Are You Ready to Use the New Evaluation and Management Codes and Services Starting January 1, 2021?

What Behavioral Health Providers Need to Know

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Authorization of Evaluation and Management (E/M) CPT Code Changes

Discussion Across Multiple Years to Alter the Coding

Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) Approved the Changes to Begin January 1, 2021

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As finalized in the CY 2020 PFS final rule, in 2021 “CMS is aligning E/M Coding with changes adopted by the AMA CPT Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021”.

Office-Based Evaluation and Management Services

Changes Beginning January 1, 2021 for Office-Based E/M Services Only

Purpose of the changes:

To reduce the burden of reporting and documentation guidelines for Evaluation and Management enabling more time devoted to psychiatric health care services and putting patients care over documentation and paperwork.

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Application to all providers, organizations and states using Evaluation and Management services currently – we know of no exceptions

We Will Only Examine the Tip of the Iceberg During Today's Webinar

Office-Based Evaluation and Management Services

Current Use of the Three Key Components To Determine The Level of E/M Through December 31, 2020

Current E/M Quality Key Components:

History	Chief Complaint
	History of Present Illness (HPI)
	Past, Family and/or Social History (PFSH)
	Review of Systems (ROS)
Exam	Number of system/body areas examined
	"Bullets" or elements completed within specific systems
Medical Decision Making	Number of Diagnoses or Management Options
	Amount and/or Complexity of Data to be Reviewed
	Risk of Significant Complications, Morbidity, and/or Mortality

Office-Based Evaluation and Management Services

Current Use of Three Components For Assembly Process Leads to the Level of E/M

Four Types of Each Key Component Currently Used:

History Type
Problem focused (PF)
Expanded problem focused (EPF)
Detailed (DET)
Comprehensive (COMP)

Examination type
Problem focused (PF)
Expanded problem focused (EPF)
Detailed (DET)
Comprehensive (COMP)

Complexity of Medical Decision Making
Straightforward
Low
Moderate
High

The Documentation Dilemma for E/M Services

For 2020 and Earlier-Selecting the Proper Code

E/M coding can be difficult because of the many factors involved in selecting the correct code. For instance, determining the level of history, level of psychiatric examination, and level of medical decision making can involve using grids, counting elements and using tables to check requirements.

Office-Based Evaluation and Management Services

Changes Beginning January 1, 2021 for Office-Based E/M Services Only

- Revisions apply to the New and Established Evaluation and Management (E/M) CPT Codes 99201-99215.
- Psychiatric Providers mostly began using the Office-Based E/M Services on January 1, 2013.
- We used the existing reporting and documentation guidelines as all physicians have done. Former codes used prior to January 1, 2013 were removed.

Office-Based Evaluation and Management Services

No Fee Structure Changes Beginning January 1, 2021 for Office-Based E/M Services Only

- Medicare had “INTENDED” to pay a single rate (Blended Rate) for E/M Visits Levels 2-4 starting in 2021.
- This new fee structure was removed and eliminated.
- Medicare and other payers will continue to have distinct payment rates for each office/outpatient E/M code in 2021 with higher levels receiving higher payment values compared to lower levels if FFS used.

Office-Based Evaluation and Management Services

Discontinuation of Level 1 code 99201

- The 2021 CPT ® code set will not include new patient level 1 code 99201
- All other E/M Office-Based services and codes remain available in 2021 and include 99202-99205; 99211-99215

E/M Change Snapshot January 1, 2021

Summary

- 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 and not to reach a score
- Reduces the scoring time for History and Psychiatric Exam and promotes more “higher level activities” in Medical Decision Making
- Alters the rules allowing clinicians to choose the E/M visit level (1-5) based on either medical decision making or time.

Evaluation and Management Summary of Revisions

History and Psychiatric Examination/Evaluation Elements Not Used for Code Selection Beginning January 1, 2021

- The Key Components of History and the Psychiatric Examination should not determine the appropriate code level for “New” or “Established” patient services.

- Psychiatric Providers should perform a “medically appropriate history and/or psychiatric examination” with the goal of establishing medical necessity in accordance with Federal, State and Payer rules.

