E&M: Looking to the Future

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September 25, 2020
Healthcare Administration Alliance: Virtual Conference 2020

Topics

- Overview of Current E&M Coding
- Concerns over Current E&M Requirements
- Patients Over Paperwork
- Finalized Changes for 2019 and 2021
- Medicare Telehealth Flexibilities Under the PHE
- 2021 PFS NPRM: Telehealth Proposals
- 2021 PFS NPRM: E&M Proposals

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When & Where to Submit Comments

- See the proposed rule for information on submitting formal comments by October 5, 2020.
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Q&A Session

- CMS must protect rulemaking process and comply with Administrative Procedure Act
- Participants invited to share initial comments or questions, but only comments formally submitted through process outlined by Federal Register taken into consideration by CMS
- See proposed rule for information on how to submit a comment

Fundamentals of Coding Evaluation and Management Services

Evaluation and Management Guidelines

The 2020 Current Procedural Terminology (CPT) manual is a medical coding set used to report medical, surgical, and diagnostic procedures to physicians and health insurance companies

Guidance on billing and coding Evaluation and Management Services can be referenced in Internet Only Manual Medicare Claims Processing Manual, Pub. 100-4, Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6, "E/M Service Codes"

The CMS Evaluation and Management Guide is a reference tool that provides direction based on the 1995 and 1997 Documentation guidelines for E/M services

1995 Documentation Guidelines for evaluation and management services provides guidance on billing the history, exam and medical decision making

1997 Documentation Guidelines for evaluation and management services provides an expanded definitions of status of chronic conditions and specialty examination scoring

Principles of Medical Record Documentation

Medical record should be complete and legible

Documentation of each patient encounter should include:

- Reason for encounter and relevant history
- Physical examination findings
- Prior diagnostic test results
- Assessment, clinical impression or diagnosis
- Plan for care
- Date and legible identity of observer:
  - Medical Review Signature Requirements (JH) (JL)

Medical Necessity

All E/M services must be adequately documented so medical necessity is evident

Medical necessity is the overarching criteria for payment in addition to the individual requirements of CPT

Medicare does not pay for services not medically necessary

References:

- Claims Processing Manual, Pub. 100-04, Chapter 12 – Physicians/Nonphysician Practitioner, Section 30.6.1.A, "Use of CPT Codes"
- The Social Security Act 1862 (a)(1)(A)

Components of an E&M Service

History
Physical Examination
Medical Decision Making

Counseling
Coordination of Care
Nature of Presenting Problem
Time

Types of E&M Services Based on Key Components

Office/Outpatient
Emergency Department
Observation
Hospital Care
Nursing Facility
Domiciliary
Home Care

Office/Outpatient Coding

New patient visits:
- Level of service determined by documentation of all three key components (history, exam, and medical decision making)
- Lowest key component sets level of service

Established patient visits:
- Level of service determined by documentation of two of the three key components (history, exam, and/or medical decision making)
- Highest two key components determines the level of service

High Level Established Patient Office/Outpatient Visits

Requires two of the three key components

History – Comprehensive:

- Extended HPI – Status of three chronic conditions OR four or more Elements
- Complete ROS – 10 or more systems
- Documentation of the pertinent positives and negatives of the involved systems with the statement "all others negative"
- Two PFSH required: Past, Family, and/or Social History (PFSH)

Physical Exam – Comprehensive:

- Documentation of eight or more systems is required per 1995 guidelines

Medical Decision Making – High Complexity:

- Documentation needs to be detailed in respect to what has been done, what is being done and what is planned to be done for the patient

Billing Based on Time - Outpatient

Encounter must be dominated by counseling and coordination of care (more than 50 percent of the face-to-face time)

Includes time spent with the physician only

Counseling and/or coordination of care must be provided in the presence of the patient

Time spent by other staff is not considered in selecting the appropriate level of service

Code selection based on total time of the face-to-face encounter

Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- **Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.**

Documenting E/M Requires Choosing the Appropriate Code

- **Currently, documentation requirements differ for each level and are based on either the 1995 or 1997 E/M documentation guidelines.**
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type (new v. established),
  - Setting of service (e.g. outpatient setting or inpatient setting), and
  - **Level of E/M service performed.**

Why Change?

