Medicare Part B Presents: Scoring Evaluation and Management Office/Outpatient Services: Now and Later

January 19, 2021

02:00 pm ET

1:00 pm CT

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Acronym List

Acronym	Definition
AMA	American Medical Association
CMS	Center for Medicare and Medicaid Services
E/M	Evaluation and Management
HPI	History of Present Illness
NPI	National Provider Identifier
NPP	Non-Physician Practitioners
MDM	Medical Decision Making
PFS	Physician Fee Schedule
PFSH	Past Medical, Family, and Social History
QHP	Qualified Health Professional
ROS	Review of Systems

Today's Presentation

- Agenda:
  - Office/Outpatient Guidelines before and after January 1, 2021
  - 2021 E/M Interactive Score Sheet
  - Frequently Asked Questions (FAQs)
- Objectives:
  - Review the guidelines for office/outpatient visits
  - Review how time is measured for 2021 office/outpatient E/M services
  - Introduce new prolonged services associated with office/outpatient visits
  - Answer the most frequently asked questions and provide additional resources available to assist

Office/Outpatient Guidelines before and after January 1, 2021

Summary of Changes Effective January 1, 2021

- CMS is implementing new coding, prefatory language, and interpretive guidance framework issued by the AMA for office/outpatient E/M visits
  - History and exam no longer used to select the level of code for office/outpatient E/M visits
  - Deletes 99201
  - Levels 2 through 5, selection of code level based on MDM or time
  - Redefines time to total time spent by the reporting practitioner on the day of the visit including time with and without direct patient contact
  - 1995 and 1997 E/M guidelines no longer be used for office/outpatient E/M visits
- New office/outpatient E/M visit complexity add-on code - G2211
- New prolonged service code finalized- G2212
- CMS Fact Sheet: Summary of Policies in the Calendar Year (CY) 2021 MPFS Final Rule

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New and Established Patients

- Definitions:
  - New Patient - a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years
  - Established Patient - patient has had a professional face-to-face service from the practitioner or from a practitioner of the same specialty in the group within three previous years
  - Reference:
    - ✓ Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6.7A "Definition of New Patient for Selection of E/M Visit Code"
- Service(s) requiring time to be spent between the physician and the patient is considered a face-to-face service (ex. surgical procedures and E/M Services)

Face-to-Face Criteria

- Surgical procedures are considered face-to-face services
- Services by NPP are considered face-to-face services
- Interpretation of EKG or X-Rays, or other diagnostic testing that do not include a face-to-face component are not considered face-to-face services
- Article: E/M (Evaluation and Management) Service: Face-to-Face Documentation

Office/Outpatient Coding

- Before January 1, 2021…
  - New patient visits:
    - ✓ Level of service determined by documentation of all three key components (history, exam, and medical decision making)
    - ✓ Lowest key component sets level of service
  - Established patient visits:
    - ✓ Level of service determined by documentation of two of the three key components (history, exam, and/or medical decision making)
    - ✓ Highest two key components determines the level of service
- After January 1, 2021…
  - New patient visits:
    - ✓ Level of service determined by medical decision making or total time
  - Established patient visits:
    - ✓ Level of service determined by medical decision making or total time

New Patient Office/Outpatient Codes Prior to 01/01/2021

Level of Service	History	Exam	Medical Decision Making	Time (minutes)
99201	Problem Focused	Problem Focused	Straightforward	10
99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward	20
99203	Detailed	Detailed	Low	30
99204	Comprehensive	Comprehensive	Moderate	45
99205	Comprehensive	Comprehensive	High	60

- Scoring requires all three key components
- Lowest scoring key component determines the level of service

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New Patient Office/Outpatient Codes Redefined

CPT Code	Definition (Effective for dates of service on and after January 1, 2021) *Current Procedural Terminology (CPT) only copyright 2020 American Medical Association. All rights reserved.*	Total time spent on date of encounter
99201	Deleted, to report, use 99202	n/a
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making	15-29 minutes
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making	30-44 minutes
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	45-59 minutes
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making	60-74 minutes

Established Office/Outpatient Codes Prior to 01/01/2021

Level of Service	History	Exam	Medical Decision Making	Time (minutes)
99211	*Minimal problem*	*Minimal problem*	*Minimal problem*	*5*
99212	Problem focused	Problem focused	Straight forward	10
99213	Expanded problem focused	Expanded problem focused	Low	15
99214	Detailed	Detailed	Moderate	25
99215	Comprehensive	Comprehensive	High	40

