# 2024 E/M DOCUMENTATION TRAINING FOR OFFICE AND OTHER OUTPATIENT VISITS & HOSPITAL ENCOUNTERS


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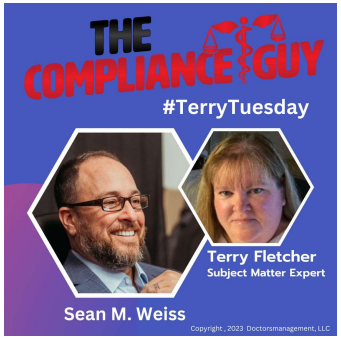
**Terry also is a host and multiple podcast guest for the Healthcare Industry. – see >>**





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# Definitions |Abbreviations

Providers - This term references physicians, nurse practitioners, and physician assistants for purposes of today's training..

Those recognized by CMS in the category as non-physician providers (NPPs) and/or qualified health care professionals (QHPs) or Advanced Practice Providers (APPs)

# 2024 E/M Rules – Office Visits

- As of Jan. 1st , 2021 and now in 2024 (updated) Evaluation and Management level of service for office or other outpatient services can be determined using one of two approaches:
- Medical Decision Making - extensive clarifications were provided in the guidelines to help define the elements of MDM
- Time - the total time spent on the date of encounter which incorporates both face-to-face and non-face-to-face services and has clear time ranges for each code

# New vs. Established Patients – 2024

►Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.

A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available.

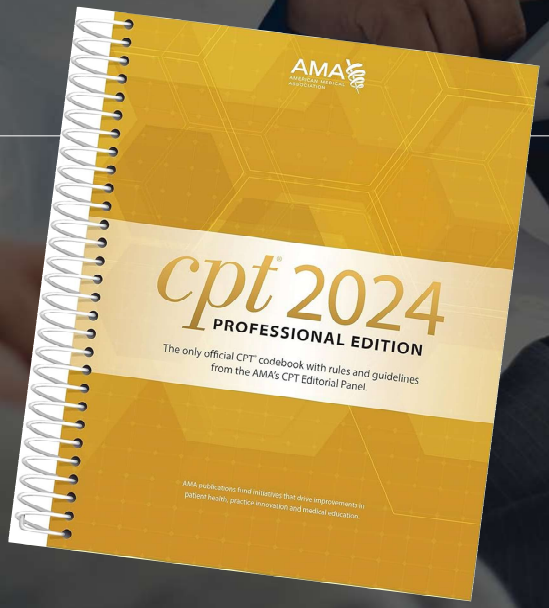
When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.◄

## There will be no “required” level of history or exam for E/M Visits (scoring), but there still needs to be a medically appropriate history and exam to determine medical necessity

***From the AMA Website from 2023 :***

- *“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 exam is determined by the treating physician or other qualified healthcare professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly ( e.g. by patient portal or questionnaire) that is reviewed by the reporting physician or other qualified healthcare professional. The extent of history and physical examination is not an element in selection of office or other outpatient services.”*[1]
- It will be the physician’s (provider’s) responsibility to make sure their history and exam is problem pertinent, while protecting the clinical integrity of the documentation and legal expectations of included information.
- The AMA MDM Grid measures the complexity of problems addressed with expressive statements such as acute, uncomplicated illness or injury, undiagnosed new problem with uncertain prognosis, acute illness with systemic symptoms, and chronic illness with exacerbation. While the history and exam elements are not used for leveling a service, a descriptive history and exam, will support medical necessity of the service, meet the CPT “medically appropriate History and/or Exam” requirement of visit encounters, and will ensure that the coder or auditor will understand the complexity of problems addressed to the extent necessary to determine medical decision-making accurately.

# E/M CHANGES 2024

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# CY 2024 CPT® UPDATES

## EVALUATION & MANAGEMENT (E&M)

| CPT® Codes | Description |
|---|---|
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15-~~29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30-~~44 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45-~~59 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60-~~74 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |

# CY 2024 CPT® UPDATES

## EVALUATION & MANAGEMENT (E&M)

| CPT® Codes | Description |
|---|---|
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10-~~19 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20-~~29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30-~~39 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40-~~54 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded. |

# Time-Based E/M: What can be included?

*"For coding purposes, time for the services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified healthcare professional and does not include time in activities normally performed by clinical staff."*

CPT® also says that the time of the physician/other qualified health care professional can include reviewing separately obtained history. But the *time* of the clinical staff member who obtains that history *may not* be included.

Also, with AI now becoming part of the healthcare platform, if the provider uses AI to document, they cannot use "time" to level their visit, as they did not perform the documentation, it was automated. We also caution you to review EVERY entry when AI is used. It has been reported that biased statements, and word "hallucinations" are typical.

## Per CPT: Physician/or other qualified health care professional time includes the following E/M activities, when performed:

These statements have to be specific to what the patient is receiving and not generic.

- § preparing to see the patient (e.g., review of tests not separately reported)
- § obtaining and/or reviewing separately obtained history (not documented by staff)
- § performing a medically appropriate examination and/or evaluation
- § counseling and educating the patient/family/caregiver (not provided by staff or a pamphlet)
- § ordering medications, tests, or procedures (not separately reported)
- § 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 (not separately reported)

# Audit reminders when scoring "time"

- Providers should *not* include time spent performing or reading EKGs, x-rays or other point-of-care tests that are being billed separately.
- Time should also *not* be counted for other services such as care coordination or tobacco cessation counseling that are billed separately.
- Providers should *not* include any time spent by their staff. This includes scribes. They are the ones documenting.
- Only time on the same date as the face-to-face visit may be counted. For instance, reviewing a chart the day prior to the visit will not count towards total time. If a physician is waiting to speak to another physician regarding the same patient, there is an exception that within 1-2 days that time can be added* but this would mean a chart would have to stay open until the completed phone call. (not recommended).

