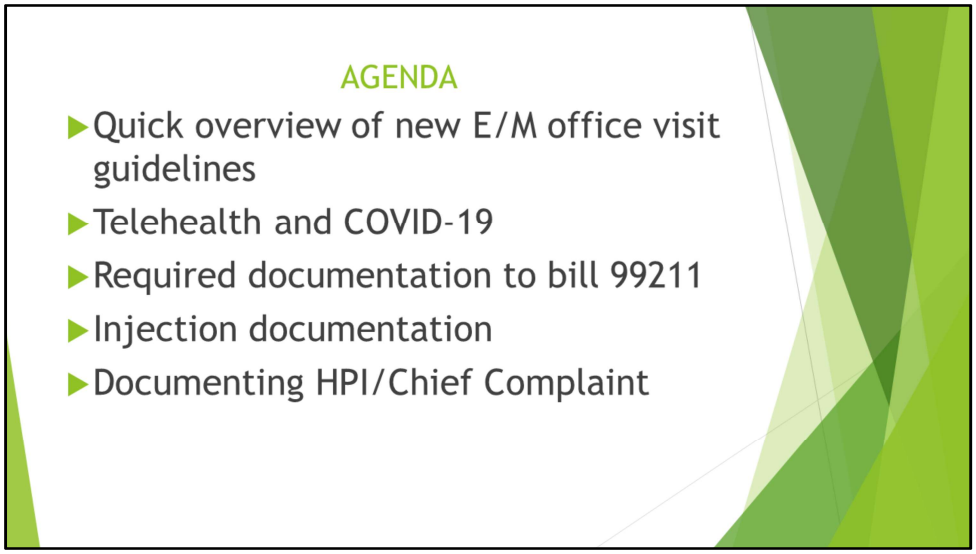
SOUTH DAKOTA SOCIETY OF MEDICAL ASSISTANTS

March 12, 2021

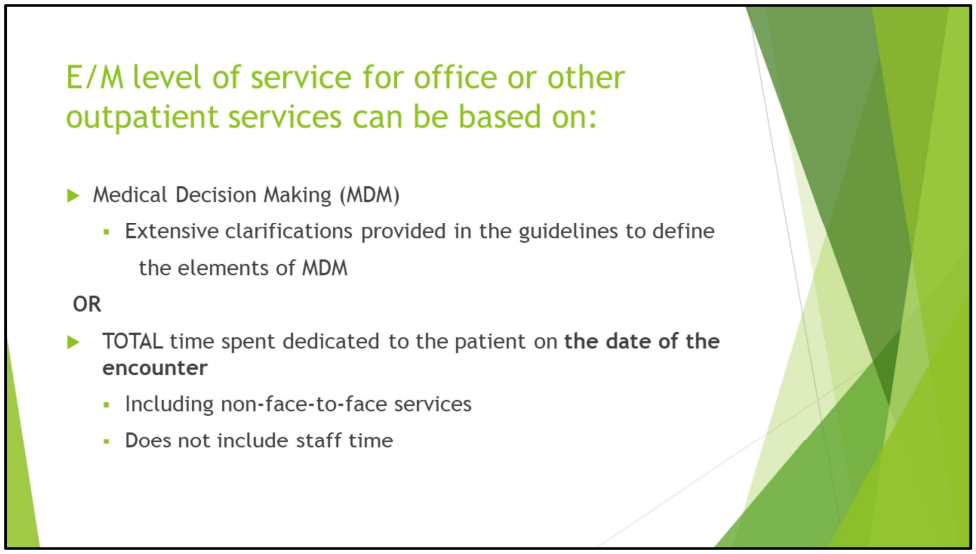


Why are the AMA and CMS making these changes?
Patients over Paperwork

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

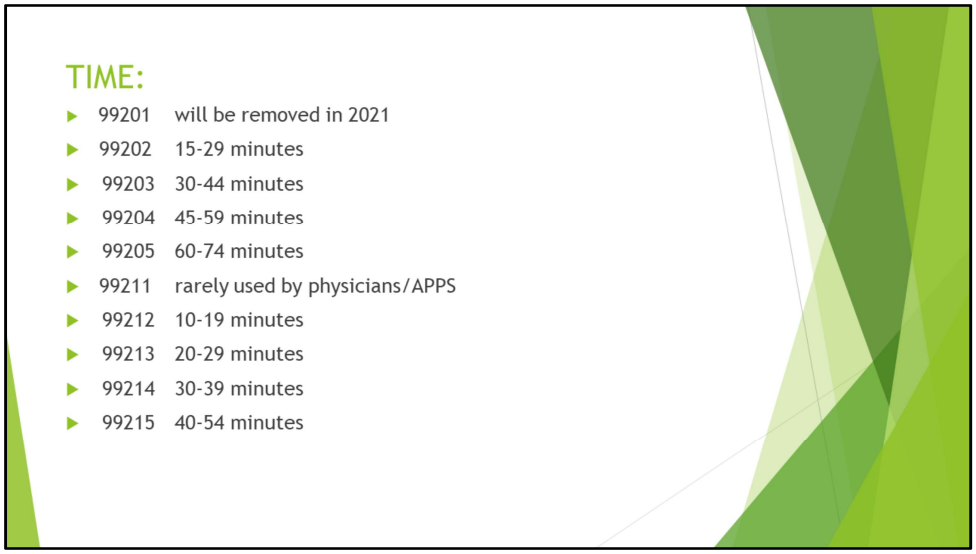


We used to use:

History
Exam
MDM OR
Time – face to face

Now only

MDM OR time – total on the same day



