Evaluation & Management 2021 E/M Guidelines for Office or Outpatient Services

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Healthcare consultant, Author and Speaker

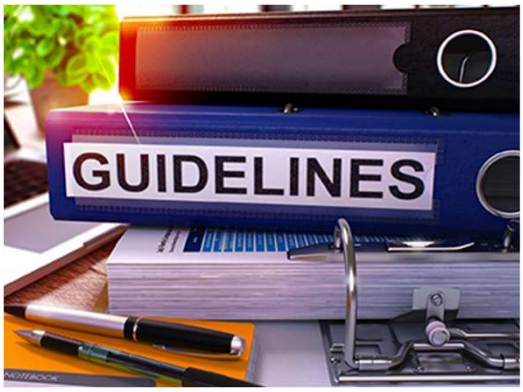
Presented to:
NIHIMA

1

AMA TACKLED THE CHANGE

The workgroup responsible for the revised guidelines for the **office E/M services was** assembled by the AMA.

- Representatives were members of its Current Procedural Terminology (CPT®) Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC).
- The leaders of the group included a former RUC chair, and former chair of the CPT Editorial Panel.



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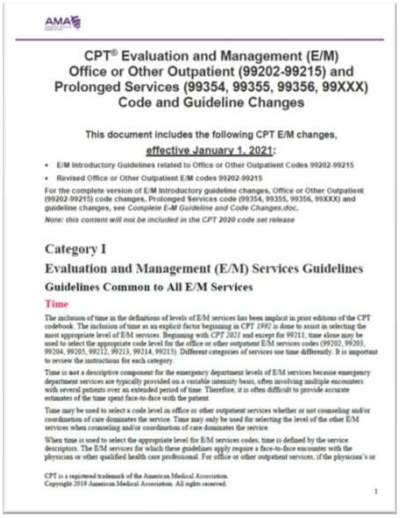
THE SOLUTION

- Guidelines updated for Office and Other Outpatient Services effective 01/01/2021
- Service can be leveled based on Time or Medical Decision Making
- Definitions provided for elements and terms



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CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes

This document includes the following CPT E/M changes, effective January 1, 2021:

- E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215
- Revised Office or Other Outpatient E/M codes 99202-99215

For the complete version of E/M introductory guideline changes, Office or Other Outpatient (99202-99215) code changes, Prolonged Services code (99354, 99355, 99356, 99XXX) and guideline changes, see *Complete E-M Guideline and Code Changes.doc.*

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

Category I

Evaluation and Management (E/M) Services Guidelines

Guidelines Common to All E/M Services

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT *1992* is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT *2021* and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or

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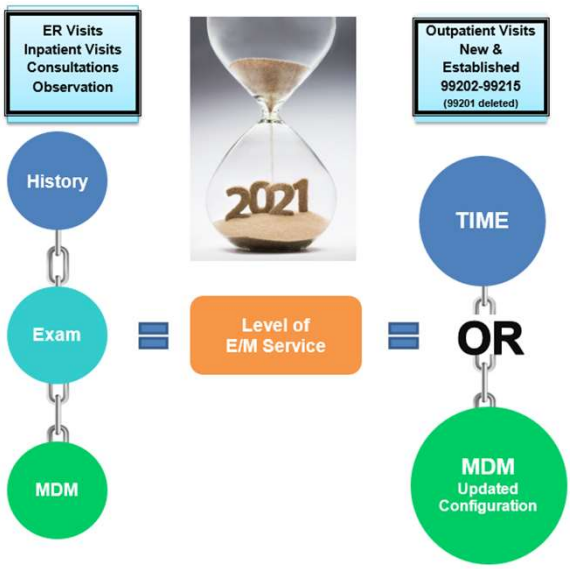
3

WHAT HAPPENED IN 2021?

Time: Time may be used for code selection IF visit is dominated (> 50%) by counseling and/or care coordination and it is documented.



Time: No requirement for counseling and/or care coordination. New time ranges for these code categories.

4

4

2021 E/M CODE REVISIONS: CPT AND CMS AGREE

Why Change?

- E/M codes have not changed since 1992 when first implemented
- Burden of documentation for office and other E/M codes
- EHR proliferation has made much of the documentation meaningless

5

5

KEY POINTS BEFORE WE DIG IN!

