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OUTLINE

- ICD-10-CM CODING CHANGES FOR 2021
- CPT® 2021 CODING CHANGES FOR 2021
- HCPCS 2021 CODING CHANGES FOR 2021
- EVALUATION AND MANAGEMENT CODE CHANGE FOR 2021
 - OVERVIEW AND BRIEF SUMMARY
 - MDM
 - TIME
- RESOURCES
- QUESTIONS

2021 ICD-10-CM CODE CHANGES IMPORTANT TO OPTOMETRY

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SUMMARY OF ICD-10-CM CODE CHANGES

- H18.5 CORNEAL DYSTROPHIES
- H43-H44 MIGRAINE AND OTHER HEADACHES
- H55.8 IRREGULAR EYE MOVEMENTS
- OTHER MISCELLANEOUS CODE CHANGES
- R51 HEADACHES
- T86.84 CORNEAL TRANSPLANT COMPLICATIONS
- Y77 OPHTHALMIC DEVICE ADVERSE EVENTS
- Z03.8 SUSPECTED DISEASES AND CONDITIONS
- Z79 LONG TERM DRUG USE
- CHAPTER 22 U07 CODE SERIES



H18.5 CODE SERIES

SEVERAL CODES ADDED EYE SPECIFIC DESIGNATIONS TO THEIR LISTINGS:

H18.5 CORNEAL DYSTROPHY SECTION CHANGES INCLUDES ADDING RIGHT EYE, LEFT EYE, OR BILATERAL EYE TO THEIR CODE LISTING

- ENDOTHELIAL CORNEAL DYSTROPHY
- EPITHELIAL (JUVENILE) CORNEAL DYSTROPHY
- GRANULAR CORNEAL DYSTROPHY
- LATTICE CORNEAL DYSTROPHY
- MACULAR CORNEAL DYSTROPHY
- OTHER INHERITED CORNEAL DYSTROPHY

H18.5 Hereditary corneal dystrophies

H18.50 Unspecified hereditary corneal dystrophies

H18.501 Unspecified hereditary corneal dystrophies, right eye H18.502 Unspecified hereditary corneal dystrophies, left eye H18.503 Unspecified hereditary corneal dystrophies, bilateral

H18.509 Unspecified hereditary corneal dystrophies, unspecified eye

H18.5 CODE SERIES

H18.51 Endothelial corneal dystrophy

Fuchs' dystrophy

H18.511 Endothelial corneal dystrophy, right eye H18.512 Endothelial corneal dystrophy, left eye

H18.513 Endothelial corneal dystrophy, bilateral

H18.519 Endothelial corneal dystrophy, unspecified eye

H18.52 Epithelial (juvenile) corneal dystrophy

H18.521 Epithelial (juvenile) corneal dystrophy, right eye

H18.522 Epithelial (juvenile) corneal dystrophy, left eye H18.523 Epithelial (juvenile) corneal dystrophy, bilateral

H18.529 Epithelial (juvenile) corneal dystrophy, unspecified eye

H18.53 Granular corneal dystrophy

H18.531 Granular corneal dystrophy, right eye H18.532 Granular corneal dystrophy, left eye

H18.533 Granular corneal dystrophy, bilateral

H18.539 Granular corneal dystrophy, unspecified eye

H18.54 Lattice corneal dystrophy

H18.541 Lattice corneal dystrophy, right eye

H18.542 Lattice corneal dystrophy, left eye

H18.543 Lattice corneal dystrophy, bilateral

H18.549 Lattice corneal dystrophy, unspecified eye

H18.55 Macular corneal dystrophy

H18.551 Macular corneal dystrophy, right eye

H18.552 Macular corneal dystrophy, left eye

H18.553 Macular corneal dystrophy, bilateral

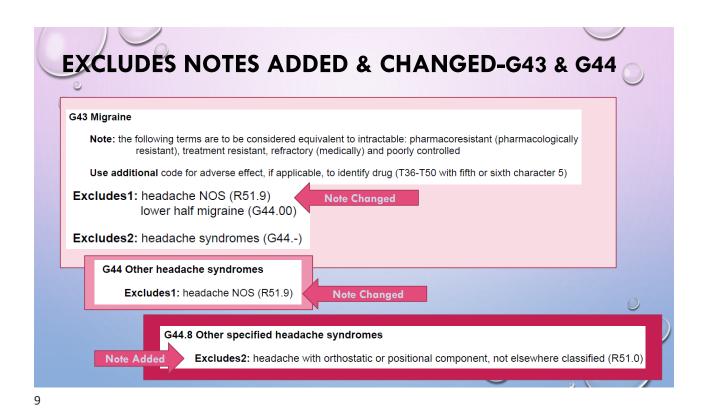
H18.559 Macular corneal dystrophy, unspecified eye

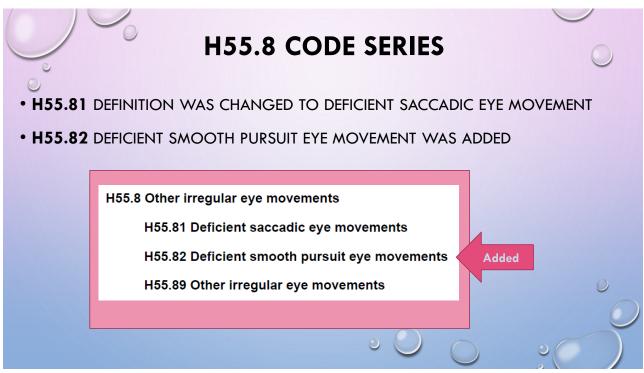
H18.59 Other hereditary corneal dystrophies

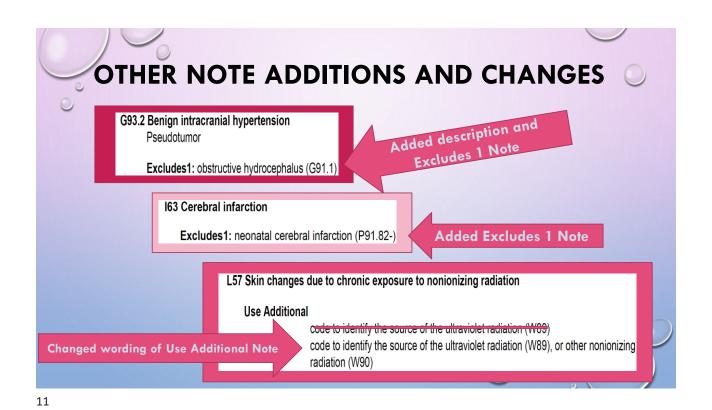
H18.591 Other hereditary corneal dystrophies, right eye H18.592 Other hereditary corneal dystrophies, left eye