Instead of just having an average time, there are ranges

No required minimum amount of time when using MDM

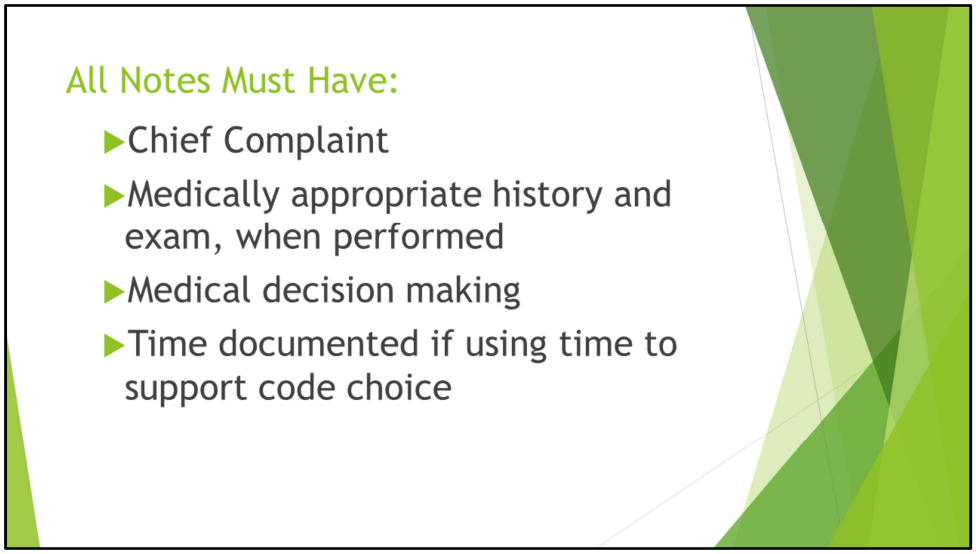
You will still need to document your specific time, you can't just say you spent between 30-39 minutes.

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



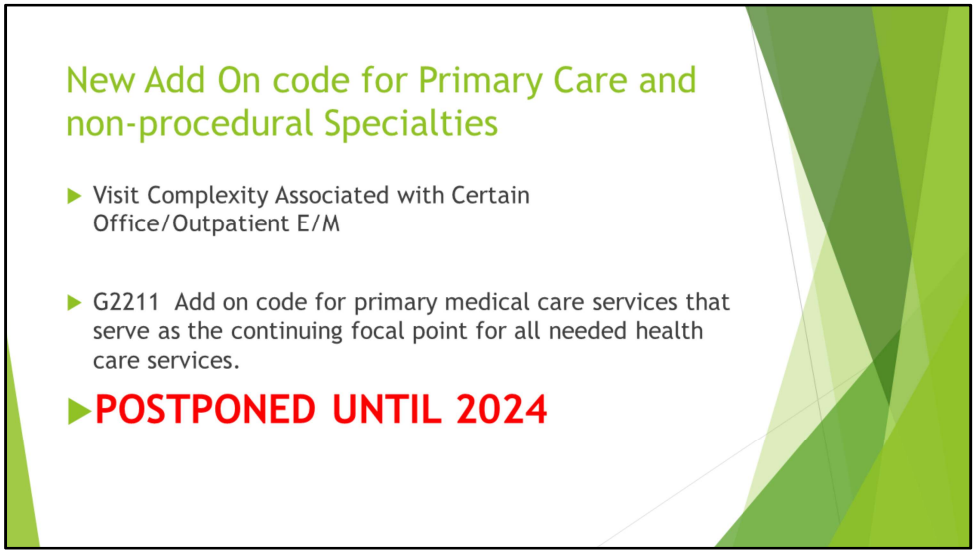
Medically appropriate history and exam – as determined by the treating physician/APP.

