New Outpatient Therapy Evaluation and Intervention E&I Codes

An introduction to the new policy and new claims coding requirements

This document was prepared in 2010 under contract by the CSC to provide information in support of the STATS project. It does not represent CMS opinion or policy.

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Disclaimer

Contents of this presentation are for educational purposes only. Clinicians should refer to Medicare manuals and contractor instructions for current policies.

Medicare outpatient therapy benefit

- Medicare Part B covers ambulatory outpatients or inpatients who have exhausted or are not eligible for Part A benefits.
- Outpatient therapy includes;
  - Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services furnished (as permitted by state law) by:

Provider Facilities	Office-Based Professionals
Hospitals	Physical therapists in private practice (PTPP)
Skilled nursing facilities (SNF)	Occupational therapists in private practice (OTPP)
Comprehensive outpatient rehabilitation facilities (CORF)	Speech-language pathologists in private practice (SLPP)
Outpatient rehabilitation facilities (ORF)	Physicians
Home health agencies (HHA)	Non-physician practitioners (NPP)

Medicare outpatient therapy benefit

- Coverage requirements;
  - Such services were required because the individual needed therapy services, and
  - A plan for furnishing such services (containing at a minimum: diagnosis(es); long term treatment goals; and type, amount, duration, and frequency of therapy services) was established by a clinician which was also periodically reviewed by a physician or NPP, and
  - Such services were furnished while the beneficiary was under the care of a physician or NPP, and
  - Such services were furnished on an outpatient basis, and
  - The physician or NPP certified the plan of care (plan of care) for the applicable payment period.

Medicare outpatient therapy benefit

- Related claim processing requirements
  - Provider facilities submit CMS 1450 (UB-04) claims (or electronic equivalent).
  - Professional offices submit CMS 1500 claims (or electronic equivalent).
  - Outpatient therapy services are identified at the claim line by the 5-digit Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for each procedure furnished on each date of service.
  - The outpatient therapy discipline furnishing the services is identified at the claim line by the GP, GO, or GN modifier representing PT, OT, or SLP services respectively.

Current claims processing per-session

- Outpatient therapy clinicians currently submit one or more of 76 available HCPCS procedure codes to describe what procedures were done to the beneficiary during the session regardless of need or complexity.
- While some codes are untimed and can only be billed one unit per-session, others are time-based and may be billed multiple units per-session.
- For more than a decade, CMS and its contractors have implemented a variety of different utilization edits in response to perceived overutilization or misuse of certain HCPCS codes.

Current claims processing per-session

- These edits include:
  - CMS DRA edits,
  - CMS MUE edits,
  - CMS CCI edits,
  - CMS proposed MPPR edits, and
  - Local MAC medical necessity edits including; limits per-HCPCS, and HCPCS and ICD-9 crosswalk edits.
- CMS and contractor systems review submitted procedure codes per-session and apply the various utilization edits.
- Those procedure codes that pass the edits are paid while those that do not are denied payment.

New per-session E&I codes

- The new HCPCS change how clinicians report and are paid for outpatient therapy services from payment per service to payment per therapy session.
- Professionals are required to submit a single new Level II HCPCS outpatient therapy E&I code to replace all individual therapy procedures currently reported in a session and now paid separately.
- Payment for the new outpatient therapy E&I codes is based the beneficiary characteristics reflected by a combination of the evaluation or assessment complexity and/or the intervention intensity for that particular session.

New claims processing per-session

- This requires that clinicians submit a single HCPCS code to describe an outpatient therapy session instead of a list of individual procedures furnished.
- There are two kinds of sessions, evaluation/re-evaluation sessions and treatment intervention sessions (which may include assessment or evaluation as part of the session).
- One of 12 outpatient therapy E&I codes describe each session.
- Only one code may be billed per session.
- Payment would be determined by the value of the code.

New evaluation/re-evaluation session codes

Evaluation/Re-Evaluation Complexity		
Minimal	Moderate	Significant
E&I Code #1	E&I Code #2	E&I Code #3

- The first three outpatient therapy E&I HCPCS codes are used for initial evaluation and re-evaluation sessions where no interventions were provided.
- These evaluation codes are differentiated as minimal, moderate, or significant complexity.
- These first three outpatient therapy E&I codes are only to be billed for services performed by a “clinician” (therapist, physician, or NPP).

