



PHOENIX HEALTHCARE SERVICES

NATIONWIDE DATA DRIVEN RCM

**CPT® 2021 Evaluation and Management (E/M) Office
& Other Outpatient Code and Guideline Changes**

Content



Proposed Changes to
office/outpatient E/M
coding



Billing E/M based on
Medical Decision
Making: Examples of
Chart Documentation
and Determining the
appropriate level



Billing E/M based on
Time: Current Time and
Proposed Time Ranges



Prolonged Services
Codes:
99417 and G2212



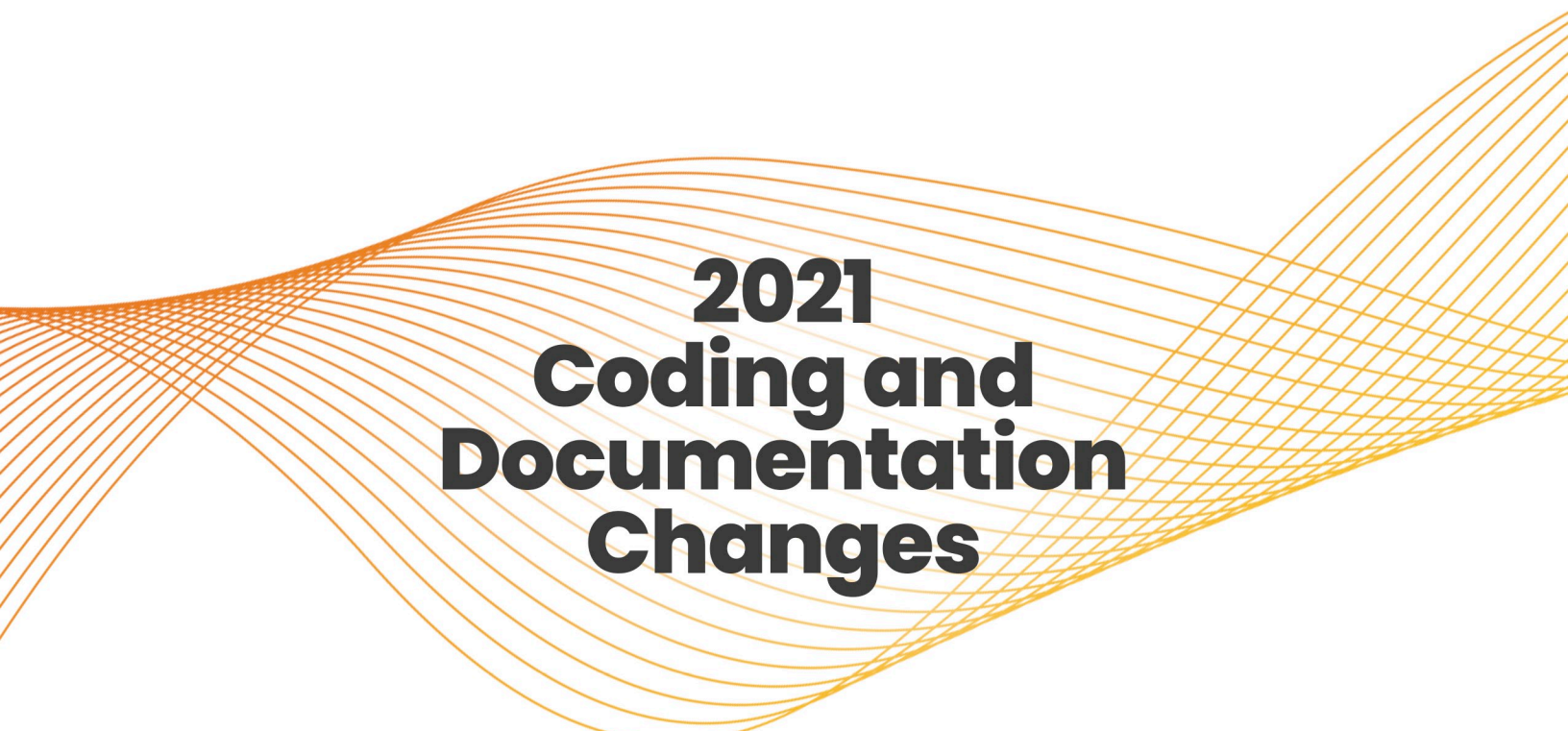
Hospital Evaluation and
Management services