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

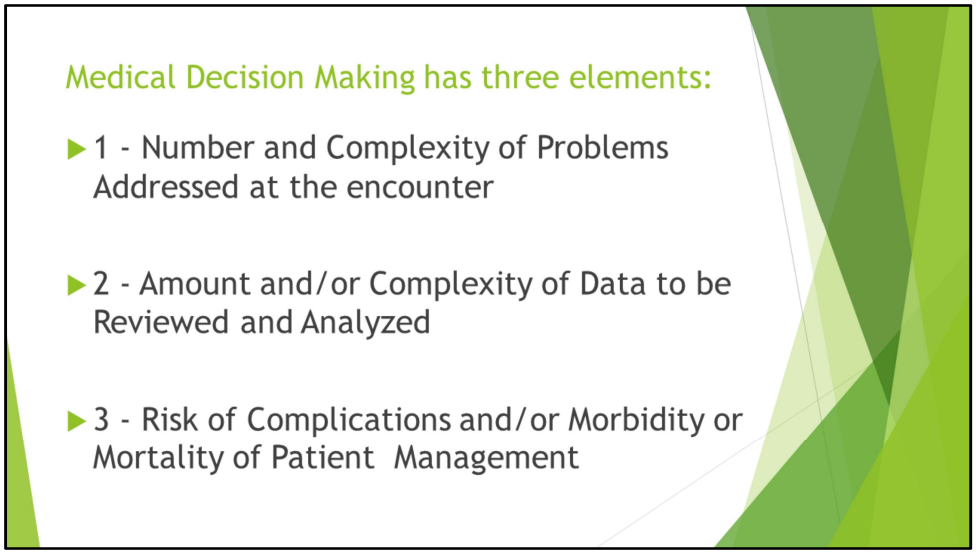
When using time, document what you spent that time doing



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

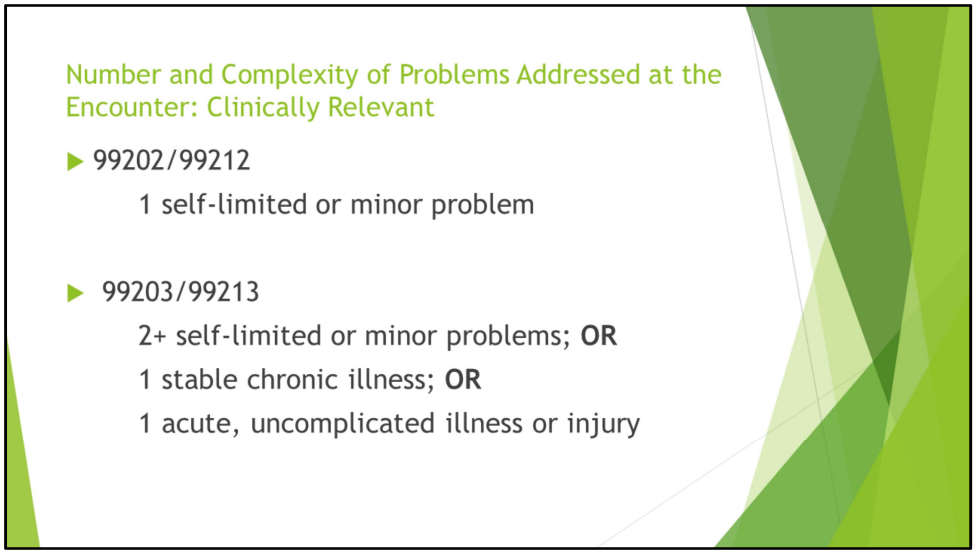


Number and Complexity also known as diagnoses
You must have addressed the problems, not just list what's on the problem list
Notation in the patient's record that another professional is managing the problem without additional assessment documented does not qualify as addressed

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.