New intervention session codes

- The remaining nine outpatient therapy E&I codes are used for all sessions that include specific treatment interventions and that may or may not include assessments or evaluations.
- These nine E&I codes are represented by the algorithm on the next slide.
- Intervention levels are differentiated as minimal, moderate, or significant.
- Evaluation/Assessment complexity is differentiated as observation, assessment, or evaluation/re-evaluation.
- The definitions of outpatient therapy E&I codes 4, 7, and 10 describe services that could be furnished by or under the permissible supervision of all qualified outpatient therapy “professionals” (clinicians, physical therapist assistants, and occupational therapy assistants).

Evaluation/assessment complexity and intervention level

		Evaluation/Assessment Complexity		
		Observation	Assessment	Evaluation/Re-Evaluation
Intervention Level	Minimal	E&I Code #4	E&I Code #5	E&I Code #6
	Moderate	E&I Code #7	E&I Code #8	E&I Code #9
	Significant	E&I Code #10	E&I Code #11	E&I Code #12

- E&I codes 5-6, 8-9, and 11-12 contain assessment or evaluation components and can only be billed if a clinician performed at least the assessment or evaluation component of the session.
  - A therapy/therapist assistant could perform the intervention portion of the session, however, the assessment or evaluation components must be performed by the clinician.
- It would be inappropriate for providers/professionals to bill more than one unit of per-session codes per-day unless the services met the definition of a distinctly separate session, and the second session was indicated in the plan of care.

New Outpatient Therapy Policy Manual Definitions

CMS has refined the existing definitions of „Assessment", „Evaluation", and „Re-Evaluation" listed in Chapter 15, Section 220.A of the Medicare Benefit Policy Manual, as demonstrated in the following slides, and has added the definition of „Observation" to support the development of these new outpatient therapy E&I HCPCS codes.

Observation

- Outpatient therapy observation is not separately payable from intervention.
- The term observation is used in Medicare outpatient therapy services to represent the routine gathering of data during treatment sessions that do not involve making clinical judgments regarding the patient‟s conditions.
- Because clinical judgments are not made regarding whether the plan of care requires adjustment, observation may be provided by qualified professionals and qualified personnel.

Assessment

- Outpatient therapy assessment is separate from evaluation, and is not separately payable from intervention.
- The term assessment as used in Medicare outpatient therapy services is distinguished from language in CPT codes that specify assessment, e.g. 97755 – assistive technology assessment (which is not separately payable from the outpatient therapy per-session HCPCS code).
- Assessments shall only be provided by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient‟s condition(s).

Assessment (cont.)

- Assessment determines, e.g., changes in the patient‟s status since the last visit/treatment day and whether the planned procedure or service should be modified.
- Based on these assessment data, the professional may make judgments about progress towards goals and/or determine that a more complex evaluation or re-evaluation is indicated.
- Routine weekly assessments of expected progression in accordance with the plan of care are not to be reported as re-evaluations.

Evaluation

- Outpatient therapy evaluation is a separately payable comprehensive service provided by a clinician, only when no interventions are furnished during the session.
- Evaluation requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities.
- Evaluation is warranted, e.g., for a new diagnosis or when a condition is treated in a new setting.
- These evaluative judgments are essential to the development of the plan of care, including goals and the selection of interventions.

Re-evaluation

- Outpatient therapy re-evaluation provides additional objective information not included in other intervention documentation.
- Re-evaluation is a separately payable comprehensive service provided by a clinician, only when no interventions are furnished during the session.
- Re-evaluation is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient‟s condition or functional status that was not anticipated in the plan of care.
- Although some state regulations and practice acts require re-evaluations at specific times, for Medicare payment, re-evaluations must also meet Medicare coverage guidelines.
- The decision to provide a re-evaluation shall be made by a clinician.

Outpatient therapy E&I code criteria

- The definition for each outpatient therapy E&I code addresses three components;
  1. Clinical presentation during that session,
  2. Intensity of activities performed during the session, and
  3. Documentation resulting from the session.
- The definitions for the 12 new E&I outpatient therapy codes are as follows:

E&I code #1 –

Therapy Evaluation/Re-Evaluation, Minimal Complexity

- Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
- The establishment (evaluation) or update (reevaluation) of a problem focused plan of care addressing one or more similar functional impairments or problems by a clinician, and
- No interventions are furnished during session, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by a clinician.

