2021 E/M Office Changes - 20 Days' In

Greater Kansas City MGMA

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ONE STEP AHEAD

New Medicare G2211 - Visit complexity inherent to evaluation and management

DELAYED 3 YEARS

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Fact Sheet - Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits

HCPCS code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).

The Consolidated Appropriations Act delays PFS payment for this code until January 1, CY 2024 or later. Practitioners may report this code for qualifying visits furnished on or after January 1, 2021, although we assigned a PFS payment status indicator of "B" (Bundled) until 2024.

Documentation Best Practices

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Templates

- Review Office E/M templates and remove or edit pre-loaded documentation that isn’t pertinent to the encounter.
- Do not copy/edit another provider’s note to use as your documentation.
- Information that is entered via patient portal or by ancillary staff for the encounter must be reviewed and accepted by the provider.

Reason for Visit

- Chief complaint (CC) should be a clear and concise
  - If the ancillary staff is documenting the CC and it is lacking detail, elaborate in your history, HPI.


"6-month follow-up"


"6-month follow-up on HTN, DMII, hyperlipidemia"

- Pre-operative exams and clearances need to state the condition for which the surgery is being performed, the surgical procedure scheduled and any chronic or underlying conditions that may influence or complicate the procedure.

Problems Addressed

- Do not report "history of" or conditions that have resolved as an active diagnosis.
- Only report conditions that you have treated and/or managed during the encounter.
- Conditions managed by other providers are only counted if that condition is affecting your management of the patient and it must be clearly stated.

Data - Review of prior external note(s) from each unique source

- External records are those from outside your organization or specialty.
- Document the source of the records, date and create a summation of your review.
- The review of an external record can only be counted one time, reviewing again at a subsequent encounter does not count.
- Simply stating “Records reviewed” will not be counted.
- Example, “On the review of records from St. Mary’s ER visit on 1/2/21 for sudden onset headache, it was determined to be a migraine. All studies were negative.”

Data - Review of the result(s) of each unique test*

- Cannot count the review of tests that were ordered within your group/specialty by another provider.
- The review of a test is included in the order.
- Count a review of a test not ordered during an encounter (test was ordered between encounters).
- Review of test from an outside source that you did not order.
- Documentation must show your analysis of the test result and how it impacts your care plan.
- Statement such as “Lab results reviewed” or “CXR report reviewed” will not count.
- Example: “Patient provided the lab results from her recent Urgent Care visit. The UA and urine culture were negative, and the CBC was abnormal with low white count.”

Data - Ordering of each unique test*

- Each test ordered that is not billed separately can be counted.
- Through documentation, each test should be linked to the condition it's being ordered for.
- Statement, “Labs ordered” will not count without detailing the specific tests.

Data - Assessment requiring an independent historian(s)

- An Interpreter does not count as an independent historian.
- Document the name, relationship to the patient.
- Document the additional history provided by the family member/informal caregiver.
- Information must be reliable and used in determining the management and treatment of the patient.

Data - Independent interpretation of tests

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
- The *review* of a report is not an independent *interpretation*.
- Document what is being viewed; film, image, pathology slides, etc.
- Document the source and date along with your interpretation.
- An independent interpretation of a test can only be counted one time.

Data - 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)
- Appropriate source would be; lawyer, parole officer, case manager, teacher.
- Document the name and relationship to the patient.
- Document the date of the discussion along with a summary of the discussion.
- The discussion can only be counted one time.

Prescription Drug Management

Prescription drug management is part of the moderate Risk category of an E/M service. These drugs require a prescription. An over-the-counter drug ordered at a higher dosage is not a prescription drug. Prescription drug management does not require a new drug, a new dosage, or a discontinuation of a current prescription. The medical record will show the physician work to determine the medical necessity of the prescription drugs. An encounter documented as only a prescription refill without documentation of an E/M service would not suffice. You can also count prescription medications considered but not given based on patient interaction, possible other drug interactions, etc. as prescription drug management. (updated 12/09/20)

WPS GHA

Prescription Drug Management

When can prescription drug management be credited in the medical decision-making risk of complications chart?