Frequently Asked
Questions



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2021 Coding and Documentation Changes

**Effective
January 1, 2021**

**Applies ONLY to
office/outpatient
CPT codes
99202–99215
(99201 deleted)**

**NOTE: No other
E/M levels are
affected.**



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What is the reason for the proposed documentation changes?



The current guidelines in place today are complex and focus on the quantity of documentation over the quality.



The new set of guidelines for 2021 are intended to help simplify E/M leveling for office and other outpatient services.



NOTE : Proposal is by CMS who governs Medicare and Medicaid. No commercial payers have commented on accepting the proposal.



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Why is Medical Record Documentation Important?

Proper and complete documentation plays a crucial role in the overall patient care

Ensures accurate and timely payment for services

Substantiates necessity of additional services, testing, and procedures

Provides backup support for liability issues and mitigates risks

Used as a tool for communication between providers and caregivers

Helps maintain quality, consistent patient care



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Changes to History and Examination requirement



Bullet points for the history and exam are no longer required to meet the level of service billed for New or Established office/outpatient services



The provider will still document a medically appropriate history and/or physical exam, when performed



NOTE: Even though the history and exam will not be included in audits both should be documented from a liability standpoint



Information may still be collected from the patient and/or caregiver directly (face to face in real time), by questionnaire or by portal



How to select the appropriate new or established office and outpatient service

Select the level of E/M service based on:

1.

The level of medical decision making (MDM) per each level of service

OR

2.

The total time for E/M service(s) performed on the date of service



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Billing based on Medical Decision Making (MDM)

There are still four levels of
medical decision making:



Straightforward



Low



Moderate



High



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Billing based on Medical Decision Making (MDM)



Straightforward

99202/99212



Low

99203/99213



Moderate

99204/99214



High

99205/99215



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Billing based on Medical Decision Making (MDM)

There are still three factors to determine complexity:

1.

Number of possible diagnoses and/or number of management options, i.e., Established problem(s) stable, controlled, etc.

2.

Amount and complexity of Data medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed

3.

The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) ordered, and/or the possible management options selected by the examiner.



The requirement of 2 of 3 areas need to "agree" to level the overall MDM



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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> 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) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment



99204 99214	Moderate	<p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; <p>or</p> <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; <p>or</p> <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; <p>or</p> <ul style="list-style-type: none"> • 1 acute complicated injury 	<p>Moderate (Must meet the requirements of at least 1 out of 3 categories)</p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	<p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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	<p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	<p>Extensive (Must meet the requirements of at least 2 out of 3 categories)</p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	<p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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



2020 vs 2021

Leveling of an E/M

- **An established office patient with osteoarthritis**

- **CC:** "knee Pain"

- **Interval History:** Patient with known osteoarthritis which had been previously controlled on Tylenol. Now states his left knee has been aching for about two weeks despite two to three doses of Tylenol per day.

- **ROS:** Musculoskeletal Negative for arthralgias or worsening joint pain elsewhere

- **Physical Exam:** Mild swelling of left knee compared to the right. Some pain with passive rotation. No overlying warmth or erythema.

- **Assessment** – 1. Worsening osteoarthritis

- **Plan** – 1. Start OTC ibuprofen 400 mg po TID, PRN

- 2. Return visit in two weeks if no improvement

2020 – 99213

- **HISTORY:** Expanded Problem Focused

- **EXAM:** Problem Focused

- **MDM:** Low

- 99213: Expanded Problem Focused History, Expanded Problem Focused Exam, and Low MDM. An established patient needs to meet 2 of 3 key components to support the selected level.