H18.593 Other hereditary corneal dystrophies, bilateral

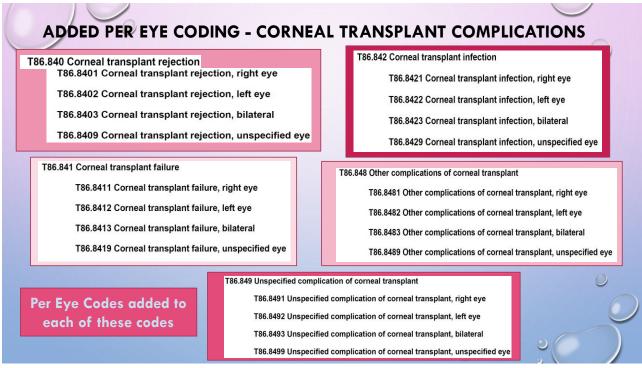
H18.599 Other hereditary corneal dystrophies, unspecified eye



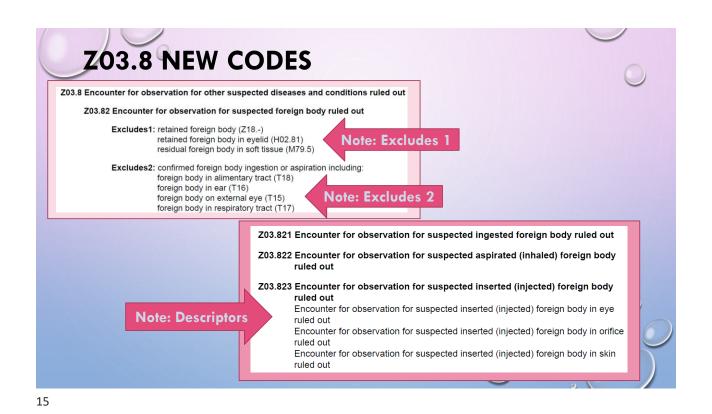


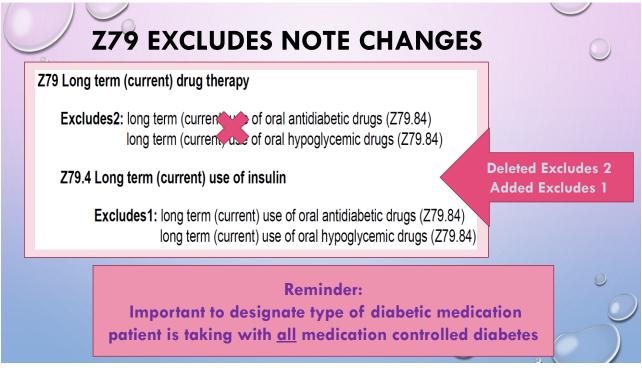


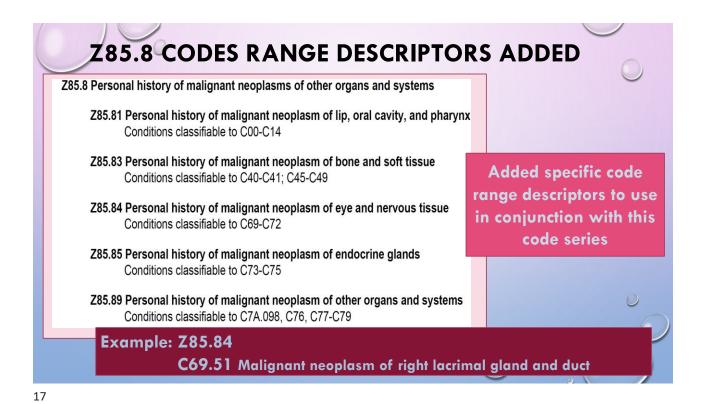
R51 CHANGES AND ADDITIONS R51 Headache Facial pain NOS Excludes1: atypical face pain (G50.1) ther headache syndromes (G43-G44) migraine a trigeminal et algia (G50.0) Added Excludes Excludes2: atypical face pain (G50.1) 2 Note migraine and other headache syndromes (G43-G44) trigeminal neuralgia (G50.0) R51.0 Headache with orthostatic component, not elsewhere classified Headache with positional component, not elsewhere classified R51.9 Headache, unspecified Added R51.0 and R51.9 Codes Facial pain NOS R52 Pain, unspecified Excludes1: headache (RoT) Revised headache (R51.9)



IMPORTANT CONTACT LENS ADVERSE INCIDENT CODE Y77 Ophthalmic devices associated with adverse incidents No Change Y77.1 Therapeutic (nonsurgical) and rehabilitative ophthalmic devices associated with adverse No Change incidents Y77.11 Contact lens associated with adverse incidents Add **ADDED** Rigid gas permeable contact lens associated with adverse incidents Add Soft (hydrophilic) contact lens associated with adverse incidents Add Y77.19 Other therapeutic (nonsurgical) and rehabilitative ophthalmic devices associated Add **ADDED** with adverse incidents VERY IMPORTANT FOR REPORTING ADVERSE CONTACT LENS INCIDENTS VITAL FOR OUR BATTLE AGAINST ILLEGAL **CONTACT LENS SALES**