Evaluation and Management Summary of Revisions

“Medically Appropriate” History and Psychiatric Examination/Evaluation Supports Quality

- The History and/or Examination portion of these E/M guidelines explains that office and other outpatient E/M services include “a medically appropriate history and/or physical examination, when performed.”
- “Medically appropriate” means that the physician or other qualified healthcare professional reporting the E/M determines the nature and extent of any history or exam for a particular service.
- The code selection does not depend on the level of history or psychiatric exam as it did in the past.

Medically Appropriate and Medical Necessity-Know Your Payer and/or State Rules

The E/M Services Must Meet the Medical Necessity of the Payor/State Rules

Medical Necessity is often supported through the E/M key components of History, and in particular the History of Present Illness (HPI) and the CMS Psychiatric Examination

Nebraska Medical Necessity Criteria Example: 471 NAC 1-002.02A: Medical Necessity

Health care services and supplies which are medically appropriate and:

1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

Know Your Medical Necessity Requirements

Medicare Guidelines

*"Services must meet specific medical necessity requirements in the statute, regulations, and manuals and specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim). For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary."**

*Medicare Learning Network (MLN) Evaluation and Management Services Guide January 2020

Evaluation and Management Summary of Revisions

All E/M Code Descriptions Have Been Modified for 2021-Sample for 99213

- **Code Description 99213**
- **The 99213 does include a time reference in 2021 and does not require a History and/or Exam Component-See Below**
- *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and* ***low level*** *of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.*

Reporting E/M Services

We Report the Level of E/M Services Performed Either Through MDM or Time

To bill any E/M code, “the services furnished must meet the definition of the code and ensure that the E/M code selected reflect the services furnished”*

Documentation is the way to comply with this requirement.

*Evaluation and Management Services Guide, January 2020, CMS

Evaluation and Management Summary of Revisions

Selection of Code Level Can Be Based on Medical Decision Making or Time

- The Medical Decision Making (MDM) Subcomponents remain the same (Problems/Diagnoses, Data and Risk).
- However, there are revisions to the elements for code selection and **many clarifying definitions**.
- There are quality and revenue advantages to using Medical Decision Making to determine the level of E/M.


Diagnosis in the MDM
Data in the MDM
Risk in the MDM
Putting it all Together

Evaluation and Management Summary of Revisions

MDM 2020

Medical Decision Making 2020
Number of Diagnoses or Management Problems (Problem Points)
Amount and/of Complexity of Data (Data Points)
Risk of Significant Complications, Morbidity, and/or Mortality

MDM 2021

Medical Decision Making January 2021
Number and Complexity of Problems Addressed during the Encounter
Amount and/of Complexity of Data to Be Analyzed- 3 categories of data: (1) tests, documents, orders, or independent historians, (2) independent test interpretation, and (3) discussion of management or test interpretation with external providers or appropriate sources (non-healthcare, non-family) e.g. case manager, probation officer.
Risk of Significant Complications, Morbidity, and/or Mortality of Patient Management – Can include “shared” MDM with the patient, family or both and options considered but not selected are a factor. E.g. deciding against hosp. for a psychiatric patient with support for OP care.

Revised Guidelines Within Medical Decision Making

The Number and Complexity of Problems Addressed at the Encounter

- The 2021 guidelines state that the final diagnosis isn't the only factor when you determine the complexity or risk. A patient may have several lower severity problems that combine to cause higher risk, or the provider may have to perform an extensive evaluation to determine a problem is of lower severity.
- The 2021 guidelines expands older guidelines, clarifying that you should not consider comorbidities and underlying diseases when you select the E/M level "unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management."

Several Other Definitions – Not Exhaustive

Psychiatric Providers will need to know CPT®'s definitions for many terms

- To qualify as a problem addressed (or managed), the provider must evaluate or treat the problem. A simple note that another professional is managing a problem does not count as addressed. There must be additional assessment or care coordination. Another area that does not qualify as addressing the problem is referral without evaluation (using history, exam, or diagnostic studies) or considering treatment.
- A self-limited or minor problem is defined 2021 E/M guidelines but have deleted the crossed-out text: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status ~~OR has a good prognosis with management/compliance~~. This term is relevant for straightforward MDM codes 99202 and 99212.
- Risk is related to probability of something happening, but risk and probability are not the same for E/M coding purposes. High probability of a minor adverse effect may be low risk, depending on the case. The terms high, medium, low, and minimal risk are meant to reflect the common meanings used by clinicians. For MDM, base risk on the consequences of the addressed problems when they're appropriately treated. Risk also comes into play for MDM when deciding whether to begin further testing, treatment, or hospitalization.

