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2021 Evaluation and Management Coding Changes and Split/Shared Evaluation and Management Services

Allison Hirschorn
Associate Director, Coverage and Reimbursement
Care Delivery Department

Georgia Society of Clinical Oncology

Administration and Business of Oncology Meeting

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Topics Covered

2021 E/M Coding Changes

- Overview of the changes.
- Technical corrections and clarifications.
- Common errors.

Split/Shared E/M Services

- CMS definitions and guidelines in 2022 vs. 2023.

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2021 Evaluation and Management Changes- Refresh and Updates

Office/Outpatient Evaluation and Management Services

Codes selected based on time or medical decision making.

Changes effective January 1, 2021

Time is defined in ranges rather than “typical” times.

New CPT and HCPCS code for a prolonged service of 15 minutes in the office/outpatient setting.

Inpatient, Observation, Discharge, and Consultation Evaluation and Management Services

Inpatient/Observation, Discharge, and Consultation E&M Visits	
2021-2022	**2023**
• Based on history, exam, and MDM. • More than 50% of time spent on coordination and care.	• MDM or Time. • Total time counted. • Includes face-to-face and non-face-to-face activities.

Time: Face- to- Face and Non-Face to Face Activities

Preparing to see the patient (e.g., review of tests).
Obtaining and/or reviewing separately obtained history.
Ordering medications, tests, procedures.
Referring and communicating with other health care professionals (when not separately reported).
Documenting clinical information in the electronic or other health record.
Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
Care coordination (not separately reported).

Elements of Medical Decision Making

Number and complexity of problems addressed.

Amount and complexity of data to be reviewed and analyzed.

Risk of complications and/or morbidity or mortality of patient management.

To select the appropriate E/M code, **two** of the three elements of medical decision making must be met or exceeded.

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: 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.*	Elements of Medical Decision Making: 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**
99204 99214	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 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(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**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
99205 99215	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 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(s) **or** **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of 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

Prolonged Services: New Codes

CPT ® Code 99417	HCPCS Code G2212
Code Description ▪ Prolonged office or other outpatient evaluation and management service(s) (beyond the **minimum** total time of the primary procedure selected based on time (either CPT code 99205 or 99215). ▪ Reported for each 15-minute unit of service. ▪ May not be reported with Prolonged Services With Direct Patient Contact, Prolonged Services Without Direct Patient Contact, or Prolonged Clinical Staff Services. ▪ Reportable to **private payers only**, unless directed to use HCPCS code G2212.	**Code Description** ▪ Prolonged office or other outpatient evaluation and management service(s) beyond the **maximum** required time of the primary procedure selected based on time (either CPT code 99205 or 99215). ▪ Reported for each 15-minute unit of service. ▪ May not be reported with Prolonged Services With Direct Patient Contact, Prolonged Services Without Direct Patient Contact, or Prolonged Clinical Staff Services. ▪ **Reportable to CMS only**, unless otherwise advised by a private payer. ▪ Included in the Medicare Telehealth list.

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2021 Evaluation and Management Changes: Technical Corrections and Clarifications

Technical Corrections to the Guidelines

Activities that do not count towards time.

Clarifications on risk and complexity of conditions.

Clarification on what is considered a “unique” test.

Defining the term “analyzed.”

Combining and counting data elements.

Defining “discussion.”

Obtaining information from an independent historian.

Defining surgery types.

Time: Activities Not Included

- The performance of other services that are reported separately.
- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.
- Activities not done on the date of the encounter.

Risk and Complexity of Conditions

- Symptoms may lead to higher complexity than the final diagnosis due to evaluation and testing required to reach that diagnosis.

- Condition risk ≠ management risk
  - Risk of complications/morbidity of patient management refers to **risk associated from testing or treatment**.

    Example: Patient with cardiac history will not have the same level of risk with paclitaxel than a patient without cardiac history.

Unique Tests

- A unique test is defined by the CPT set.
- Multiple results of the same test count as one unique test.
- Tests that have overlapping elements are not unique, even if they have distinct CPT codes.

