Premier

MANAGEMENT COMPANY

February 17, 2021
Provider Education Webinar

Presented by

Crescent Beavers, CRC, CPC

Senior Manager, Risk Adjustment Programs

Agenda

Topics
2021 E/M Changes Basics
Chronic Care Management Billing
In Closing

2021 E/M Changes

Crescent Beavers, CRC, CPC
Senior Manager, Risk Adjustment Programs

What we need to know about 2021 E/M Changes.

Premier MANAGEMENT COMPANY

Effective January 1, 2021 CMS implemented sweeping changes for evaluation and management (E/M) codes and overhauled CPT code descriptors and guidelines. But this is only for office and outpatient service codes 99201 through 99215. Providers will have to code on a hybrid of guidelines. One for the office and outpatient and another for inpatient hospital services.

Let's take a look at what has changed….

Prior to 2021
History, Exam, MDM
Face to Face Time
Time- 50% counseling and/or coordination of care
99201 could be billed
Table of Risk

Currently in 2021
MDM or Time
Total Time
Not required
99201 has been deleted
MDM table

Let's Break it down….

Time Defined for Level of Visit

- Preparing to see the patient (e.g., review of test)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family caregiver
- Documenting clinic information in the electronic or other health record
- Independently interpreting results (not separately reported) and communication results to the patient/family/caregiver
- Care Coordination (not separately reported)

Time Documentation Recommendations

- Include only the time for the date of service
- Clinical Staff time **can not** be included
- Time Spent performing other billable services **can not** be included
- Total Time needs to be documented
  - *Not required to associate the time to each activity*
- Activities performed need to be documented

Code	Time (mins)	Code	Time (mins)
99211			
99212	10-19	99202	15-29
99213	20-29	99203	30-44
99214	30-39	99204	45-59
99215	40-54	99205	60-74

Prolonged Services Time- CPT

Premier MANAGEMENT COMPANY

- New prolonged service codes are to only be used with a level 5 visit (99215 or 99205) when time is used for determining the level of service.

Total Duration of New Patient Office (Use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1, 99417 x1
90-104 minutes	99205 x 1, 99417 x 2
105 minutes or more	99205 x 1, 99417 x 3 or more for each add'l 15 minutes

Total Duration of New Patient Office (Use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-69 minutes	99215 x 1, 99417 x1
70-84 minutes	99215 x 1, 99417 x 2
85 minutes or more	99215 x 1, 99417 x 3 or more for each add'l 15 minutes

Prolonged Services Time- CMS 2021 Final Rule

Total Duration of New Patient Office (Use with 99205)	Code(s)
90-74 minutes	99205
89-103 minutes	99205 x 1, G2212 x1
104-118 minutes	99205 x 1, G2212 x 2
119 minutes or more	99205 x 1, G2212 x 3 or more for each add'l 15 minutes

Total Duration of New Patient Office (Use with 99215)	Code(s)
40-54 minutes	99215
69-83 minutes	99215 x 1, G2212 x1
84-98 minutes	99215 x 1, G2212 x 2
99 minutes or more	99215 x 1, G2212 x 3 or more for each add'l 15 minutes

Chronic Care Management (CCM) Billing

CMS defines CCM services (CPT 99490) as **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised or monitored.
- Note- CPT 99439 has replace HCPCS G2058 for each add'l 20 minutes of CCM as of 1/1/2021

Comprehensive Care Plan

CMS defines Comprehensive Care Plan to include the following:

- Problem List
- Expected Outcome and/or prognosis
- Measurable treatment goals
- Symptom Management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialist outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of care plan.

Tips to consider for Medicare CCM Billing

1. Medicare requires that the patient understands and agrees to the CCM services before they are offered and billed and;
2. that an Annual Wellness Visit (AWV) or Comprehensive E/M visit be billed prior to CCM services are billed.
    - During this first visit, document the discussion with the patient described above, the patient's acceptance or denial, and the care plan that CCM will follow.
3. Set up a system that can keep track of time spent on non-face-to-face services provided, including:
    - Phone calls and email communications with the patient
    - Time spent coordinating care with other clinicians, facilities, community resources and caregivers
    - Time spent on prescription management and medication reconciliation
4. When billing for CCM make sure the date of service range the calendar month in which you are billing, for example- 01/01/2021-01/31/2021
5. CCM can be billed concurrently with TCM (99495, 99496) as of the 2021 Final Ruling in the same month for the same patient when "reasonable and necessary".

In Closing…..

This is the basic overview of the changes that have come with in the CMS 2021 Final Ruling for Time Based 2021 E/M Coding and CCM changes.
If you have you have any further questions or need more information please feel free to contact myself or your PBE.

There will also be new billing and coding tip sheets uploaded to our website for you convenience that you may download and share with your staff.

Thank you!