- Scoring requires two of three key components
- Lowest scoring key component not used in determining level

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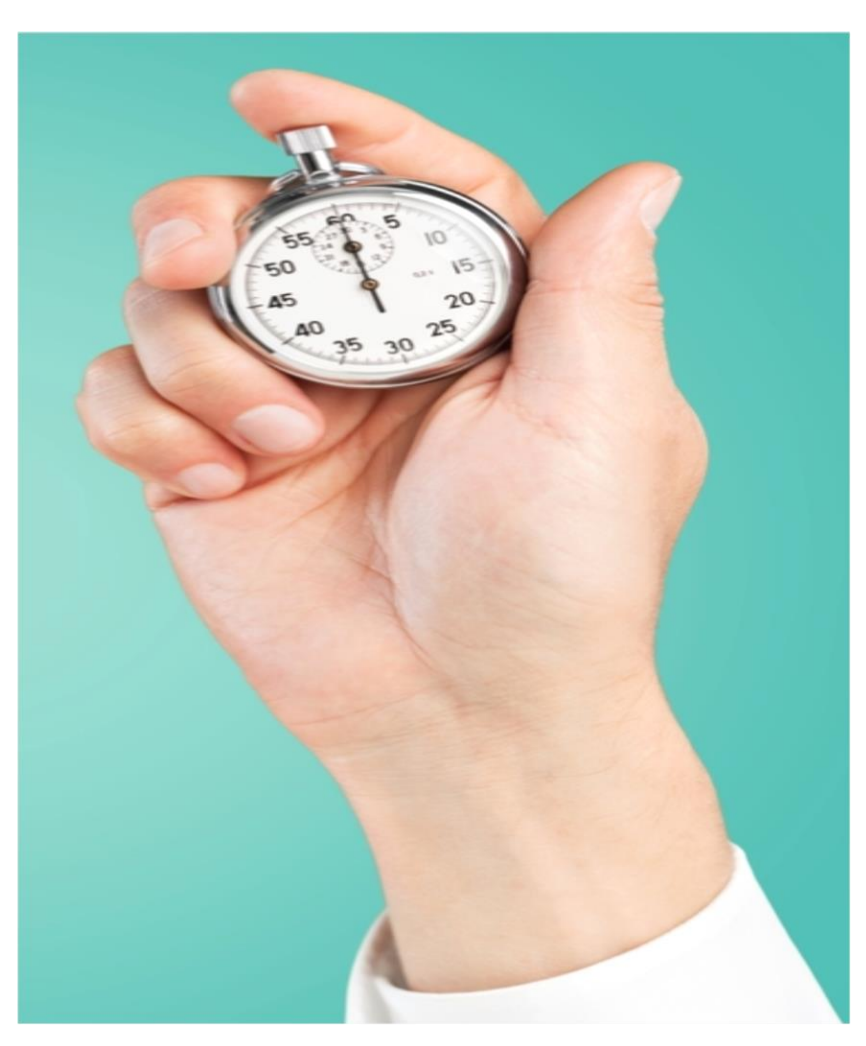
Established Office/Outpatient Codes Redefined

CPT Code	Definition (Effective for dates of service on and after January 1, 2021) *Current Procedural Terminology (CPT) only copyright 2020 American Medical Association. All rights reserved.*	Total time spent on date of encounter
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	Time component removed
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making	10-19 minutes
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making	20-29 minutes
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	30-39 minutes
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making	40-54 minutes

Billing Based on Time for Outpatient Prior to 01/01/2021

- Encounter must be dominated by counseling and coordination of care (more than 50 percent of the face-to-face time)
- Includes time spent with the physician only
- Counseling and/or coordination of care must be provided in the presence of the patient
- Time spent by other staff is not considered in selecting the appropriate level of service
- Code selection based on total time of the face-to-face encounter



Counting Office Visit Time in 2021

- Time redefined to "total time" spent on day of encounter, does not include time spent by clinical staff
- Total time on date of service includes all face-to-face and non-face-to-face time by practitioner
- Time spent on activities attributed to total time on date of service, whether or not counseling/coordination of care dominates service
- All activities attributed to total time on date of service should be documented
- Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)
- Separately billed services is not included in the E/M visit time