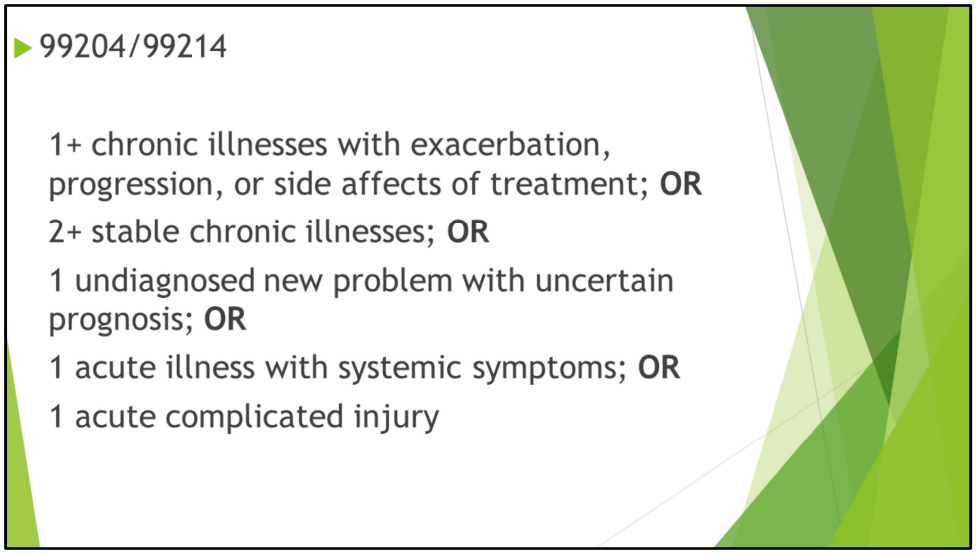
Level 2 – would go away without any intervention

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.

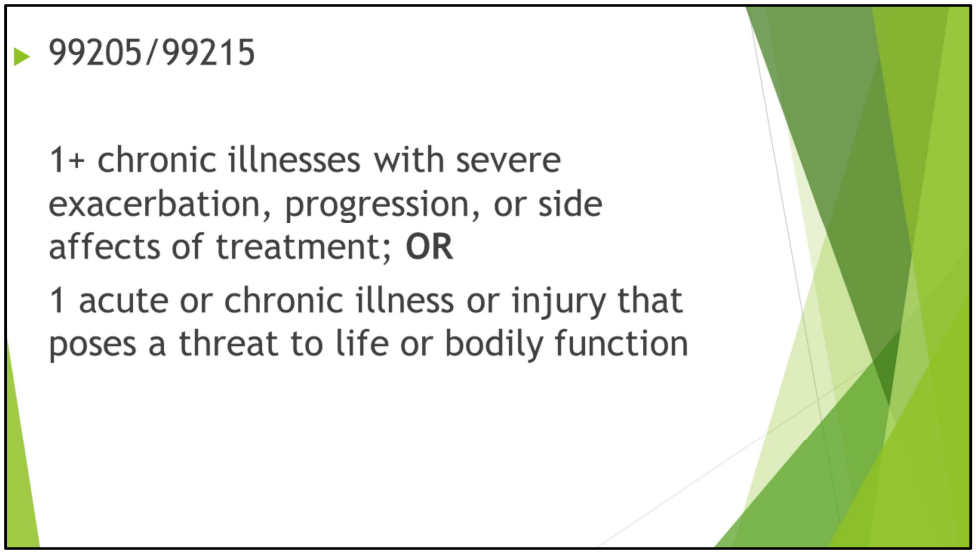
A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness



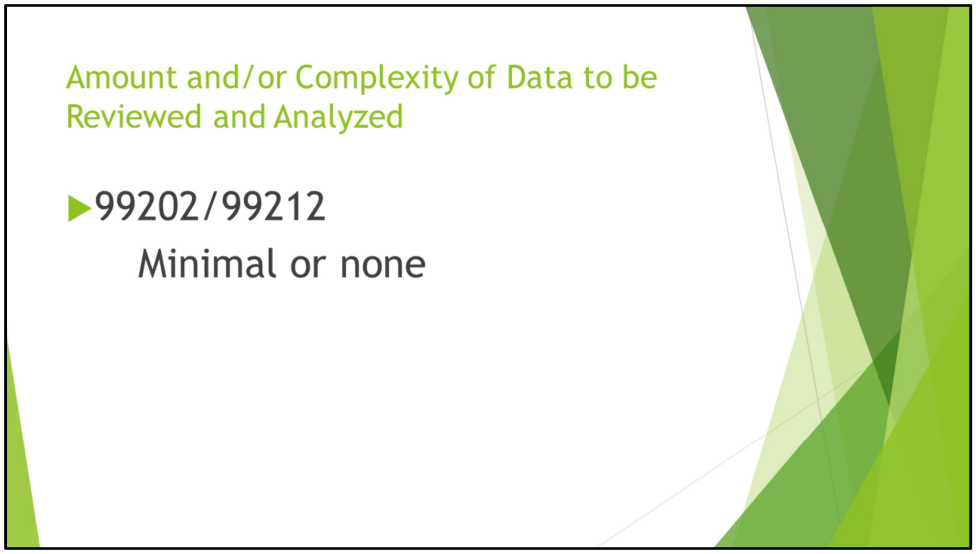
A problem where the risk of morbidity/mortality without treatment is moderate;