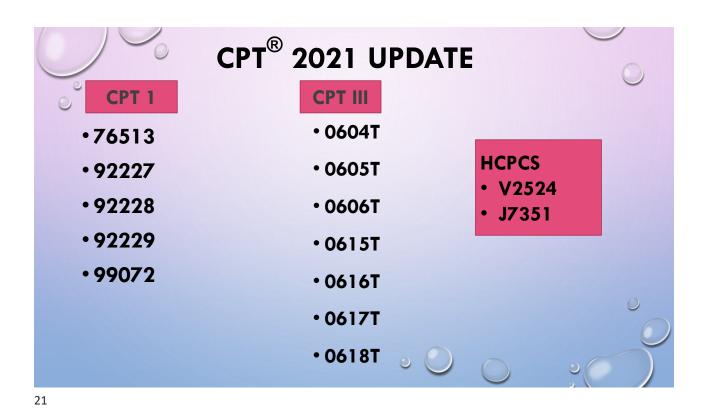


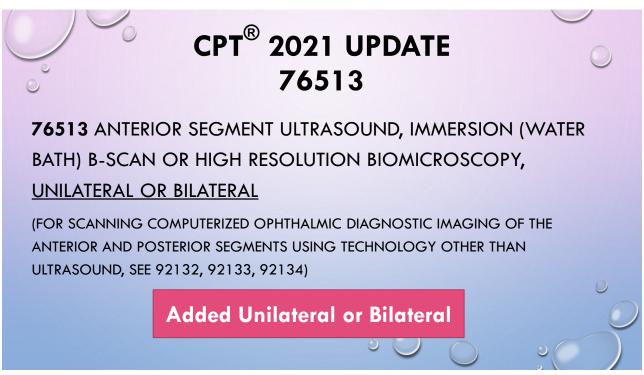


CHAPTER 22 Codes for special purposes (U00-U85) **NEW CHAPTER** This chapter contains the following blocks: U00-U49 Provisional assignment of new diseases of uncertain etiology or emergency use Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49) U07 Emergency use of U07 U07.0 Vaping-related disorder Dabbing related lung damage Dabbing related lung injury E-cigarette, or vaping, product use associated lung injury [EVALI] Electronic cigarette related lung damage Electronic cigarette related lung injury Use Additional code to identify manifestations, such as: abdominal pain (R10.84) acute respiratory distress syndrome (J80) U07.1 COVID-19 diarrhea (R19.7) drug-induced interstitial lung disorder (J70.4) Use Additional code to identify pneumonia or other manifestations lipoid pneumonia (J69.1) Excludes1: coronavirus infection, unspecified (B34.2) weight loss (R63.4) coronavirus as the cause of diseases classified elsewhere (B97.2-) pneumonia due to SARS-associated coronavirus (J12.81) Example: U07.1 **B30.8** Other viral Conjunctivitis



CPT 2021 CODE CHANGE OVERVIEW Added Deleted Revised 329 Evaluation and Management Services Total 0 0 0 Anesthesia 11 11 changes 2 6 Radiology Procedures Pathology and Laboratory Procedures 43 9 10,623 18 Medicine Services and Procedures 0 Category II Codes 0 Total codes Category III Codes 45 in 2021 PLA Codes 85 3 code set 206 **Grand Total**







CPT[®] 2021 UPDATE 92227,92228 REVISED

92227 IMAGING OF RETINA FOR DETECTION OR MONITORING OF DISEASE; WITH REMOTE CLINICAL STAFF REVIEW AND REPORT, UNILATERAL OR BILATERAL

<u>CPT CHANGES: AN INSIDER'S VIEW</u> 2011, 2017, 2020, 2021; <u>CPT ASSISTANT</u> FEB 11:7, MAY 11:9, OCT 12:9, JUL 16:9, AUG 19:11 (DO NOT REPORT 92227 IN CONJUNCTION WITH 92133, 92134, 92228, 92229, 92250)

92228 ;WITH REMOTE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL

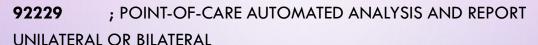
<u>CPT CHANGES</u>: <u>AN INSIDER'S VIEW 2011, 2017, 2021</u> <u>CPT ASSISTANT</u> FEB 11:7, MAY 11:9, OCT 12:9 (DO NOT REPORT 92228 IN CONJUNCTION WITH 92133, 92134, 92227, 92229, 92250)

Added Code 92229 to" Do Not Report With..."

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CPT[®] 2021 UPDATE 92229 NEW CODE



CPT CHANGES: AN INSIDER'S VIEW 2021

(DO NOT REPORT 92229 IN CONJUNCTION WITH 92133, 92134, 92227, 92228, 92250)B

92229 [IMAGING OF RETINA FOR DETECTION OR MONITORING OF DISEASE]; POINT-OF-CARE AUTOMATED ANALYSIS AND REPORT UNILATERAL OR BILATERAL

Essentially Artifical Intelligence Use for Remote Retinal Imaging
No Physician Work

AMA-CPT® using term Augmented Intelligence



CPT® CODE 99072 ACTIVE BEGINNING SEPTEMBER 8, 2020

99072 ADDITIONAL SUPPLIES, MATERIALS, AND CLINICAL STAFF TIME OVER AND ABOVE THOSE USUALLY INCLUDED IN AN OFFICE VISIT OR OTHER NON-FACILITY SERVICE(S), WHEN PERFORMED DURING A PUBLIC HEALTH EMERGENCY AS DEFINED BY LAW, DUE TO RESPIRATORY-TRANSMITTED INFECTIOUS DISEASE

(NATIONAL VALUATION = \$6.57 (WILL VARY BY INSURANCE AND GEOGRAPHIC AREA))

Used to report extra time required for such things as:

Patient symptom checks over the phone

Patient symptom checks upon arrival

Donning and removing personal protective equipment (PPE)

Increased sanitation measures to prevent the spread of communicable disease Only be reported when service is in non-facility place of service (POS) setting (11-office)

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CPT® CODE 99072 ACTIVE BEGINNING SEPTEMBER 8, 2020

- REPORT 99072 TO ALL PAYERS (DO NOT USE 99070 FOR THIS BILLING AT THIS TIME)
- REPORT ONCE PER PATIENT ENCOUNTER E&M OR PROCEDURE OR BOTH
- REPORT FOR <u>ALL PATIENTS</u> PRIVATE PAY, INSURANCE, VISION PLAN COVERAGE (WE DO NOT KNOW IF CMS WILL COVER FOR OFFICE VISITS AT THIS TIME)
- SOME PAYERS MAY NOT IMMEDIATELY REIMBURSE THESE COSTS BUT COULD REVISIT PAYMENT IN THE FUTURE SO, AGAIN, REPORT THIS CODE TO ALL PAYERS
- PATIENT BILLING FOR 99072 SHOULD BE DONE IN ACCORDANCE WITH PAYER CONTRACT
- BE <u>AWARE OF STATE LAW WITH REGARD TO CHARGING PATIENTS FOR PPE COSTS AS</u>
 SOME STATES CURRENTLY HAVE RESTRICTIONS IN PLACE FOR SUCH BILLING
- CONSIDER USING AN <u>ADVANCE NOTICE TO BENEFICIARY (ABN)</u> IF COVERAGE UNKNOWN

AOA working hard to solve any issues with this codes and claims being rejected rather than code payment being denied

EXISTING CPT® III CODES FOR EYE CARE

- 0100T PLACEMENT OF A SUBCONJUNCTIVAL RETINAL PROSTHESIS RECEIVER AND PULSE GENERATOR, AND IMPLANTATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY, WITH VITRECTOMY
- 0191T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE TRABECULAR MESHWORK; INITIAL INSERTION
- 0376T EACH ADDITIONAL DEVICE INSERTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0198T MEASUREMENT OF OCULAR BLOOD FLOW BY REPETITIVE INTRAOCULAR PRESSURE SAMPLING, WITH INTERPRETATION AND REPORT
- 0207T EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL
- 0563T EVACUATION OF MEIBOMIAN GLANDS, USING HEAT DELIVERED THROUGH WEARABLE, OPEN-EYE
 EYELID TREATMENT DEVICES AND MANUAL GLAND EXPRESSION, BILATERAL

