2020 1st Quarter Newsletter

active MANAGEMENT
Practice Management, Medical Billing & Consulting
Maximizing Your Office Potential

CMS COVID-19 UPDATE: PODIATRISTS CAN PROVIDE E/M SERVICES REMOTELY

The Centers for Medicare and Medicaid Services (CMS) has announced major changes to services that podiatrists can provide remotely under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

This waiver allows Medicare to pay for office, hospital, and other visits furnished via telehealth. **This change means podiatrists can submit CPT 99201–99215 when these services are provided remotely**.

Any device that has interactive audio and video and allows real time communication may be used. **Providers are permitted to reduce or waive cost-sharing for these services if they wish during the Public Health Emergency. Additionally, CMS shared that typical HIPAA guidance does not apply to these services as long as health-care providers are providing these services in good faith. FaceTime and Skype were given as examples of services we can use to provide these services.**

When submitting these services, the normal CPT 99201–99215 codes may be used and no special modifiers are necessary. Place of Service "02" (the location where health services and health related services are provided or received, through a telecommunication system) should be used when submitting these claims. Evaluation and management services will be paid at the facility rate and, when medically necessary, can be provided for any pathology, whether or not it is related to COVID-19.

Cont'd

The guidance provided in the March 16 webinar is all still accurate and still an option, but this announcement allows more flexibility in the services we can provide to our patients during this emergency.

Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

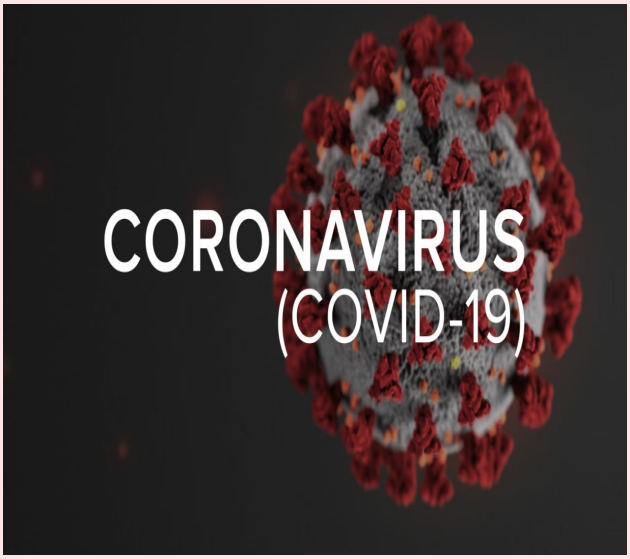
These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

Cont'd

See references below:

CMS Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

CMS FAQ: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf



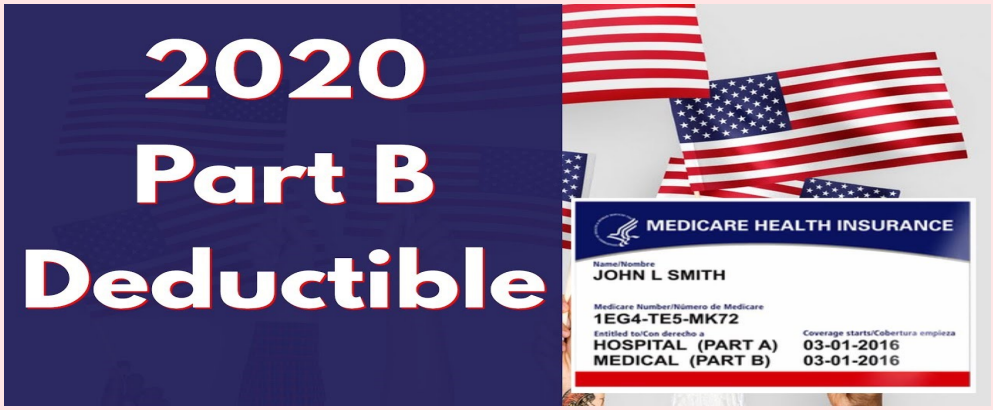
CMS Announces the 2020 Medicare Part B Deductible

On November 8, 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2020 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

Medicare Part B Deductible

For 2020, the annual deductible for all Medicare Part B beneficiaries is **$198**, an increase of $13 from the annual deductible of $185 in 2019.

