

# SOUTH DAKOTA SOCIETY OF MEDICAL ASSISTANTS

March 12, 2021

## AGENDA

- ▶ Quick overview of new E/M office visit guidelines
- ▶ Telehealth and COVID-19
- ▶ Required documentation to bill 99211
- ▶ Injection documentation
- ▶ Documenting HPI/Chief Complaint

Why are the AMA and CMS making these changes?  
Patients over Paperwork

Decrease administration burden of documentation and coding

Decrease the need for audits

Decrease unnecessary documentation in the EMR that is not needed for patient care  
Also known as note bloat

E/M level of service for office or other outpatient services can be based on:

- ▶ Medical Decision Making (MDM)
  - Extensive clarifications provided in the guidelines to define the elements of MDM

OR

- ▶ TOTAL time spent dedicated to the patient on **the date of the encounter**
  - Including non-face-to-face services
  - Does not include staff time

We used to use:

History

Exam

MDM OR

Time – face to face

Now only

MDM OR time – total on the same day

TIME:	
▶ 99201	will be removed in 2021
▶ 99202	15-29 minutes
▶ 99203	30-44 minutes
▶ 99204	45-59 minutes
▶ 99205	60-74 minutes
▶ 99211	rarely used by physicians/APPS
▶ 99212	10-19 minutes
▶ 99213	20-29 minutes
▶ 99214	30-39 minutes
▶ 99215	40-54 minutes

Instead of just having an average time, there are ranges

No required minimum amount of time when using MDM

You will still need to document your specific time, you can't just say you spent between 30-39 minutes.

Time:

- ordering meds, tests or procedures
- Referring and communicating with other professionals
- Documenting your notes – can't count if you are very slow!
- Independently interpreting results – not reported separately
- Care coordination – not reported separately
- Preparing to see the patient
- Obtaining and/or reviewing separately obtained history

Performing a medically necessary appropriate  
exam and/or evaluation  
Counseling and education patient/family/caregiver

### All Notes Must Have:

- ▶ Chief Complaint
- ▶ Medically appropriate history and exam, when performed
- ▶ Medical decision making
- ▶ Time documented if using time to support code choice

Medically appropriate history and exam – as determined by the treating physician/APP.

CMS states “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

Patient presents with abdominal pain

Auditor would expect to see an abdominal exam

When using time, document what you spent that time doing

**New Add On code for Primary Care and non-procedural Specialties**

- ▶ Visit Complexity Associated with Certain Office/Outpatient E/M
- ▶ G2211 Add on code for primary medical care services that serve as the continuing focal point for all needed health care services.
- ▶ **POSTPONED UNTIL 2024**

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, or complex chronic condition

CMS says that they expect this add-on code to be billed for every primary care patient.

This code is not limited to just primary care

This will be used for furnishing services to patients on an ongoing basis that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape

Medical Decision Making has three elements:

- ▶ 1 - Number and Complexity of Problems Addressed at the encounter
- ▶ 2 - Amount and/or Complexity of Data to be Reviewed and Analyzed
- ▶ 3 - Risk of Complications and/or Morbidity or Mortality of Patient Management

Number and Complexity also known as diagnoses

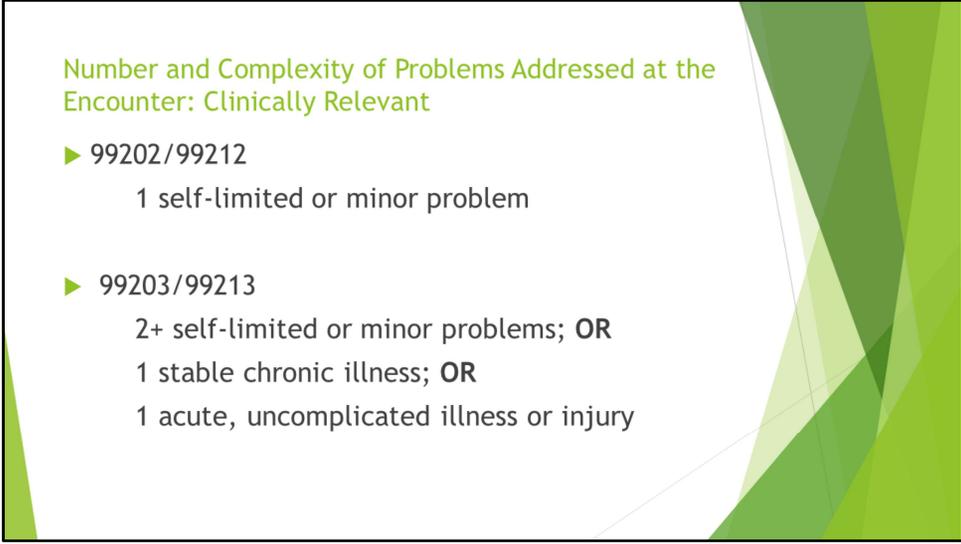
You must have addressed the problems, not just list what's on the problem list