- Stakeholders have said that the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.
- According to stakeholders, some aspects of required documentation are redundant
- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.

Patients Over Paperwork

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The changes to the Physician Fee Schedule address those problems head-on, by streamlining documentation requirements to focus on patient care and modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.

Medical Decision Making or Time

- In 2018, we proposed to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either MDM or time as a basis to determine the appropriate level of E/M visit.
- This would allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.
- It would also reduce the impact Medicare may have on the standardized recording of history, exam and MDM data in medical records, since practitioners could choose to no longer document many aspects of an E/M visit that they currently document under the 1995 or 1997 guidelines for history, physical exam and MDM.

Final Policies for E/M Visits Starting in 2019

For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for E/M visits, that do not require changes in coding/payment.

- For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.
- Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Payment for Office/Outpatient Evaluation and Management (E/M) and Analogous Visits

Last year, we finalized aligning E/M visit coding and documentation policies with changes by the CPT Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021.

- This includes:
  - Code redefinitions that rely on time or medical decision making for selecting visit level, with performance of history and exam as medically appropriate
  - Deletion of the level 1 new patient code (CPT 99201)
  - A new prolonged services code specific to office/outpatient E/M visits (CPT 99XXX)

We also adopted revised medical decision making guidelines adopted by the CPT Editorial Panel. Additional information about the American Medical Association (AMA) CPT changes are available on the AMA website

Changes to E&M Documentation

Effective January 1, 2021 CMS is aligning E/M coding with changes adopted by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/ outpatient E/M visits, which:

- Retains 5 levels of coding for established patients, reduces the number of levels to 4 for office/outpatient E/M visits for new patients, and revises the code definitions
- Revises the times and medical decision making process for all of the codes, and requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level based on either medical decision making or time

For more information, review the CY 2020 Physician Fee Schedule Fact Sheet and the Medicare Learning Network®(MLN) Connects Physician Fee Schedule and OPPS/ASC Final Rules Call transcript, recording and presentation.

Changes to E&M Documentation

Effective January 1, 2021, CMS is consolidating and increasing payment for the Medicare-specific add-on code, HCPCS code GPC1X, for office/outpatient E/M visits for primary care and non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

This code is not intended to reflect a difference in payment by enrollment specialty, but rather a better recognition of differences between kinds of visits.

Extending Telehealth

Advancing Virtual Care

To support access to care using communication technology, we finalized policies to pay clinicians for:

- Virtual check-ins – brief, non-face-to-face assessments via communication technology; (HCPCS code G2012)
- Remote evaluation of patient-submitted photos or recorded video; (HCPCS code G2010)
- Online digital evaluation service (e-Visit) (CPT Codes 99421-99423, 98970-98972)

Telehealth Overview

- Specified by Section 1834 (m) of the Social Security Act and related regulations, Medicare telehealth services are services ordinarily furnished in person that are instead furnished via a telecommunications system and are subject to geographic, site of service, practitioner, and technological restrictions.
- 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.

Telehealth Flexibilities Under the PHE

- Waived geographic restrictions
- Waived originating site restrictions
- Enforcement discretion on HIPAA complaint technology
- Enforcement discretion on established relationship with provider
- Expanded set of provider types allowed to bill
- Allowed audio-only interactions for a defined subset of services
- Allowed cost sharing to be waived
- Expanded list of telehealth services under Category 2

Documentation for E&M Telehealth Services During the PHE

- Interim policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time (all of the time associated with the E/M on the day of the encounter);
- Remove any requirements regarding documentation of history and/or physical exam in the medical record for these services
- Similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule.
- It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care.
- This policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for the COVID-19 pandemic.