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 •

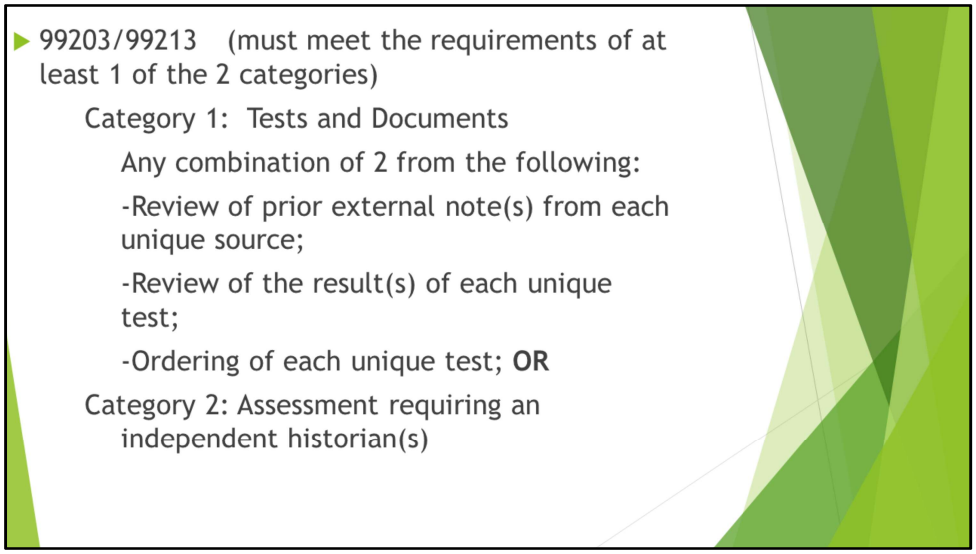
Increased probability of prolonged functional impairment



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

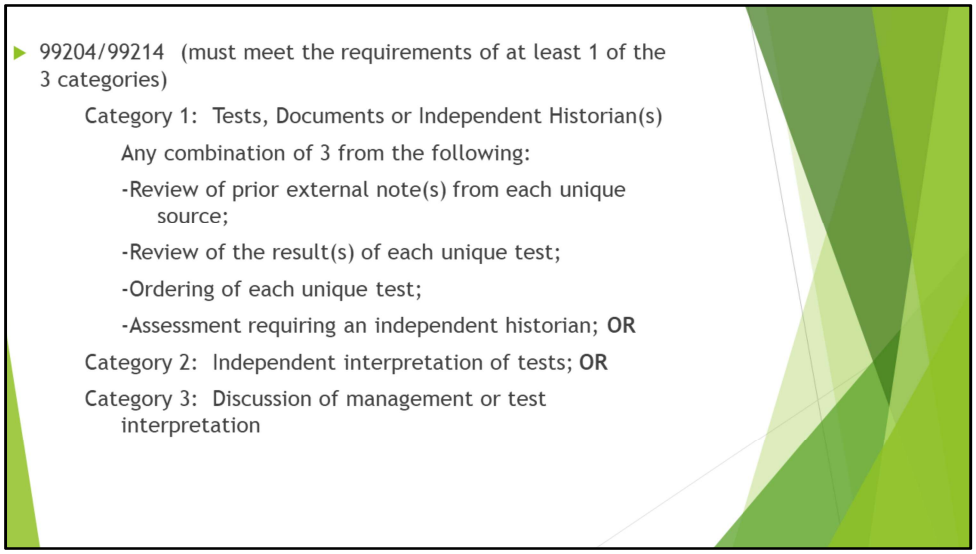


There are two categories

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



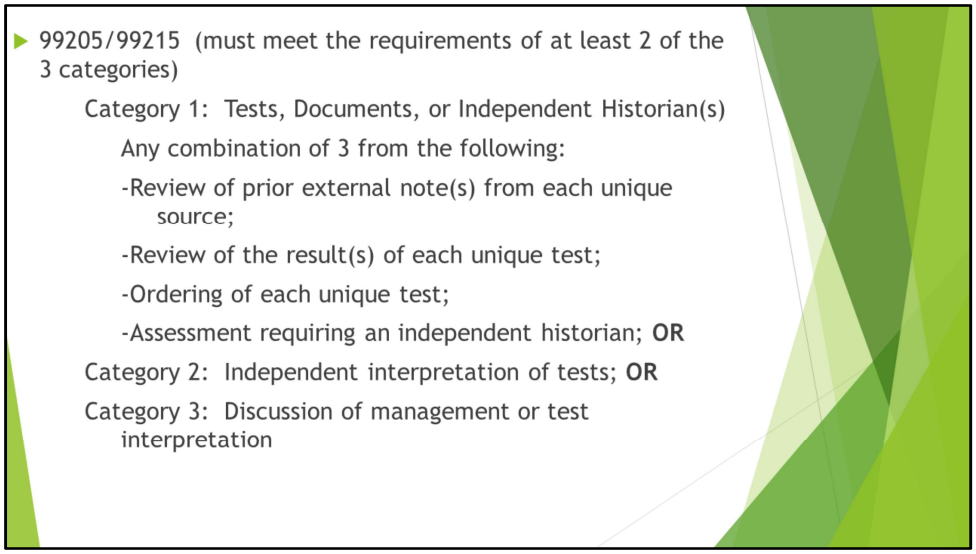
This keeps building. Categories 1 and 2 for level 3 have been combined into one category for levels 4 & 5