- **Changes apply to new (9920x) and established (9921x) outpatient visit codes only beginning January 1, 2021.**
  - Inpatient E/M codes may be similarly revised in 2022 or later. Stay tuned!
- **History and Exam, although no longer "counted" to determine the level of E/M code, should continue to be documented as "medically appropriate" per the AMA.**
  - Remember, the documented History and Exam will be needed to obtain precertification for diagnostic testing (e.g., CT scan, MRI) and surgery!
- **Documentation should reflect the History and Exam "medically appropriate" for the patient's presenting problem.**
  - "Medical necessity" is the rationale for performing a service a procedure.
- **The lowest level for a new patient will be 99202.**
- **Documentation changes will be necessary to comply fully with the revised guidelines.**
- **Work RVU's with the exception of 99211 have been increased**

6

6

2021 RVUS: E/M NEW AND ESTABLISHED VISITS

CPT Code	Work RVU 2021	Total RVU-NF 2021	Total RVU-F 2021
99211	0.18	0.68	0.27
99202	0.93	2.13	1.42
99212	0.70	1.67	1.06
99203	1.60	3.28	2.42
99213	1.30	2.68	1.95
99204	2.60	4.93	3.96
99214	1.92	3.81	2.88
99205	3.50	6.51	5.38
99215	2.80	5.33	4.27
Conversion Factor	$34.89		

7

7

CODE DESCRIPTION CHANGE

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires ~~**these 3 key components**~~**; a medically appropriate history and/or examination and low level medical decision making.**

- ~~A detailed history;~~
- ~~A detailed examination;~~
- ~~Medical decision making of low complexity.~~

~~Counseling and/or coordination with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

8

CRITERIA FOR MDM

9

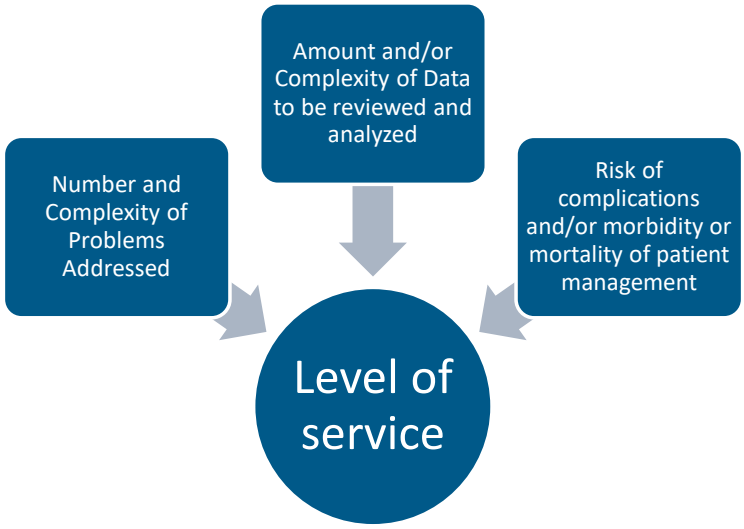
MEDICAL DECISION MAKING

- **Effective January 1, 2021**
  - Level of Decision-Making Table
    - A guide to assist in selecting the level of service when MDM is used
    - Used for office or other outpatient E/M services only
    - Includes 4 levels of MDM (unchanged from current MDM)
      - Straightforward
      - Low
      - Moderate
      - High

10

10

MEDICAL DECISION MAKING TABLE 2021



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11

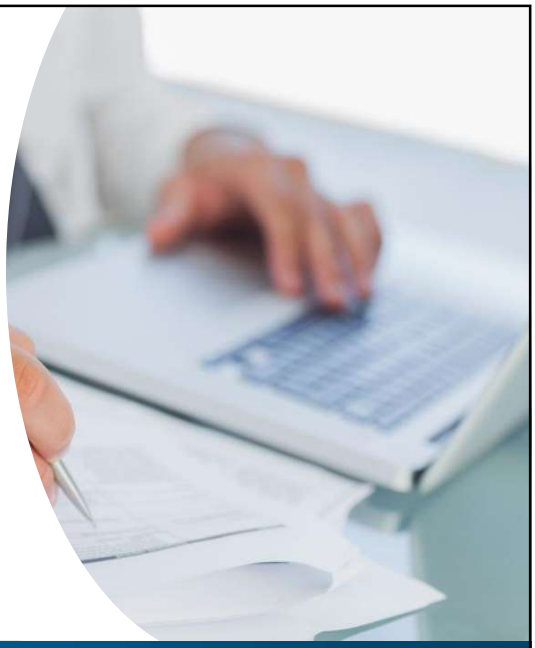
OVERVIEW OF THE NEW MEDICAL DECISION MAKING (MDM) ELEMENTS 2021

		Choose MDM Based on 2 of 3 Elements		
Code	**Level of MDM**	**1) Number and Complexity of Problems Addressed**	**2) 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*	**3) Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	Minimal	Minimal or none	Minimal
99203 **99213**	**Low**	Low	Limited	Low
99204 **99214**	**Moderate**	Moderate	Moderate	Moderate
99205 **99215**	**High**	High	Extensive	High