## Q: *Is it okay for providers to use time always? Does the provider have to document everything they did in the time it took?*

A: Yes, but we wouldn't recommend it.

Providers have to document time and what they did to reach that time. They are not just trying to meet a coding threshold. The medical record, especially in a hospital setting, each provider needs to know what the other providers are doing and what the response of treatment has been. The reason is, this information may impact what the consulting physician(s) need to order, or how they need to modify treatment, or that they're not conflicting in medical treatment.

There might be instances where a patient isn't responding well to medication, and it's changed. It's important for another physician to know why and what occurred. So, don't just look at the medical record from a coding standpoint. The number one reason why we have medical documentation is to support care delivered from a clinical perspective as well as quality initiatives that we have as well as to support services in a possible legal challenge. Documentation should not just be looked at from the lens of coding and billing, but from a plausibility perspective.  Make it Make Sense.

Payer audits are reflecting "medically unbelievable days". i.e., 10 level 5 visits all timed in a 4-hour patient block, or generic statements of time – not specific to this patient.

## 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215) (Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

G. Medical Review When Practitioners Use *Time* to Select Visit Level

*"Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit."*

This tells me that the "medically unbelievable visit" is being found.

# CY 2024 CPT® UPDATES

## EVALUATION AND MANAGEMENT UPDATES – PROLONGED SERVICE WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN EVALUATION AND MANAGEMENT SERVICE

Code +99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of **office or other outpatient services**, office consultation, or other outpatient evaluation and management services (ie, 99205, 99215, 99245, 99345, 99350, 99483).

(+G2212 for Medicare OOV)

Code +99418 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an **inpatient** evaluation and management service (ie, 99223, 99233, 99236, 99255, 99306, 99310).

Prolonged total time is time that is 15 minutes **beyond** the time threshold required to report the highest-level primary service (office visit code level 99205 or 99215 only). Medicare did not adjust their time range to align with CPT® 2024.
Example: 99205, G2212 = 89 minutes not 75 per CPT®

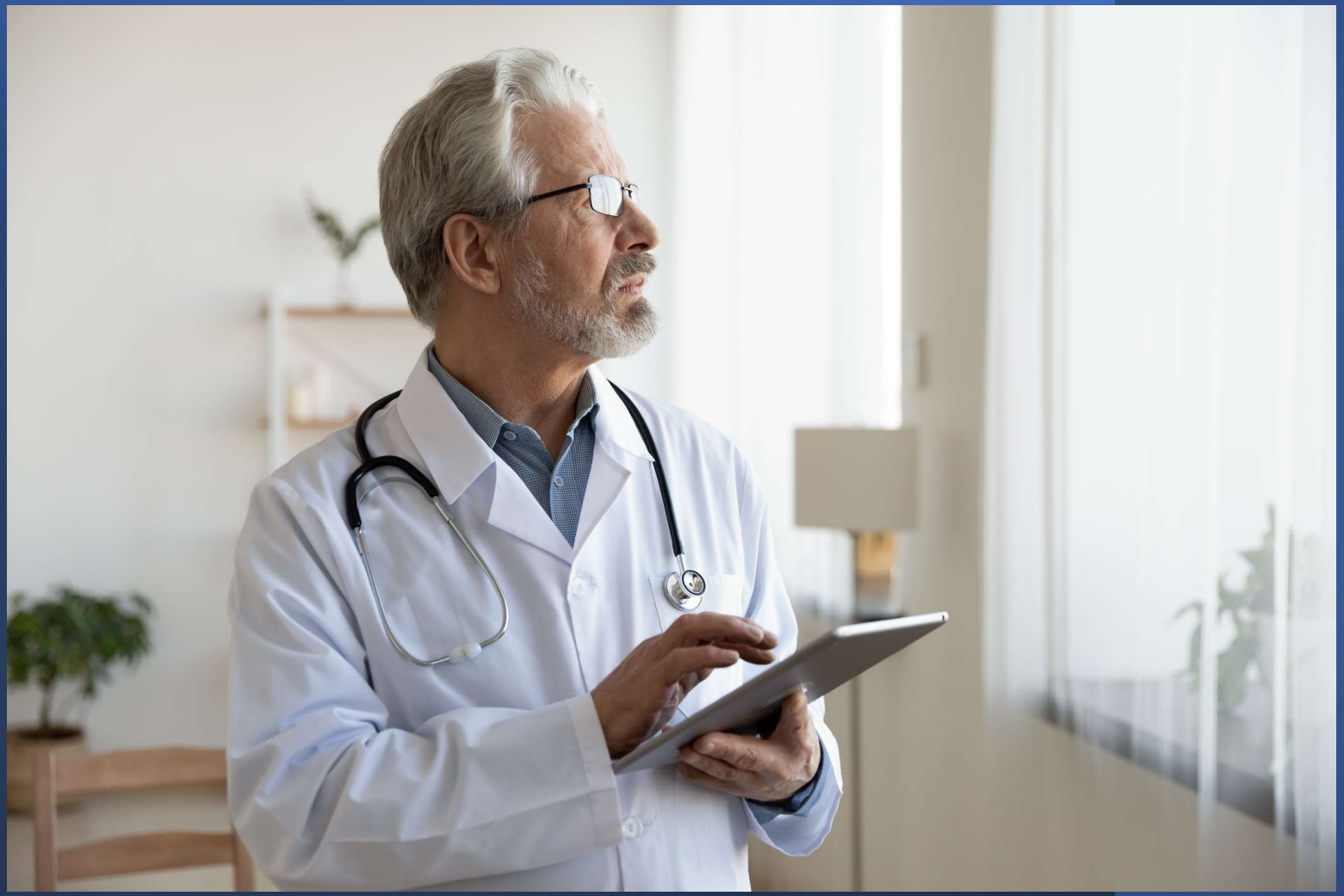
HCPCS Code +G2212

CMS

Codes +99417, +99418 are only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level service has been exceeded by 15 minutes