"Incident To" Provision

- Definition:
  - Services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis, or treatment, of injury or illness
- Commonly furnished in physician's offices or clinics
- Integral although incidental:
  - Course of treatment initiated by physician
  - Physician involvement reflects continuing active participation in and management of care
  - Commonly rendered without charge or included in the physician's bill
- Direct Supervision:
  - Supervising physician can be a member of the group
  - Must be present in the office suite and immediately available
  - Does not have to be in the same room

“Incident To” Documentation Requirements

- Identify who rendered the service
- Indicate supervision requirement is met
- Show physician’s initiation and continued involvement in treatment
- Reasonable and necessary
- Within scope of practice for NPP

Unacceptable Documentation

- NPP performs the initial visit and the supervising physician documents a note in the medical record similar to the following:
  - "I have reviewed the physician assistant's note, examined the patient and agree with..."
  - “Nurse practitioner performed the history and physical and I was present for the entire encounter and my treatment plan is as follows…”

Non-Physician Practitioners (NPP)

- NPP can perform a new patient visit and bill under own NPI
- Must meet the face-to-face criteria
- May only designate primary licensure (nurse practitioner, physician assistant, etc.)
- NPPs may not designate sub-specialties
- Assume the specialty of the group practice
- New patient visit by a NPP counts as a new patient visit for all practitioners of the group practice
- New patient visits by a NPP will cause denials of all other new patient visits by physicians of the same group practice, regardless of specialty:
  - Appeal if NPP is trained as a different specialty or sub-specialty
  - Article: Appealing New Patient Denials

Billing 99211

- May not require the presence of a physician
- Documentation must support:
  - Face-to-face encounter
  - Evaluation and management of patient
- Requires direct physician supervision
- Modifier 25 not appropriate
- Not paid with drug administration services, therapeutic, or diagnostic injection codes:
  - Including flu and pneumonia injections

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Interactive “Incident To” Resources

- Interactive "Incident To" Tool:
  - Used to assist providers with understanding the CMS Part B "incident-to" requirements and to apply the rules to their individual given patient/provider circumstances and to understand documentation requirements
- Incident-To Specialty Page:
  - Central location for all "Incident to" services information, including links to related Centers for Medicare & Medicaid Services (CMS) resources and references

2021 Interactive Scoresheet

2021 E/M Interactive Score Sheet

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Disclaimer with Signature Verification

Print

E/M Interactive Score Sheet

*** Indicates a required field.**

Evaluation and management (E/M) services refer to visits furnished by physicians and qualified, licensed, non-physician practitioners. Billing Medicare for a patient visit requires the selection of the code that best represents the level of E/M service performed. The purpose of this interactive worksheet is to assist providers with identifying the appropriate E/M code based upon either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services or AMA CPT E/M Code and Guideline Changes for 2021 (effective for office/outpatient visits only for dates of service on and after January 1, 2021).

Since the 1995 and 1997 guidelines or AMA CPT E/M Code and Guideline Changes for 2021 (effective for office/outpatient visits only for dates of service on and after January 1, 2021) each specify different criteria to determine the level of E/M service performed, only one set of guidelines may be used to document a specific patient visit. This interactive worksheet offers providers the option to select either their preferred set of guidelines (1995 or 1997) or to select both for the purpose of comparison.

To emphasize the importance of medical necessity when reporting E/M services consider the following: all E/M services reported to Medicare must be adequately documented so the medical necessity is clearly evident because federal law requires that Medicare not pay for services for which the documentation does not establish such. For E/M services medical necessity of a visit as well as the CPT "level" of the service must both be documented. Per the CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 A, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

Does the documentation for service(s) billed include the date and legible signature of the rendering provider? ☐ **Yes** ☐ **No**

Accept/Decline Disclaimer

Print

E/M Interactive Score Sheet

*** Indicates a required field.**

Evaluation and management (E/M) services refer to visits furnished by physicians and qualified, licensed, non-physician practitioners. Billing Medicare for a patient visit requires the selection of the code that best represents the level of E/M service performed. The purpose of this interactive worksheet is to assist providers with identifying the appropriate E/M code based upon either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services or AMA CPT E/M Code and Guideline Changes for 2021 (effective for office/outpatient visits only for dates of service on and after January 1, 2021).

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Does the documentation for service(s) billed include the date and legible signature of the rendering provider? ☑ **Yes** ☐ **No**

Accept Decline

Patient Details

E/M Interactive Score Sheet

* Indicates a required field.

