BILLING AND CODING: REFRESHER AND 2021 UPDATES

Matthew Fowler, DO

Clinical Assistant Professor

OSU Family Medicine

Tulsa, OK

Objectives

- Discuss old rules for office visits
- Learn about early drafts of changes
- Figure out how to use new rules to make our lives easier
- Continue to be reimbursed for our time/effort
- Cover modifiers and various additional codes/visit types

Relative value unit

- Physician work RVU
  - Relative level of time, skill, training and intensity to provide a given service
  - Your money
- Practice expense RVU
  - This is the portion that goes towards clinic/hospital for rent, equipment, supplies, non-physician staff costs

RVU CHANGES

CPT Code	CY 2020 wRVU Value	CY 2021 wRVU Value	Variance	% Increase
99202	0.93	0.93	0	0%
99203	1.42	1.6	0.18	13%
99204	2.43	2.6	0.17	7%
99205	3.17	3.5	0.33	10%

CPT Code	CY 2020 wRVU Value	CY 2021 wRVU Value	Variance	% Increase
99211	0.18	0.18	0	0%
99212	0.48	0.7	0.22	46%
99213	0.97	1.3	0.33	34%
99214	1.5	1.92	0.42	28%
99215	2.11	2.8	0.69	33%

Old rules and new rules

- The last E/M coding guideline update was in 1997
  - Uses combination of history, physical exam, and visit complexity to determine level of service
  - These components are/were used for all office visits 99202-99215 (level 1 visits do not involve the provider)
  - Neither set of rules applies to well woman exams, routine preventive exams, medicare wellness, well child checks, or procedures
- Early versions of these changes medicare planned on paying a "blended rate" for levels 2-5
  - Huge provider outcry/backlash
  - Further revisions to current plans

Elements of Visit

- History
  - Chief Complaint
  - History of Present Illness
  - Review of Systems
  - PMSH
    - Medical/Surgical
    - Social
    - Family
- Physical Exam
- Assessment
- Plan

CODING A NEW PATIENT

Need 3 of 3	99201	99202	99203	99204	99205
History (need all HPI ROS PFSH	1	1 1	4 2 1	4 10 3	4 10 3
Exam	1	2	5	8	8
MDM	Straight Forward	Straight Forward	Low	Moderate	High
Time if counseling >50%	10	20	30	45	60

ESTABLISHED PATIENT

Need 2 of 3	99211	99212	99213	99214	99215
History (need all HPI ROS PFSH	Non-physician Visit	1	1 1	4 2 1	4 10 2
Exam		1	2	5	8
MDM		Straight Forward	Low	Moderate	High
Time if counseling >50%		10	15	25	40

OVERALL DECISION MAKING TABLE

Type of MDM	Straight-forward 99201/02 99212	Low 99203 99213	Moderate 99204 99214	High 99205 99215
# dx	1	2	3	4+
Amt data	0 or 1	2	3	4+
Overall Risk	minimal	low	moderate	high

Need 2 of 3 elements to qualify for given level, numbers are points for each area

Components of the new system

- Only requires a history and exam to be performed when medically appropriate
  - When is that?
  - Likely more limited/targeted resulting in shorter, possibly more readable notes
- Medical Decision Making
  - Option 1: Time based
  - Option 2: Updated MDM requirements

Time based coding

- Time the physician (or other health professional) spent on that patient on the day of the encounter
  - Includes time spent before, during, and after the visit (currently office coding is only face-to-face time)
  - Time spent after day of visit CANNOT BE COUNTED
- Time is now in ranges as opposed to a single number
- When using time to code visits, document it at the end of the note i.e. "My total time spent caring for the patient on the day of the encounter was *** minutes."
- Additional time based codes such as advance care planning or tobacco cessation should be clearly documented as separate time.

TOTAL TIME PLUS PROLONGED SERVICES TEMPLATE

Visit Level	Established patient visit	New patient visit
Level 2	99212 10-19 minutes	99202 15-29 minutes
Level 3	99213 20-29 minutes	99203 30-44 minutes
Level 4	99214 30-39 minutes	99204 45-59 minutes
Level 5	99215 40-54 minutes	99205 60-74 minutes
99XXX x 1	X code + 99215 55-69 minutes	X code + 99205 75-89 minutes
99XXX x 2	X code + 99215 70-84 minutes	X code + 99205 90-104 minutes
99XXX x 3 (or more for each additional 15 minutes	X code + 99215 >84 minutes	X code + 99205 >105 minutes

Medical decision making

- Three elements
  - Problems you are evaluating during the office visit
  - Data
  - Risk
- Highest level met by at least two of the three elements

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: 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.*	Elements of Medical Decision Making: 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)
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			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