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EXISTING CPT® III CODES FOR EYE CARE

- 0253T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE
- 0290T CORNEAL INCISIONS IN THE RECIPIENT CORNEA CREATED USING A LASER, IN PREPARATION
 FOR PENETRATING OR LAMELLAR KERATOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR
 PRIMARY PROCEDURE)
- 0308T INSERTION OF OCULAR TELESCOPE PROSTHESIS INCLUDING REMOVAL OF CRYSTALLINE LENS OR INTRAOCULAR LENS PROSTHESIS
- 0329T MONITORING OF INTRAOCULAR PRESSURE FOR 24 HOURS OR LONGER, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 0330T TEAR FILM IMAGING, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 0333T VISUAL EVOKED POTENTIAL, SCREENING OF VISUAL ACUITY, AUTOMATED, WITH REPORT
- O464T VISUAL EVOKED POTENTIAL, TESTING FOR GLAUCOMA, WITH INTERPRETATION AND REPORT



EXISTING CPT® III CODES FOR EYE CARE

- 0356T INSERTION OF DRUG-ELUTING IMPLANT (INCLUDING PUNCTAL DILATION AND IMPLANT REMOVAL WHEN PERFORMED) INTO LACRIMAL CANALICULUS, EACH
- 0378T VISUAL FIELD ASSESSMENT, WITH CONCURRENT REAL TIME DATA ANALYSIS AND ACCESSIBLE
 DATA STORAGE WITH PATIENT INITIATED DATA TRANSMITTED TO A REMOTE SURVEILLANCE CENTER
 FOR UP TO 30 DAYS; REVIEW AND INTERPRETATION WITH REPORT BY A PHYSICIAN OR OTHER
 QUALIFIED HEALTH CARE PROFESSIONAL
- 0379T TECHNICAL SUPPORT AND PATIENT INSTRUCTIONS, SURVEILLANCE, ANALYSIS, AND TRANSMISSION OF DAILY AND EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
- 0402T COLLAGEN CROSS-LINKING OF CORNEA, INCLUDING REMOVAL OF THE CORNEAL EPITHELIUM AND INTRAOPERATIVE PACHYMETRY, WHEN PERFORMED (REPORT MEDICATION SEPARATELY)
- 0444T INITIAL PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING FITTING, TRAINING, AND INSERTION, UNILATERAL OR BILATERAL
- 0445T SUBSEQUENT PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING RE-TRAINING, AND REMOVAL OF EXISTING INSERT, UNILATERAL OR BILATERAL

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EXISTING CPT® III CODES FOR EYE CARE

- **0449T** INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; INITIAL DEVICE
- 0450T EACH ADDITIONAL DEVICE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0469T RETINAL POLARIZATION SCAN, OCULAR SCREENING WITH ON-SITE AUTOMATED RESULTS, BILATERAL
- 0472T DEVICE EVALUATION, INTERROGATION, AND INITIAL PROGRAMMING OF INTRAOCULAR RETINAL ELECTRODE ARRAY (EG, RETINAL PROSTHESIS), IN PERSON, WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST FUNCTIONALITY, SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, INCLUDING VISUAL TRAINING, WITH REVIEW AND REPORT BY A QUALIFIED HEALTH CARE PROFESSIONAL
- 0473T DEVICE EVALUATION AND INTERROGATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY (EG, RETINAL PROSTHESIS), IN PERSON, INCLUDING REPROGRAMMING AND VISUAL TRAINING,
- 0474T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITH CREATION OF INTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACILIARY SPACE HEN PERFORMED, WITH REVIEW AND REPORT BY A QUALIFIED HEALTH CARE PROFESSIONAL



- 0506T MACULAR PIGMENT OPTICAL DENSITY MEASUREMENT BY HETEROCHROMATIC FLICKER PHOTOMETRY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 0507T NEAR-INFRARED DUAL IMAGING (IE, SIMULTANEOUS REFLECTIVE AND TRANSILLUMINATED LIGHT) OF MEIBOMIAN GLANDS, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 0509T ELECTRORETINOGRAPHY (ERG) WITH INTERPRETATION AND REPORT, PATTERN (PERG)
- 0514T INTRAOPERATIVE VISUAL AXIS IDENTIFICATION USING PATIENT FIXATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0552T LOW-LEVEL LASER THERAPY, DYNAMIC PHOTONIC AND DYNAMIC THERMOKINETIC ENERGIES, PROVIDED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

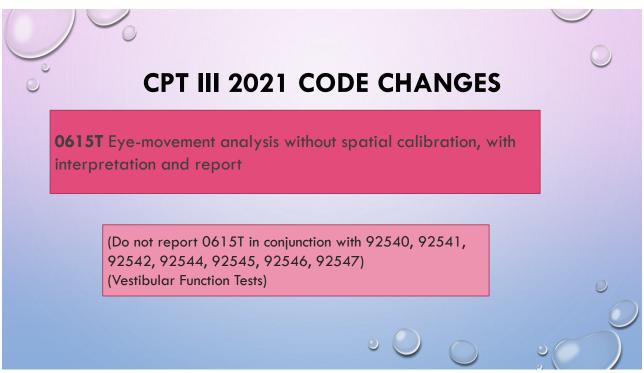
CPT III 2021 CODE CHANGES

0604T Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment

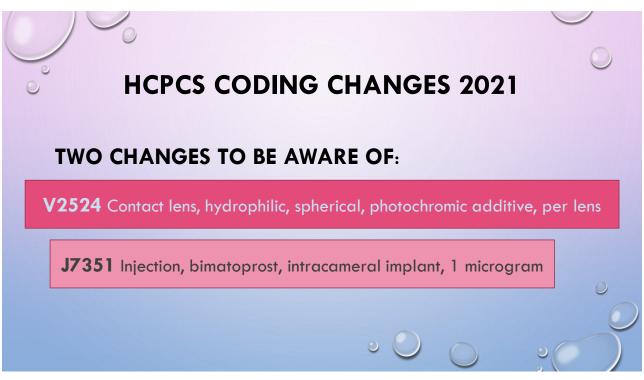
0605T ;remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days