The increase in the Part B premiums and deductible is largely due to rising spending on physician-administered drugs. These higher costs have a ripple effect and result in higher Part B premiums and deductible.



Importance of 99024-Postoperative Visits

Code 99024 captures services normally included in the surgical package, indicating an evaluation and management (E/M) service was performed during a postoperative (post-op) period for reasons related to the original procedure. Although you may not think you get paid for it, it's included in the payment for surgery.

Since Medicare pays for the service "in advance," it is appropriately interested in whether those services are performed. CPT 99024 is a Medicare bundled code with zero relative value units (RVUs) and no fee on the Medicare Physician Fee Schedule (MPFS), so you may wonder why CMS is interested in collecting this data. Thorough post-op care reduces the risk of complications of surgery (including pain), helps to manage side effects of treatment, and supports recovery.

In fact, a Medicare bundled code is reimbursed by Medicare, but not at the time the service is performed. According to the MPFS, "… payment for them is subsumed by the payment for the services to which they are incident." In other words, payment for post-op care "tomorrow" is included in payment for the surgery "today."

One reason for CMS's decision to gather more data was that CMS realized not all surgeons who perform post-op visits report 99024. If CMS is to use reported data to determine the fee schedule, then accurate data is essential: Surgeons must report all post-op care they provide using 99024.

It's About Capturing Physician Work in Patient Care

Reporting 99024 for post-op care will not only help to ensure surgeons are reimbursed adequately for all the work they perform, but also serve as a reminder of the value and importance of post-op physician visits in achieving better health outcomes for patients.

Cont'd

Value of Procedures Performed

When the value of any procedure is determined, the number of global postoperative visits that typically follow is taken into consideration. For example, the value of CPT 11750, (Excision of nail and nail matrix, partial or complete, for permanent removal) that may be used for ingrown or deformed nails was determined with the assumption that podiatrists are providing one postoperative visit within the 10-day global period. Podiatrists will get paid more for CPT 11750 if the Centers for Medicare and Medicaid Services (CMS) know that they are providing a "free" global visit. Ultimately, however, the Centers for Medicare and Medicaid Services (CMS) only knows for sure that a global visit was provided when one submits CPT 99024.

The Problem Caused

In the 2019 Medicare Part B Physician Fee Schedule Proposed Rule, CMS published its concern that postoperative global visits are occurring so infrequently that they may lower the values associated with procedures that carry a global period. From the CMS perspective, if the global visit is not occurring, it should not be included in the value of the procedure. This can lead to the assigned value of our procedures being reduced.

What Can be Done?

The greatest concern is that CMS is working with inaccurate information. This would be the case if these postoperative global visits are, in fact, occurring but are not being reported. Some may not report these visits because they think it wastes time to submit a claim with a $0 charge. Some may even lose money by submitting these visits if they have to pay a clearinghouse or some other entity every time they submit a claim.

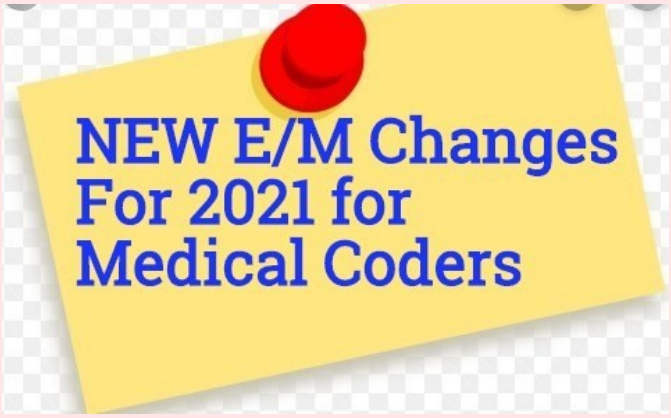
The most important thing that podiatrists can do right now is to submit CPT 99024 every time they perform a postoperative global visit during the global period following a procedure. Even though this code does not carry any monetary value, the aforementioned analysis shows that CMS uses submission rates to make important decisions.