Evaluation and Management Summary of Revisions

Selection of Code Level Can Be Based on Medical Decision Making on January 2021

Modifications to the Criteria for Medical Decision Making

- Created sufficient detail in CPT code set to reduce variation
- Align criteria with clinically intuitive concepts
- Use existing CMS tools to reduce disruption in coding patterns

Evaluation and Management Summary of Revisions

Modifications to the Criteria for Medical Decision Making

- Current AMA ® CMS Table of Risk Used as foundation to create the level of Medical Decision Making (MDM) table.
- Current CMS Contractor Audit Tools used to minimize disruption in MDM level criteria
- Ambiguous terms have been removed (e.g. Mild) and previously ambiguous concepts have been defined such as acute/chronic illness with “systemic symptoms”.
- In 2021 MDM Guidelines CPT ® states that MDM “includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.”

Evaluation and Management Summary of Revisions

Level of Medical Decision Making Table – Effective January 1, 2021

- Guide to assist in selecting the level of Medical Decision Making Defined by the AMA
- Used only for office/outpatient E/M Services
- Includes the four (4) levels of Medical Decision Making which are **Unchanged** from current levels:
  - Straightforward
  - Low
  - Moderate
  - High

Medical Decision Making

Using Medical Decision Making to Select the Appropriate Code

- The Medical Decision Making for each distinct code level is the **same**, regardless of whether the code is for a “New” or “Established” patient.
- Level 2 codes 99202 and 99212 both require **Straightforward** MDM.
- Level 3 codes 99203 and 99213 both require **Low** MDM
- Level 4 codes 99204 and 99214 both require a **Moderate** MDM
- Level 5 codes 99205 and 99215 both require a **High** MDM

Medical Decision Making

Use the MDM "Table of Risk" By the AMA to Determine the MDM Level = E/M Code Level

- Number and Complexity of **Problems** Addressed at the Encounter
- Amount and/or Complexity of **Data** to be Reviewed and Analyzed
- **Risk of Complications*** and/or Morbidity or Mortality of Patient Management

*Prescription Drug Management Meets the Moderate Level of Risk

Determining the Medical Decision Making Level

Analyze the Problems, Data Elements and Risk

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

*American Medical Association

Use of MDM to Determine the Level of E/M*

Example of MDM to Determine the Level of E/M for "Established Patient"

- **Number and complexity of problems addressed at the encounter**
  - Recurrent depression, severe with worsening progression, unemployed (found in HPI, Psychiatric Exam) = MODERATE
- **Amount and complexity of data to be reviewed and analyzed** (The Data are divided into three categories – Category 1 – Tests and Documents; Category 2 – Assessment requiring an independent historian for Low MDM and Assessment requiring independent interpretation of tests for Moderate MDM; Category 3 – Discussion of management or test interpretation).
  - None performed = 0 data
- **Risk of complications and morbidity or mortality of patient management**
  - Prescription Drug Management and treatment is limited by social determinants of health = MODERATE
  - To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded (concept unchanged from current guidelines)
- **MODERATE PROBLEM COMPLEXITY AND MODERATE RISK = LEVEL 4 E/M 99214**

*Use AMA MDM Table

Use of Time to Determine the Level of E/M

Use the Summation of Time on the DATE of the Encounter

- Use the sum of the
  - Pre-service
    - Intra-service
      - Post-Service

- Use the Physician or other Qualified Health Professional **face-to-face and non-face-to-face** time
- Other Clinician time cannot be included

Evaluation and Management Summary of Revisions

Selection of Code Level Can Be Based on Time as of January 2021

- Definition of Time will now be "minimum time" rather than "typical time" as it was prior to 2021.
- Represents total time of the physician/qualified health care professional on the day of service. Time cannot be accumulated from before or after the date of service.
- Time providing care coordination (on the day of service) can be included, but this is not required in 2021.
- Use of time to capture the E/M Service may increase the cost of the service proportional to the time used.

