specialty information and diagnoses are different**

Important Claim Facts

- NPP E/M claims submitted without specialty information in loop 2400 NTE segment will continue to deny when an E/M claim has been paid to another group member NPP
  - on the same date of service or
  - a new patient visit has been paid to an NPP within three years
- **Primary diagnoses** on claims must vary, supporting care for two different clinical conditions

Anticipated Outcomes

- **Significant decrease** in rate of denial on E/M claims submitted by NPPs
- **Significant decrease** in rate of appeals, correlative to the lower denial rate
- **Significant increase** in provider revenue



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Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

- Working in specialty
  - 26 psychiatry, 06 cardiology, 20 orthopedic

Claim Notes	2300	NTE02	S	Claim Notes description field
	2400		S	

- Remember to enter the diagnosis specific to specialty visit

Diagnosis or nature of illness or injury	2300	HI01-02

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Helpful Information

- What is the reference for the root of this issue in the IOMs?
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15 Section 30
- Can you tell us the denial message and remark code used for concurrent care?
  - D984= Coverage/program guidelines were not met
  - N20= Service not payable with other service rendered on the same date
- Where can one find the list of specialty codes?
  - NGS Website > Enrollment > Helpful Tips > Medicare Provider/Supplier Specialty Codes

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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