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



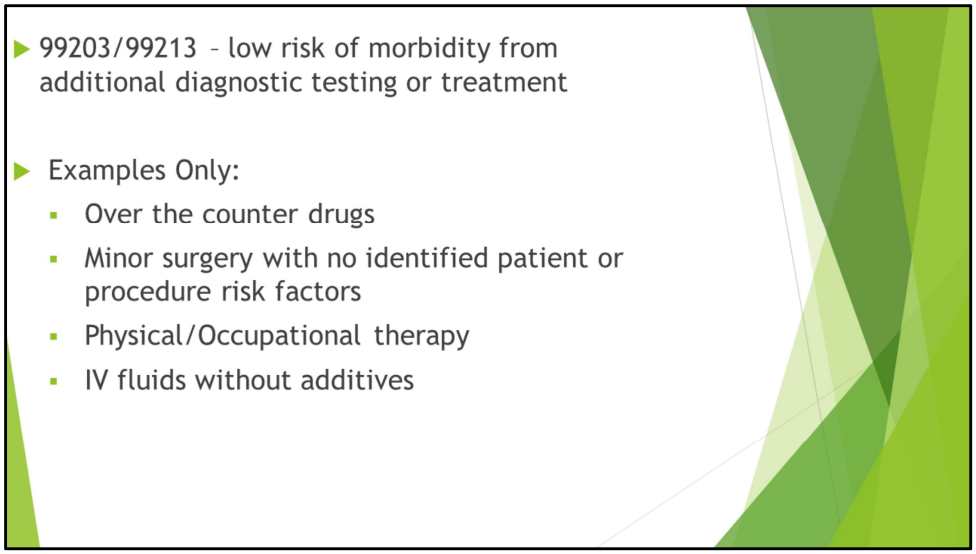
Same as level 4 but instead of 1 requirement, you need 2

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:

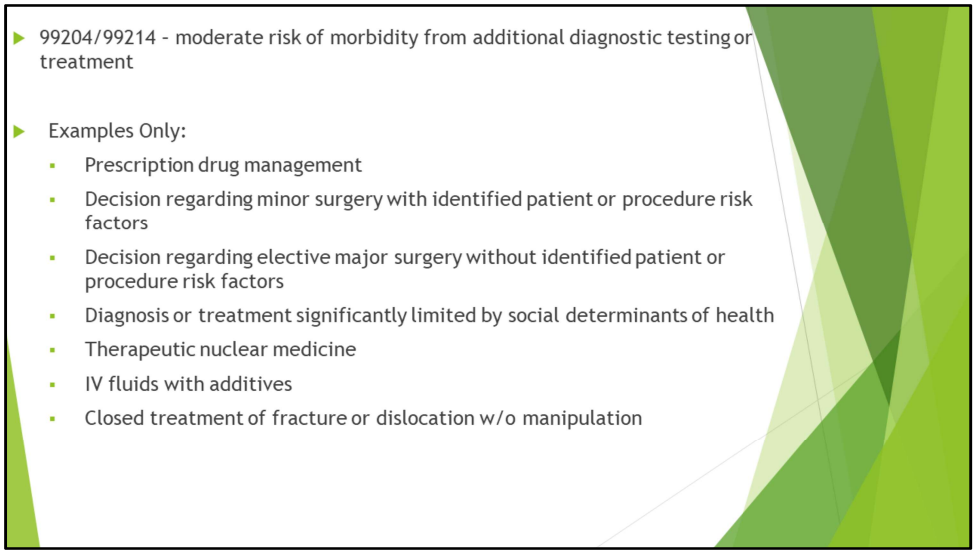
- Rest
- Elastic bandages
- Superficial dressings



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.