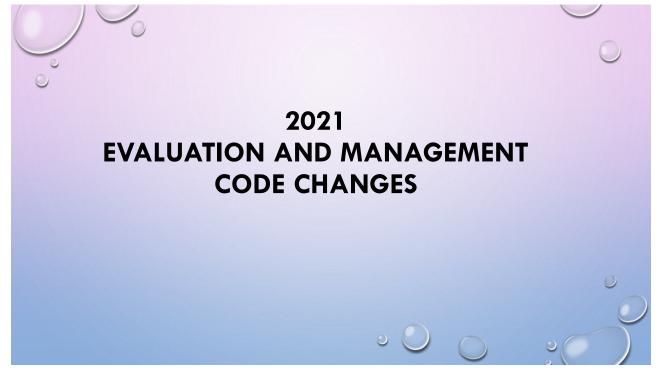
0606T ;review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days

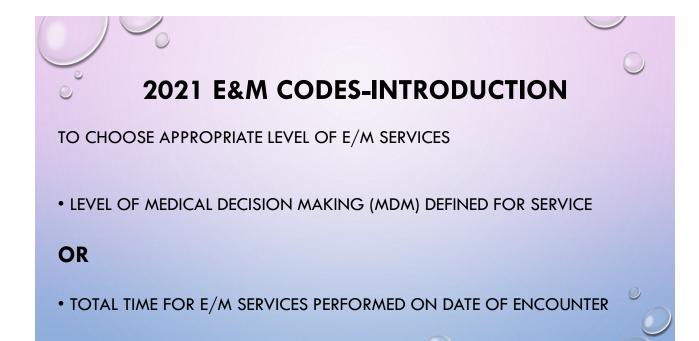
(Do not report 0604T, 0605T, 0606T in conjunction with 99457, 99458)
Remote Physiological Monitoring











2021 E&M CODES-INTRODUCTION WHY CHANGE NOW? • PHYSICIANS STRUGGLING WITH BURDENSOME REPORTING GUIDELINES • ELECTRONIC HEALTH RECORDS (EHRS) INCREASED "NOTE BLOAT" IN PATIENT RECORDS • CMS PROPOSED CHANGES TO E&M REIMBURSEMENT AND CHALLENGE TO REVISE GUIDELINES

2021 E&M CODES-INTRODUCTION

GOALS:

- DECREASE ADMINISTRATIVE BURDEN OF DOCUMENTATION/CODING
- DECREASE AUDIT NECESSITY BY ADDING AND EXPANDING KEY DEFINITIONS/GUIDELINES
- DECREASE DOCUMENTATION IN MEDICAL RECORD NOT NECESSARY FOR PATIENT CARE
- PROMOTE RESOURCE BASED PAYMENT
- NOT GOAL FOR PAYMENT REDISTRIBUTION BETWEEN SPECIALTIES

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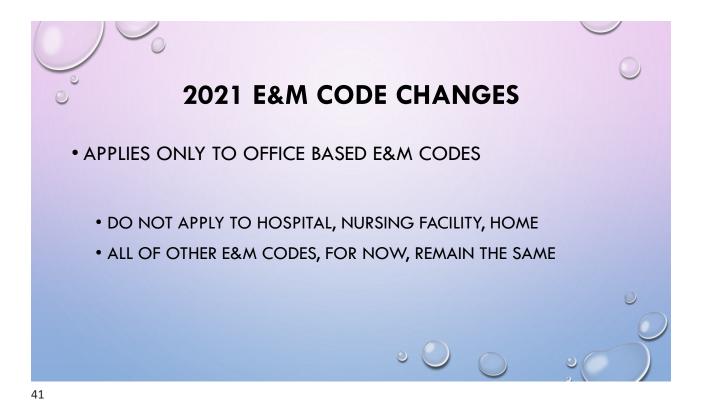
2021 E&M CODES-SUMMARY OF CHANGES

- APPLIES ONLY TO OFFICE BASED E&M CODES
- DELETION OF CODE 99201
- REVISED CODES 99202–99205, 99211–99215
- CHANGED CODE SELECTION COMPONENTS USED TO:

MEDICAL DECISION MAKING (MDM) OR TIME (WAS HISTORY, EXAMINATION, MDM, AND TIME)

- CHANGED DEFINITION OF MDM AND TIME COMPONENTS
- ADDED NEW, SHORTER PROLONGED SERVICES CODE
- MANY E & M GUIDELINE ADDITIONS, REVISIONS, AND RESTRUCTURING





