Welcome to the Joint ATS/CHEST Webinar on the Medicare 2021 Final Rule
The webinar will begin shortly...

All participants will be on mute during the webinar.

The webinar will be recorded and posted on the ATS and CHEST websites for future reference.
The webinar will begin shortly...

Please use the webinar chat function to submit questions.

The Q/A session will happen at the end of the webinar.
Everything You Need to Know About the CMS 2021 Final Payment Rule

Tuesday, January 26, 2021
Speaker Disclosures

**Omar Hussain, DO**
Has no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of his presentation.

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Consultant, AGS
Has no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of her presentation.
Scott Manaker, MD, PhD

Disclaimers

Opinions - my own

Consultant – see disclosure* in program

No representation, guarantee or warranty of fitness

- Consultant to RAND.
- DSMB for Cerecor.
- Expert witness in workers’ compensation and in medical negligence matters.
- Stock held in 3M; and (spouse) Pfizer, Johnson & Johnson.
- Member of AMA RUC.
- Trustee, National Board for Respiratory Care (NBRC).
- Section Editor (Critical Care), UpToDate; Associate Editor, CHEST.
Disclaimers

• Presentation uses CMS Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule. Files updated on CMS web site dated 12/29/2020

• G codes may not be recognized by non-Medicare payers.

• Medicare has created some variance from CPT 2021.

• Please check with your local payers on these issues.
Agenda - January 26, 2021

Medicare Physician Fee Schedule CY 2021

1. COVID-19 Public Health Emergency and Provision of Virtual Medical Services
2. Congressional Changes to the Final Rule CY 2021
3. 2021 Evaluation and Management (E/M) Changes
4. Prolonged Service Codes
5. Your Questions
Medicare Telehealth Services During the Public Health Emergency (PHE) and Beyond

PHE still in effect
Medicare Telehealth Updates

• CMS has made major changes to telehealth policies since March.

• CMS has **permanently** added 10 codes to the Medicare Telehealth list. Of interest to ATS/CHEST communities is the following code—
  • Prolonged Services (use HCPCS code G2212)

• Additional services have been added **temporarily** through the end of the calendar year during which the PHE ends—
  • Critical Care Services (CPT 99291–99292)
  • Hospital discharge day management (CPT 99238–99239)
  • Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224–99226)
Audio-Only Telephone Evaluation and Management

• During the PHE, CMS recognized 99441-99443 (telephone evaluation and management (E/M) services) for payment.

• CMS is paying for those services at the rate of the analogous in-person E/M service.
  • 99441: telephone E/M service; 5-10 minutes of medical discussion
  • 99442: telephone E/M service; 11-20 minutes of medical discussion
  • 99443: telephone E/M service, 21-30 minutes of medical discussion

• CMS did not propose to continue to recognize the audio-only codes (99441 - 99443) after the PHE but recognized the potential for continued need for audio-only interaction that is longer than the virtual check-in service.
# Telephone E/M Codes – Payment Rates

12/29/2020 updated CMS files

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-Facility Payment Rate during PHE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>telephone E/M service; 5-10 minutes of medical discussion</td>
<td>$56.88 (99212 rate)</td>
</tr>
<tr>
<td>99442</td>
<td>telephone E/M service; 11-20 minutes of medical discussion</td>
<td>$92.47 (99213 rate)</td>
</tr>
<tr>
<td>99443</td>
<td>telephone E/M service, 21-30 minutes of medical discussion</td>
<td>$131.20 (99214 rate)</td>
</tr>
</tbody>
</table>
Medicare Telehealth Audio-Only

CMS now allows certain codes on the telehealth list to be performed via audio only. This is temporary during the PHE. There has been no indication from CMS that these changes would be made permanent.

- Advanced Care Planning Codes 99497, 99498
- Face-to-Face Prolonged Services Codes 99354, 99355, 99356, 99357
- The Initial and Subsequent Annual Wellness Visit Code G0438, G0439
- New Prolonged Care Code G2212

But wait... Should I bill these or the telephone codes??

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Which Code Should I Bill?

You perform Advanced Care Planning (99497) by explaining and discussing advanced directives/ code status for 30 minutes

Should I bill 99497 or the telephone E/M code?