Example

One Unique Test

80050- General health panel

- Comprehensive metabolic panel (80053)
- Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)
- Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
- Thyroid stimulating hormone (TSH) (84443)

Defining “Analyzed”

Analyzed is “the process of using the data as part of the MDM”.

Tests are:
Presumed to be analyzed when results are reported if included in thought process.
Count when ordered unless ordered outside of encounter.
Counted on the encounter in which they were analyzed if recurring or ordered outside the encounter.
Not counted if separately reported.

Defining "Analyzed"

Presumed to be analyzed

At the doctor's visit, Dr. A ordered a CBC and noticed Bruno's hemoglobin is low. Because of the result, he orders a transfusion and will postpone the scheduled chemotherapy by a week.

The hemoglobin was not analyzed since the result is not dependent on interpretation. It would be counted as one data element since it has taken into account for medical decision making.

Outside of encounter

Debra saw her oncologist on Thursday. The following Tuesday, she started running a fever, but she lives an hour away from the office. The doctor ordered labs to be drawn in her hometown, and she will be seen the next day.

The labs will count as data elements when the results are analyzed at the next visit.

Recurring order

A CBC is ordered at an encounter as a recurring order through course of treatment.

The test will be counted as ordered and reviewed at the initial encounter.

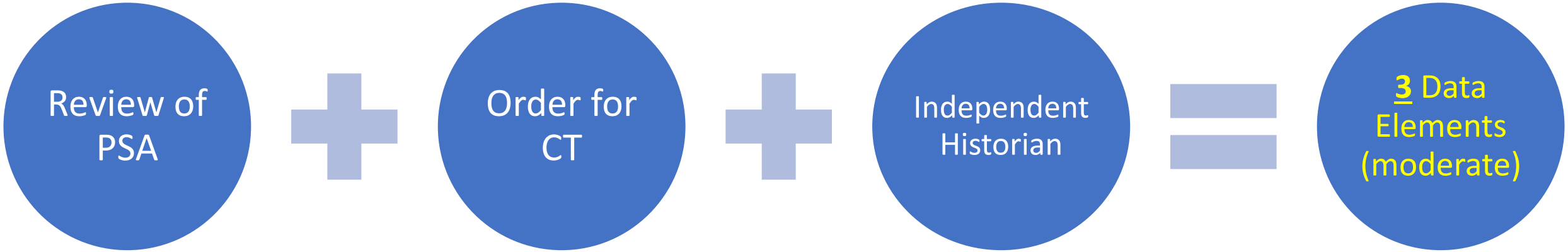
Subsequent results for the recurring order are analyzed at future encounters and will count for a single test on the encounter in which it was analyzed.

Combining and Counting Data Elements

- A combination of different data elements allows these elements to be summed.
- Does **not** require each item type or category to be represented.

Combining and Counting Data Elements

Example: A patient with prostate cancer is seen. The physician reviews the latest PSA. At the visit, the patient states that he has no complaints. However, the patient's wife reports the patient is experiencing considerable pain in the hip. Considering this, the doctor orders a CT of the abdomen & pelvis to check for progression.



Defining “Discussion”

Discussions are

- Interactive.
- Provider to provider.
- In a short timeframe after a visit.
- Counted once.
- Used in the decision-making process.

Discussions are not

- Notes/exchanges within progress notes.
- Always on the date of encounter.
- Required to be in person.

Independent Historian

"An individual (e.g., 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 (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary."

AMA CPT® Professional Edition 2022
Number and Complexity of Problems Addressed at the Encounter

Independent Historian

Does not need to be in person.

Must be obtained directly from the historian providing information.

Document **who** the historian is and **why** their history is required.

Surgery Types

Elective

Planned in advance

Emergent

Performed immediately or with minimal delay

- Includes minor or major procedures.
- Defined by common meaning NOT surgical package classification.
- Risk factors are relevant to patient and procedure.
- Evidence-based risk calculators may be used in assessing risk (not required).

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Common Errors

Counting time

- Do not count time that is not on the date of service, i.e., chart prep the day before the encounter.