2021 E&M CODE CHANGES

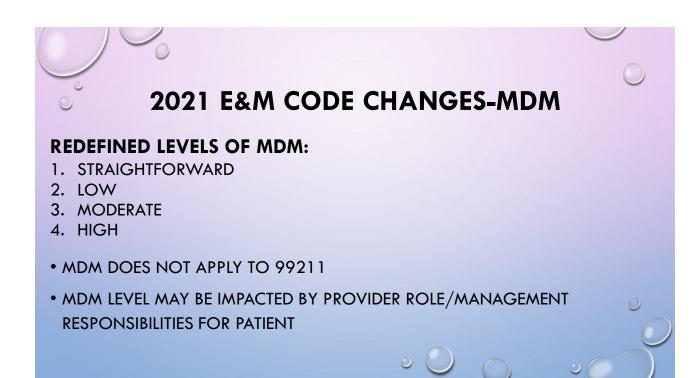
WHY DELETION OF 99201

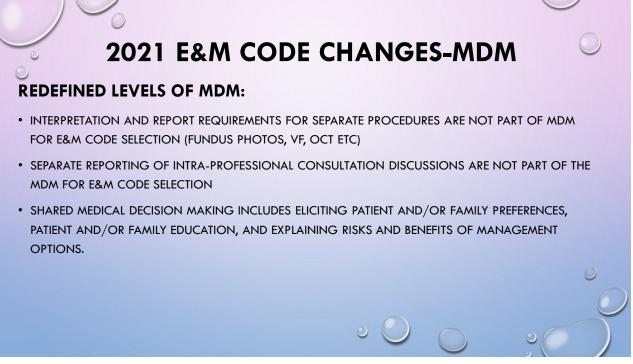
• CURRENT 99201-99202 HAD STRAIGHTFORWARD MEDICAL DECISION MAKING

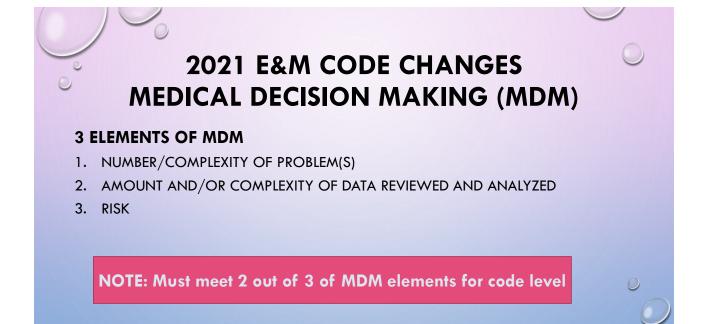
• DIFFERENTIATED ONLY BY HISTORY AND EXAMINATION LEVELS

• HISTORY/EXAMINATION COMPONENTS WILL NOT BE RELEVANT TO CODE CHOICE

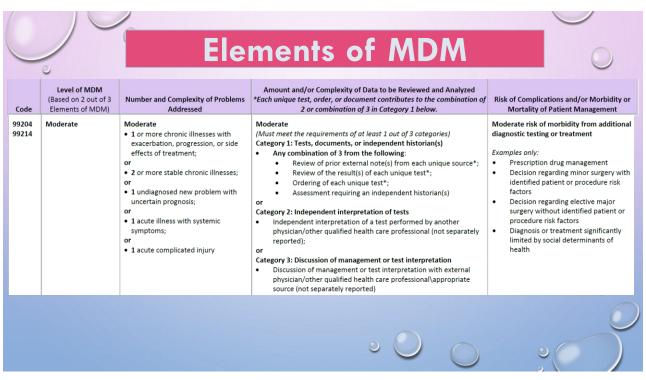
THUS, DUPLICATION OF CODES IF DID NOT ELIMINATE 92201

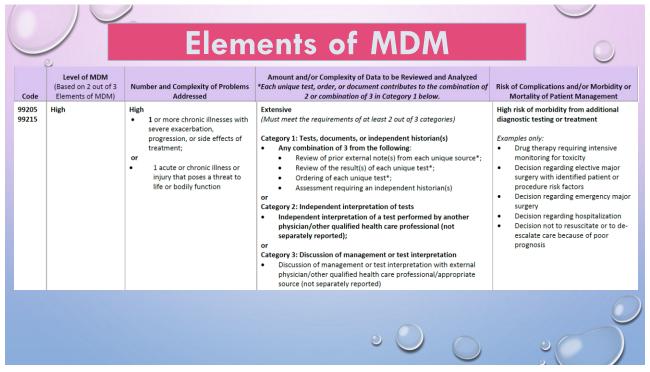






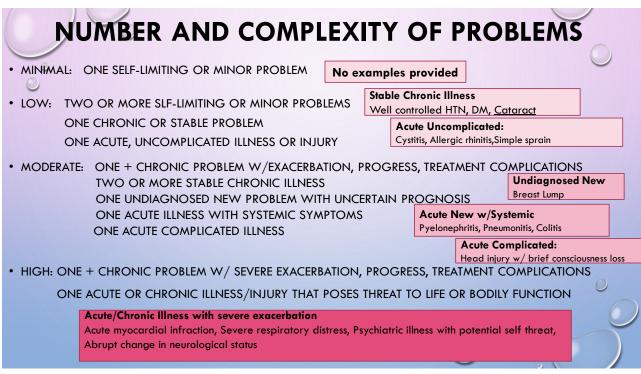
0		Elen	nents of MDM	
Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (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) (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





TY	PE OF DECIS NOTE: Must meet 2 of	out of 3 of MDM ele	ements for code level	P
		Applies to new a	nd established patients at each c	ode level
# Diagnoses/ Management Options	Amount/ Complexity Data Reviewed	Risk: Complications Morbidity Mortality	Decision Making type	
Minimal	Minimal or none	Minimal	Straightforward	99202 99212
Limited	Limited	Low	Low complexity	99203 99213
Multiple	Moderate	Moderate	Moderate complexity	99204 99214
Extensive	Extensive	High	High complexity	99205 99215







DATA COMPLEXITY

Extensive (At least 2 of 3 categories)

Category 1: Test documents or independent historian

(any combination of 3 for category 1)

- 1. Review of prior external notes from unique source
- 2. Review results of each unique test
- 3. Ordering of each unique test
- 4. Assessment requiring an independent historian

Category 2: Independent interpretation of tests

Independent interpretation of test performed by another physician/QHP (not separately reported)

Category 3: Discussion of management or test Interpretation

Discussion of management or test interpretation with external physician/QHP – appropriate source (not reported separately)

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DATA COMPLEXITY

CAN THE INDEPENDENT VISUALIZATION OF A TEST BE COUNTED IN THE MEDICAL DECISION WAKING IF THE PHYSICIAN IS ALSO BILLING FOR THE TEST?

- PER AMA, ACTUAL PERFORMANCE AND/OR INTERPRETATION OF DIAGNOSTIC TESTS/STUDIES
 DURING PATIENT ENCOUNTER ARE NOT INCLUDED IN DETERMINING LEVEL OF E/M SERVICE WHEN
 REPORTED SEPARATELY
- PHYSICIAN PERFORMANCE OF DIAGNOSTIC TESTS/STUDIES FOR WHICH SPECIFIC CPT CODES ARE AVAILABLE MAY BE REPORTED SEPARATELY, IN ADDITION TO THE APPROPRIATE E/M CODE
- PHYSICIAN'S INTERPRETATION OF RESULTS OF DIAGNOSTIC TESTS/STUDIES (I.E., PROFESSIONAL COMPONENT) WITH PREPARATION OF SEPARATE DISTINCTLY IDENTIFIABLE SIGNED WRITTEN REPORT MAY ALSO BE REPORTED SEPARATELY, USING APPROPRIATE CPT CODE AND, IF REQUIRED, WITH MODIFIER 26 APPENDED.

If test/study is independently interpreted in order to manage patient - as part of E/M service but is not separately reported - then is part of medical decision making.





RISK LEVELS DEFINED

- I MINIMAL RISK OF MORTALITY FROM ADDITIONAL DIAGNOSTIC TESTING OR TREATMENT
- 2. LOW RISK OF MORTALITY FROM ADDITIONAL DIAGNOSTIC TESTING OR TREATMENT
- 3. MODERATE RISK OF MORTALITY FROM ADDITIONAL DIAGNOSTIC TESTING OR TREATMENT
- 4. HIGH RISK OF MORTALITY FROM ADDITIONAL DIAGNOSTIC TESTING OR TREATMENT

Risk

- a) Complications, morbidity, mortality of patient management decisions made at the visit
- b) Associated patient's problem(s)
- c) Diagnostic procedure(s) and treatment(s)
- d) Possible management options selected and those considered, but not selected
- e) Includes shared medical decision making with the patient and/or family

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RISK LEVEL EXAMPLES

Minimal Risk: No Examples

Low Risk: No Examples

Moderate Risk Examples:

Prescription drug management

Decision-minor surgery with patient/procedure risk factors identified

Decision-major surgery with patient/procedure risk factors identified

Diagnosis or treatment significantly limited by social determinants of health

High Risk Examples:

Drug therapy requiring intensive monitoring for toxicity

Decision-elective major surgery with patient/procedure risk factors identified

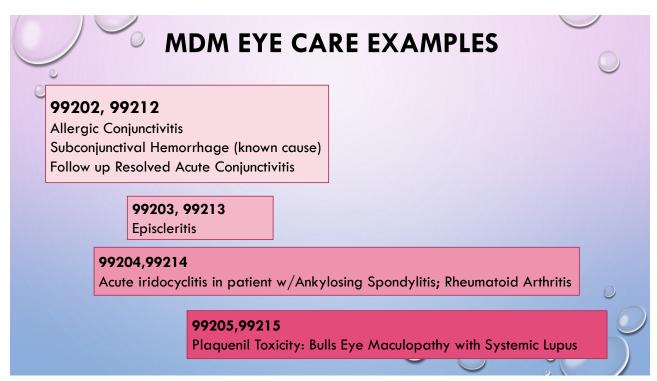
Decision-emergency major surgery

Decision regarding hospitalization

Decision to Not resuscitate or de-escalate care due to poor prognosis



	SU	MMARY C	F EACH	I LEVEL - M	NDM	
O Co	ode	MDM	Problems	Data	Risk	
99	211	NA	NA	NA	NA	
99	202	Straightforward	Minimal	Minimal/None	Minimal	
99	212	Straightforward	Minimal	Minimal/None	Minimal	
99	203	Low	Low	Limited (1/2)	Low	
99	213	Low	Low	Limited (1/2)	Low	
99	204	Moderate	Moderate	Moderate (1/3)	Moderate	
99	214	Moderate	Moderate	Moderate (1/3)	Moderate	
99	205	High	High	Extensive (2/3)	High	
99	215	High	High	Extensive $(2/3)$	High	
	N		out of 3 of MDM oblem • Data •	l elements for code l Risk	evel	
Applies to New and Established Patients for each code level						



2021 E&M CODE CHANGES -TIME

- BEFORE 1992 TIME WAS IMPLICIT IN CODE DEFINITIONS
- IN 1992 TIME BECAME EXPLICIT IN CODE DEFINITIONS
- BEFORE 2021, TIME COULD ONLY BE USED WHEN COUNSELING/CARE COORDINATION DETERMINED CODE LEVEL

BEGINNING IN 2021

- TIME CAN BE USED FOR CODE LEVEL SELECTION INDEPENDENT OF COUNSELING AND/OR COORDINATION
 OF CARE PORTION OF SERVICE
- TOTAL TIME SPENT BY THE PHYSICIAN/QHP ON THE DAY OF ENCOUNTER
- TIME IS SPECIFICALLY DEFINED IN EACH E&M SERVICE DESCRIPTOR
- TIME GUIDELINES REQUIRE FACE-TO-FACE ENCOUNTER WITH PROVIDER
- IF PROVIDER TIME IS <u>ONLY</u> SPENT IN CLINICAL STAFF SUPERVISION AND CLINICAL STAFF PERFORM SERVICE → USE 99211

2021 E&M CODE CHANGES -TIME

PROVIDER TIME INCLUDES:

TIME DOES NOT INCLUDE STAFF TIME

- 1. Preparing to see patient like review of tests
- 2. Obtaining and/or reviewing separately obtained history
- 3. Performing medically appropriate examination and/or evaluation
- 4. Counseling and educating the patient/family/caregiver
- 5. Ordering medications, tests, or procedures
- 6. Referring/communicating with other health care professionals not separately reported
- 7. Documenting clinical information in electronic or other health record
- 8. Independently interpreting results-not separately reported -and communicating results to the patient/family/caregiver
- 9. Care coordination when not separately reported

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2021 E&M CODE CHANGES -TIME Code Time 99211 Not application 99202 15-29 minutes 99212 10-19 minutes **MUST DOCUMENT TIME SPENT** 99203 30-44 minutes IN MEDICAL RECORD 20-29 minutes 99213 99204 45-59 minutes 99214 30-39 minutes 99205 60-74 minutes 99215 40-54 minutes



99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time

(List separately in addition to codes 99205, 99215 for office or other outpatient E&M services) (Use 99417 in conjunction with 99205, 99215)

(Do not report 99417 on same date of service as 99354, 99355, 99358, 99359, 99415, 9416) (Do not report 99417 for any time unit less than 15 minutes)

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PROLONGED SERVICE CODING

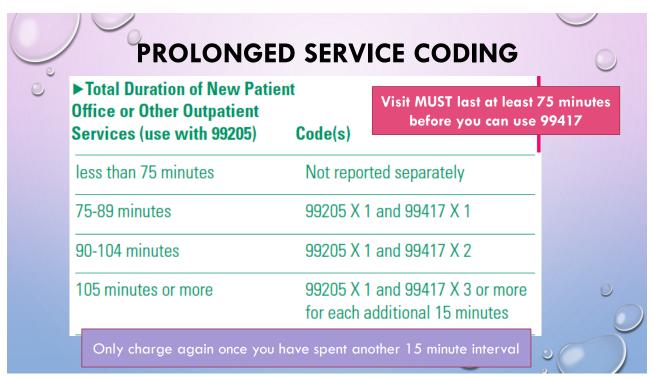
99417 IS ONLY USED WHEN THE OFFICE OR OTHER OUTPATIENT SERVICE HAS
BEEN SELECTED USING TIME ALONE AS THE BASIS AND ONLY AFTER THE MINIMUM
TIME REQUIRED TO REPORT THE HIGHEST-LEVEL SERVICE

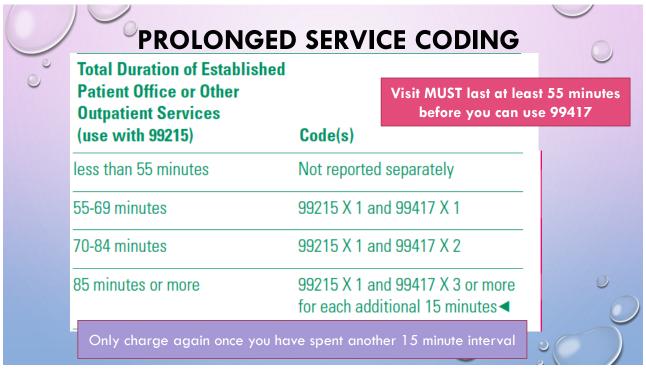
THIS MEANS 99205 OR 99215 TIME HAS BEEN EXCEEDED BY 15 MINUTES