Initial Advanced Care Planning, 99497 - $80.70

OR

99443 (21-30 minutes) being paid at the rate of 99214 - $131.20
Final RVU and Payment Rates for New Virtual Check in Code 12/29/2020
updated CMS files

<table>
<thead>
<tr>
<th>CPT/ HCPCS</th>
<th>Description</th>
<th>Work RVU</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Facility</td>
</tr>
<tr>
<td>G2252</td>
<td>Brief chkin by md/qhp, 11-20</td>
<td>0.50</td>
<td>$26.87</td>
</tr>
</tbody>
</table>

**Helpful Tip!** You are better off billing 99442 (telephone E/M 11-20 min) during the PHE. 99442 currently pays $92.47.

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Direct Supervision by Interactive Telecommunications Technology

• During the PHE, direct supervision requirements can be met through interactive audio-video real-time communications technology
  • “Incident to” scenarios
  • Virtual Presence of a Teaching Physician Using Audio/Video Real-Time Communications Technology

• Permanent allowances for rural area

Medicare Telehealth

We help the world breathe®
PULMONARY • CRITICAL CARE • SLEEP

AMERICAN COLLEGE OF CHEST PHYSICIANS
Congressional Changes to the Final Rule CY 2021

2021 Evaluation and Management (E/M) Changes

Prolonged Service Codes
Medicare Final Rule: January 1, 2021
Office Visit Payment Increases: Consequences

<table>
<thead>
<tr>
<th></th>
<th>2020: $36.09</th>
<th>2021: $34.89 (-3.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>=</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Relative Value Unit (RVU) X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Work</td>
<td>RVU x GPCI*</td>
<td></td>
</tr>
<tr>
<td>Practice Expense</td>
<td>RVU x GPCI*</td>
<td></td>
</tr>
<tr>
<td>Malpractice</td>
<td>RVU x GPCI*</td>
<td></td>
</tr>
</tbody>
</table>

*Geographic Practice Cost Index
### Medicare Final Rule: January 1, 2021
Office Visit Work RVUs and Payments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>0.93</td>
<td>77</td>
<td>0.93</td>
<td>74</td>
</tr>
<tr>
<td>99203</td>
<td>1.42</td>
<td>109</td>
<td>1.60</td>
<td>114</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
<td>167</td>
<td>2.60</td>
<td>170</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
<td>211</td>
<td>3.50</td>
<td>224</td>
</tr>
<tr>
<td><strong>Established</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99211</td>
<td>0.18</td>
<td>23</td>
<td>0.18</td>
<td>23</td>
</tr>
<tr>
<td>99212</td>
<td>0.48</td>
<td>46</td>
<td>0.70</td>
<td>57</td>
</tr>
<tr>
<td>99213</td>
<td><strong>0.97</strong></td>
<td><strong>76</strong></td>
<td><strong>1.30</strong></td>
<td><strong>92</strong></td>
</tr>
<tr>
<td>99214</td>
<td>1.50</td>
<td>110</td>
<td>1.92</td>
<td>131</td>
</tr>
<tr>
<td>99215</td>
<td>2.11</td>
<td>148</td>
<td>2.80</td>
<td>183</td>
</tr>
</tbody>
</table>

99201 eliminated in 2021

Other payers: what’s in your contract?

Peters S. New billing rules for outpatient office visits. CHEST 158: 298-302, 2020
Decrease administrative burden of documentation and coding
Decrease the need for audits
Decrease unnecessary documentation not needed for patient care
Ensure payment is resource based
No direct goal for payment redistribution between specialties

No change to hospital visit or critical care documentation guidelines!
Medicare FFS, but contracted payers depend on contract
  • RVUs, payments, prolonged services

Office visit documentation simplified
  • history or exam, *only as medically appropriate*!
    - no more Past/Family/Social Hx or ROS required
    - no more physical examination bullet points/elements
  • choose visit level based on *either*:
    - simplified medical decision making; *or*
    - total time *on calendar day*!
# Medicare Final Rule: January 1, 2021
## Office Visit Total Calendar Day Times