E/M Interactive Score Sheet

Use of this tool is at the discretion of the provider and is not intended to grant rights or impose obligations. This tool requires interpretation of provider documentation. Because interpretations may differ, use of this tool does not guarantee a specific audit result. It is the responsibility of the provider of services to ensure the correct submission of claims and responses to any remittance advice.

Helpful Resources

To begin, please complete the following:

Patient Details

Beneficiary name:

* **Date of service:**

Chief Complaint:

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New vs Established Definitions

Information to identify what qualifies patient for new vs established:

The terms **"new"** or **"established"** problem on the E/M score sheet refer to whether or not the problem is new or established to the examiner, e.g. physician/ NPP, and whether or not that problem is stable/worsening or whether the physician plans to conduct additional workup on that problem or not.

In CPT, a **"new"** patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

An **"established"** patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

CMS interprets the phrase **"new patient"** to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Currently, under the CMS enrollment process, NPPs cannot designate a sub-specialty. An NPP can only designate their primary licensure, e.g. nurse practitioner, physician assistant, certified nurse midwife, etc.

Service Type

Service Type

To determine the appropriate level of service for a patient's visit, it is necessary to first determine whether the patient is new or already established.

Please select one of the following:

- ○ **New patient – Office or other outpatient services**
- ◉ **Established patient – Office of other outpatient services**

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Time

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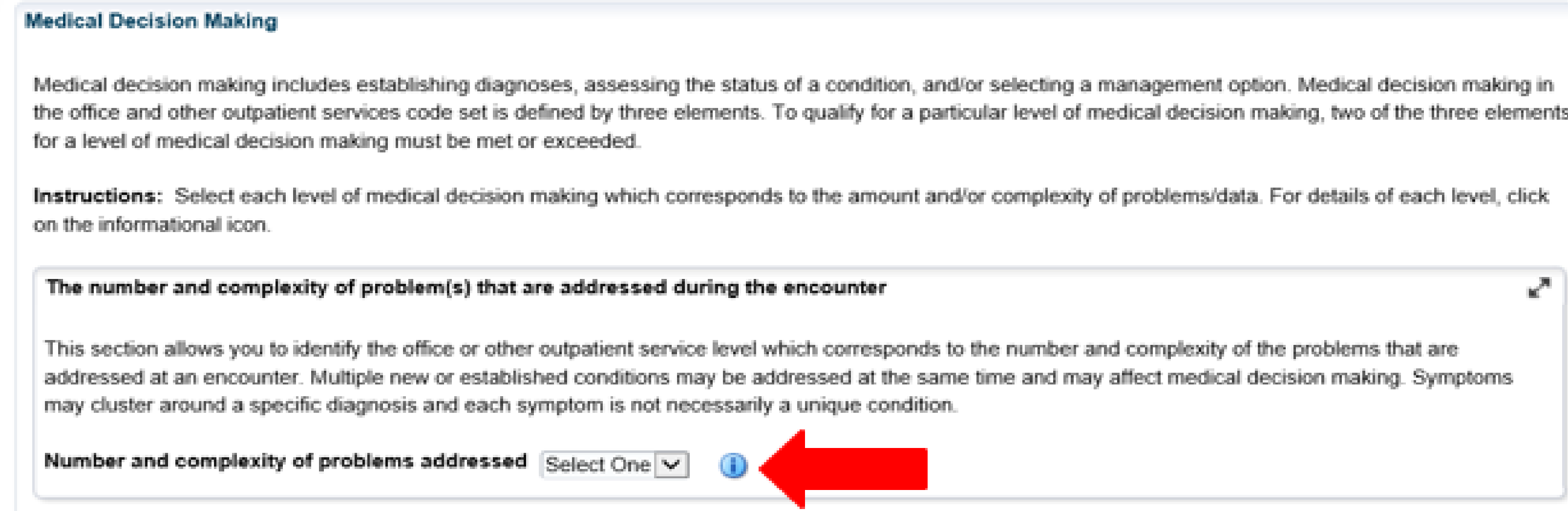
Number and Complexity of Problem(s) Addressed During the Encounter Table



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Number and Complexity of Problems Addressed- Help Screen

