Patient Visits: E&M In Radiology

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Agenda

- Introduction
- Overview of 2023 Changes
- E&M Documentation
- Office & Outpatient Visits
- Inpatient Visits
- Consultation
- Prolonged Services
- Final Thoughts & Considerations

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Sources/References

Introduction

- History of E&M Coding
  - Complex
  - Multiple components/factors driving CPT code selection
  - 1995/1997 Guidelines
- 2021 changes applied to office/outpatient
- 2023 changes apply to majority of other patient types including Hospital inpatients, observation care, consultations*, nursing facility services, and home, rest home and domiciliary care E&M codes
- Understanding payer guidelines

**Reminder that not all payers accept the consultation codes, and therefore office/outpatient and inpatient visit codes may be utilized depending on the payer.*

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Overview of 2023 Changes

- These changes model the 2021 changes to office and outpatient visits
- Factors driving code selection and level of service are TIME & Medical Decision Making (MDM)
- Changes apply to majority of other patient types including Hospital inpatients, observation care, consultations*, nursing facility services, and home, rest home and domiciliary care E&M codes
- Observation codes have been deleted-inpatient code revisions now address observation services
  - Reporting the correct place of service on the claim is essential
- Prolonged Services:
  - AMA: 99417 (revised)/99418 (new)
  - CMS: G2212/G0316-G0318*(new)
- Supplemental handbook from AMA

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Reducing the Documentation Burden

- Rationale-too complex & burdensome
  - History, exam, MDM, counseling, coordination of care, nature of presenting problem, and in some instances time
  - 1995/1997
- Documentation components of E&M service:
  - Medically Appropriate H&P
  - Time (if using time for code selection)
  - MDM
  - Assessment & Plan
- It is important that documentation includes patient-specific information for the current visit:
  - Do not routinely copy/paste from prior encounters or repeated on all patients.

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Medically Appropriate H&P

- Requirement for all encounters
- Not utilized for CPT code selection
- History
  - Chief Complaint
  - History of Present Illness
  - ROS-relevant and necessary
- Exam
  - Clinically relevant
  - Medically necessary

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Time

- Total time spent by the physician or other QHP for the E&M service
  - Face-to-face AND non-face-to-face time
  - SAME DOS
- Counseling/coordination of care is no longer required to use as basis for code selection
- Time is not a factor for selecting level in the Emergency Department
- Includes all not separately reported activities that occur for the encounter on the same DOS
- Does not include time spent on separately reported services

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Time

- Activities that may be included in total time:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination

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Time

- Activities that may NOT be included in total time:
  - The performance of other services that are reported separately
  - Travel
  - Teaching that is general and not limited to discussion that is required for the management of a specific patient
  - Clinical staff time

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Medical Decision Making

- Same guidelines are applicable now for all types of visits
- Four levels of MDM:
  - Straightforward
  - Low
  - Moderate
  - High
- Level of the visit is determined by 3 elements:
  - Number and complexity of problem(s) addressed during the encounter
  - Amount/complexity of data to be reviewed and analyzed
  - Risk of complications, morbidity/mortality of patient management decisions made at the visit
- Code selection requires 2 of the 3 elements to be met

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Uniform Medical Decision Making (MDM) Table

		Straightforward/Minimal	Low/Limited	Moderate	High/Extensive
2 of the 3 components must be met or exceeded to meet MDM level	Number & Complexity of Problems	1 self-limited or minor problem	2+self-limited or minor problems OR 1 stable chronic illness OR 1 acute, uncomplicated illness or injury	1+ chronic illnesses with exacerbation, progression, side effects OR 2+ stable chronic illnesses OR 1 undiagnosed new problem w/uncertain prognosis OR 1 acute illness w/systemic symptoms OR 1 acute complicated injury	1+ chronic illnesses w/severe exacerbation, progression, or side effects of treatment OR 1 acute or chronic illness or injury that poses a threat to life bodily function
	Data to be Reviewed & Analyzed (*each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1)	None	Must meet requirements of at least 1 out of 2 categories: <u>Category 1:</u> Tests and Documents (any comb of 2): • Review of prior external notes from each unique source • Review of the results of each unique test • Ordering of each unique test <u>Category 2:</u> Assessment requiring an independent historian (for the categories of independent interpretation of tests and discussion of mgmt. or test interpret, see moderate or high)	Must meet requirements of at least 1 out of 3 categories: <u>Category 1:</u> Tests and Documents (any comb of 3): • Review of prior external notes from each unique source • Review of the results of each unique test • Ordering of each unique test • Assessment requiring and independent historian <u>Category 2:</u> Independent interpretation of a test performed by another physician QHP (not separately reported) <u>Category 3:</u> Discussion of management or test interpretation with external physician/QHP (not separately reported)	Must meet requirements of at least 2 out of 3 categories: <u>Category 1:</u> Tests and Documents (any comb of 3): • Review of prior external notes from each unique source • Review of the results of each unique test • Ordering of each unique test • Assessment requiring and independent historian <u>Category 2:</u> Independent interpretation of a test performed by another physician QHP (not separately reported) <u>Category 3:</u> Discussion of management or test interpretation with external physician/QHP (not separately reported)
	Risk of Complications of Patient Management	Minimal	Low	Moderate	High