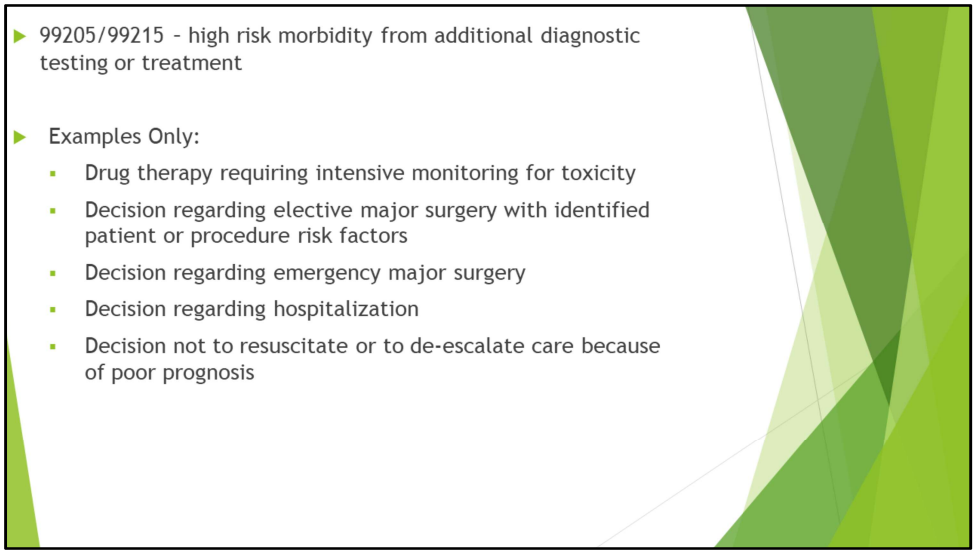


Prescription drug management – either new or renewed or changed.

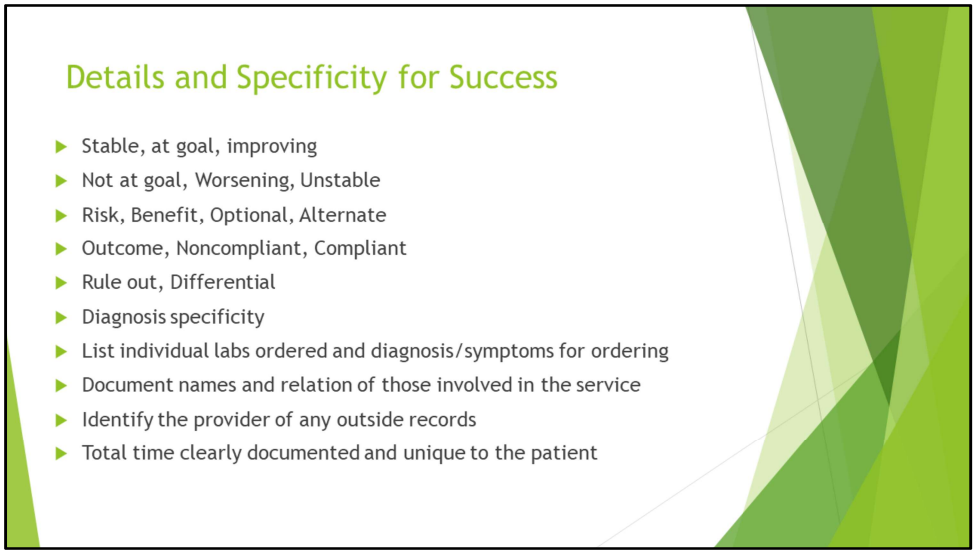
If you document "Continue current meds", you will not be given credit if you do not clearly document which drugs were addressed in the documentation or why the patient is on this/these prescription(s)

Social determinants of health – this is new

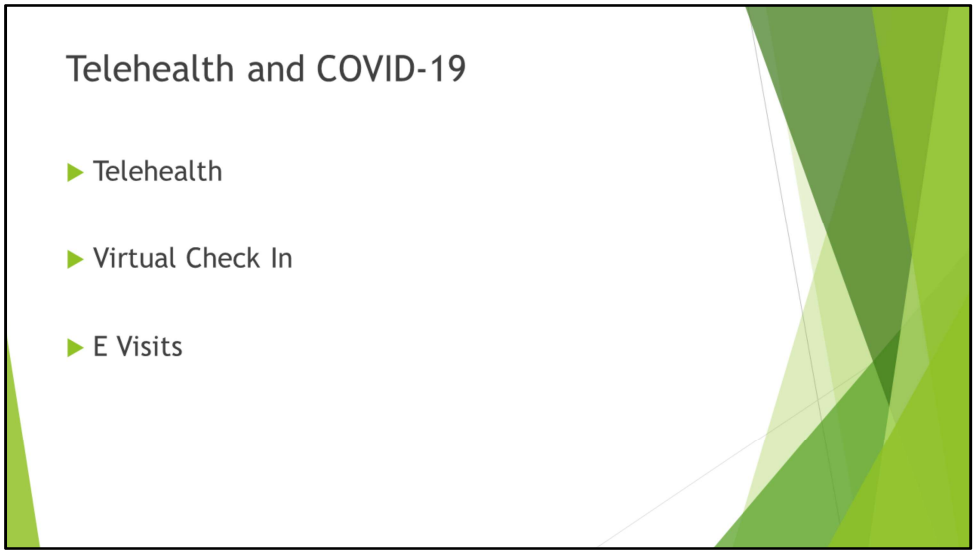
According to the CDC, SDOH encompasses economic and social conditions that influence the health of people and communities. It typically includes homelessness, food insecurity, unsafe living conditions (access to clean water, pollution free air), and economic insecurity. One specific example is not having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