<table>
<thead>
<tr>
<th></th>
<th>CPT Code</th>
<th>2021 (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td></td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td></td>
<td>45-60</td>
</tr>
<tr>
<td>99205</td>
<td></td>
<td>61-74</td>
</tr>
<tr>
<td><strong>Established</strong></td>
<td>99211</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>10-19</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>20-29</td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>30-39</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>40-54</td>
</tr>
</tbody>
</table>

- No longer face-to-face time
- No longer >50% counseling & coordinating
- **NOT** CMS times used for rate setting
- **MUST** write the exact number (not range!) of minutes

When exceeding 89 (for new) or 69 (for established) minutes, start reporting G2212 (Prolonged services)

Peters S. New billing rules for outpatient office visits. CHEST 158: 298-302, 2020
<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed</th>
<th>General/Specific Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99201</td>
<td>Straightforward</td>
<td>Minimal: 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99202</td>
<td>Low</td>
<td>2 or more self-limited or minor problems; 1 stable chronic illness; or 1 acute, uncomplicated illness or injury</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99203</td>
<td>Moderate</td>
<td>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</td>
<td>Moderate (Must meet the requirements of at least 1 out of 3 categories)</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99204</td>
<td>High</td>
<td>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</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>

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
- 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 not to Richt to or to de-excite care because of poor prognosis
Low Complexity MDM: 2 of 3
99203/99213

Tests and documents:
- each unique note/result/order counts as one
- unique by encompassing CPT code
- can combine 2 notes (or results or orders or 1 of each!)

Independent historian:
- can be family or caregivers/providers (eg, pharmacist or EMT)
Moderate Complexity MDM: 2 of 3
99204/99214

Independent interpretation:
- your review of a study* (eg, image, tracing, data)
- unique by encompassing CPT code
- can combine 3 notes (or results or orders or 1 of each!)

Discussion - management or test interpretation
Decision – can be deciding not!
Risk factors – (eg, age, weight, anticoagulation, you decide!)
Social determinants - economic and social, you state!

*You didn’t bill
Severe – you determine!
Monitoring for toxicity – CPT (lab, imaging, EKG, echo, PFT) test, at least every 3 months
“Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.”

0.61 wRVUs ($32) per unit, but only allowed after 15 minutes above the maximal time for 99205/99215
### Medicare Final Rule: January 1, 2021

**G2212 – Prolonged Services**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (minutes) for New</th>
<th>Time (minutes) for Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205/99215</td>
<td>61-88</td>
<td>40-68</td>
</tr>
<tr>
<td>99205/99215 +G2212</td>
<td><strong>89-103</strong></td>
<td><strong>69-83</strong></td>
</tr>
<tr>
<td>99205/99215 +G2212 x2</td>
<td>104-118</td>
<td>84-98</td>
</tr>
<tr>
<td>99205/99215 +G2212 x3</td>
<td>119-133</td>
<td>99-113</td>
</tr>
<tr>
<td>99205/99215 +G2212 x4</td>
<td>134-148</td>
<td>114-128</td>
</tr>
<tr>
<td>99205/99215 +G2212 x5</td>
<td>149-163</td>
<td>129-143</td>
</tr>
<tr>
<td>etc</td>
<td>etc</td>
<td>etc</td>
</tr>
</tbody>
</table>

**Incremental** 15 minute thresholds

Still all on same calendar day

**MUST** write the exact number (not range!) of minutes

Includes time for NF2F (99358) no longer billable on same calendar day
“Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time”

0.61 wRVUs per unit, but allowed after 15 minutes above the minimal time for 99205/99215
## Medicare G2212 vs CPT 99417
### Start Times

<table>
<thead>
<tr>
<th>CPT Office Visit Code</th>
<th>Office Visit Time Range</th>
<th>Use G2212 (Medicare, above maximal office visit time)</th>
<th>Use 99417 (non-Medicare, above minimal office visit time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>60-74</td>
<td>89-103</td>
<td>75-89</td>
</tr>
<tr>
<td>99215</td>
<td>40-54</td>
<td>69-83</td>
<td>55-69</td>
</tr>
</tbody>
</table>
Thank you!

Q/A Session

Reminder use the chat feature to ask your question.