Welcome to the Joint ATS/CHEST Webinar on the Medicare 2021 Final Rule

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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.

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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.

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Everything You Need to Know About the CMS 2021 Final Payment Rule

Tuesday, January 26, 2021

Speakers

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Speaker Disclosures

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Disclaimers

Opinions - my own

Consultant – see disclosure* in program

No representation, guarantee or warranty of fitness

- Grand Rounds speaker, lecturer, consultant, and expert witness on documentation, coding, billing, and reimbursement to hospitals, physicians, departments, practice groups, insurers, professional societies, and attorneys (defense, plaintiff "qui tam", US Attorneys General, and the Office of the Inspector General).
- 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*.

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- 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**

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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*

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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

Code	Description	Non-Facility Payment Rate during PHE
99441	telephone E/M service; 5-10 minutes of medical discussion	$56.88 (99212 rate)
99442	telephone E/M service; 11-20 minutes of medical discussion	$92.47 (99213 rate)
99443	telephone E/M service, 21-30 minutes of medical discussion	$131.20 (99214 rate)

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??

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

CPT/ HCPCS	Description	Work RVU	Payment Rate	
			Non-Facility	Facility
G2252	Brief chkin by md/qhp, 11-20	0.50	$26.87	$25.47

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

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

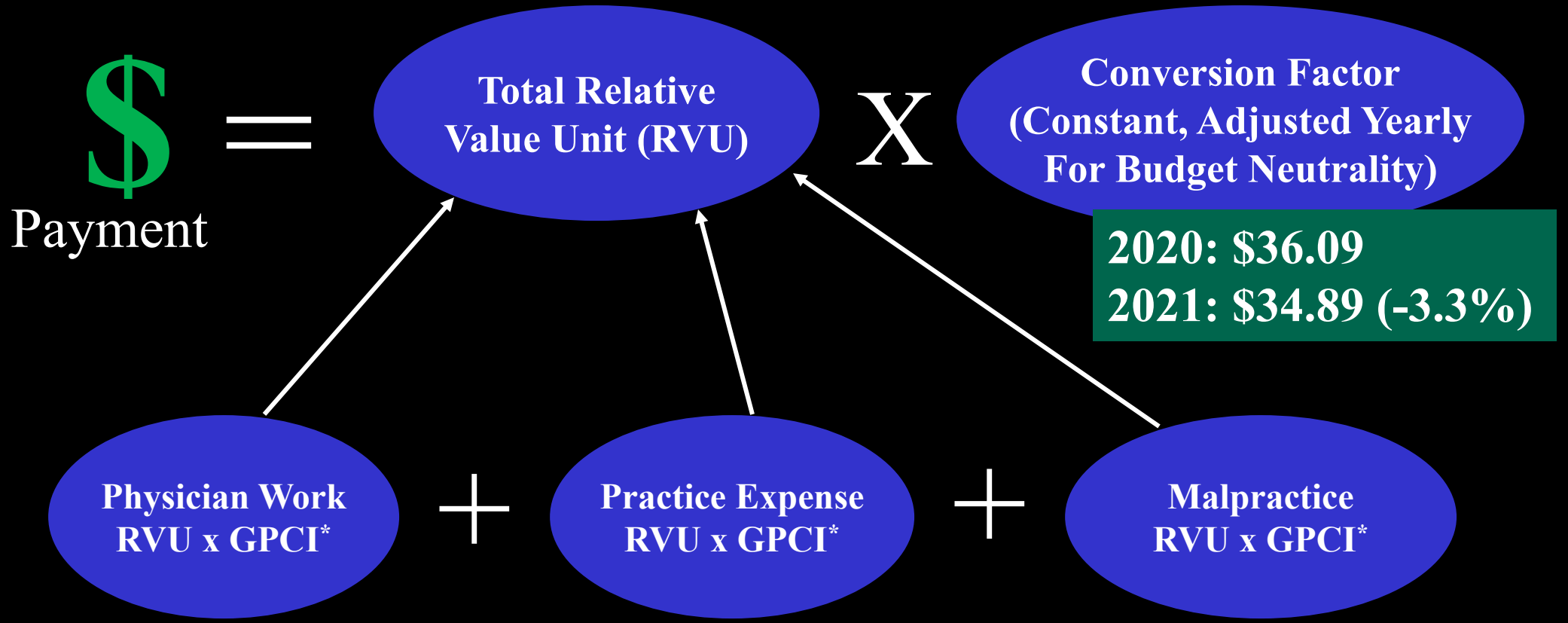
- Permanent allowances for rural area

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



*Geographic Practice Cost Index

Medicare Final Rule: January 1, 2021
Office Visit Work RVUs and Payments

99201 eliminated in 2021

Other payers: what's in your contract?

	CPT Code	2020		2021	
		wRVU	$	wRVU	$
New	99202	0.93	77	0.93	74
	99203	1.42	109	1.60	114
	99204	2.43	167	2.60	170
	99205	3.17	211	3.50	224
Established	99211	0.18	23	0.18	23
	99212	0.48	46	0.70	57
	99213	**0.97**	**76**	**1.30**	**92**
	99214	**1.50**	**110**	**1.92**	**131**
	99215	**2.11**	**148**	**2.80**	**183**

Peters S. New billing rules for outpatient office visits. CHEST 158: 298-302, 2020

Medicare Final Rule: January 1, 2021

Office Visit Documentation Changes: Guiding Principles

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 Final Rule: January 1, 2021
Office Visit Documentation ***Simplified***!

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

	CPT Code	2021 (minutes)
New	99202	15-29
	99203	30-44
	99204	45-60
	99205	61-74
Established	99211	N/A
	99212	10-19
	99213	20-29
	99214	30-39
	99215	40-54

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

Medical Decision Making: 2 of 3

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	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.*	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)
			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)
				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

Low Complexity MDM: 2 of 3
99203/99213

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

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

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

*You didn't bill

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!

High Complexity MDM: 2 of 3
99205/99215

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)
	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)
		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

Severe – you determine!

Monitoring for toxicity – CPT (lab, imaging, EKG, echo, PFT) test, at least every 3 months

Medicare Final Rule: January 1, 2021
G2212 – Prolonged Services

"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

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

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

CPT 2021
99417 – Prolonged Services

"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

CPT Office Visit Code	Office Visit Time Range	Use G2212 (Medicare, above maximal office visit time)	Use 99417 (non-Medicare, above minimal office visit time)
99205	60-74	89-103	75-89
99215	40-54	69- 83	55-69

Thank you!

Q/A Session

Reminder use the chat feature to ask your question.