2021 – 99213

- **MDM:** Low

- 99213: Based on 2 out of 3 elements of MDM 1 acute, uncomplicated illness or injury, No data reviewed, and Low risk of morbidity from additional diagnostic testing or treatment



Selecting the level of E/M using MDM: Example Chart

- **CC:** Follow up hypertension and diabetes
- **Interval History:** The patient's hypertension has been well controlled on current medications. Diabetes is stable as well, with no significant hyperglycemia or episodes of symptomatic hyperglycemia. Dyslipidemia remains well controlled on statin therapy.

Medications:

- Lisinopril 20 mg po qd
- Atorvastatin 10 mg po qd
- Glyburide 10 mg po qd

ROS:

- General: Negative for fatigue, weight loss, or anorexia
- Cardiovascular: Negative for chest pain, orthopnea or PND
- Neurologic: Negative for paresthesias
- Pertinent PFSH remarkable for mild OA which has been quiescent

Physical Exam:

- General: NAD, conversant
- Vitals: 120/80, 65, 98.6
- HEENT: No JVD or carotid bruits
- Lungs: CTA
- CV: RRR
- Extremities: No peripheral edema
- Labs: BUN 12, creatinine 0.8, HGBA1C 6.8, spot microalbumin/creatinine ration is 28mcg/g; LDL 77

Assessment:

1. Well controlled Type 2 NIRDm
2. Well controlled hypertension
3. Stable dyslipidemia



Selecting the level of E/M using MDM: 99214 Moderate

PLAN:

1. Continue current medications unchanged
2. Repeat renal profile, spot microalbumin/creatinine at next visit, along with CBC
3. Check LFTs at next visit as well as due to ongoing statin therapy
4. Continue lifestyle modification and exercise for weight loss
5. Return visit in four months

99204 99214	Moderate	Moderate <ul style="list-style-type: none"> • 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 <i>(Must meet the requirements of at least 1 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <i>Examples only:</i> <ul style="list-style-type: none"> • 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
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Billing Based On Time



The total time for E/M service(s) performed on the date of service



Time applied is the total time spent with the patient on the date of service



Includes both face-to-face and non-face-to-face time personally spent by the rendering provider on the date of service



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Examples of Time Spent

- Review of records, tests, labs, etc.
- Ordering any required tests, labs, etc.
- Obtaining history
- Performing the exam
- Documenting all pertinent information in the medical record
- Independent interpretation of tests that are not separately billable (independent review of x ray for example)
- Counseling/educating the patient/caregiver
- Care coordination (not separately billed)



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Billing Based On Time

- Current requirements when billing based on time require TOTAL minutes spent face to face with the patient along with a comment that "greater than 50% was spent counseling and coordinating care" followed by what the patient was counselled on.
- For the 2021 proposal there have been no details distributed regarding a new time statement other than the total time spent needs to be noted. Stay tuned for updates.



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Billing Based On Time

Current Time Ranges:

99202 = 20 minutes
99203 = 30 minutes
99204 = 45 minutes
99205 = 60 minutes
99211 = 5 minutes
99212 = 10 minutes
99213 = 15 minutes
99214 = 25 minutes
99215 = 40 minutes

Proposed Time Ranges:

99202 = 15-29 minutes
99203 = 30-49 minutes
99204 = 45-59 minutes
99205 = 60-74 minutes
99211 = N/A
99212 = 10-19 minutes
99213 = 20-29 minutes
99214 = 30-39 minutes
99215 = 40-54 minutes



Documentation Updates

Continue to use 1995 and 1997 documentation guidelines

2021

2020

Use current rules, MDM or time



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Prolonged Services



New Prolonged Services codes (99417/G2212) can be reported in addition to only the highest E/M levels: 99205/99215



These codes are to be reported when the service has been selected using time alone and only after total physician time exceeds the minimum/maximum time by 15 minutes



Prolonged time can include combined time with and without direct patient contact by the provider on the date of service.