E&I code #2 –

Therapy Evaluation/Re-Evaluation, Moderate Complexity

- Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety), and/or
- The establishment (evaluation) or update (reevaluation) of a detailed plan of care addressing 2-3 dissimilar functional impairments or problems by a clinician, and
- No interventions are furnished during session, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

E&I code #3 –

Therapy Evaluation/Re-Evaluation, Significant Complexity

- Clinical presentation with unstable and unpredictable characteristics to patient condition and/or patient has significant cognitive deficits affecting safety, and/or
- The establishment (evaluation) or update (reevaluation) of a comprehensive plan of care addressing 4 or more dissimilar functional impairments or problems by a clinician, and
- No interventions are furnished during session, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by a clinician.

E&I code #4 –
Therapy Intervention Minimal, with Observation

- Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
- Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Routine observations are documented by qualified professionals or personnel.

E&I code #5 –

Therapy Intervention Minimal, with Assessment

- Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during the session, and
- Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Assessment findings and judgments are documented by clinician.

E&I code #6 –

Therapy Intervention Minimal, with Evaluation

- Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and
- Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

E&I code #7 –
Therapy Intervention Moderate, with Observation

- Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
- Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Routine observations are documented by qualified professionals or personnel.

E&I code #8 –

Therapy Intervention Moderate, with Assessment

- Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during session, and
- Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
- Assessment findings and judgments are documented by clinician.

E&I code #9 –
Therapy Intervention Moderate, with Evaluation

- Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and
- Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

E&I code #10 –
Therapy Intervention Significant, with Observation

- Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
- Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
- Routine observations are documented by qualified professionals or personnel.

E&I code #11 –

Therapy Intervention Significant, with Assessment

- Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during session, and
- Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
- Assessment findings and judgments are documented by clinician.

E&I code #12 –

Therapy Intervention Significant, with Evaluation

- Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and
- Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

Coding examples for E&I codes – Episode Initial Encounter

- Initial encounter – PT evaluated patient and initiated treatment
  - Patient is cognitively intact and has back pain when moving about that varies from 3-7/10 and left ankle sprain from a fall limits function by about 50 %.
  - Intervention included 15 minutes manual therapy 30 minutes therapeutic exercise and 10 minutes ultrasound.
  - PT documented evaluation, plan of care, and intervention.
- HCPCS codes submitted
  - E&I code #9 (Therapy intervention moderate, with evaluation) and GP modifier

Coding examples for E&I codes – 5th Session

- 5th session (12 calendar days later) – PTA continued treatment
  - Patient has back pain only when moving about that limits function by about 25%. No ankle pain.
  - Intervention included 15 minutes manual therapy 30 minutes therapeutic exercise and 10 minutes ultrasound.
  - PTA documented intervention and observations.
- HCPCS codes submitted
  - E&I code #7 (Therapy intervention moderate, with observation) and GP modifier

Coding examples for E&I codes – 30 Calendar Days

- 11th session – PT reassessed patient and continued treatment
  - Patient has back pain when moving about that limits function by about 10%
  - PT performed tests and measures and assessed progress.
  - Intervention included 10 minutes manual therapy 15 minutes therapeutic exercise
  - PT documented assessment, updates to the plan of care and intervention.
- HCPCS codes submitted
  - E&I code #5 (Therapy intervention minimal, with assessment) and GP modifier

Benefits of new bundled per-session E&I codes

- Per-session payments increase predictability of provider payments.
- Per-session payments permit provider flexibility in furnishing necessary services.
- Per-session payments more accurately reflect patient need for services and complexity of services furnished.
- Per-session payments provide useful data towards developing per-episode payment models.
- Per-session payments reduce provider burden in long run (next slide).

Provider burden is offset

- Initial increased burden to learn new codes and update billing systems.
- Reduced burden with no further need to submit KX modifier with each claim line once cap limit is approached or exceeded.
- Reduced burden with no further need to manage 76 separate outpatient therapy HCPCS codes and related policies (e.g. contractor ICD-9-HCPCS medical necessity crosswalks, CCI, etc).
- Reduced burden if separate per-session HCPCS by therapy type since GN, GO, and GP modifiers are no longer necessary to identify therapy type.