Use 99417 in conjunction with 99483, when the total time on the date of the encounter exceeds the typical time of 99483 by 15 minutes or more

# Medical Decision Making



# MDM – Three Elements

- Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

- Medical decision making in the office and other outpatient services code set is defined by three elements:

1. Number and complexity of problems addressed;
2. Amount and/or complexity of data reviewed; and analyzed
3. Overall risk of complications, morbidity, and/or mortality.

# Number and Complexity of Problems Addressed
# 2024
# MDM
# (Element 1)

# MDM – The number and complexity of problem(s) that are addressed during the encounter.

**1. The number and complexity of problem(s) that are addressed during the encounter.**

**Problem addressed:** A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.

This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.

Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

# PROBLEMS ADDRESSED

This is an important clarification. How do we define “evaluated or treated”? When the condition is discussed in the HPI (history of present illness), or in the assessment and plan. Mentioning, “he has a history of…” or the inclusion of it on the problem list does not meet the 2024 CPT E/M criteria of evaluated and treated.

***Example where an extra diagnosis cannot be counted as addressed:***

- An Orthopedic surgeon sees a patient for knee pain and stiffness, and notes that the patient also has CKD (Chronic Kidney Disease) and notes “managed by nephrologist.” This would *not* be counted as a problem on that date of service.

- An Orthopedic physician sees a patient with OA and is discussing ways to manage it, but also notes they have CAD (Coronary Artery Disease) and notes “managed by cardiologist” or “will follow with cardiologist”. This would *not* be counted as a problem on that date of service. Yes, the ICD-10-CM code could be added as a secondary diagnosis, but the physician would not get MDM credit for it because this diagnosis was not “addressed” or didn’t have any link to the treatment plan from the Orthopedic physician.

***Example where an extra diagnosis CAN be counted as addressed:***

- Orthopedic physician sees a patient for post MRI discussion of shoulder surgery, and notes that the patient is diabetic and has CKD, both managed by their internist, however, there was an elevated BP noted today at arrival, and since the patient is DM Type 2 and insulin dependent, there is a need for clearance for surgery and anesthesia to determine any potential side effects from anesthesia or surgical risk. The physician speaks to the internist about these issues on the same date as the encounter and documents the conversation. This problem was evaluated and *can* be counted as “addressed” meaning evaluated and/or treated, in the MDM calculation.

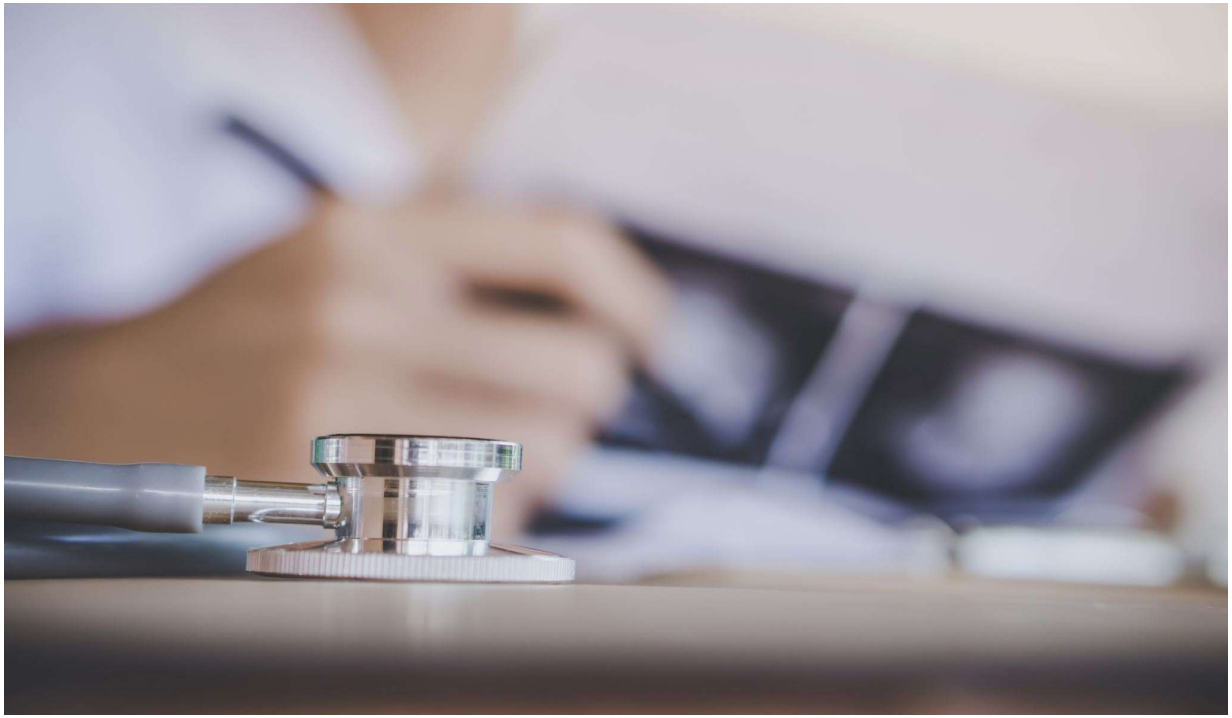
***Of Note:***

- A referral without an evaluation is *not* counted as a problem. “Patient wants a referral to the rheumatologist” isn’t sufficient. The HPI or Exam, or a discussion in the assessment, would need to describe the patient’s debilitating arthritis, or chronic joint pain not relieved by treatment, etc. to reflect insight and a clear path to the Medical Decision of a specialty referral.