Medical Decision Making Tips

- Utilize CPT Manual
- Complexity of problems:
  - Acute vs. Chronic
  - Only diagnoses receiving active assessment/treatment can be used in selecting level
- Data to review:
  - Unique tests
  - Reviewed AND analyzed-results alone will not suffice
  - Independent historian
  - Independent interpretation
  - External Physician
  - Beware of double dipping on ordering/interpreting tests (same physician or group practice)
- Risk:
  - Management options “considered but not selected”
  - Selecting levels is determined by the provider

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Medical Decision Making Tips-RISK

MINIMAL	LOW	MODERATE	HIGH
• No examples provided	• No examples provided	• RX Drug management • Decision regarding minor surgery w/patient or procedure risk factors • Decision regarding elective major surgery w/o 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 w/identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Provided in CPT Manual-Examples Only

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Office & Outpatient Visits

- **New Patient**
  - HAS NOT received any face to face professional services from the provider (or provider of same specialty within the same group practice)within the last 3 years.
- **Established Patient**
  - Has received face to face professional services by the same provider (or provider of same specialty within the same group practice) during the prior 3 year period.
- The presence of a new condition does not affect the type of visit performed
- For Medicare purposes, the members of a group practice are considered to be a single physician.

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Office & Outpatient Visits-Criteria

CPT CODES/CRITERIA			
NEW PATIENT		ESTABLISHED PATIENT	
99202	Straightforward MDM (15-29 minutes)	99211	Low level (<10 minutes)
99203	Low MDM (30-44 minutes)	99212	Straightforward MDM (10-19 minutes)
99204	Moderate MDM (45-59 minutes)	99213	Low MDM (20-29 minutes)
99205	High MDM (60-74 minutes)	99214	Moderate MDM (30-39 minutes)
		99215	High MDM (40-54 minutes)

A medically appropriate H&P should be documented but is not used to select the level of E&M service.

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Hospital Inpatient Visits

- Changes for 2023
  - Code selection is now based on time OR MDM
  - Observation codes have been deleted and are now included with the inpatient visits.
- Initial Visit
  - Any provider (or provider of same specialty or subspecialty* within the same group practice) that sees the patient for the first time **during the stay** should bill an initial hospital service code (99221-99223).
  - AMA and Medicare are now generally in alignment on when providers should utilize the initial visit codes. (Previously only the admitting physician was to use the initial code per AMA guidelines).
  - Only the admitting physician should report the initial visit code with modifier -AI.
- Subsequent Visit
  - Any provider (or provider of same specialty or subspecialty* within the same group practice) that sees the patient for an encounter following the initial encounter should use the subsequent hospital care codes (99231-99233).

**CMS does not recognize subspecialties*

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Notes regarding Inpatient/Observation

- Only one initial or subsequent code per day
- Observation is an admission status not a location
- From AMA: *If a patient is admitted to IP or OBS status in the course of an encounter from another site of service (including a consultation), the services in the initial site MAY be separately reported using modifier -25.*
  - New AMA Guideline
  - CMS will not allow
  - CMS will accept only ONE E&M service per day
  - Documentation is key
  - OIG REPORT:
    - *Use of Modifier 25 (OEI-07-03-00470; 11/05) (hhs.gov)*

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Hospital Inpatient Visits-Criteria

CPT CODES/CRITERIA			
INITIAL VISIT		SUBSEQUENT VISIT	
99221	Straightforward/Low MDM (40 minutes)	99231	Straightforward/Low MDM (25 minutes)
99222	Moderate MDM (55 minutes)	99232	Moderate MDM (35 minutes)
99223	High MDM (75 minutes)	99233	High MDM (50 minutes)

A medically appropriate H&P should be documented but is not used to select the level of E&M service.