Cancer = High Complexity

- Cancer does not always constitute a high level of complexity
- The current condition must pose an acute threat to life or bodily function (i.e., consideration of admission).

Intensive Monitoring for Toxicity

- A chemotherapy patient requiring labs before chemotherapy does not necessarily constitute drug therapy requiring intensive monitoring for toxicity.
- If the testing is to check for therapeutic efficacy or is routine in nature, the monitoring does not meet criteria.
- The drug in question must have risk of serious morbidity or death.

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Split/Shared E/M Services

Centers for Medicare and Medicaid Services
2022 MPFS Final Rule: Split/Shared Services

Definition of split (or shared) E/M visits.

Defining substantive portion of the visit in 2022 and 2023.

New patients and initial E/M services.

Split/shared services modifier.

Documentation of a split/shared service.

Definition of Split/Shared Services

A split (or shared) visit refers to an E/M visit that is performed ("split" or "shared") by both a physician and an NPP who are in the same group.

Non-Physician Practitioners (NPP): Nurse Practitioner (NP), Physician's Assistant (PA), Clinical Nurse Specialist (CNS)

Setting for Split/Shared Services

Facility/Institutional Setting- A setting in which payment for services and supplies furnished "incident to" a physician or practitioner's professional services **is prohibited**.

Split/shared rules are not applicable in an **office setting** as incident to rules apply.

Place of service codes:
Inpatient facility (POS 21)
Emergency Department (POS 23)
Outpatient On Campus (POS 22)
Outpatient Off Campus (POS 19)

Do not report a split/shared service for POS 11 (Office).

Practitioner Distinct Time

Only distinct time may be counted toward determining the substantive part of the visit (the time spent *separately* by each practitioner on the service).

If the practitioners jointly meet with or discuss the patient, the time may only be attributed to the practitioner who performed the *substantive* part of the visit.

Services for New Patient and Initial E/Ms

Split/shared services may now be provided to **new and initial** E/M services, *in addition to* established and subsequent services.

Definition of "Substantive Portion"

CMS Definition of Substantive Portion	
2022	**2023**
▪ Two options (select one): A. <u>One</u> of the three key components (history, exam, or MDM). The component must be performed in its entirety by the billing practitioner. **OR** B. More than half of the total time spent by the physician and NPP performing the split (or shared) visit. ▪ One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner).	▪ More than half of the total time spent by the physician and NPP performing the split (or shared) visit. ▪ One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner). ▪ The substantive portion could be entirely with OR without direct patient contact (face to face or non face to face activities).

Why is the definition of “substantive portion” changing in 2023?

2022	
Office/Outpatient E/M Services	**Inpatient and Observation E/M Services**
Time OR Medical Decision Making.	Key components: History, Exam, or Medical Decision Making.

2023	
Office/Outpatient E/M Services	**Inpatient and Observation E/M Services**
Time OR Medical Decision Making.	

Time in 2022 vs. 2023

2022 Inpatient Hospital and Observation Services

- Time is defined as “typical” time.
- Fifty percent of the service must be spent on counseling or coordination of care to report based on time.
- Face to face activities only.