12

12

ELEMENT # 1: NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED



13

ELEMENT #1: PROBLEM(S) ADDRESSED

CPT Definitions

Problem	Problem Addressed
A: • disease • condition • illness • injury • symptom • sign • finding • complaint • or other matter addressed at the encounter… …with or without a diagnosis being established at the time of the encounter	• A problem is addressed or managed when it is *evaluated or treated* at the encounter by the physician or other qualified health care professional reporting the service. • It includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/ surrogate choice. • Notation in the patient's medical record that another professional is managing the problem *without* additional assessment or care coordination documented does *not* qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. • Referral *without* evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does *not* qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

14

14

ELEMENT #1: PROBLEM(S) ADDRESSED

What constitutes a problem?
CPT does not provide a very clear definition.

KZA's Interpretation:
A single problem is one that requires its own diagnosis and its own treatment plan

Remember:

- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
- Comorbidities/underlying diseases, in and of themselves, are *not* considered in selecting a level of E/M service *unless* they are addressed *and* their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

15

15

ELEMENT #1: DEFINING PROBLEMS, ILLNESS & INJURY

Level of Medical Decision Making Based on 2 of 3 Elements	1) Number and Complexity of Problems Addressed & Definitions	
	N/A (99211)	Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).
	Straightforward (99202, 99212) ☐ **1 self-limited or minor problem**	Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status.
	Low (99203, 99213) ☐ **2 or more self-limited or minor problems;** **OR** ☐ **1 stable chronic illness;** **OR** ☐ **1 acute, uncomplicated illness or injury**	Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). **'Stable' for the purposes of categorizing medical decision-making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.** For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia. Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. **A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.** Examples may include cystitis, allergic rhinitis, or a **simple sprain**.

16

16

ELEMENT #1: DEFINING PROBLEMS, ILLNESS & INJURY

Level of MDM	1) Number and Complexity of Problems Addressed & Definitions
Moderate (99204/99214) • **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**	Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care. Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision-making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. (examples see above) Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast. Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis. Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

17

17

ELEMENT #1: DEFINING PROBLEMS, ILLNESS & INJURY

Level of MDM	1) Number and Complexity of Problems Addressed & Definitions
High (99205/99215) • **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**	Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care. Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

18

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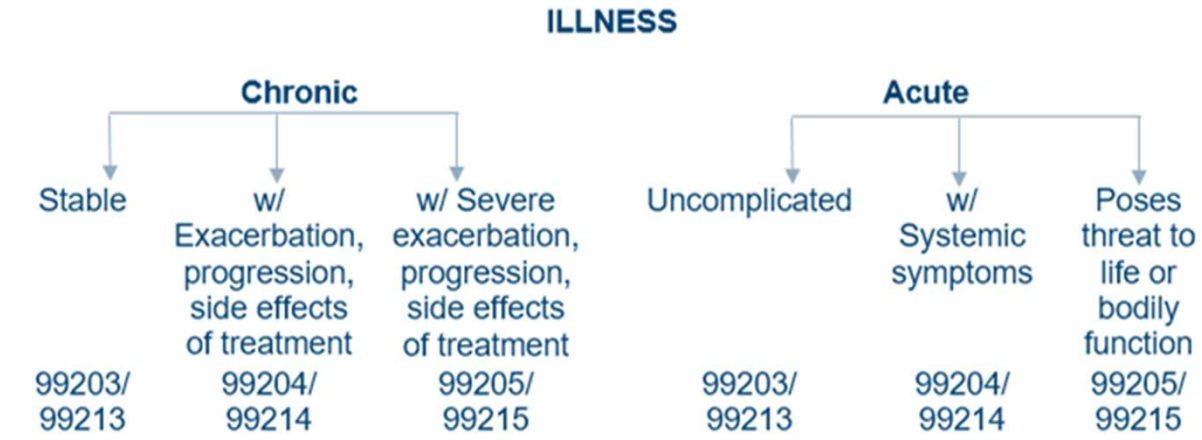
ELEMENT #1: PROBLEMS, ILLNESSES AND INJURIES

Number and Complexity of Problems Addressed



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19

ELEMENT #1: PROBLEMS, ILLNESSES AND INJURIES

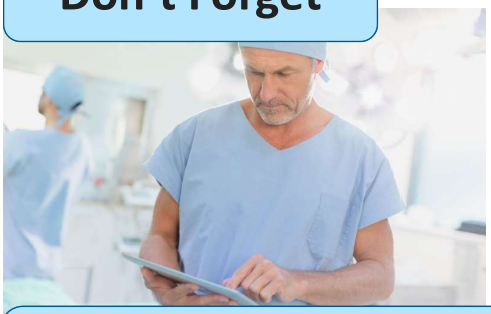
Number and Complexity of Problems Addressed