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Updating the Telehealth Services List

- Receive suggested services by February in a given year
- Review services as either:
  - Category 1 – similar to existing telehealth services
  - Category 2 – not similar
    - Requires additional evidence of clinical benefit to patients
- Add to list through formal rulemaking to be in effect the next year

Telehealth Proposals

We propose these services as permanent additions to the Medicare telehealth services list:

Service	Related Code(s)
Group Psychotherapy	CPT code 90853
Domiciliary, Rest Home, or Custodial Care services, Established patients	CPT codes 99334-99335
Home Visits, Established Patient	CPT codes 99347- 99348
Cognitive Assessment and Care Planning Services	CPT code 99483
Visit Complexity Inherent to Certain Office/Outpatient E/Ms	HCPCS code GPC1X
Prolonged Services	CPT code 99XXX
Psychological and Neuropsychological Testing	CPT code 96121

Telehealth Proposals

We propose these services as Category 3, temporary additions to the Medicare telehealth services list:

Service	Related Code(s)
Domiciliary, Rest Home, or Custodial Care services, Established patients	CPT codes 99336-99337
Home Visits, Established Patient	CPT codes 99349-99350
Emergency Department Visits, Levels 1-3	CPT codes 99281-99283
Nursing facilities discharge day management	CPT codes 99315-99316
Psychological and Neuropsychological Testing	CPT codes 96130- 96133

Services we are NOT Proposing to Add

Services we are **not** proposing to add to the Medicare telehealth services list but **are** seeking comment:

Service	Related Code(s)
Initial nursing facility visits, all levels (Low, Moderate, and High Complexity)	CPT 99304-99306
Psychological and Neuropsychological Testing	CPT codes 96136-96139
Therapy Services, Physical and Occupational Therapy, All levels	CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507
Initial hospital care and hospital discharge day management	CPT 99221-99223; CPT 99238- 99239
Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent	CPT 99468- 99472; CPT 99475- 99476
Initial and Continuing Neonatal Intensive Care Services	CPT 99477- 99480

Services we are NOT Proposing to Add Cont'd

Services we are **not** proposing to add to the Medicare telehealth services list but **are** seeking comment:

Service	Related Code(s)
Critical Care Services	CPT 99291-99292
End-Stage Renal Disease Monthly Capitation Payment codes	CPT 90952, 90953, 90956, 90959, and 90962
Radiation Treatment Management Services	CPT 77427
Emergency Department Visits, Levels 4-5	CPT 99284-99285
Domiciliary, Rest Home, or Custodial Care services, New	CPT 99324- 99328
Home Visits, New Patient, all levels	CPT 99341- 99345
Initial and Subsequent Observation and Observation Discharge Day Management	CPT 99217- 99220; CPT 99224- 99226; CPT 99234- 99236

Payment for Office/Outpatient E/M Visits and Analogous Services

E/M Proposals

- Clarify the reporting times for prolonged office/outpatient E/M visits (CPT 99XXX)
- Revise the times used for rate setting for this code set
- Seeking public comment on how to clarify the definition of HCPCS add-on code GPC1X, previously finalized for office/outpatient E/M visit complexity, and if we should refine our utilization assumptions

E/M Proposals

- Revalue the following code sets that include, rely upon, or are analogous to office/outpatient E/M visits in line with the increases in values we finalized for office/outpatient E/M visits for 2021:
  - End-Stage Renal Disease Monthly Capitation Payment Services
  - Transitional Care Management Services
  - Maternity Services
  - Cognitive Impairment Assessment and Care Planning
  - Initial Preventive Physical Examination and Initial and Subsequent Annual Wellness Visits
  - Emergency Department Visits
  - Therapy Evaluations
  - Psychiatric Diagnostic Evaluations and Psychotherapy Services

E&M Resources

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Evaluation-and-Management-Visits

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management


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