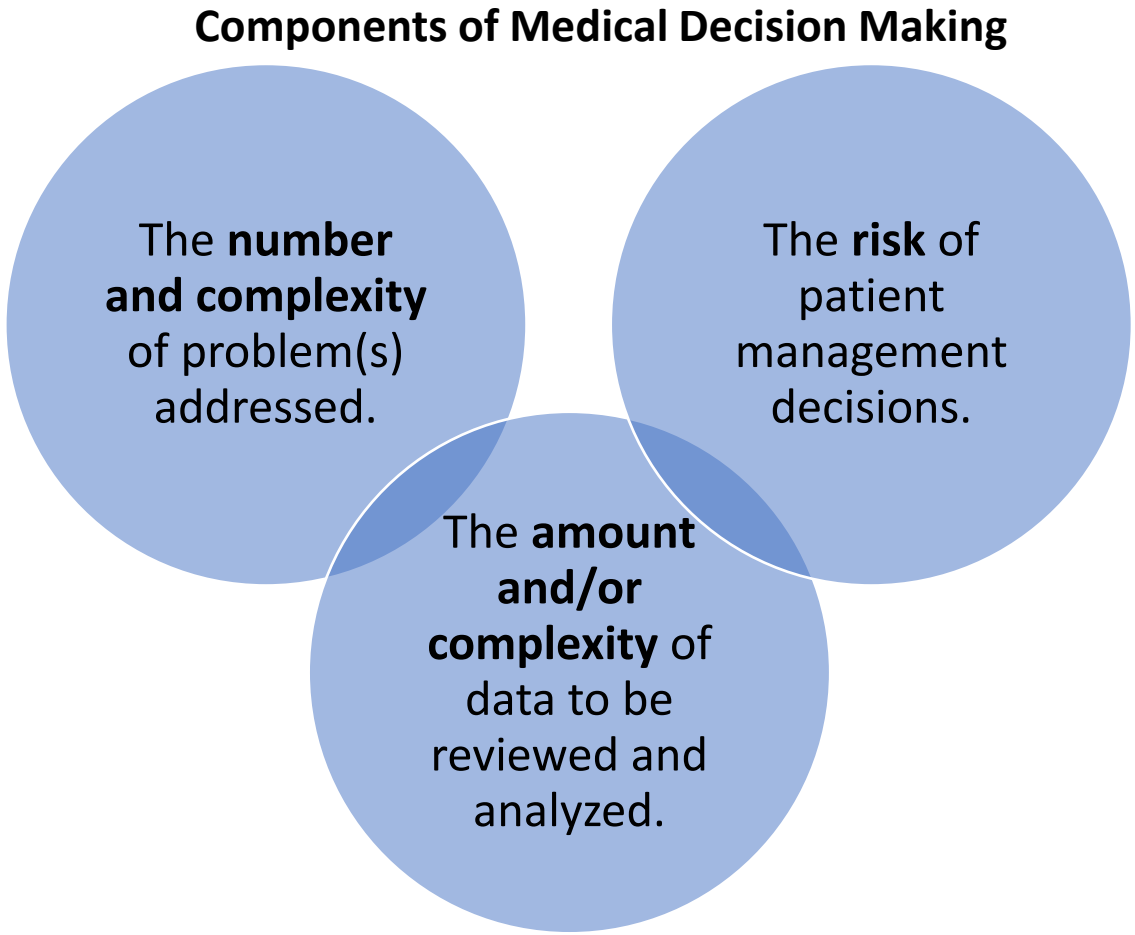
2023 Inpatient Hospital and Observation Services

- Time is defined in ranges as opposed to “typical time.”
- The “fifty percent rule” no longer applies.
- Includes both face to face *and* non face to face activities.

Physician/QHP Time

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

Split/Shared Visits
What about medical decision making in 2023?



- Both the physician and the NPP would be addressing the same problem(s) and reviewing the same information during the encounter. There is no “key” component to MDM in 2023.
- A service selected based on MDM cannot be attributed to one provider and considered a split/shared service.

Split/Shared Services 2022 vs. 2023

Split/Shared Services 2022 vs. 2023		
E/M Visit	**2022 Substantive Portion**	**2023 Substantive Portion**
Other Outpatient (facility setting) (Does not apply to office visits)	History, or exam, or **MDM*** OR More than half of total time	More than half of total time
Inpatient/Observation/ Hospital/SNF	History, or exam, or MDM, OR More than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, OR More than half of total time	More than half of total time
Critical care	More than half of total time	More than half of total time

Claim Identification

Modifier -FS must be appended to the appropriate code to indicate a split/shared visit

Do **not** use modifier -52 (reduced service)!

For outpatient services, E/Ms are selected based on time OR MDM. Since history and exam are no longer used to select the code as a key component, only MDM may be considered. Therefore, the billing practitioner would need to perform MDM in its entirety to be the "substantive portion" in 2022.

Prolonged E/M Services

Accounts for time *in addition to* an E/M service.