20

20

ELEMENT #1: PROBLEMS, ILLNESSES AND INJURIES

Don't Forget



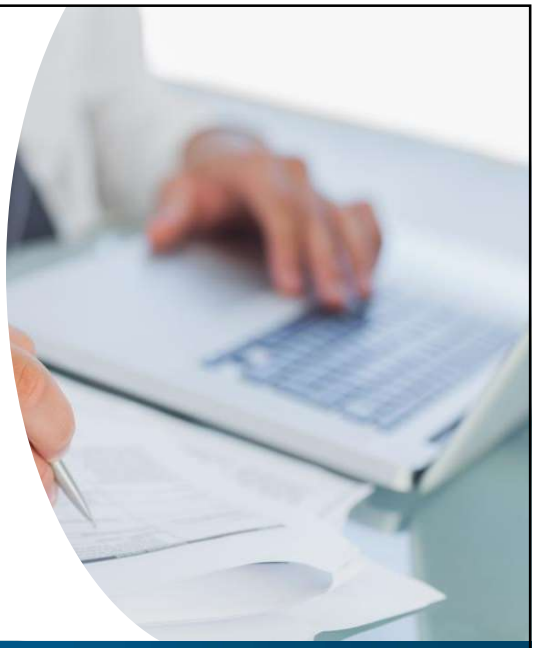
- This is only 1 of the 3 MDM elements.
- Data or Risk is required to choose final level of service.
- *2 or more self-limited or minor problems moves from Minimal to Low complexity while *2 or more stable chronic illnesses moves from Low to Moderate complexity.

TIP: It is the provider's responsibility to document each problem addressed and indicate stable, chronic, acute, exacerbation for each problem!

21

21

ELEMENT # 2: AMOUNT AND COMPLEXITY OF DATA REVIEWED AND ANALYZED



22

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVIEWED AND ANALYZED

Defining External Note(s)

- External note(s) are record(s), communication(s), and/or test result(s) from an external physician, other QHP, facility or health care organization.

Defining Independent Historian(s)

Note: An IH is considered Category 2 data for "Limited" (99203, 99213)

- An independent historian is an individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to the history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
- Key to this definition is that the independent historian should provide **additional information,** and not merely restate information already provided by the patient.

23

23

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVISED AND ANALYZED

Defining and Documenting Independent Tests

Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

- Document "I personally reviewed the CT scan and my interpretation is…"

Defining 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)

- An external physician or QHP is an individual who is not in the same group practice or is a different specialty or subspecialty.
- **Question?** Can this be verbal? Can this be a phone conversation?

24

24

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVIEWED AND ANALYZED

What is a Test? CPT says:

- Tests are services that result in imaging, laboratory, psychometric, or physiologic data.
- The differentiation between single and multiple unique tests is defined in accordance with the CPT code set.
- When a CPT code representing a clinical laboratory, panel is reported (e.g., CPT code 80047, Basic metabolic panel (Calcium, ionized)), it is considered a **single test.**
- The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- An x-ray, an ultrasound, a CT, a lab test ordered or reviewed are each considered a separate and unique test.
- Reviewing an x-ray and ordering a new x-ray, counts as two unique tests as long as you are not separately billing for the test.
- If you order and bill for the test do not count the order. If you order the test but don't bill a CPT code for the test COUNT IT!

25

25

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVIEWED AND ANALYZED

Level of Medical Decision Making Based on 2 of 3 Elements	2) Amount and/or Complexity of Data to be Reviewed and Analyzed – Definitions **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below*	
	Straightforward (99202, 99212)	**Minimal or none**
	Low (99203, 99213)	**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)

26

26

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVIEWED AND ANALYZED

Level of Medical Decision Making Based on 2 of 3 Elements	2) Amount and/or Complexity of Data to be Reviewed and Analyzed – Definitions **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below*	
	Moderate **(99204, 99214)**	**Moderate** (Must meet the requirements of at least 1 out of 3 categories below) 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 **(99205, 99215)**	**Extensive** (Must meet the requirements of at least *2 out of 3* categories listed in Moderate)

27

27

ELEMENT #2: AMOUNT & COMPLEXITY OF DATA REVIEWED AND ANALYZED

Bottom Line:

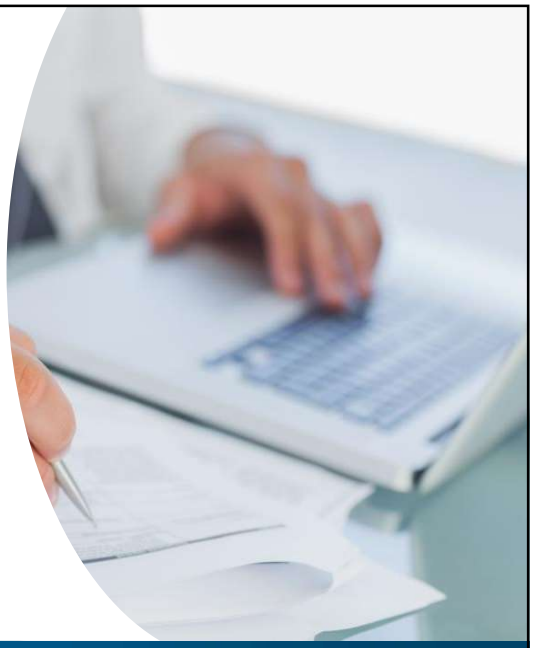
If you/your practice is billing for the test interpretation, then you may not "count" the test as "ordered or analyzed" in determining Medical Decision Making (MDM).

If you/your practice is NOT billing for the test interpretation, then you may "count" the test as "ordered or analyzed" in determining Medical Decision Making.

28

28

ELEMENT 3: RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT



29

ELEMENT #3: RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

30

30

ELEMENT #3: RISK OF COMPLICATIONS OF PATIENT MANAGEMENT

Level of Medical Decision Making based on 2 of 3 Elements	3) Risk of Complications and/or Morbidity or Mortality of Patient Management	
	Straightforward (99202/99212)	Minimal risk of morbidity from additional diagnostic testing or treatment
	Low (99203/99213)	Low risk of morbidity from additional diagnostic testing or treatment
	Moderate (99204/99205)	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 (99205/99215)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • 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 • Drug therapy requiring intensive monitoring for toxicity

31

31

EXERCISE: DETERMINING LEVEL OF RISK

Elements of MDM (Based on 2 of 3 Elements)			
Code	**Level of MDM**	**3) Risk of Complications Complications and/or Morbidity or Mortality of Patient Management**	**CPT Says:**
99211	**SNA**	Not Applicable	N/A
99202 **99212**	**Straight-forward**	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**MORBIDITY** A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. **SOCIAL DETERMINANTS OF HEALTH** Economic and social conditions that influence the health of people and communities (eg, food or housing insecurity).
99203 **99213**	**Low**	**Low risk of morbidity from additional diagnostic testing or treatment**	

32

32

EXERCISE: DETERMINING LEVEL OF RISK

Elements of MDM (Based on 2 of 3 Elements)			
Code	**Level of MDM**	**3) Risk of Complications Complications and/or Morbidity or Mortality of Patient Management**	**CPT Says:**
99204 **99214**	**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	**DRUG THERAPY requiring Intensive monitoring for toxicity** -A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. - The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases.

33

33

EXERCISE: DETERMINING LEVEL OF RISK

Elements of MDM (Based on 2 of 3 Elements)			
Code	**Level of MDM**	**3) Risk of Complications Complications and/or Morbidity or Mortality of Patient Management**	**CPT Says:**
99205 **99215**	**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 de-escalate care because of poor prognosis	**DRUG THERAPY requiring Intensive monitoring for toxicity** -A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. - The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases.

34

34

USING TIME

35

USING TIME TO DETERMINE LEVEL OF SERVICE

You can choose E/M code 99202-99215 based on MDM or **TIME**!

CPT Code	2021 Code Total Time (Minutes)	CPT Code	2021 Code Total Time (Minutes)
NEW PATIENT VISITS		ESTABLISHED PATIENT VISITS	
99201	Code deleted	99211	N/A
99202	15 - 29	99212	10 - 19
99203	30 - 44	99213	20 - 29
99204	45 - 59	99214	30 - 39
99205	60 - 74	99215	40 - 54

Total time for coding purposes, is the total time on the date of the encounter.
It includes both:

- face-to-face, and
- non-face-to-face time personally spent by the *physician and/or other QHP* on the date of the encounter.

This includes time in activities that **require the physician or QHP** and **does not** include time in activities normally performed by clinical staff (e.g. rooming patient).

36

36

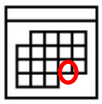
USING TIME TO DETERMINE LEVEL OF SERVICE

Total Time

Total physician/other qualified health care professional time on the day of the encounter includes the following activities, when performed:

- 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

On The Day



- independently interpreting results (not separately reported)
- and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Documentation Tip:
When reporting time, itemize the time spent in specific activities. "This encounter took 45 minutes of time including taking a history, performing the examination, reviewing the CT scan, reviewing the PCP's notes, counseling the patient on his new diagnosis of ____ as well as documenting in the EHR."