Help

Number and complexity of problems addressed	
Minimal	• **One** self-limited or minor problem
Low	**One** of the following: • Two or more self-limited or minor problems, **or** • One stable chronic illness, **or** • One acute uncomplicated illness or injury
Moderate	**One** of the following: • One or more chronic illnesses with exacerbation, progression, or side effects of treatment, **or** • Two or more stable chronic illnesses, **or** • One undiagnosed new problem with uncertain prognosis, **or** • One acute illness with systemic symptoms, **or** • One acute complicated injury
High	**One** of the following: • One or more chronic illnesses with severe exacerbation, progression, or treatment side effects, **or** • One acute or chronic illnesses or injuries that may pose a threat to life or bodily function

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Amount and Complexity of Data to be Reviewed Table

The amount and/or complexity of data to be reviewed and analyzed

This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data is divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
- Independent interpretation of tests.
- Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

This section allows you to identify the office or other outpatient service level which corresponds to the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

Amount and/or complexity of data to be reviewed and analyzed

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Amount and/or Complexity of Data to be Reviewed and Analyzed Table

Help

Amount and/or complexity of data to be reviewed and analyzed	
Minimal	Minimal or none
Low	**Limited** - Must meet the requirements of at least one of the two categories **Category 1 - Tests and documents** Any combination of **two** 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)
Moderate	**Moderate** - Must meet the requirements of at least one of the **three** categories **Category 1 – Tests, documents, or independent historian(s)** Any combination of three 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 of test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Extensive	**Extensive** - Must meet the requirements of at least two of the three categories **Category 1 – Tests, documents, or independent historian(s)** Any combination of three 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 of test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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Amount and/or Complexity of Data to be Reviewed and Analyzed- Minimal and Low

Amount and/or complexity of data to be reviewed and analyzed	
Minimal	Minimal or none
Low	**Limited** - Must meet the requirements of at least one of the two categories **Category 1 - Tests and documents** Any combination of **two** 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)

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Amount and/or Complexity of Data to be Reviewed and Analyzed - Moderate

Moderate	**Moderate** - Must meet the requirements of at least one of the three categories **Category 1 – Tests, documents, or independent historian(s)** Any combination of three 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 of test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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Amount and/or Complexity of Data to be Reviewed and Analyzed - Extensive

Extensive	**Extensive** - Must meet the requirements of at least two of the three categories **Category 1 – Tests, documents, or independent historian(s)** Any combination of three 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 of test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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Risk of Complications and/or Morbidity or Mortality of Patient Management Table

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

The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

This section allows you to identify the office or other outpatient service level which corresponds to the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

Amount and/or complexity of data to be reviewed and analyzed

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Risk of Complications and/or Morbidity or Mortality of Patient Management Table- Help

Help

Risk of complications and/or morbidity or mortality of patient management	
Minimal	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	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
High	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 deescalate care because of poor prognosis

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Suggested E/M Code

Suggested E/M Code

Medical decision making	E/M code
None	

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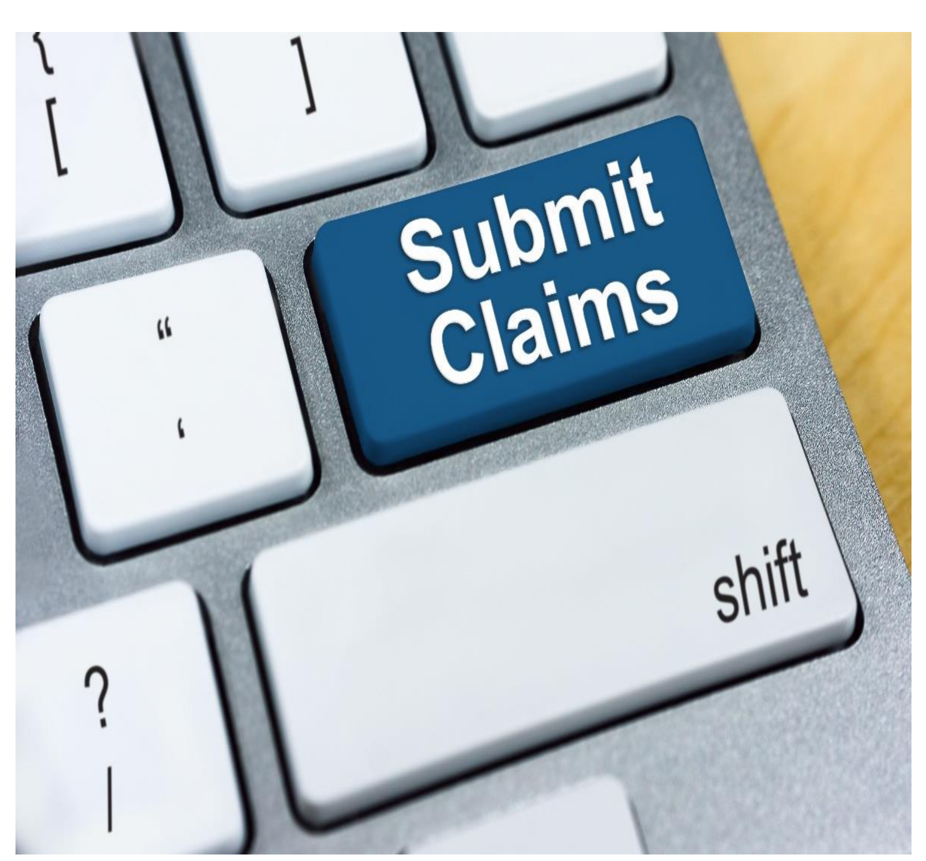
Points to Consider