HCPCS code G2212:	15-minute prolonged service, office/outpatient
CPT® codes 99354-99355:	1-hour prolonged service, direct contact (except office/outpatient)
CPT® codes 99356-99357:	1-hour prolonged service, inpatient/observation
CPT® codes 99358-99359:	1-hour prolonged service, office/outpatient, different day

Prolonged E/M Services

	2022		2023
E/M Visit Family	**Key Component**	**Time**	**Time Only**
Other Outpatient (facility setting) (Does not apply to office visits, POS 11)	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212.	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212.	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212.
Inpatient/Observation/ Hospital/Nursing Facility	Combined time of both practitioners must meet the threshold for reporting 99354-9 (60+ minutes > typical).	Combined time of both practitioners must meet the threshold for reporting 99354-9 (60+ minutes > typical)	Combined time of both practitioners must meet the threshold for reporting prolonged services.

- The time requirements for the primary E/M service *and* the prolonged service code must BOTH be attained.
- The physician or practitioner who spent more than half the total time would bill for the primary E/M visit **and** the prolonged service code(s).

Split/Shared Services Example- Distinct Time Only

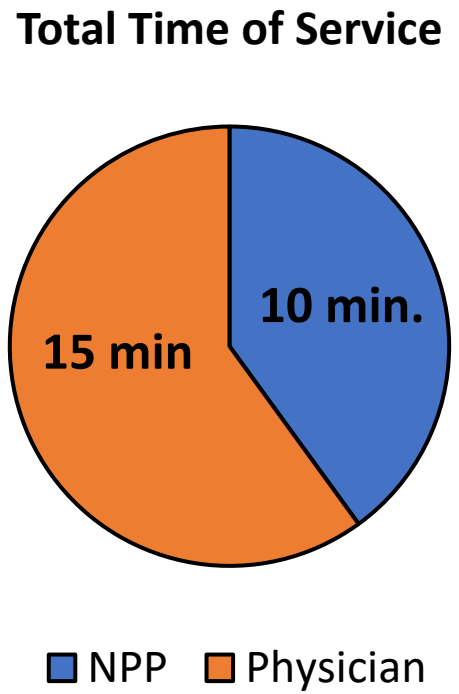
NPP spends **10** minutes with the patient

Physician spends **15** minutes with the patient.

Total time= **25** minutes

The **physician** spent the substantive portion of the visit with the patient (**more than half of 25 minutes**).

Therefore, the **physician** would report the service.



Split/Shared Services Example- Joint Time

NPP spends **10** minutes with the patient

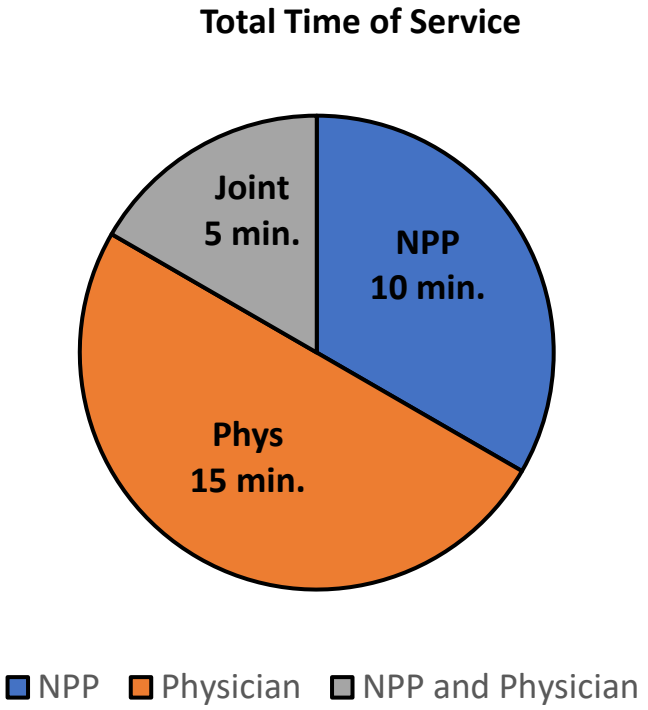
Physician spends **15** minutes with the patient.