Notation in the patient's record that another professional is managing the problem without additional assessment documented does not qualify as addressed

There are four levels of Medical Decision Making

Straightforward	level 2
Low	level 3
Moderate	level 4
High	level 5

Two of the three elements must be met or exceeded to meet the level.



Number and Complexity of Problems Addressed at the Encounter: Clinically Relevant

- ▶ 99202/99212  
1 self-limited or minor problem
- ▶ 99203/99213  
2+ self-limited or minor problems; **OR**  
1 stable chronic illness; **OR**  
1 acute, uncomplicated illness or injury

Level 2 – would go away without any intervention

A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status

A patient that is not at their treatment goal is not stable.

Acute, uncomplicated – recent or new short-term problem with low risk of morbidity for which treatment is considered.

A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness

► 99204/99214

1+ chronic illnesses with exacerbation,  
progression, or side affects of treatment; **OR**

2+ stable chronic illnesses; **OR**

1 undiagnosed new problem with uncertain  
prognosis; **OR**

1 acute illness with systemic symptoms; **OR**

1 acute complicated injury

A problem where the risk of morbidity/mortality without treatment is moderate;

Undiagnosed new problem with uncertain prognosis:

A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. • Example: Lump in breast •

Increased probability of prolonged functional impairment

▶ 99205/99215

1+ chronic illnesses with severe exacerbation, progression, or side affects of treatment; **OR**

1 acute or chronic illness or injury that poses a threat to life or bodily function

A problem where the risk of morbidity without treatment is high to extreme  
Moderate to high risk of mortality without treatment  
High probability of severe, prolonged functional impairment

Amount and/or Complexity of Data to be Reviewed and Analyzed

▶ 99202/99212

Minimal or none

No tests

► 99203/99213 (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)