Credit is given for prescription drug management when documentation indicates medical management of the prescription drug by the physician who is rendering the service. Medical management includes a new drug being prescribed, a change to an existing prescription or simply refilling a current medication. The drug and dosage should be documented as well as the drug management.

If medications are just listed in patient's medical record, credit is given for past history.

Novitas

Social Determinates of Health - SDOH

- Report when the SDOH is negatively impacting the treatment of the patient.
  - Problems related to education and literacy
  - Problems related to employment and unemployment
  - Problems related to housing and economic circumstances
  - Problems related to social environment
  - Problems related to upbringing
  - Other problems related to primary support group, including family circumstances
  - Problems related to certain psychosocial circumstances
  - Problems related to other psychosocial circumstances
- Must clearly document the impact of the SDOH.

Surgery with identified patient or procedure risk factors

- Patient-specific risk factors must be clearly documented.
- Procedure risk factors must be clearly documented.
- The discussion with the patient regarding their risk and/or procedure risk should be detailed and tailored to their personal state of health.
- Avoid using a statement or macro that is the same for all patients.

E/M Encounter Based on MDM

- AMA defines the Encounter when using MDM as:
  - **Within 3 days Prior to Visit:** Review of prior medical records and data. Communicate with other members of your healthcare team prior to visit. Incorporate any pertinent information provided by portals or questionnaires.
  - **Day of Visit:** Review of vitals, history and other information gathered by ancillary staff. Obtain medically appropriate history, including pertinent, HPI, ROS and PFSH. Perform a medically appropriate exam. Synthesize the relevant history, exam to formulate a differential diagnosis and treatment plan. Order medically appropriate testing, Discuss treatment plan with patient and family. Provide education and respond to questions. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with QPP's, etc.
  - **Within 7 Days After Visit:** Answer follow-up questions from patient and/or family that may occur within 7 days and respond to treatment failures. Review and analyze testing results. Communicate results and any treatment plan modifications with the patient/family. Respond to queries from pharmacy regarding medication changes or formulary issues, etc.

Time

- Time statement should reflect exact time. Do not use generalities such as "approximately", "more than __", "greater than __", or "about", with the time.
- Time spent providing other billable services must be carved out of the time used to select the E/M level.
- Start and stop time are not required.
- Document time on the date of the encounter by activities, “I spent 51 minutes with the patient and daughter reviewing treatment options, and an additional 7 minutes are spent on documentation today.”

Time Documentation

Q. Do we have to separate time into different activities? Can we include a single reference to the total time?

A. Medicare would not require the physician to “stop-watch” the patient. We can accept a total time. However, the best practice is to identify the activities and the time spent. Medicare must be able to verify the time reported.

Q. Do we have to identify the different activities in the patient’s medical record?

A. The patient’s medical record must support the claim submitted to Medicare. Best practice is to identify the activities and time spent.

(WPS GHA E/M Q&A updated 12/09/20)

Time and Residents

Question: When level-setting a service based on time in the office or outpatient setting, is time spent alone by a resident added to time spent by the teaching physician with counted in total time spent?

Answer: When level-setting a service based on time, only time spent by an enrolled Medicare provider who is permitted to perform and bill for an E/M service is counted toward total time spent. This limits counted time to time spent by a physician or NPP (PA or NPP). Clinical staff time cannot be counted and, in this context, the resident's time would be considered as clinical staff time and is not counted. There is an exception to this rule in the PCE setting, described in the next FAQ below.

Question: When level-setting a service based on time in a Primary Care Exception outpatient setting, is time spent alone by a resident added to time spent by the teaching physician counted in total time spent?

Answer: In a PCE setting, a teaching physician supervises up to four qualified residents and must remain available to the residents throughout the clinic session to see a patient personally at a resident's request. Residents are permitted to see patients without the direct personal presence of the teaching physician and must review the plan of care for each patient with the teaching physician before the close of the clinic session. In the PCE setting only, total time for level-setting a visit includes the teaching physician's time (in seeing the patient and/or reviewing the plan of care) and the resident's time during his/her F2F encounter with the patient.

Question: Can the discussion between the resident and the teaching physician count as category 3 – "discussion of management or test interpretation"?

Answer: No. The discussion between the resident and the teaching physician is part of the teaching physician guidelines.

Questions

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