Telehealth Options

- Video visits
  - Requires both audio and video connection through an approved service
  - Billed as a regular office visit
  - Triage appropriately
- Telephone encounters
  - 99421 for 5–10 minutes of time spent
  - 99422 for 11–20 minutes
  - 99423 for 21 minutes or more
- E-visits
  - Through your patient portal, cumulative time over 7 days; do not bill if related to E/M service provided in last 7 days or next 24 hours
  - G2061/98970 - 5-10 minutes
  - G2062/98971 - 11-20 minutes
  - G2063/98972 - 21 or more minutes

Preventive Examinations

- NO Chief complaint or HPI
- MUST HAVE
  - Comprehensive ROS (10 organ systems)
  - Comprehensive or interval PFSH
  - Comprehensive assessment of risk factors appropriate to age
  - Multi-system physical exam appropriate to age and risk factors (RF)
  - Assessment/Plan which includes counseling, anticipatory guidance and RF reduction

Preventive Exam

- New vs. Return rules are the same
- Coding based on age of patient
- NO specific guidelines for what to include with each age group
- Documentation of anticipatory guidance/risk factor reduction is the common missing element
- Can refer to previous ROS, PMH, FH, etc.

Medicare Wellness

- **Who can perform an Annual Wellness Visit?**
  - Physician (doctor of medicine or osteopathy)
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
  - Medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician (doctor of medicine or osteopathy)

Medicare Wellness

- Welcome to Medicare
  - all beneficiaries within the first 12 months after the effective date of their first Medicare Part B coverage period
- Initial Annual Wellness Visit
  - One per beneficiary in their lifetime
- Subsequent Annual Wellness Visit
  - One every 12 months
  - Calendar year or since last visit varies

Welcome to Medicare (G0402)

- **Past History:** illnesses, hospital stays, operations, allergies, injuries, treatments
- **Medications:** prescriptions, OTC, vitamin/mineral/herbal supplements
- **Family History**
- **Substances:** alcohol, tobacco, illicit drugs
- **Diet**
- **Physical Activity**
- **Depression Screening:** GDS or other screening tool
- **Screenings:** hearing impairment, ADLs, fall risk, home safety
- **Visual Acuity Measurement:** Snellen eye chart or other tool
- **Vital Signs:** Ht, Wt, BP, BMI
- **End of Life Planning:** verbal or written info given to pt; document provider's willingness to honor pt's advanced directive
- **Counseling:** education, counseling & referral based upon patient's risk factors
- **Written Plan:** brief written checklist provided to patient with recommendations for covered preventive services

Initial Annual Wellness Visit (G0438)

- **Health Risk Assessment Form**
- **Past History:** illnesses, hospital stays, operations, allergies, injuries, treatments
- **Medications:** prescriptions, OTC, vitamin/mineral/herbal supplements
- **Family History**
- **Depression Screening:** GDS or other screening tool
- **Screenings:** hearing impairment, ADLs, fall risk, home safety
- **Vital Signs:** Ht, Wt, BP, BMI (or waist circumference)
- **Provider List:** list of providers, DME suppliers, home health agencies, etc
- **Cognitive Assessment:** directly observe and consider concerns raised by family or others
- **Written 5 to 10 Year Plan:** preventive testing, immunizations
- **List of Risk Factors:** including any mental health conditions with a list of treatments and their risks/benefits
- **Health Counseling and Referral:** health ed, lifestyle mod, exercise, wt loss program, smoking cessation, fall prevent, nutrition

Subsequent Annual Wellness Visit (G0439)

- **Health Risk Assessment Form**
- **Past History:** illnesses, hospital stays, operations, allergies, injuries, treatments
- **Medications:** prescriptions, OTC, vitamin/mineral/herbal supplements
- **Family History**
- **Vital Signs:** Ht, Wt, BMI (or waist circumference)
- **Provider List:** list of providers, DME suppliers, home health agencies, etc
- **Cognitive Assessment:** directly observe and consider concerns raised by family or others
- **Written 5 to 10 Year Plan:** preventive testing, immunizations
- **List of Risk Factors:** including any mental health conditions with a list of treatments and their risks/benefits
- **Health Counseling and Referral:** health ed, lifestyle mod, exercise, wt loss program, smoking cessation, fall prevent, nutrition

Documents Needed

- Health Risk Assessment Form (required for **Initial AWV** and **Subsequent AWV**)
- Hearing Handicap Inventory Form (required for **IPPE** and **Initial AWV**)
- Home Safety Questionnaire (required for **IPPE** and **Initial AWV**)
- Geriatric Depression Screening Form (required for **IPPE** and **Initial AWV**)
- 5 to 10 Year Plan Form (required for **Initial AWV** and **Subsequent AWV** or generate/print using EMR)