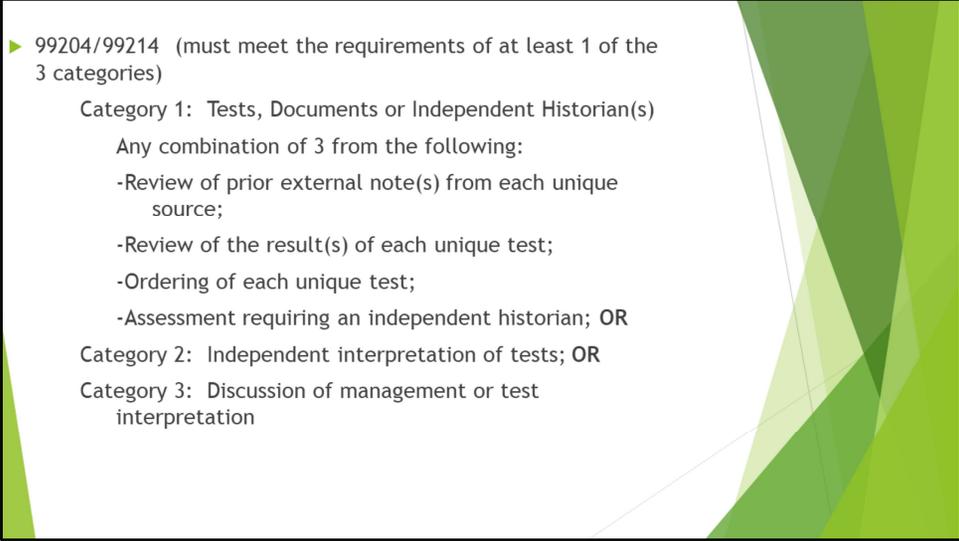
There are two categories

Prior external note – from someone not in your clinic  
or a different specialty

Independent historian

- parents
- children
- guardian
- surrogate
- spouse or witness

Must document that there is an independent historian and why



► 99204/99214 (must meet the requirements of at least 1 of the 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; **OR**

Category 2: Independent interpretation of tests; **OR**

Category 3: Discussion of management or test interpretation

This keeps building. Categories 1 and 2 for level 3 have been combined into one category for levels 4 & 5

Interpretation if you bill for the interpretation of an xray, you can't count it here

radiologist read xray and you personally look at the x-ray and do your own interpretation

Discussion of management or test interpretation  
an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient – lawyer, parole officer, case manager, teacher

This does NOT include discussion with family or informal caregivers

► 99205/99215 (must meet the requirements of at least 2 of the 3 categories)

Category 1: Tests, Documents, or Independent Historian(s)

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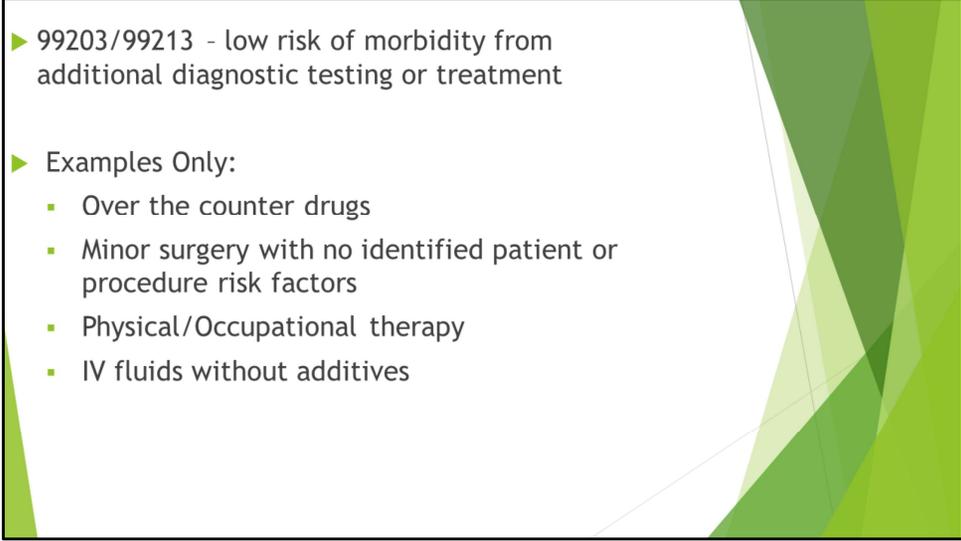
Same as level 4 but instead of 1 requirement, you need 2

## Risk of Complications and/or Morbidity or Mortality of Patient Management

- ▶ 99202/99212 - minimal risk of morbidity, from additional diagnostic testing or treatment

### Examples Only:

- Rest
- Elastic bandages
- Superficial dressings



- ▶ 99203/99213 - low risk of morbidity from additional diagnostic testing or treatment