A low submission volume has led CMS to believe that these services are not being provided. That misconception can have a negative impact on the value of many procedures performed.

E/M 2021: Grasp the Future Roles of Time and MDM for Accurate Coding

Evaluation and management (E/M) code descriptors for office and other outpatient visits will look a lot different in the 2021 CPT code set. One of the first steps in preparing for this major overhaul is understanding how medical decision making (MDM) and time will affect 99202-99215 in 2021.

Quick background: The American Medical Association (AMA), which maintains the CPT code set, has announced that the 2021 code set will not include level-one new patient code 99201, and codes 99202-99215 will have revised guidelines and descriptors. These changes were in response to Medicare's plans to revise office and outpatient E/M coding to focus on time and MDM.



Both time and MDM have been important E/M concepts for many years, so you will have to be careful not to fall into old habits when you start applying the new rules in 2021.

See MDM's Place in Revised Codes

The new E/M coding rules will allow you to choose from new patient codes 99202-99205 and established patient codes 99212-99215 based on either MDM or time. (Established patient code 99211 will still be valid, but the descriptor will not reference MDM or time.) First let's look at MDM.

CONT'D

The current structure of the office and outpatient E/M codes uses history, examination, and MDM as the three key components for determining the correct code level. In contrast, the 2021 E/M office and outpatient E/M codes will state the level of MDM required for a service (when coding based on MDM rather than time), but won't require specific levels of history or exam.

For instance, the 2020 descriptor for new patient code 99203 includes the phrase "requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity."

In 2021, the descriptor for 99203 will instead state the code "requires a medically appropriate history and/or examination and low level of medical decision making."

Spend Time With New MDM Guidelines

To help you determine the correct MDM level, the 2021 CPT® guidelines will add more specific information, including a new MDM table, which is similar to the Table of Risk in the CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. (The 1995 and 1997 Documentation Guidelines will be obsolete in 2021 for office/outpatient visits.)

The 2021 MDM table will have columns with these headers:

⇒ Code

⇒ Level of MDM (Based on 2 out of 3 Elements of MDM)

⇒ Number and Complexity of Problems Addressed

—The rows provide the level required for each code. For instance, 99202 and 99212 have a "Minimal" requirement, which the table states is one self-limited or minor problem.

CONT'D

⇒ 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.

—The rows include the levels that match the codes and the requirements for reaching that level. As an example, the row for 99203 and 99213 lists "Limited" as the level. To reach that level, you have to meet the conditions listed under either "Category 1: Tests and documents" or "Category 2: Assessment requiring an independent historian."

⇒ Risk of Complications and/or Morbidity or Mortality of Patient Management

—-The rows list the levels, and the highest two levels include examples, such as "prescription drug management" under the "Moderate" level on the row for 99204 and 99214.

There are more details in the 2021 MDM table and guidelines, so be sure to work your way through those as you prepare for the 2021 updates. Pay particular attention to the definitions included in the guidelines, such as those for acute and chronic illnesses, to help you use the MDM table correctly.

Adjust to New Meaning for Office/Outpatient Time

When you don't use MDM to choose a code from 99202-99215, you will be able to use time. How you count the time and when you can use time to determine your code choice will change from 2020 to 2021.

In 2020, you can use time as the deciding factor for your E/M code only when counseling, coordination of care, or both take up more than 50 percent of the encounter. The 2021 changes for 99202-99205 and 99212-99215 will mean that you can use time as the deciding factor for your code choice even when counseling and coordination of care don't dominate the visit.