# DATA POINTS 2024
# MDM
# (Element 2)

# Data Points

| | Elements of Medical Decision Making<br>Amount and/or Complexity of Data to be Reviewed and Analyzed<br>**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* |
|---|---|
| | N/A |
| 99202/99212 | **Minimal or none** |
| 99203/99213 | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* |
| 99204/99214 | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) |
| 99205/99215 | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) |



# *Understanding the Data Points*

- Physicians should be aware that, for the purposes of medical decision making, they *cannot* count labs, tests or diagnostics at both the time of the order and the follow-up appointment when reviewed.
- These tests should be counted on the date that they are ordered only, and not when the patient returns. *(p.8 CPT 2024)*

# *Assessment Requiring an Independent Historian-2024*

At the low level of complexity, this component of work is “rated” as Category 2, but once we move to Moderate and High it shifts to Category 1

<u>However, the concept and guidelines do not change</u>

►Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. *It does not include translation services*.

The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information. ◄

• *Controversy can arise when we see a patient who appears to be of sound mind, of reasonable age and reason, but there is an add-in within the documentation of the encounter from another source, like a spouse who is in the room with the patient during the encounter and has additional information that either conflicts or omitted by the patient.*

## Category 2: Moderate or High (Level's 4/5) Only has one component: Independent Interpretation

► **Independent interpretation:** The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. *This does not apply when the physician or other qualified health care professional who reports the E/M service is billing for or has previously billed for the test*. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.◄

* *The AMA Errata (3/2023) stated that you can be the ordering physician and still capture this Data Point, but said it should be Independent visualization of image, tracing or specimen itself (not simply review of report), similar to the 1997 rules, and again, not something you are charging for. So, you order an MRI, and the radiologist did not go over the findings with the patient, so the orthopedic provider has the actual MRI to independently interpret to the patient, determine a plan of care/management based on this interpretation, and it is documented in the record.*

**Giving a provider credit for a "Discussion of management or test interpretation" – w/external physician or QHP/source** (**Category 3** under Data Points of MDM level 4/5):

28

**Examples Discussion of Management:**

**1. Physical Therapist** – is concerned that the patient is unable to ambulate > 20 feet and recommends SNF placement.

***My response***: I would say yes here because of the acuity of the condition, and because the patient's care seems to be getting elevated due to progression. I would also want to know if the PT saw the patient in person and when. I know that isn't mandated for this, but I had a recent PT give advice to a provider who followed it, and they hadn't seen the patient in a year, and it was not appropriate advice for the current status of the patient.

2. **An Orthopedic Physician discusses a previous procedure performed by another Orthopedic Physician in their same practice**. – No credit under CAT 3. This is considered one provider, same specialty, same group practice.

3. **A Cardiologist** sees a New patient for SOB and chest pain, but the patient did not bring in his previous records from his PCP, of a recent stress test and did not know why he was taking his prescription Eliquis (blood thinner). Cardiologist called the PCP and they discussed the testing and prescriptions while patient was there and decided on the best course of treatment. This conversation and time well-documented. YES, credit given.

* This must be an interactive exchange and *not* through intermediaries

# MDM – Risk
# A/P
# 2024

**Step 3: Calculate Risk of Complications and/or Morbidity or Mortality of Patient Management Decisions Made at the Visit Associated with the Patient's Problems, the Diagnostic Procedure(s), and Treatment(s)** - Select the risk level associated with the patient's problems, diagnostic procedures and treatments. This risk is distinct from the risk associated with the condition.

This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

| | | | | |
|---|---|---|---|---|
| **Description** | Minimal risk of morbidity from additional diagnostic testing or treatment<br>Examples only<br>• Rest<br>• Gargles<br>• Elastic bandages<br>• Superficial dressings | Low risk of morbidity from additional diagnostic testing or treatment<br>Examples only<br>• OTC drugs<br>• Minor surgery w/no identified risk factors<br>• Physical/Occ therapy | Examples only<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health | Examples only<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization or escalation of hospital-level of care<br>• Decision not to resuscitate or to deescalate care because of poor prognosis<br>Parenteral controlled substances |
| **Risk Level** | **Minimal** | **Low** | **Moderate** | **High** |
| | 99202/99212 | 99203/99213 | 99204/99214 | 99205/99215 |

# When surgery is part of the MDM (discussion,  intent, scheduled)

**Surgery (minor or major, elective, emergency, procedure or patient risk) (3-9-21):**

**Surgery–Minor or Major**: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.

**Surgery–Elective or Emergency**: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

**Surgery–Risk Factors, Patient or Procedure**: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

# Level 99213 MDM

- An established office patient with osteoarthritis

  CC : " left knee pain."  ICD-10-CM: M25.562

Interval History : Patient with known osteoarthritis which had been previously controlled on Tylenol.  Now states her left knee has been aching for about two weeks despite two to three doses of Tylenol per day.

ROS :  Musculoskeletal--Negative for arthralgias or worsening joint pain elsewhere

Physical Exam

Mild swelling of left knee compared to the right.  Some pain with passive rotation.  No overlying warmth or erythema.