Use of Time to Determine the Level of E/M

Example of Time to Determine the Level of E/M for "Established Patient" On SAME DAY

- Psychiatric provider reviews lab results ordered in previous encounter on the day of the E/M service – 4 minutes.
- Psychiatric provider reviews history of response to treatment from a case manager group of 8 notes since last psychiatric visit 90 days prior and creates a two-sentence summary - 8 min.
- Psychiatric provider performs a medically necessary history and psychiatric exam (use only "medically appropriate" elements e.g. HPI for two problems and 7 exam bullets-no score from these)– 14 minutes.
- Psychiatric provider submits clinical findings through a phone call or written info. To staff member requesting MCO UM service authorization - 5 min.
- 31 minutes total = Level 4 E/M - 99214

Use of Time to Determine the Level of E/M

Other Psychiatric Functions Used to Claim Time To Determine the Level of E/M

- Ordering tests, medications or procedures-(**part of the MDM**)
- Referring and communicating with other health care professionals to collaborate on the care (can be internal or external), just not reported separately by another professional-(**part of the MDM**)
- Documenting clinical information in the electronic or other health record (The purpose of the New E/M guidelines are to reduce the documentation)
- Care Coordination (not required)
- Communicating results of care to client/family/caregivers

Evaluation and Management Summary of Revisions

Selection of Code Level Can Be Based on Time as of January 2021

- No counseling and coordination of care dominating the encounter (50%) with patient and/or family is required after 2020. It still can be provided.
- The addition of a shorter 15-minute prolonged service code (99XXX – code not released as of this writing).
- Prolonged service can be reported only when the visit is based on time and after the total time of the highest-level service (e.g. 99215 or 99205) has been exceeded.

E/M Time Use Table - 2021

E/M CPT Code	Medical Decision Making Level	Minutes if Using Time
99202	Straightforward	15-29
99203	Low	30-44
99204	Moderate	45-59
99205	High	60-74
99212	Straightforward	10-19
99213	Low	20-29
99214	Moderate	30-39
99215	High	40-54

Evaluation and Management Summary of Revisions

Selection of Code Level Can Be Based on Time as of January 2021

- Using time will likely result in a higher cost for the provider or organization using payer rates.
- Using MDM could be performed more efficiently.
- Most Medicaid E/M rates are based on 3 encounters per hour (about 20 min each).
- Organizations will need to consider their preference for the use of MDM or time and may consider policy guidance to support the system.

Add-on Psychotherapy Codes

Psychotherapy Remains the Same Using the Add-On Codes to E/M

- There is no change for the add-on psychotherapy codes for 2021. The following three codes are available to add to an E/M Service currently and after 2021:
  - +90833 – 30 minutes (16-37 minutes)
  - +90836 – 45 minutes (38-52 minutes)
  - +90838 – 60 minutes (53-89 minutes)

- Psychiatric Providers must document the precise time for the add-on Psychotherapy codes following the CPT ® time-based rules.
- Rates for add-on Psychotherapy Services are determined by the payer.
- Psychiatric Providers must complete a brief/concise psychotherapy note to document the psychotherapy added into an E/M service.

Organizations Need to Plan for The E/M Changes

A Limited Set of Recommendations for Successful Transition

- Identify and task a small team to organize the information and provide guidance to your organization. A sample of activities are targets:
  - Revise and Update policies for E/M Service Provision
  - Review and revise E/M formatted templates (EHR) tools that can help psychiatric providers deliver the services effectively, efficiently and with quality.
  - Know and follow the Medical Necessity rules for your state and payers.
  - Train staff on the new code descriptions for the office-based E/M code levels used in the organization.
  - Train staff on the revised definitions such as Medical Decision Making elements and the use of time to determine the level of E/M.
  - If purchasing Telepsychiatry, inquire how the contracted providers are being prepared for the practice change and determine how to distribute organizational change information to clinicians assigned to your organization.
- Develop Compliance and Quality Review Capabilities based on the revisions
- Use Rapid-Cycle change process before and after January 1, 2021 to test compliance and look for the benefits of reduced the documentation and assembly burden

References

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