TO REPORT A UNIT OF 99417, 15 MINUTES OF ADDITIONAL TIME MUST HAVE BEEN ATTAINED

DO NOT REPORT 99417 FOR ANY ADDITIONAL TIME INCREMENT OF LESS THAN 15 MINUTES







PROLONGED CLINICAL STAFF SERVICES

99415 PROLONGED CLINICAL STAFF SERVICE (THE SERVICE BEYOND THE TYPICAL SERVICE TIME) DURING AN EVALUATION AND MANAGEMENT SERVICE IN THE OFFICE OR OUTPATIENT SETTING, DIRECT PATIENT CONTACT WITH PHYSICIAN SUPERVISION; FIRST HOUR

(LIST SEPARATELY IN ADDITION TO CODE FOR OUTPATIENT EVALUATION AND MANAGEMENT SERVICE) (USE 99415 IN CONJUNCTION WITH 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)

(DO NOT REPORT 99415 IN CONJUNCTION WITH 99354, 99355, 99XXX)

99416 ;EACH ADDITIONAL 30 MINUTES

(LIST SEPARATELY IN ADDITION TO CODE FOR PROLONGED SERVICE)
(USE 99416 IN CONJUNCTION WITH 99415)
(DO NOT REPORT 99416 IN CONJUNCTION WITH 99354, 99355, 99XXX)

Requires <u>Direct Physician</u>
<u>Supervision</u>

Bill only Once per day

Clinical Staff Time does not have to be continous

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PROLONGED CLINICAL STAFF SERVICES

		Requires Direct Physic
Total Duration of Prolonged Services	Code(s)	<u>Supervision</u>
less than 45 minutes	Not reported s	eparately
45-74 minutes (45 minutes - 1 hr. 14 min.)	99415 X 1	
75-104 minutes (1 hr. 15 min 1 hr. 44 min.)	99415 X 1 AN	ND 99416 X 1
105 or more (1 hr. 45 min. or more)	99415 X 1 AN or more for ea 30 minutes.	

PROLONGED E&M BEFORE/AFTER DIRECT PATIENT CARE

Used for prolonged services on <u>date other than date of</u>
<u>face-to face encounter</u>

99358 PROLONGED EVALUATION AND MANAGEMENT SERVICE BEFORE AND/OR AFTER DIRECT PATIENT CARE; FIRST HOUR

99359 ;EACH ADDITIONAL 30 MINUTES

- (LIST SEPARATELY IN ADDITION TO CODE FOR PROLONGED SERVICE)
- (USE 99359 IN CONJUNCTION WITH 99358)
- (DO NOT REPORT 99358, 99359 ON THE SAME DATE OF SERVICE AS 99XXX)
- (DO NOT REPORT 99358, 99359 DURING THE SAME MONTH WITH 99484, 99487-99489, 99490, 99491, 99492, 99493, 99494)
- (DO NOT REPORT 99358, 99359 WHEN PERFORMED DURING THE SERVICE TIME OF CODES 99495 OR 99496, IF REPORTING 99495 OR 99496)

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PROLONGED E&M BEFORE/AFTER DIRECT PATIENT CARE

EXAMPLE: EXTENSIVE RECORD REVIEW MAY RELATE TO PREVIOUS E&M SERVICE PERFORMED AT AN EARLIER DATE

- 1. <u>MUST RELATE TO SERVICE OR PATIENT WHERE (FACE-TO-FACE) PATIENT CARE HAS</u>
 OCCURRED OR WILL OCCUR AND RELATE TO ONGOING PATIENT MANAGEMENT
- 99358 AND 99359 ARE USED TO REPORT TOTAL DURATION OF NON-FACE-TO-FACE TIME SPENT BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL ON A GIVEN DATE
- 3. PROVIDING PROLONGED SERVICE, EVEN IF NOT CONTINUOUS TIME
- 4. DO NOT REPORT 99358, 99359 FOR TIME WITHOUT DIRECT PATIENT CONTACT REPORTED IN OTHER SERVICES

PROLONGED E&M BEFORE/AFTER DIRECT PATIENT CARE

99358 USED TO <u>REPORT 1 ST HOUR OF PROLONGED SERVICE</u> ON GIVEN DATE REGARDLESS OF PLACE OF SERVICE

- REPORT ONLY ONCE PER DATE
- PROLONGED SERVICE < 30 MINUTES TOTAL DURATION ON GIVEN DATE NOT SEPARATELY REPORTED

99359 used to report each additional 30 minutes after 1st Hour

Used to report final 15-30 minutes of prolonged service on a given date)

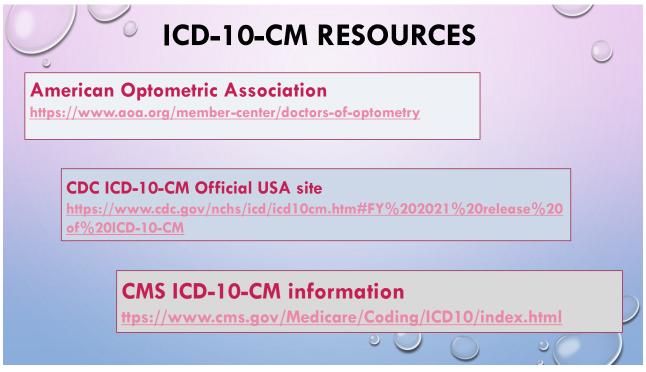
Prolonged service of <15 minutes beyond 1st Hr or <15 minutes beyond final 30 minutes not separately reported

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PROLONGED E&M BEFORE/AFTER DIRECT PATIENT CARE

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	Code(s)	
less than 30 minutes	Not reported separately	
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1	
75-104 minutes (1 hr. 15 min 1 hr. 44 min.)	99358 X 1 AND 99359 X 1	C
105 or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes.	

Code Patient Co	ntact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use In Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service	
99358 Non-Face-t	o-Face Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99205, 99212-99215, 99417 On same date of service	99354, 99356	
▶99359 Non-Face-to	o-Face Only	Each additional 15 minutes (Beyond 99358)	99358	99202-99205, 99212-99215, 99417 On same date of service	99354, 99356	
Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-to-Face-t		Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A	
		(Total time on the date of encounter)				
*Do not count the time of any separately reported service as prolonged services time 99355 is for prolonged services time beyond 99354 and may be reported in multiple units 99357 is for prolonged services time beyond 99356 and may be reported in multiple units 99359 is for prolonged services time beyond 99358 and may be reported in multiple units 99417 is for prolonged services time beyond 99205 or 99215 and may be reported in multiple units of at least 15 minutes ■						





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