- Assessment

1. Worsening osteoarthritis
2. Plan Start OTC ibuprofen 400 mg po TID, PRN
3. Return visit in two weeks if no improvement

# Low or moderate MDM?

Number & Complexity of problems addressed? MOD – level 4

Data – zero Minimal

A/P – OTC & RTC 3-4 weeks if not improved –LOW

Best 2/3 is LOW. 99213

**Medical Decision-Making Table**

| Level | Number and Complexity of Problems Addressed | Amount or Complexity of Data to be Reviewed and Analyzed<br>*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 decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s). |
|---|---|---|---|
| **LOW**<br>**99203**<br>**99213** | 2 or more self-limited or minor problems;<br>Or<br>1 stable chronic illness;<br>Or<br>1 acute, uncomplicated illness or injury | **Limited: Must meet the requirements of at least 1 of the 2 categories**<br>**Category 1: Tests and documents**<br>**Any combination of 2 from the following:**<br>1. Review of prior external notes(s) from each unique source*;<br>2. Review of the result(s) of each unique test*;<br>3. Ordering of each unique test*<br>*Or*<br>**Category 2: Assessment requiring an independent historian(s)**<br>(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<br>OTC Meds<br>RTC > 3 mos or PRN<br>• Minor surgery w/no identified risk factors<br>• Physical/Occ therapy |
| **MODERATE**<br>**99204**<br>**99214** | 1 or more chronic illnesses with exacerbation, progression, or side effects or treatment;<br>Or<br>2 or more stable chronic illnesses<br>Or<br>1 undiagnosed new problem with uncertain prognosis<br>Or<br>1 acute illness with systemic symptoms<br>Or<br>1 acute complicated injury | **Moderate: Must meet the requirements of at least 1 of the 3 categories**<br>**Extensive: Must meet the requirements of at least 2 of the 3 categories**<br>**Category 1: Tests and documents**<br>**Any combination of 3 from the following:**<br>1. Review of prior external notes(s) from each unique source*<br>2. Review of the result(s) of each unique test *;<br>3. Ordering of each unique test*<br>4. Assessment requiring an independent historian<br>*Or*<br>**Category 2: Independent interpretation of tests** | **Moderate Risk**<br>**Examples only:**<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

# Common Prescription Drug Management Confusion

- Appropriate documentation of ***prescription drug management*** continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate.
- Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided.
- Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: *"Stable hypertension; continue Valsartan 10 milligrams, will refill for 4 months until next follow-up visit."*
- Simply stating that the medication list was reviewed ***will not*** meet the definition of prescription management.


# Prescription Drug Management- Moderate

- It would have been helpful if 2021 or now 2024 DG had provided a definition within guidelines of RX management to finally put to rest much ambiguity within the auditing world, but unfortunately AMA did not.
- There are many MACs that do have published guidance on this topic, and Noridian is pretty clear. Their guidance states: *".. prescription drug management is the initiation, continuation, discontinuation, or modification of any prescription medication. This does NOT include medications that are OTC and prescriptions that are ONLY prescribed for insurance benefits*."
- Keep in mind that patient convenience and reimbursement rules NEVER make such determinations. A key word in the description that causes confusion is "management". Oftentimes, coders/auditors hear the word management and infer that this would mean a longtime use of a prescription drug; but look up the word.

Management in healthcare is defined as: *the coordination and administration of tasks to achieve a goal*.

How to determine RX Management?:

1. Did it require prescriptive authority
2. Is the provider of record managing the RX?

# CY 2024 CPT® UPDATES

## EVALUATION AND MANAGEMENT UPDATES - RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT

***Parenteral controlled substances:*** The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.
(under level 5 “risk” but consider with caution)

### Parenteral controlled substances

- **Opioids**
- **Stimulants**
- **Depressants**
- **Hallucinogens**
- **Anabolic Steroids**