Decision regarding hospitalization.



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

Must be an established patient

Must be following a plan of care

What services are you providing?

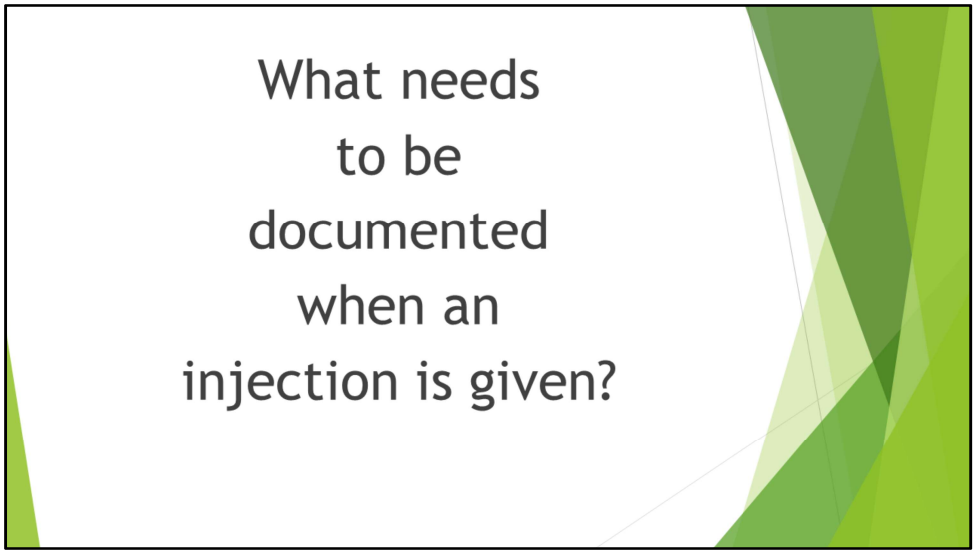
BP/Wt Check

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?



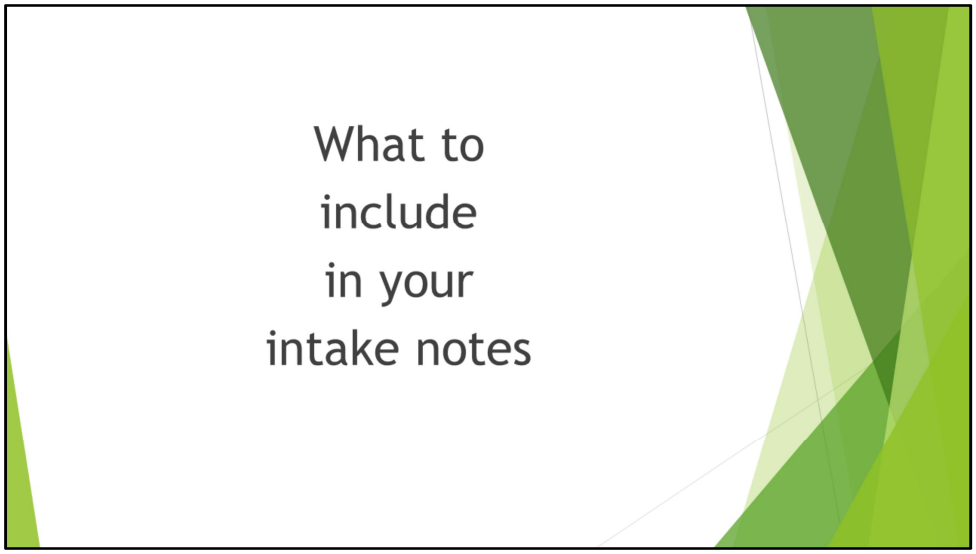
Why is the patient getting this injection? – document diagnosis

What are you injecting?

Where are you injecting it?

How much are you injecting?

NDC/NDU/Lot Number/Expiration Date



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.

Thank you!