2021 Office Visit Evaluation and Management Documentation Changes

Questions to Ask Private Payers

The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) coordinated fundamental changes in the methodology to document and select CPT levels for office visit evaluation and management (E/M) services. These changes will impact multiple aspects of your practice, including claims processing, fee schedule payment rates, and auditing requirements. To support you through this process, the American Academy of Family Physicians (AAFP) has developed a list of questions to ask your contracted insurance payers. These questions will help you gather key information about how each payer plans to update their system, as well as what potential revenue increases or decreases are associated with claims adjudication and audit. It’s important for you to fully understand how your practice’s claims payments will be affected and how any payment lags will impact your practice’s viability. You also need to know if any of your contracted insurance payers will provide training that can complement your own staff training and education efforts on the new E/M guidelines.

Start by reviewing your private payer contracts.

- Perform a practice financial impact/revenue audit to determine what payers compose the largest portion of your payer mix (outside of traditional Medicare).
  - File the fiscal audit information for reference.
- Review your private payer contracts and their renewal dates.
  - If you do not have a copy of your current full fee schedule, ask your provider relations representative for one.
  - Determine how your current full fee schedule is structured.
    - Does the payer pay a percentage of the Medicare Physician Fee Schedule (MPFS)?
    - If so, is the payment based on the current MPFS or a prior year’s MPFS?
  - Ensure your current full fee schedule accurately reflects the services you provide. If you provide services that are not reflected, consider adding them.
- Contact your provider relations representative to determine whether the payer will reflect new E/M documentation requirements and update your fee schedule by automatically issuing new contracts or by amending existing contracts.

continued on the next page
Next, use the following questions to guide your discussions with private payers.

**Documentation Questions**
- What is the payer’s implementation schedule for updates?
- How will the payer communicate with my practice and provide general notifications?
- Will the payer’s documentation requirements align with the updated office visit E/M guidelines developed by the AMA and adopted by CMS?
  - Will the payer utilize the revised medical decision-making criteria?
  - How must I document face-to-face and non-face-to-face time in my electronic health record (EHR)?
- How will the payer’s audit policies change?

**Fee Schedule Questions**
- How will the increased relative value units (RVUs) for office visit E/M services (CPT codes 99202-99205, 99212-99215) be reflected in my fee schedule?
- How will changes to the RVUs for office visit E/M services impact other services?
  - Will payment for other services decrease?
- How will the increased RVUs impact capitated, per member per month, and care management payments?
- How will the increased RVUs impact value-based payment contracts?
- Will updates apply across all lines of business?
- Will the payer cover the add-on Healthcare Common Procedure Coding System (HCPCS) code GPCIIX*?
  - If not, does the payer plan on incorporating the value of the add-on code into its changes to the RVUs for office visit E/M services?
- Will the payer’s policies on prolonged services CPT codes 99358 and 99359 change?
  - Will the payer cover the new prolonged services CPT code 99XXX**?

**Claims Management Questions**
- Will my practice be asked to hold claims submissions before or after January 1, 2021?
- Will the payer notify patients prior to January 1, 2021, about fee schedule increases?
- Will the payer have a hotline for patient inquiries about changes in deductibles, coinsurance, and copays related to fee schedule increases?
- Has the payer tested and confirmed accurate data transmission with clearinghouses?
  - What is the planned process for addressing any data transmission issues between the payer and clearinghouses that may occur?
- Have there been any communications between the payer and clearinghouses that should be disseminated to my practice?
- Have any of the payer’s reporting processes changed due to implementation of the new fee schedule?
- How will the payer provide claims management support to my practice after implementation (e.g., dedicated hotline)?
- Does the payer expect a lag in claims processing?
- Will updates require any downtimes for the payer’s system?

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Finally, review these additional practice considerations.

- Verify that your private payer contracts and full fee schedules have been accurately updated and are accessible to the appropriate practice staff.
- Ensure that your practice’s charges are high enough to account for the increase in allowables.
  - If you use an external billing company, ensure it is aware of the reimbursement changes and is auditing allowables against the updated fee schedule.
- Verify that your practice management system has been updated.
  - Has your billing staff reviewed the updated fee schedule for accuracy?
- Consider having your staff post test claims and test payments/denials to confirm system functionality and fee schedule accuracy.
- Consider adding a notification regarding fee schedule increases and their impact on patient cost share to your practice’s billing statements and electronic patient communications.
  - If you add a notification, confirm that it has been properly formatted and implemented.
- Develop a plan to trend changes in revenue specific to each payer and to trend payment lag and denials rates.
  - Ensure your practice’s billing staff closely monitors payments from each payer to verify use of the new allowables.
  - Track issues related to electronic payment posting.
  - If you use an external billing company, confirm that they will be monitoring payments and tracking issues and will communicate any concerns to you in a timely manner.
  - Communicate any discrepancies or issues to your provider relations representative immediately.
- Schedule staff meetings to confirm that the updated fee schedule has been implemented, as well as to identify any known issues your practice is experiencing and/or additional training and education needs.
- Conduct a payer-specific internal audit of your practice’s first quarter.

* HCPCS code GPC1X = 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. HCPCS code GPC1X is a placeholder code. CMS will release the final code later this year.

** CPT code 99XXX = Prolonged service with or without direct patient contact on the date of an office or other outpatient service. CPT 99XXX represents a placeholder code. The AMA will release the final code later this year.