37

37

USING TIME TO DETERMINE LEVEL OF SERVICE OVERVIEW

Time performing a procedure cannot be "counted" toward the E/M code level time.

38

38

TOTAL TIME ON THE DATE OF THE ENCOUNTER

- Time threshold now a range of time
- Non-face-to-face activities are now recognized
- Code selection is when using time
  - Not a required minimum amount when using MDM
- Time spent by ancillary clinical staff is not included
- When more than one clinician addressed (count only 1 clinician per minute)
- Can only use new prolonged service code when using time and the highest E/M level (99205 or 99215)

39

TIME

TIME QUALIFIERS

When time is used to choose the level of service, a face-to-face encounter is required by the billing provider on the date of service.

Total time on the date of the encounter can be the combined time (the physician and QHP).

Clinical staff time does not count toward total time.

40

40

TIME

Split/Shared service is defined as a visit in which the physician and QHP jointly provide the face-to-face and non-face-to-face work related to the visit.

Only distinct time should be summed for split/shared visits (e.g., Physician and PA meet to discuss the patient - only the time of 1 provider counts).

Time is not used for 99211 OR if the total time is:

< 15 minutes for a new patient visit OR

< 10 minutes for an established patient visit.

Time performing a procedure is not added into the E/M code time.

Added time for an interpreter or translator, on the same day of service, does count toward total time.

41

41

PROLONGED SERVICE CODES 2021: CHOOSING THE RIGHT CODE

+99417 – NEW IN 2021
Description and code finalized in 2021 CPT manual.
Use with 99205 or 99215 when selecting E/M code based on time
Use when you've gone at least 15 minutes beyond the maximum amount of time assigned to 99205 or 99215.
Face-to-face and non-face-to-face time may be summed.

42

42

PROLONGED SERVICE CODE (99417)

The addition in 2021 of a shorter 15-minute prolonged service code (99417)

Prolonged Services/Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service

★+●99417 Prolonged office or other outpatient evaluation and management service(s) (beyond the total 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 (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

- **(Use 99417 in conjunction with 99205, 99215)**
- **(Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)**
- **(Do not report 99417 for any time unit less than 15 minutes)**

43

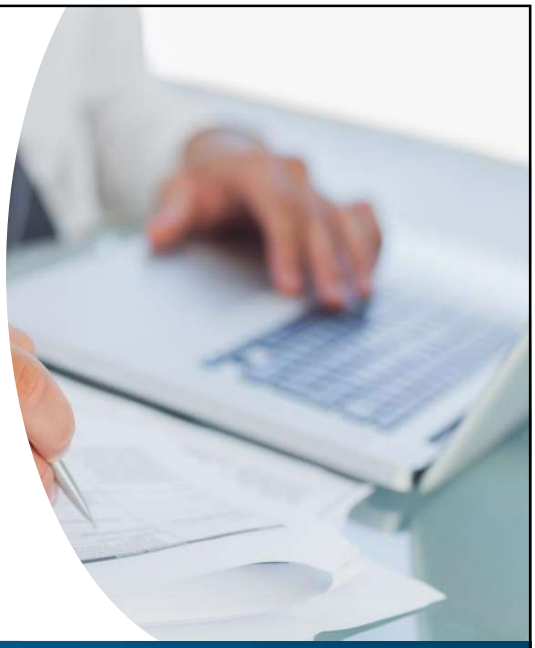
PROLONGED SERVICE CODES 2021: CHOOSING THE RIGHT CODE

Codes	Time ranges	Per CPT, use add on code 99417 for these visit lengths	Per CMS, use add on code G2212 for these visit lengths
99205	60—74 minutes	75-89 minutes	89-103 minutes
99215	40-54 minutes	55-69 minutes	69-83 minutes

44

44

E/M CASES: 2020 VS 2021



45

Code	Level of MDM	1) Number and Complexity of Problems Addressed	2) Amount and/or Complexity of Data to be Reviewed and Analyzed	3) Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	*probably minimal	Not Applicable	Not Applicable
99202 99212	Straight forward	**Minimal** ❑ 1 self limited or minor problem	**Minimal or none**	**Minimal risk** of morbidity from additional diagnostic testing or treatment
99203 99213	Low	**Minimal** ❑ **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:** Any combination of 2 from the following: ○ __Review of prior external note(s) from each unique source*, ○ __1 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**: 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 independent historian(s) OR □ **Category 2:** 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 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**)* *(immediately above)*	**High risk** of morbidity from additional diagnostic testing or treatment* *Examples only:* • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • DNR Decision or de-escalate of care due to poor prognosis • Drug therapy requiring intensive monitoring for toxicity