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Consultations

- 2023 changes
  - Level 1 codes 99241/99251 deleted
  - Code selection is now based on time OR MDM
- Medicare does not recognize/reimburse consultation services
- Consultation Guidelines:
  - Must be at request of another physician, QHP, or appropriate source to recommend care for a specific condition or problem
  - Consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit
  - Consultant's opinion and any services ordered/performed must be communicated by written report to the requesting provider

- ***Many payers follow Medicare guidelines. CONFIRM PAYER GUIDELINES***

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Consultations-Criteria

*Commercial/Non-Medicare**

OFFICE/OUTPATIENT**		INPATIENT/OBSERV**	
CPT CODES/CRITERIA			
99242	Straightforward MDM (20 mins)	99252	Straightforward MDM (35 minutes)
99243	Low MDM (30 minutes)	99253	Low MDM (45 minutes)
99244	Moderate MDM (40 minutes)	99254	Moderate MDM (60 minutes)
99245	High MDM (55 minutes)	92255	High MDM (80 minutes)

- ***A medically appropriate H&P should be documented but is not used to select the level of E&M service.***
- ****Many payers follow Medicare guidelines. CONFIRM PAYER GUIDELINES.***

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Consultations-Criteria

*Medicare**

OFFICE/OUTPATIENT**		INPATIENT/OBSERV**	
CPT CODES/CRITERIA			
99202	Straightforward MDM(15-29 minutes)	99221	Straightforward/Low MDM (40 minutes)
99203	Low MDM (30-44 minutes)	99222	Moderate MDM (55 minutes)
99204	Moderate MDM (45-59 minutes)	99223	High MDM (75 minutes)
99205	High MDM (60-74 minutes)		

- ***A medically appropriate H&P should be documented but is not used to select the level of E&M service.***
- ****Many payers follow Medicare guidelines. CONFIRM PAYER GUIDELINES.***

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Prolonged Services

- 2023 Changes
- Prolonged services codes are add-on to highest level of service code by patient type
- Can only be used when time is used to select level of service.
- Does not have to be continuous time
- No frequency limitation
- Cannot be reported for less than 15 minutes
- Medicare/AMA Variance

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Prolonged Services-AMA vs. CMS

- Rationale for Medicare/AMA Variance
- AMA:
  - Must meet max time threshold and exceed it by 15 minutes or more
  - Same calendar day of primary EM visit
- CMS:
  - Minimum time thresholds and timeframe are different than CPT code descriptions –*See Final Rule pg. 590*
  - Thresholds are based on surveyed* timeframe
  - Same calendar day as primary EM visit for office/OP, inpatient/obs visits, but more complicated when it comes to other types of visits regarding the timeframe for prolonged services which may be included in time reported (*refer to table in Final Rule*)

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Prolonged Services

Primary E&M Service	Type of EM Visit	AMA/CPT Prolonged Service Code	AMA/CPT Time Threshold	CMS Prolonged Service Code	CMS Time Threshold
99205	Office/OP-NEW	+99417	75 minutes	G2212	89 minutes
99215	Office/OP-ESTAB	+99417	55 minutes	G2212	69 minutes
99223	Inpatient/OBS -Initial	+99418	90 minutes	G0316	105 minutes
99233	Inpatient/OBS -Subsequent	+99418	65 minutes	G0316	80 minutes
99245	Outpatient-Consult	+99417	70 minutes	N/A	N/A
99255	Inpatient-Consult	+99418	95 minutes	N/A	N/A

- ***Many payers follow Medicare guidelines. CONFIRM PAYER GUIDELINES.***
- ***Multiple units for each add 'l 15 minutes***

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Final Thoughts and Considerations

- Challenges with E&M Workflow & Technology
  - Access to Documentation
  - System Integration
- Challenges with E&M Coding
  - Complex Coding Guidelines
  - Subjectivity
- Global Surgery Package
  - Routine Pre- and Post- Operative Care
  - 0, 10, & 90 Day Postoperative Period
  - 99024 Utilization*
- Education of the providers and their **documentation** is key
- PHE Projected Sunset-May 11

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Q&A

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Questions?

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