Time spent on performing separately reported services does not apply towards the E/M of prolonged services.



AMA and CMS Comparison Between Total Time for Office/Outpatient Services

New Patient Provider Total Time	AMA — Prolonged Service CPT Code Use
60–74 minutes	99205
75–89 minutes	99205 x1 and 99417 x1
90–104 minutes	99205 x1 and 99417 x2
105 minutes or more	99205 x1 and 99417 x3 or more for each additional 15 minutes

New Patient Provider Total Time	CMS — Prolonged Service CPT Code Use
60–74 minutes	99205
89–103 minutes	99205 x1 and G2212 x1
104–118 minutes	99205 x1 and G2212 x2
119 minutes or more	99205 x1 and G2212 x3 or more for each additional 15 minutes



AMA and CMS Guidelines for Prolonged Service CPT code use

► AMA 99417

A Prolonged office or other outpatient evaluation and management service(s) beyond the **minimum** required 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 additional 15 minutes (*List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services*).

► CMS G2212

Prolonged office or other outpatient evaluation and management service(s) beyond the **maximum** required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (*List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services*).

Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, or 99416.

Do not report G2212 for any time unit less than 15 minutes.



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Hospital Evaluation and Management Services

Observation Billing:

- The patient physical location does not require the patient to be physically in the Observation area of the Hospital. It solely depends on the patient's status.
- Only the admitting provider bills the Observation series of CPT codes. Any other provider that sees the patient bills the appropriate outpatient series CPT codes.
- CPT series for Observation services:

Admitting Provider:

- Initial Observation services (99218-99220)
- Subsequent Observation services (99224-99226)

All Other Providers:

- New or Established patient services
- NOTE: Keep in mind the new proposal for 99202-99215, documentation must meet TIME or MDM for the level billed.



Hospital Evaluation and Management Services

Inpatient Billing:

- Initial Inpatient services (99221-99223)
- Subsequent Inpatient services (99231-99233)
- Inpatient Consultation services (99251-99255)

Inpatient Tips:

- For Medicare, the provider that admits the patient to the hospital will apply the AI modifier to the admission CPT
- AI reflects the principal physician of record
- Differentiates the providers that must bill the Initial Inpatient CPT codes for a "Consultation" due to Medicare guidelines
- Consultation for Commercial payers are billed with the Inpatient Consultation series CPT (99251-99255)



Key Takeaways



These changes only apply to office and outpatient service CPT codes (99202-99215)



Providers will base the level of service upon just the medical decision making OR total time



CPT code 99201 will be deleted



Total time is defined as "total time spent on the date of service"



History and Examination will no longer be needed to determine the level of service; however, these elements should still be documented from a liability standpoint



There are new Prolonged Services Codes (99417/G2212) reported in addition to only the highest level of E/M office/outpatient services (99205/99215) when the minimum/maximum time required exceeds 15 minutes



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FAQ

What is the purpose of these proposed changes?

To reduce documentation overload so that physicians can focus more on patient care.

Why are the History and Exam elements no longer required to determine the level?

These elements are significant; however, these elements alone should not be required to determine a visit's code level.

How will our practice document E/M levels for commercial payers?

These proposed changes are from CMS who govern Medicare and Medicaid. Commercial payers have yet to comment on if they will be following the proposed changes; documentation will remain the same.

Will these changes affect overall patient care?

Yes, these changes would allow physicians to move away from adding up tasks to focusing on tasks that affect the management of a patient's condition.



Plans for 2021



Through audits, Phoenix will provide monthly feedback to ensure compliance with the proposed changes.



Phoenix will follow up with emails as new information is released regarding coding changes and updates.



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Resources

AMA releases 2021 CPT code set

CPT® Evaluation and Management (E/M)

What's Changing for E/M Codes 99201–99215 in 2021?

Evaluation and Management Services Guide



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