2024

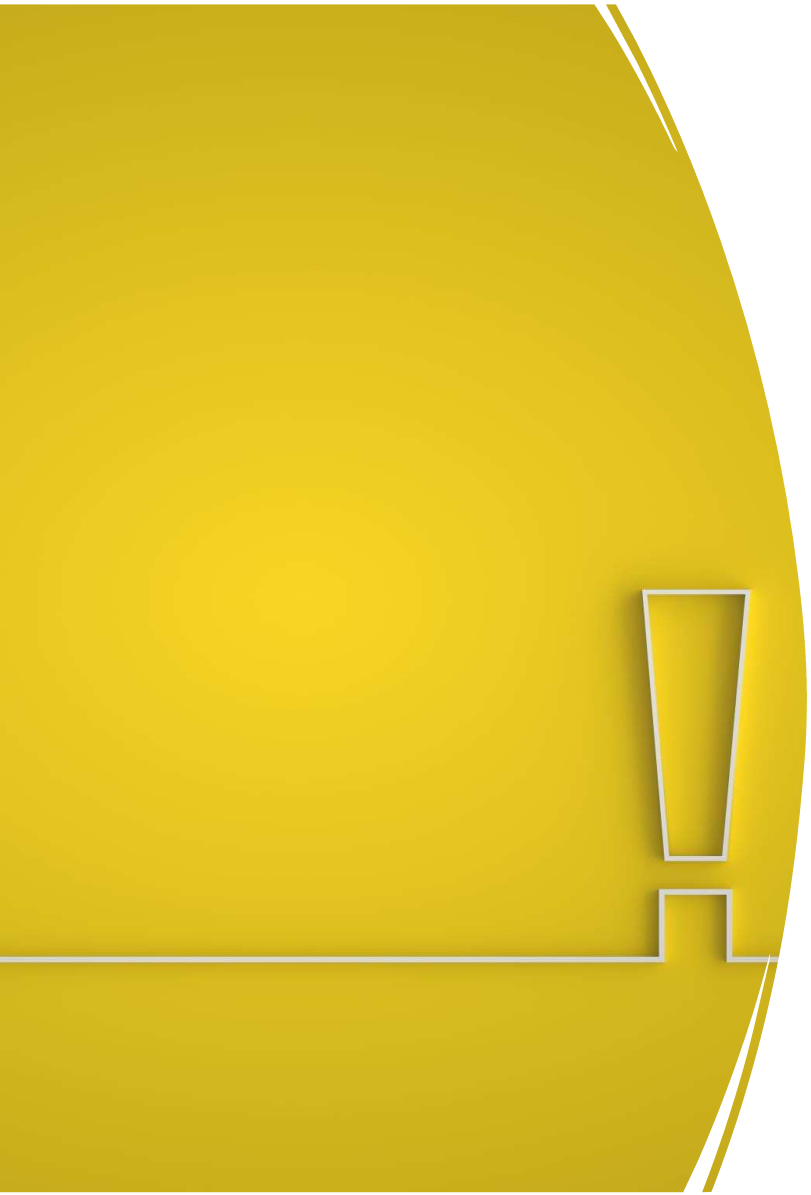
# New 2024 Medicare add on code + G2211

- **G2211** Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

# +G2211 more direction from CMS final rule

*(Resource: Codingintel.com)*

- CMS also states that not all E/M would be eligible. *"…E/M visit complexity add-on code would not be appropriately reported, such as when the care furnished during the O/O E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine or time-limited nature…"* .
- They provide specific examples of conditions that *would not require the add on complexity code:* mole removal, treatment of a simple virus, seasonal allergies, new onset GERD, treatment for a fracture, and/or *"when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time."* p. 432 Final Rule. *(85 FR 84570 and 84571)*.



# +G2211

*(reference: CodingIntel.com)*

**CMS will pay for add-on code G2211 in 2024**

**(effective date 1-1-2024, implementation date 1/18/2024)**

- G2211 (definition below) is an add-on code to office and other outpatient services, 99202–99215.
- CMS believes it will be used by primary care and other specialties who treat a single, serious condition or a complex condition with a consistency and continuity over a long period of time. CMS is emphasizing the “longitudinal relationship” between the practitioner and the patient.
- CMS *will not* allow G2211 to be used with an E/M service if modifier 25 is appended to the E/M service
- MLN Matters 13473 discusses documentation for G2211 (released 1/18/2024)
- As of 2/1/2024 it has been reported that this code is being rejected as included in the office visit codes, and not separately payable. We hope CMS will fix this soon and update their software. Make sure you keep a list of these claims, as I am sure we will get some kind of direction for resubmission or how they will retro-pay soon.

# Assessment of Social Determinants of Health (SDoH) 2024

- New 2024 HCPCS Code G0136 Administration of a standardized evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, ***not*** more often than every 6 months.
- This is NOT an add on code.
- CMS defines SDoH into broad groups: “economic stability, education access and quality, neighborhood and built environment, and social and community context, which include factors like how soon, food and nutrition access, and transportation needs.”
- Represented by ICD-10-CM codes Z55—Z65
- Added permanently to telehealth list

***Risk assessment in relation to SDoH factors that influence diagnosis and treatment of medical conditions***

- Must be done on the day of an E/M service (not including 99211)
- Is not a screening service, but an assessment tool.
- May also be billed on the same day as 90791, 96156, 96158, 96159, 96164, 96165, 96167, 96168.
- May be billed with hospital discharge codes IF there will be follow up of unmet needs after assessment.

*(Resource: CodingIntel.com)*

# When to Report G0136 SDoH

- This assessment can be done on the day of an E/M service, not including code 99211. During the comment period, CMS was asked about the patient using an on-line portal rather an having the service done on the day of an E/M service.
- They believe this is ***not a screening*** but an assessment, and it is to be used when the practitioner believes that the patient has unmet SDoH needs that are interfering with the diagnosis or treatment of an illness and needs to be an in-person assessment.
- CMS is requiring that the SDoH needs that are identified during the assessment be documented in the medical record and "actively encouraging Z-code reporting to improve our data…" p. 357 Final Rule.
- The Z codes in question are in categories Z55-Z65.
- CMS did not finalize the requirement that the assessment **must** be done on the same day as one of these visits, but it seems likely that is when it will be done. They do not believe it will be performed in advance, via a portal, because it is not a screening. *It is performed as an assessment based on the practitioner's evaluation of the patient's situation.*
- G0136 will be subject to cost sharing, (co-pay and deductible) unless it is done at an Annual Wellness Visit (AWV).
- Non-Facility total RVU is 0.57 = $19.80
- Facility total RVU is 0.27 = $8.84

*Resource: CMS Final Rule p345-358, Medicare RVU file 12/12/23*

# Social Determinants of Health Examples

- Illiteracy and low-level literacy —> Low health literacy may require different or more extensive efforts with patient education (i.e. all verbal instruction because patient can't read written instructions)
- Inadequate housing —> Patient may lack refrigeration in their home so can't be prescribed cold storage medications, so you have to prescribe something else. May have mold infestation so have to intensify management of their asthma.
- Extreme poverty or Low income —> May not be able to afford medications or other over-the-counter type therapies/devices.
- Disappearance and death of family member —> May decide to defer addressing some medical issues to prioritize providing emotional support for bereavement.
- Child in welfare custody. —> May have to spend extra time educating new foster parent on medical management or on how to provide support care for medical condition


# CPT Pelvic Add on Code 2024

CPT® 2024 includes a new add-on pelvic exam code, +99459 (*Pelvic examination [List separately in addition to code for primary procedure]*), discussed in *Ob-Gyn Coding Alert* volume 26, number 11 article, "Mystery Surrounds How to Use Pelvic Examination CPT® Code." However, how you should use this code hasn't been clear — until now.