46

CASE 1

SUBJECTIVE: The patient is a 60-year-old female who comes in today for follow up for psoriasis. She notes that the psoriasis is actually getting a bit worse on her forearms. She only has it there. She also had some erythema on her nasal columnar that we had frozen with liquid nitrogen for the chance that it could be an actinic keratosis. She also has some brown discoloration in the right nasal ala that we were watching and did look relatively benign and she notes it has not changed. She notes she does not really go out much. She is using DesOwen lotion twice a day to the elbows as well as desonide twice a day.

ASSESSMENT AND PLAN: Chronic Psoriasis: The patient had several very thin pink plaques on her forearms, and it does look like she has new patches of psoriasis. We discussed that since she does not get really any sunlight, to give herself 15 minutes every day and that itself can help clear psoriasis. She can continue on with the desonide twice a day and the Dovonex twice a day as the lesions do look relatively thin and minimal. She had a little bit of macular erythema on the nasal columnar but no evidence of any scaling, and we discussed with her she can just simply watch this. She also had the brown discoloration on the right nasal ala that looks actually improved from last time and not concerning, and we will continue to watch this. It could be a small patch of post inflammatory hyperpigmentation. We will see her back in two months.

47

47

CASE 1

Problems Addressed	Moderate	1 or more chronic illness with exacerbation
Data Reviewed and Analyzed	Minimal	None
Risk of Patient Management	Moderate	Prescription drug management
MDM	Low	

Code	Level of MDM	Choose MDM Based on 2 of 3 Elements (headings are abbreviated)		
		1) Problems Addressed	2) Data	3) Risk of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 **99214**	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

48

48

CASE 2

The established patient presents today for follow-up, recently noted for E. coli urinary tract infection. She was treated with Macrobid for 7 days, and only took one nighttime prophylaxis. She discontinued this medication to due to skin rash as well as hives. Since then, the rash had resolved.

Office note details medically appropriate history and examination.

Medical Decision Making:

Renal ultrasound, April 14, 2021, reviewed, no evidence of hydronephrosis, bladder mass or stone. Discussed.

Previous urine cultures had shown E. coli, November 2020, May 7, 2020, and April 14, 2021
CATHETERIZED URINE: Discussed, agreeable done using standard procedure. A total of 30 mL was obtained.

IMPRESSION: Recurrent and chronic urinary tract infection in a patient recently noted for another Escherichia coli urinary tract infection, completed the therapeutic dose, but stopped the prophylactic Macrodantin due to hives. This has resolved.

PLAN: We will send the urine for culture and sensitivity We will call patient with results on Monday, She will be placed on Keflex nighttime 500mg prophylaxis, We will see her back in the office in 1 week

49

49

CASE 2

Problems Addressed	Moderate	1 or more chronic illness with exacerbation
Data Reviewed and Analyzed	Low	Reviewed renal US (1 data point) Ordered urine culture (1 data point)
Risk of Patient Management	Moderate	Prescription drug management
MDM	Moderate	

Code	Level of MDM	Choose MDM Based on 2 of 3 Elements (headings are abbreviated)		
		1) Problems Addressed	2) Data	3) Risk of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 **99214**	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

50

50

CASE 3

Mrs. Jones is an established patient that has had a six-month history of some right shoulder pain and it has not gotten much better. She does not have a history of trauma. It does bother her at night when she sleeps, and she is here now to have it checked out. She has no other focal findings, no numbness or tingling to the fingers and no soreness at the elbow or neck. She is right hand dominant.

Office note details medically appropriate history and examination.

Medical Decision Making:

Chronic shoulder pain worsening. At this point, with her consent, explaining the risks and benefits, we talked about cortisone shots. We will try some physical therapy, Tramadol, 50mg 1 tab. Q8hs for pain medicine only as needed and a sleep aide as needed, and then follow-up. We will consider a cortisone shot at that point. All questions were answered. Therapy for shoulder impingement was outlined. The patient will return in 3 weeks.

51

51

CASE 3

Problems Addressed	Moderate	1 or more chronic illness with exacerbation, progression or side effects of treatment
Data Reviewed and Analyzed	Minimal	None
Risk of Patient Management	Moderate	Prescription drug management

Code	Level of MDM	Choose MDM Based on 2 of 3 Elements (headings are abbreviated)		
		1) Problems Addressed	2) Data	3) Risk of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 **99214**	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

52

52

CASE 4

60-year-old established patient returns after ankle injury four months ago. All swelling and bruising has resolved. She reports no instability or reinjury. She's found that she no longer needs to wear an AFO when she attends exercise classes at the YMCA. She's here because she thought she was supposed to return for a final check. Imaging: None

Office note details medically appropriate history and examination.