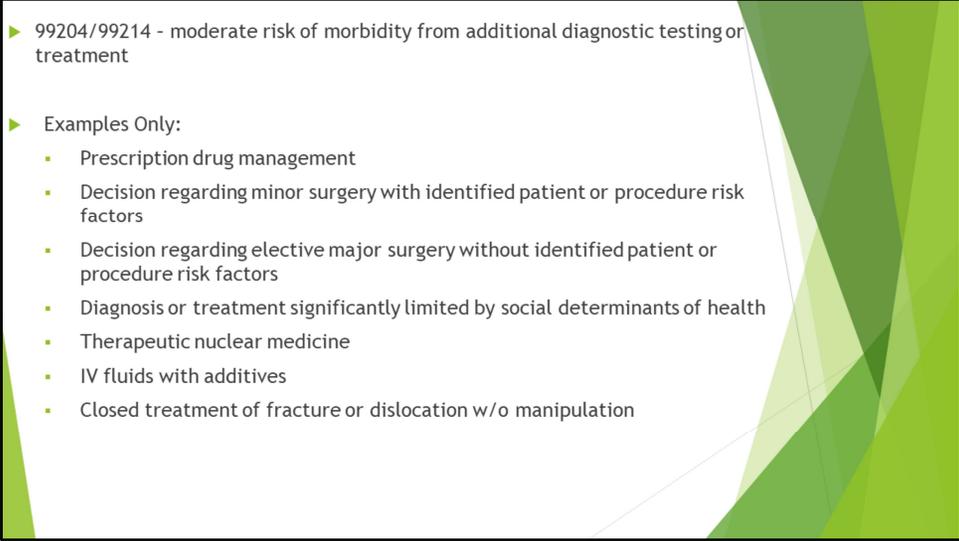
- ▶ Examples Only:

- Over the counter drugs
- Minor surgery with no identified patient or procedure risk factors
- Physical/Occupational therapy
- IV fluids without additives

The new guidelines now read “decision regarding minor surgery with no identified patient or procedure risk factors,” “decision regarding major surgery with patient or procedure risk factors,” and “decision regarding minor surgery with patient or procedure risk factors.”

It is recommended that you document risk factors that are inherent to the procedure (bleeding, puncturing the lung, paralysis) and risk factors related to co-morbidities and conditions of the patient.

Where the procedure is done and the type of anesthesia will also factor into this determination. Skin procedures that can be done in the office with lidocaine would be more likely to be minor procedures than procedures done in the operating room under general anesthesia. Treating a non-displaced fracture without manipulation has fewer procedure-inherent risks than taking a patient to the operating room to reduce an open fracture.

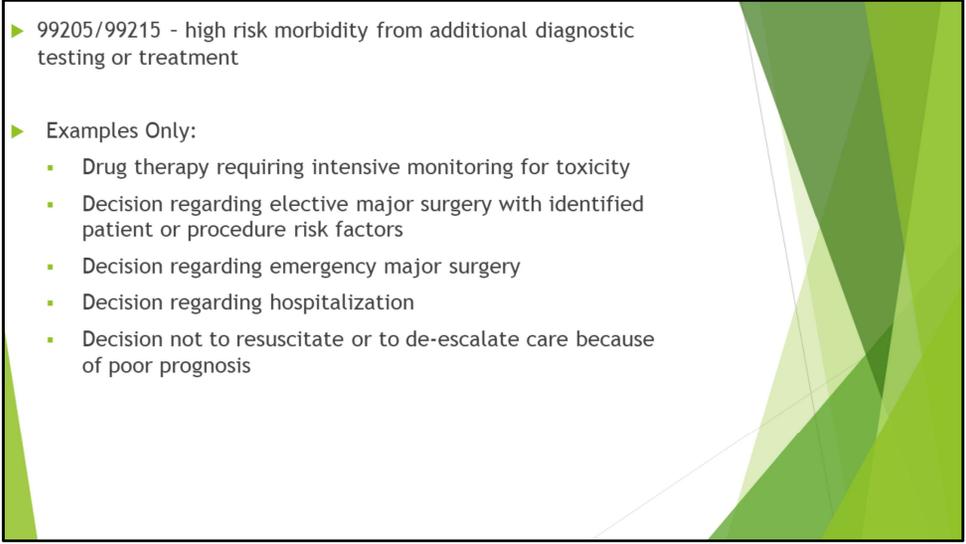
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- ▶ 99204/99214 - moderate risk of morbidity from additional diagnostic testing or treatment
  
  - ▶ Examples Only:
    - Prescription drug management
    - Decision regarding minor surgery with identified patient or procedure risk factors
    - Decision regarding elective major surgery without identified patient or procedure risk factors
    - Diagnosis or treatment significantly limited by social determinants of health
    - Therapeutic nuclear medicine
    - IV fluids with additives
    - Closed treatment of fracture or dislocation w/o manipulation

Prescription drug management – either new or renewed or changed.