**The *Federal Register* states:**

Pelvic Exam (CPT® add code +99459)

- In September 2022, the CPT® Editorial Panel created a new CPT® code for reporting a pelvic exam – CPT® code +99459. The specialty societies noted that reimbursement for the work would be captured with the problem-oriented E/M code billed for the visit. The CPT® Editorial Panel agreed, thus the new code is a practice expense only code that captures the direct practice expenses associated with performing a pelvic exam in the non-facility setting.
- *CPT® code +99459 (Pelvic Exam) captures the 4 minutes of clinical staff time associated with chaperoning a pelvic exam.*

***Per CMS**: "We proposed the RUC-recommended direct-PE inputs for CPT® code +99459 without refinement. As a PE-only service, the RUC did not recommend, and we did not propose a work RVU for this code."*

- *Non-Facility PE RVU: 0.68 = $22.266*
- In other words, this means that if your ob-gyn practice wants to capture the work of a clinical staff member chaperoning a pelvic exam, then you would use +99459. A clinical staff member can include "employees (leased or contracted staff) who work under the supervision of a physician or other QHP to perform, or assist in the performance of, a specified professional service as allowed by law, regulation, and facility policy; but who do not individually report that professional service (payer-specific policies may also affect who may report specific services). Clinical staff includes medical assistants, licensed practical nurses, registered nurses, and the like," according to your CPT® manual.

*AAPC article 12/11/23 – no guarantee of payment, per HHS and CMS*

# 2024 Hospital/Observation E/M

# Updated E/M Guidelines for Hospital Inpatient and Observation Care

- ➢There are 2 subcategories: Initial vs. Subsequent. (“New” vs. “Established” does not apply)
- ➢An initial service is when the patient has not received any professional services from a provider of the exact same specialty and subspecialty who belongs to the same group practice, *during the inpatient, observation, or nursing facility admission and stay.*
- ➢When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.
- ➢For reporting Initial vs. Subsequent hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. This means that the initial visit may be an admit into Observation while the subsequent visits on following days may be Observation or Inpatient.

# Initial Services – 2024

►Some categories apply to both new and established patients (eg, hospital inpatient or observation care, or nursing facility care). 99221 – 99223: Initial hospital inpatient or observation care, per day

These categories differentiate services by whether the service is the initial service or a subsequent service.

*For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.*

An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, *during the inpatient, observation, or nursing facility admission and stay.*

# Subsequent Service – 2024 Hospital/Facility

► A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay. – 99231-99233 initial or observation subsequent hospital services, per day (Medicare inpatient only)

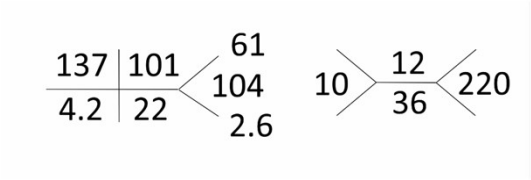
# A Hospital Progress Note – What's the code?

***Ref:*** *E/M University 2024*

CC: CHF and AKI

INTERVAL HISTORY: Patient continues to complain of DOE (Dyspnea on exertion).

EXAM: BP 164/74, HR 72, RR 20
Lungs Bibasilar crackles
Heart: RRR, no MRGs
EXT: Symmetric bipedal edema




ASSESSMENT

1.Worsening AKI*, likely secondary to cardiorenal syndrome
2.Worsening CHF
3.Worsening HTN

PLAN

Lasix 40 mg IV BID
1.Repeat BMP in a.m. to monitor electrolytes and AKI

Total time spent: 25 minutes.

*(****Acute Kidney Injury*** *(AKI) is the term that has recently replaced the term ARF. AKI is defined as an abrupt (within hours) decrease in kidney function, which encompasses both injury (structural damage) and impairment (loss of function)*

## The Medical Decision-Making Table

The table to the right is from the 2021 E/M guidelines, first released in 2021, with minor revisions added in 2023. This table is still applicable in 2024.