CONT'D

Another important change is that the term "time" in 2020 means intraservice time, which is face-to-face time with the patient or family in the office or outpatient setting. For 2021, rather than using intraservice time, you will use total time, which includes face-to-face and non-face-to-face time spent by the E/M provider. You won't include time spent on separately reported services or time spent on activities the clinical staff usually performs when you determine the total time.

Each 2021 office or outpatient E/M code level will specify the time range that applies to the code:

New patient codes:

⇒ 99202: 15-29 minutes

⇒ 99203: 30-44 minutes

⇒ 99204: 45-59 minutes

⇒ 99205: 60-74 minutes

Established patient codes:

99212: 10-19 minutes

99213: 20-29 minutes

99214: 30-39 minutes

99215: 40-54 minutes

CPT also will introduce a new add-on code in 2021 for you to use for prolonged office or outpatient E/M services. You'll report the code once for each 15 minutes in addition to 99205 or 99215.

CONT'D

Remember the Outlier 99211

For office or outpatient E/M, the exception to the new MDM and time rules will be 99211.

The 2021 descriptor will be similar to the 2020 descriptor, but will remove the crossed out time reference: *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.*

The guidelines state that one appropriate use of 99211 will be when the billing provider's time is spent supervising the clinical staff who perform the face-to-face part of the encounter.

NEW PATIENT E/M DENIALS: PUZZLE UNRAVELED

New patient evaluation and management (E/M) claims are being denied when the patient was previously seen by a specialty physician assistant or specialty nurse practitioner on staff. This is happening when another provider of a different specialty in the same multi-specialty group sees the patient for the first time and bills a new patient E/M service.

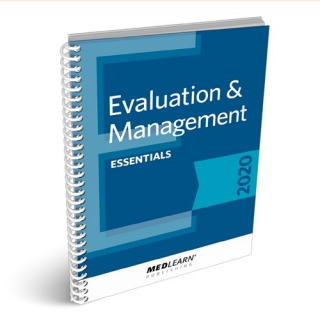
Why Are New Patient E/M Claims Being Denied?

Medicare has only one taxonomy for physician assistants (PAs) and nurse practitioners (NPs), without any specialty designation. This means their services are not delineated or assigned to any particular specialty, even though they may be practicing a particular specialty. As a result, the patient is considered established to all the providers in the group when seen within the past three years, and all but initial new patient E/M visits performed at the multi-specialty group are automatically denied by the Medicare Part B carrier.

You Have the Right to Appeal

The new patient E/M denial does not have to stand. An appeal to the carrier, showing that the non-physician practitioner's (NPP's) specialty is different than the provider who is billing a new patient E/M, should get the claim paid correctly. Some Medicare Part B carriers, such as Novitas, allow you to use a re-opening to reprocess these claims. A spreadsheet with the following information will assist the carrier in reprocessing the claim accordingly:

CONT'D



⇒ Provider first and last name

⇒ NPI

⇒ Provider specialty and sub-specialty (if applicable)

⇒ Specialty code (optional)

Only Medicare approved specialties apply. A complete listing of the physician and non-physician specialties is available in the **Internet Only Manual (IOM) Pub 100-04, Chapter 26 Completing and Processing Form CMS 1500 Data Set, Section 10.8.**

Keep the spreadsheet on file to simplify all new patient E/M denial re-opening appeals.

THE IMPORTANCE OF PATIENT RELATIONSHIP CATEGORIES AND CODES (PRC)

Patient Relationship Categories and Codes (PRC) were established to help attribute patients and care episodes to physicians and other clinicians for measuring cost, particularly in the Quality Payment Program. Beginning in 2020, voluntarily reporting PRC on claims may count toward the Improvement Activity performance category of MIPS for the 2020 performance year.

HCPCS Level II code modifiers:

X1 – Continuous/Broad services = For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship.

X2- Continuous/Focused services = For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.

X3 -Episodic/Broad services = For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization.

X4 – Episodic/Focused services = For reporting services by specialty focused clinicians who provide time limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.

X5 – Only as Ordered by Another Clinician = For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the four categories described above.