If you document “Continue current meds”, you will not be given credit if you do not clearly document which drugs were addressed in the documentation or why the patient is on this/these prescription(s)

Social determinants of health – this is new

According to the CDC, SDOH encompasses economic and social conditions that influence the health of people and communities. It typically includes homelessness, food insecurity, unsafe living conditions (access to clean water, pollution free air), and economic insecurity. One specific example is not having the money to afford medications. It does not include smoking or alcohol use.

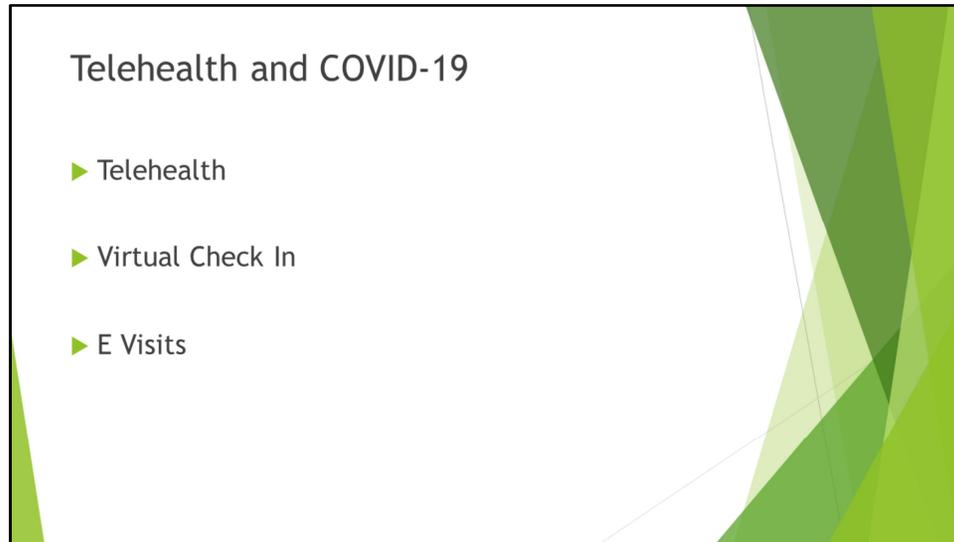
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- ▶ 99205/99215 - high risk morbidity from additional diagnostic testing or treatment
  
  - ▶ Examples Only:
    - Drug therapy requiring intensive monitoring for toxicity
    - Decision regarding elective major surgery with identified patient or procedure risk factors
    - Decision regarding emergency major surgery
    - Decision regarding hospitalization
    - Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision regarding hospitalization.

## Details and Specificity for Success

- ▶ Stable, at goal, improving
- ▶ Not at goal, Worsening, Unstable
- ▶ Risk, Benefit, Optional, Alternate
- ▶ Outcome, Noncompliant, Compliant
- ▶ Rule out, Differential
- ▶ Diagnosis specificity
- ▶ List individual labs ordered and diagnosis/symptoms for ordering
- ▶ Document names and relation of those involved in the service
- ▶ Identify the provider of any outside records
- ▶ Total time clearly documented and unique to the patient

Notes that lack detail or only rely on templates that do not accurately relay the level of care provided to the patient will have a negative impact



#### Telehealth- 99202-99215

many were added during PHE and will continue after  
some will drop off

#### Virtual Check In

needs to be an established patient initiated by the patient  
not related to visit previous 7 days nor will lead to one within 24  
business hours or soonest available appointment

#### E Visits

online patient portal  
established patient  
cumulative time during 7 days  
PT/OT/Psychologists can bill even though they can't bill E/M services



Documentation  
to support  
billing  
99211

Must be an established patient

Must be following a plan of care

What services are you providing?