***Ref:*** *E/M University 2024*

| MDM | Number and complexity of problems addressed | Amount and/or complexity of data reviewed | Risk of complications and/or morbidity |
|---|---|---|---|
| SF/ 99231 | •One self-limited or minor problem | •Minimal or none | •Minimal risk or morbidity from additional diagnostic testing or treatment |
| Low/ 99231 | •Two or more self-limited or minor problems<br>•One stable chronic illness<br>•One stable acute illness<br>•Acute uncomplicated illness or injury<br>•One acute uncomplicated illness or injury requiring hospital inpatient or observation level care | *(Must meet the requirements for 1 of 2 of the categories)*<br>**Category 1: Tests and documents**<br>(Requires any combination of 2 from the following)<br>•Review of prior external notes<br>•Review of results or each unique test<br>•Ordering of each unique test<br>**Category 2: Assessment requiring an independent historian** | •Low risk of morbidity from additional diagnostic testing or treatment |
| Mod 99232 | •One or more chronic illness with mild exacerbation, progression, or side effects of treatment<br>•Two or more stable chronic illnesses<br>•One undiagnosed new problem with uncertain prognosis<br>•One acute illness with systemic symptoms<br>•Acute complicated injury | (*Must meet the requirements for 1 of 3 of the categories)*<br>**Category 1: Tests and documents, historian**<br>Any combination of 3 of the following:<br>•Review of prior external records<br>•Review of results of each unique test<br>•Ordering of each unique test<br>•Assessment requiring an independent historian<br>**Category 2: Interpretation of tests**<br>•Independent interpretation of a test performed by another physician/NPP<br>**Category 3: Discuss management/tests**<br>•Discussion of management or tests with an external physician/NPP | •Prescription drug management<br>•Decision regarding minor surgery with identified patient or procedure risk factors<br>•Decision regarding elective major surgery without identified patient or procedure risk factors<br>•Diagnosis or treatment significantly limited by social determinants of health |
| High 99233 | **•Severe exacerbation of chronic illness**<br>**•Acute or chronic illnesses that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, abrupt change in neurological status** | ***Same as moderate, but requirements for 2 out of the 3 categories must be met*** | **•Drug therapy requiring intensive monitoring for toxicity**<br>•Decision for elective major surgery with identified patient or procedure risk factors<br>•Decision regarding hospitalization or escalation of level of care<br>•Decision for DNR or to de-escalate care<br>•Parenteral controlled substances |
| Requires 2 out of 3 to qualify for any given level of MDM | | | |

*For hospital progress notes, the level of care is driven by the MDM required for the visit or the total time spent before, during and after the visit on the date of the encounter. To determine the correct level of care, first calculate the MDM needed for the visit, then add up time spent, then select the level of care which is highest.*

## Answer and Analysis

### Correct Level of Care: 99233

The reimbursement is $115.26. This level of subq hosp code is used about 40% by internists, and 50% by cardiologists, and 56% by nephrologists.

### MDM: High Complexity

This encounter qualifies for high complexity MDM based on the severity of the problem(s) being addressed and the presence of high risk due to the provision of IV diuretics, which will require close monitoring of electrolytes.(See red bold text in MDM table below.)

### Time: 25 Minutes

Total time spent before, during and after visit on the date of the encounter was 25 minutes. If coding for this visit, based on time, we would only qualify for the 99231 level of care.

| Hospital Progress Notes (Subsequent Hospital Care) | | | | |
|---|---|---|---|---|
| E/M Code | History | Exam | MDM | Time- met or exceeded |
| 99231 | A medically appropriate history and/or exam, the extent of which is left up to the examiner | | SF/Low | 25 |
| 99232 | | | Mod | 35 |
| 99233 | | | High | 50 |

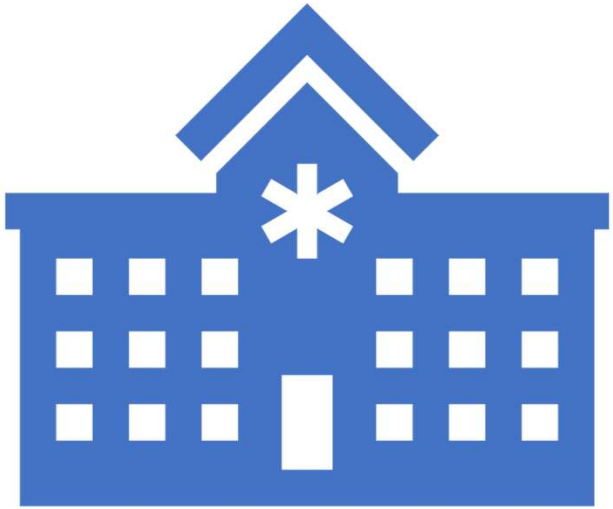
# Consults and an Admitting doctor asking a consultant to follow a patient CPT® 2024 (P.18)

*"If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or other qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233)."*

This instruction applies whether the consultation occurred on the date of the admission or a date previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation). – But how far back does this encounter refer to? AMA needs to clarify

*"For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate. For the purpose of reporting an initial hospital inpatient or observation care service, a transition from observation level to inpatient does not constitute a new stay."*

# Example of a requested in-patient consult 2024



- Patient was seen in consultation, in your office for a pre-op for hip surgery on 1/10/2024. Patient was cleared by their PCP and high-risk medications modified. Code 99214 was billed, with a secondary dx reflecting pre-op.
- Patient was admitted to the inpatient hospital on 1/25/2024 for staged hip surgery by his orthopedic surgeon.
- Orthopedic surgeon called the PCP and asked him to consult the patient and follow during stay.

Orthopedic reported surgery only

PCP reports 99233-99231 subsequent hospital for the consult during this stay, since there was a *related consult* (E/M) prior to anticipated admit.

*Page 18, CPT 2024*

# CY 2024 CPT® UPDATES

## EVALUATION AND MANAGEMENT UPDATES - SPLIT OR SHARED VISITS

Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service.

*(reminder that CMS says S/S visits can only be reimbursed if provided in a facility setting, not an office setting. "Incident to" defaults to office when using extenders)*

# CY 2024 CPT® UPDATES

## EVALUATION AND MANAGEMENT UPDATES - SPLIT OR SHARED VISITS

- For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan.

- Independent interpretation of tests and discussion of management plan or test interpretation ***must be personally performed by the physician or other QHP*** if these are used to determine the reported code level by the physician or other QHP.

# Presentation References and Resources:

- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule
- https://www.cms.gov/about-cms/contact/newsroom
- https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu24a
- https://codingintel.com/
- https://www.ama-assn.org/member-benefits/practice-benefits-discounts/cpt-assistant-member-benefits
- https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

# Questions?

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