Medical Decision Making:

Plan: I've explained that her sprain has healed well. She should continue to monitor for any pain or feeling of instability, but otherwise there's no need for further follow up.

53

53

CASE 4

Problems Addressed	Minimal	1 self limited or minor problem
Data Reviewed and Analyzed	None	
Risk of Patient Management	Minimal	Self-modified activity

Code	Level of MDM	Choose MDM Based on 2 of 3 Elements (headings are abbreviated)		
		1) Problems Addressed	2) Data	3) Risk of Patient Management
99211	N/A	N/A	N/A	N/A
99202 **99212**	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

54

54

DOCUMENTATION IMPROVEMENT TIPS TO ASSIST WITH 2021 E/M CHANGES

Problems Addressed

- State “acute” vs “chronic” conditions
- EPSET: exacerbation of illness, progression, side effects of treatment
- Injury: complicated vs uncomplicated
- Severity (remember: this is the difference between Moderate and High complexity)

55

55

DOCUMENTATION IMPROVEMENT TIPS TO ASSIST WITH 2021 E/M CHANGES

Data

- Document unique:
  - Test(s) ordered
  - Report(s) reviewed
  - External note(s) reviewed
- Independent historian(s): who (role), what (info obtained), why (necessity for independent historian)
- Discussion of management with external source
- Discussion of interpretation with external source

56

56

DOCUMENTATION IMPROVEMENT TIPS TO ASSIST WITH 2021 E/M CHANGES

Risk

- Itemize specific procedure risk(s)
  Example: We discussed the risk factors which include but are not limited to paralysis, infection, delayed wound healing,

  or
- State patient co-morbid condition(s) affecting surgical risk
  Example: Patient is at additional risk for wound healing issues due to smoking, diabetes, obesity

57

57

7 ELEMENTS OF DOCUMENTATION

1. Itemize risk factors for procedures
2. Itemize patient risk factors / co-morbidities
3. Document information obtained from independent historian (IH):
   WHO the IH is (e.g., spouse, parent)
   WHY IH is needed (e.g., patient age)
   WHAT information was obtained
   (e.g., state specific info obtained by IH)
4. Injury: complicated vs uncomplicated
5. Illness: E = exacerbation (severe)
   P = progression (intent to control)
   SET = side effects of treatment (severe)
6. Discussion of patient management with external source
   OR
   Discussion of test interpretation with external source
7. Unique time of all participating physician/QHP
   (qualified health care professional) – not MA, RN, LVP/LPN

58

58

DOCUMENTATION IMPROVEMENT TIPS TO ASSIST WITH 2021 E/M CHANGES

Stable, At goal, Improving	Not at goal, Worsening, Unstable	Risk, Benefit, Optional, Alternate	Outcome, Noncompliant, Compliant
Rule out, Differential	Diagnosis specificity	List Individual Lab ordered	List Diagnosis test ordered
Document names and relation of those involved in the service	Identify the provider of any outside records	Total time clearly documented and unique to the patient	

59

7 ELEMENTS OF DOCUMENTATION

- Remove EHR "suggestion" for level of service based on old guidelines.
  - REMEMBER: If you report outpatient consultations, 2 sets of guidelines
  - are used in the office-original and 2021.
- Eliminate unnecessary bullets filled in automatically in the history and exam for new and established patient office visits.
- Run a report listing your top 10 diagnoses for office visits by volume and determine the "type of problem, illness or injury" based on the CPT definitions.
- Evaluate (audit) your "typical" medical decision-making office documentation.
  - (new & established visit) using the KZA audit tool.
- Review the same notes (in #4 above) with the KZA flashcards focusing on work done but not documented correctly.

60

60

TO DO LIST 2021

- Revise templates focusing on documentation of
  - Problems addressed.
  - Tests ordered and or reviewed or independently interpreted.
  - Risk of patient management including procedure risks.
- Evaluate office flow considering the revised guidelines.
- Review current guidelines for use in the ER and inpatient services.
- Perform a coding and documentation review (audit) in the next six months. Review at least 5-10 notes per practitioner using the 2021 guidelines to ensure compliance.
- Audit and monitor at a minimum annually. Audit more frequently if the practitioners coding accuracy falls below 95%.
- If any practitioner's documentation is not sufficient implement a clinical documentation improvement plan for the individual practitioner

61

61

QUESTIONS

62

Thank You

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63