99483 Cognitive Care Planning

- Cognition-focused evaluation including a pertinent history and examination
- Medical decision making of moderate or high complexity
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR])
- Medication reconciliation and review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)
- Evaluation of safety (eg, home), including motor vehicle operation
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
- Development, updating or revision, or review of an Advance Care Plan
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Domain	Suggested measures	Comments
Cognition	Mini-Cog	≤ 3 min, validated in primary care
	GPCOG	Patient/informant components
	Short MoCA	~ 5 min, needs testing in primary care
Function	Katz (ADL), Lawton-Brody (IADL)	Caregiver rated
Stage of cognitive impairment	Dementia Severity Rating Scale	Caregiver rated, correlates with Clinical Dementia Rating
Decision-making	3-level rating: able to make own decisions, not able, uncertain/needs more evaluation	Global clinician judgment
Neuropsychiatric symptoms	NPI-Q	10 items
Depression	BEHAVE 5+	6 high-impact items
	PHQ-2	Depression identification
Medication review and reconciliation	Med list + name of person overseeing home meds	Identify/reconsider high-risk meds; assess for reliable administration by self or other
Safety	Safety Assessment Guide	7 questions (patient/caregiver)
Caregiver identification and needs assessment	Caregiver Profile Checklist	Ability/willingness to care, needs for information, education, and support
	Single-Item Stress Thermometer	Rapid identification of stress
	PHQ-2	Depression
Advance care planning	End-of-Life Checklist	Screen for preferences and legal needs

99497/99498 Advanced Care Planning

- Explanation, discussion, and completion of advanced directive forms
- 99497 for first 30 minutes (minimum 16 minutes)
- 99498 for subsequent 30 minutes (minimum 46 before that can be billed)
- Use a –33 modifier to waive their coinsurance/deductible

Transition Care Management

- Can be done after discharge from the following facility types:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Long-Term Care Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Hospital outpatient observation or partial hospitalization
  - Partial hospitalization at a Community Mental Health Center

- Must return to their community setting
  - Home
  - Domiciliary
  - Rest home
  - Assisted living facility

TCM Components

1: An interactive contact within 2 business days following discharge, you must make an interactive contact with them and/or their caregiver via telephone, email, or face-to-face

2: Certain non-face-to-face services

- Unless you determine they are not medically indicated or needed
- Review discharge information, pending tests, referrals to specialists or needed community resources, home health communication

TCM Components

3: Face-to-face visit

- CPT Code 99495
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit within 14 calendar days of discharge
- CPT Code 99496
  - Medical decision making of high complexity
  - Face-to-face visit within 7 calendar days of discharge

TCM components

- Only one health care professional may report TCM services
- Report services once per beneficiary during the TCM period
- Same provider is okay, but not the same day as discharge
- Can bill E/M code for separate clinical issues
- Not billable during global surgery period

MODIFIERS

- 25 modifier - Significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service
- 52 modifier – reduced services (procedure aborted)
- 50 modifier – bilateral procedure such as knee injection

Other codes to make sure you are billing

- Home Health Codes: G0179 (recertification) and G0180 (certification); G0181 (Review of HH services/care coordination, more than 30 minutes in 30 days)
- Hospice care supervision: G0182 (30 minutes or more, within calendar month)
- Vaccine counseling codes through 18 years old: 90460 (first component), 90461 (each additional component)
  - Physician/provider performs face-to-face counseling
  - Document counseling was personally performed

Other codes to make sure you are billing

- Tobacco cessation – 99406 (3-10 minutes, 0.24 wRVU) and 99407 (>10 minutes, 0.5 wRVU)
  - Up to eight in a 12-month period (four of each)
  - Need to document:
    - The patient's tobacco use
    - Advised to quit and impact of smoking
    - Assessed willingness to attempt to quit
    - Providing methods and skills for cessation
    - Medication management of smoking session drugs
    - Resources provided
    - Setting quit date
    - Follow-up arranged
    - Amount of time spent counseling patient
- EKG interpretation and report: 93000 (wRVUs – 0.17)
  - Need to document more than just "normal", should have a full interpretation

COMMON PROCEDURES

- Joints
  - 20600 (fingers, toes)
  - 20605 (TMJ, AC, wrist, elbow, ankle)
  - 20610 (shoulder, hip, knee)
- IUD
  - 58300 (in)
  - 58301 (out)
- Implantable
  - 11981 (in)
  - 11982 (out)
  - 11983 (out/in)
- Punch biopsy
  - 11100
- Destruction (cryo)
  - 17110 (<15)
  - 17111 (15 or greater)

CPT Code	Work RVU's
20600	0.66
20605	0.68
20610	0.79
58300	1.01
58301	1.27
11981	1.48
11982	1.78
11983	3.3
11100	0.81
17110	0.7
17111	0.97

References

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Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

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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)
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			• 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)
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				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