Total distinct time: **25 minutes** (**Physician** performed the substantive portion)

The physician and NPP met for **5 minutes** to discuss the patient (joint time).

Total time: 25 minutes of distinct time + **5 minutes** of joint time= **30 minutes**

The **physician** spent the substantive portion of the visit in *distinct* time. The **5 minutes** of *joint* time would be attributed to the billing provider (**physician**).



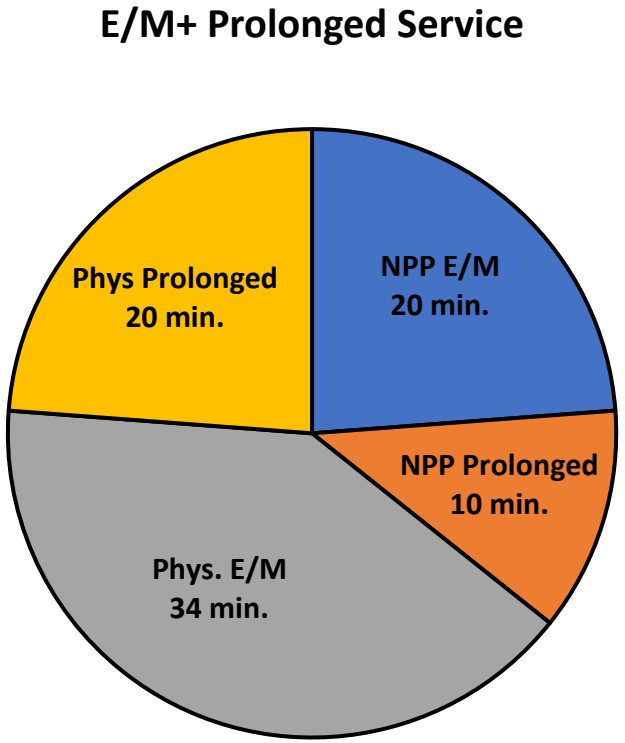
Split/Shared E/M Plus Prolonged Services

Outpatient facility service (Time)

NPP time: **20 minutes**
Physician time: **34 minutes**
Total time of service was **54 minutes**
Primary service= CPT® code 99215 (40-54 minutes)

PLUS
NPP time: **10 minutes**
Physician time: **20 minutes**
Total time of the prolonged service was **30 minutes**.
(The threshold of 15 minutes beyond the total time of the primary was met).
Add on service= HCPCS code G2212 x 2 (2 x 15-minute service)

Primary Service + Add On Service= 84 minutes
NPP total time: **30 minutes**
Physician total time: **54 minutes**



The **physician** would report both the primary AND prolonged service, as they provided the substantive portion of the visit.

Documentation

The medical record must identify both the physician and NPP who performed the visit.

The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

Reimbursement

Payment is made to the practitioner who performs the substantive portion of the visit.

To report under the physician NPI, a substantive portion of the visit must be performed by the physician. The service cannot be reported under the physician if the substantive portion was performed by the NPP.

Reporting Steps

1

- **Determine who provided the substantive portion of the visit**.
  - 2022- Either history, exam, or MDM OR more than half the total time.
  - 2023- More than half the total time.

2

- **Enter documentation in the patient's medical record.**
  - Identify the physician and NPP that performed the service.
  - Practitioner who performed the substantive portion of the visit must sign and date the medical record.

3

- **Select the appropriate CPT code**
  - Append modifier -FS to the selected code.

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Resources

Resources

Evaluation and Management Services

American Medical Association

- CPT ® 2022 Professional Edition
- *CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes*
- *Errata and Technical Corrections - CPT® 2021, September 3 2021*.

American Society of Clinical Oncology

- ASCO Practice Central (practice@asco.org)
  - ASCO's Guide to the 2021 Evaluation and Management Changes

Resources

Split/Shared Evaluation and Management Services

American Society of Clinical Oncology

- ASCO Practice Central (practice.asco.org)
  - NEW- Split/Shared Evaluation and Management Services

Centers for Medicare and Medicaid Services

- CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

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Questions and Discussion

Inquiries may be sent to ASCO staff at practice@asco.org.