CONT'D

Table 6: Patient Relationship Categories for Team-based Clinicians			
Service	Clinician Type	Category	Rationale
Management of Hypertension, Diabetes, and Atrial Fibrillation; Routine Health Maintenance	Nurse Practitioner	X1	Ongoing, broad care
Management of Atrial Fibrillation	Cardiologist	X2	Ongoing, specialized care
Diabetic Foot Screening	Podiatrist	X2	Ongoing, specialized care
Diabetic Retinopathy Screening	Ophthalmologist	X2	Ongoing, specialized care

What is the value of reporting patient relationships for clinicians?

The patient relationship categories and codes provide an opportunity for clinicians to self identify their relationship with and responsibility for a patient at the time of furnishing an item or service. Reporting patient relationships is intended to improve the accuracy of attributing episodes to clinicians, if the patient relationship codes are incorporated into the attribution methodology for episode-based cost measures in the future.

Team-Based Care Example

Scenario	Patient Relationships
Patient Traoré has hypertension, diabetes, and atrial fibrillation. She sees a ***cardiologist*** regularly for her atrial fibrillation.	***Continuous/Focused – X2***
She sees a ***podiatrist*** for foot checks.	***Continuous/Focused – X2***
She also sees an ***ophthalmologist*** for eye exams, given her diabetes.	***Continuous/Focused – X2***
Her ***nurse practitioner*** coordinates with the cardiologist, podiatrist, and ophthalmologist as part of her routine health maintenance.	***Continuous/Broad – X1***

CONT'D

CMS does have several goals for the voluntary reporting period:

⇒ For clinicians to gain familiarity with the categories and experience submitting the codes;

⇒ To collect data on the use and submission of the codes for analyses to inform the potential future use of these codes in cost measure attribution methodology in the Quality Payment Program.

The codes are currently in a voluntary reporting period. Whether and how the codes are reported on claims will not affect Medicare reimbursement. For now, the modifiers have no impact on beneficiaries.

Reporting of these modifiers will be mandatory in the near future and CMS advises clinicians to participate during the voluntary reporting period to ease transition.

E/M Changes Only to Office/ Outpatient-Effective 2021 for 99202 -99215|Overview

⇒ Medicare adopts CPT E/M changes for 2021, rescinding the plan for bundled payment for three levels of codes

⇒ Clinicians can select new and established patient visit based on time or medical decision making (MDM)

⇒ New guidelines for using time for 99202—99215, new definitions in MDM

⇒ Revised MDM guidelines

The changes below relate only to new and established patient visits in 2021, codes 99202-99215:

⇒ Code 99201 will be deleted effective January 01, 2021.

⇒ Clinicians may use either time or medical decision making to select a code.

⇒ There will be no required level of history or exam for visits 99202-99215. From the AMA website for 2021,

"Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services."

⇒ Time will be defined as total time spent, including non-face-to-face work done on that day, and will no longer require time to be dominated by counseling.

⇒ Visits will have a range for time, e.g., 99213 will be 20-29 minutes, 99214 will be 30-39 minutes

⇒ There will be new definitions within MDM.

⇒ The MDM calculation will be similar to, but not identical to, the current MDM calculation.

Cont'd

⇒ CPT is providing numerous definitions to clarify terms in the current guidelines, such as "chronic illness with exacerbation, progression or side effects of treatment," and "drug therapy requiring intensive monitoring for toxicity."

Typical times vs. planned times for 2021

E/M code	Typical	2021 time
99201	10	N/A, code deleted
99202	20	15-29
99203	30	30-44
99204	45	45-59
99205	60	60-74
99211	5	N/A, no time listed
99212	10	10-19
99213	15	20-29
99214	25	30-39
99215	40	40-54

All other E/M services that are defined by the three key components will continue to use the 1995 and/or 1997 Documentation Guidelines, not just in 2020, but in 2021.

Please note for all other places of service the respective E&M code remain the same and are defined by the 3 key components.

Stay Tuned For More Updates……