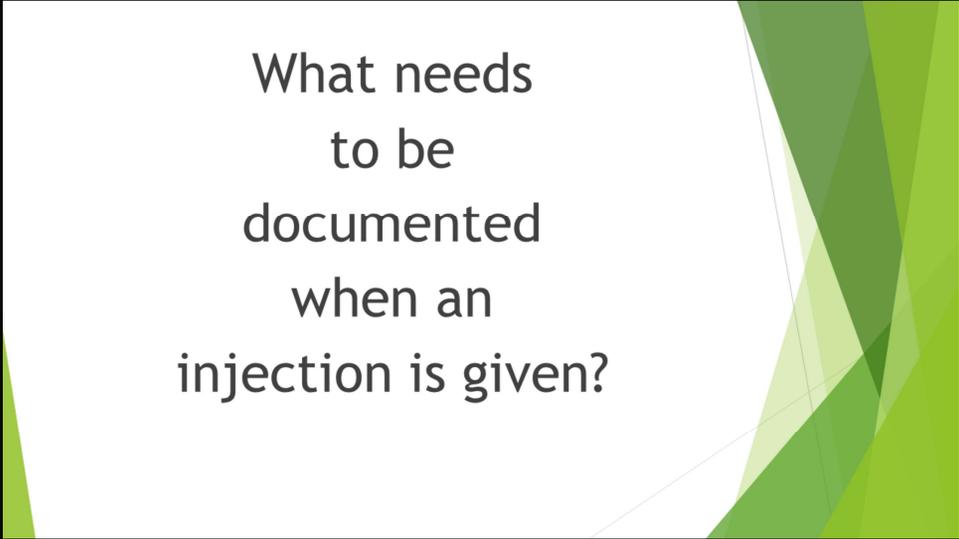
BP/Wt Check

Is it medically necessary?

How is the patient doing?

If you are removing sutures, whose plan of care are you following?

How does the wound look?



What needs  
to be  
documented  
when an  
injection is given?

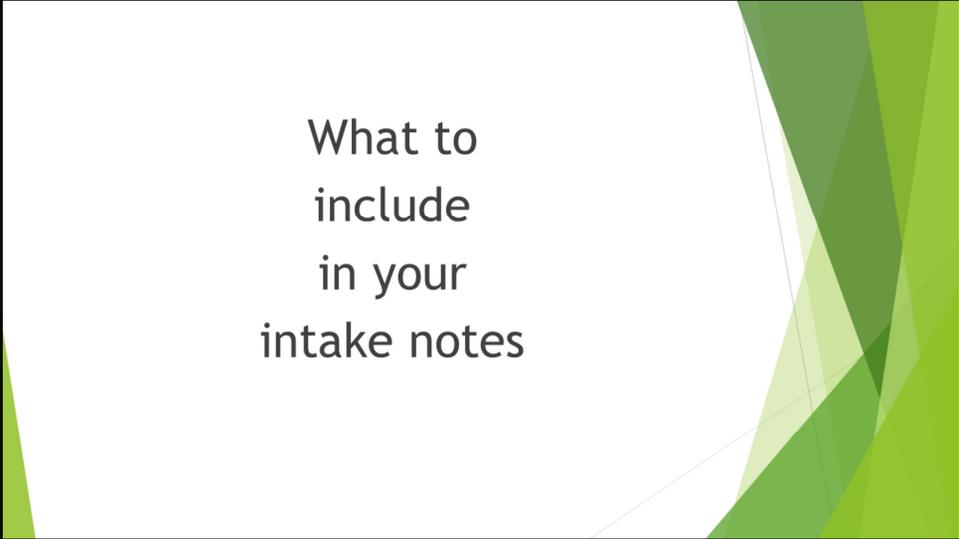
Why is the patient getting this injection? – document diagnosis

What are you injecting?

Where are you injecting it?

How much are you injecting?

NDC/NDU/Lot Number/Expiration Date



## What to include in your intake notes

If your physician/APP states:

See Nurses' notes

What do you need to document?

Why is the patient coming in? Can't just be "follow up". Follow up of what?

What has been going on with the patient? HPI/ROS/PFSH

These aren't counted toward the level of service but are still needed to support medical necessity.



# Questions?

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Thank you!