Documentation Guidelines

- Providers should submit adequate documentation to ensure claims are supported as billed
- CMS developed a fact sheet to provide nationally consistent education to help providers understand how to provide accurate and supportive medical record documentation
  - Medicare Learning Network® (MLN®) Fact Sheet-Complying with Medical Record Documentation Requirements

Reminders

- 2021 AMA CPT E/M changes are mandatory
- Changes apply only to office visit codes
- Time is allowed even on non-counseling dominated visits
- Ensure all services are medically necessary
- Review and understand the guidelines for evaluation and management services
- Use the resources available to you to assist with documentation and coding questions



Novitas Solution's Website

- Evaluation and Management Center (JH) (JL):
  - Interactive Tools & Printable E/M, Specialty Score Sheets
  - Fact Sheets
  - Coding Instructions
  - E/M Frequently Asked Questions
  - Education and Training
  - CERT program findings
  - Targeted Probe and Educate
  - Additional Coding Assistance

Evaluation and Management Guidelines

- Guidance on billing and coding Evaluation and Management Services can be referenced in Internet Only Manual Medicare Claims Processing Manual, Pub. 100-4, Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6, "E/M Service Codes"
- The CMS Evaluation and Management Guide is a reference tool that provides direction based on the 1995 and 1997 Documentation guidelines for E/M services
- 1995 Documentation Guidelines for evaluation and management services provides guidance on billing the history, exam and medical decision making
- 1997 Documentation Guidelines for evaluation and management services provides an expanded definitions of status of chronic conditions and specialty examination scoring

2021 E/M Changes

- Key changes to E/M services taking place in 2021, including recent and upcoming revisions impacting E/M coding and documentation guidelines:
  - Centers for Medicare & Medicaid Services (CMS) Fact Sheet: Finalized Policy, Payment and Quality Provision Changes to Medicare Physician Fee Schedule for CY 2020
  - Centers for Medicare & Medicaid Services (CMS) Fact Sheet: Summary of Policies in the Calendar Year (CY) 2021 MPFS Final Rule
  - American Medical Association (AMA) Current Procedural Terminology® (CPT) Revisions – 2021
  - AMA Table: CPT E/M Office Revisions - Medical Decision Making (MDM)
  - Evaluation and Management Service Guide
  - AMA issues checklist for the transition to E/M office visit changes

Summary

- Today we have reviewed:
  - The guidelines for office/outpatient services
  - “Incident to” provisions
  - The score sheet revisions
  - Documentation reminders
  - Where to locate additional resources

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Jurisdiction L:
  - Customer Contact Center- 1-877-235-8073
  - Provider Teletypewriter- 1-877-235-8051
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - http://www.medicare.gov

Thank You for Attending

- Complete the event satisfaction survey:
  - Pops up immediately after the event ends
- Continuing Education Unit (CEU):
  - Once your attendance for an event is confirmed, you will receive an email notification that you have completed the course:
    - ✓ This process could take up to seven days
  - After you receive your event completed notification email, you can print your CEU Certificate via the Novitas Learning Center:
    - ✓ Click Completed Training icon from Home Page
    - ✓ Certificate icon will be on the left of the Class activity name
    - ✓ Click icon to print your certificate

	Activity	Code	Estimated Credit Hours	Completion Date	Expiration Date
	VILT Course: 01/16/2019 TCD TEST	01162019_TCD_TEST		1/16/2019	