2020 REMINDER PAGE

ATTN: ALL PROVIDERS

Evaluation & Management (E&M) Coding in 2021 - Reminder

Currently through the end of 2020: Evaluation & Management (E&M) Coding is based on the 1995 or 1997 Centers for Medicare Services (CMS) in association with the American Medical Association (AMA) guidelines which considers three key components: History, Physical Exam, and Medical Decision Making (MDM).

1995: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

1997: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Each E&M CPT code should include documentation of the key components, History, Exam, and Medical Decision Making (MDM); see component descriptors below.

Office or Other outpatient visits for the E&M of a **new** patient, which requires specific documentation of **all three** of the key components to determine the level of service (LOS) selected:

CPT	History		Exam		MDM		Time	WRVU
99201	Problem focused	PF	Problem focused	PF	Straightforward	SF	10	0.48
99202	Expanded Problem Focused	EPF	Expanded Problem Focused	EPF	Straightforward	SF	20	0.93
99203	Detailed	D	Detailed	D	Low complexity	L	30	1.42
99204	Comprehensive	C	Comprehensive	C	Moderate complexity	M	45	2.43
99205	Comprehensive	C	Comprehensive	C	High complexity	H	60	3.17

Office or Other outpatient visits for the E&M of an **established** patient, which requires specific documentation of **only two of the three** key components to determine the LOS selected: (NOTE: For BCBS MDM must be one of the two.)

CPT	History		Exam		MDM		Time	WRVU
99211	Minimal						5	0.18
99212	Problem Focused	PF	Problem Focused	PF	Straightforward	SF	10	0.48
99213	Expanded Problem Focused	EPF	Expanded Problem Focused	EPF	Low Complexity	L	15	0.97
99214	Detailed	D	Detailed	D	Moderate Complexity	M	25	1.50
99215	Comprehensive	C	Comprehensive	C	High Complexity	H	40	2.11

TIME: There is a provision in the current E&M guidelines that allows providers to use Time as the controlling factor to determine the LOS selected. When the **provider** spends the entire above referenced **Time** per CPT code **face-to-face** with the patient **AND** at least HALF of that time must is for "counseling and coordination of care." The counseling and coordination of care **topics must** be documented as well as the time of the entire visit and that >50% of the time was spent counseling and coordination of care.

NOTE: The definition of New and Established patient remains the same, i.e., not seen Face-to-Face (F2F) within 3 years, see E&M Guidelines.

2021 FOCUS

MDM & TIME

As always, medical necessity is the overarching criteria for the visit.

History of Present Illness (HPI)

Beginning January 1, 2021, Office and Outpatient E&M guidelines specific only to CPT codes 99202-99215 will give providers the option to code LOS based on the:

Total **time** spent and documented on a patient's care **on the date of service**

-OR-

Medical Decision Making (**MDM**) documented

NOTE: For 2021, Office or other outpatient services must only include a **medically appropriate history and/or physical examination**. The nature and extent of the history and/or physical examination is determined by the provider reporting the service but is not an element in selection of the office or other outpatient LOS. The care team may collect information and the patient or caregiver may supply information directly (i.e., by portal or questionnaire) that is reviewed by the reporting provider.

Chief Complaint (CC) / History of Present Illness (HPI) are used to support **medical necessity**.

Office or Other outpatient visits for the E&M of a **new** patient, which requires specific documentation of **only** the MDM component to determine LOS selected **or** Time:

The 2021 AMA definitions of time:

CPT	History	AND / OR Exam	MDM	Prior Time	Time	WRVU*
99201	*deleted*			10		
99202	*Medically Appropriate*	*Medically Appropriate*	Straightforward	20	15-29	0.93
99203	*Medically Appropriate*	*Medically Appropriate*	Low Level	30	30-44	1.60
99204	*Medically Appropriate*	*Medically Appropriate*	Moderate Level	45	45-59	2.30
99205	*Medically Appropriate*	*Medically Appropriate*	High Level	60	60-74	3.50
99417	Prolonged Services - for services 90 minutes or longer* *(in 15 min increments)*			N/A	90+	0.61

Office or Other outpatient visit for the E&M of an **established** patient, which requires specific documentation of **only** the MDM component to determine LOS selected **or** Time:

CPT	History	AND / OR Exam	MDM	Prior Time	Time	WRVU*
99211	Minimal Problems – *typically performed by a nurse/clinician*			5	7	0.18
99212	*Medically Appropriate*	*Medically Appropriate*	Straightforward	10	10-19	0.70
99213	*Medically Appropriate*	*Medically Appropriate*	Low Level	15	20-29	1.30
99214	*Medically Appropriate*	*Medically Appropriate*	Moderate Level	25	30-39	1.92
99215	*Medically Appropriate*	*Medically Appropriate*	High Level	40	40-54	2.80
99417	Prolonged Services - for services 70 minutes or longer* *(in 15 min increments)*			N/A	70+	0.61

**WRVUs are proposed… not finalized.*

Example: Where 99XXX = 99417

▶Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes◀

New 'G' Add-on codes:
Pending enumeration; additional efforts used with standard above E&M codes by primary providers, and non-surgical provider:*

- *GPC1X - Additional resources to address complexities in E&M visits associated with primary care services (for established patients)*
- *GCG0X - Additional resources to address complexities in E&M visits associated with certain nonprocedural care – to include interventional pain management-centered care (for new or established patients)*

Code	*Short Description*	*Proposed 2021 WRVU*
GPC1X	*VISIT, COMP, W/PRIM MED CARE*	*0.33*
GCG0X	*VISIT, COMPLEX, E&M ADD ON*	*0.33*

** = Pending listing of specialties*

TIME… *SUBJECT TO CHANGE PER 2020 FEDERAL REGISTER*

For 2021, time is defined as "total time spent on the day of the encounter",
i.e., if the provider enters clinical information into the medical record days later, that time** (to enter) is NOT counted.

The 2020 counseling/coordination of care restriction will not apply to E&M codes 99202-99215 and providers will be able to report code LOS based on "**both** the face-to-face **and** non-face-to-face time **personally spent by the physician and/or other qualified health care professional(s)** on the day of the encounter."

The 2021 guidelines state:
Activities that a provider can count toward total time include:

- ❑ ___ minutes to Prepare for the visit, for example, review test results.
- ❑ ___ minutes to Obtain or review 'separately' obtained patient history.
- ❑ ___ minutes to Perform a medically necessary examination and/or evaluation.
- ❑ ___ minutes to Counsel and educate the patient, a family member or a caregiver related to diagnosis.
- ❑ ___ minutes to Order test, medicine, additional services.
- ❑ ___ minutes to Refer or communicate with other health care professionals.
- ❑ ___ minutes to Enter clinical information in the patient's medical record.
- ❑ ___ minutes to Interpret and share test results with the patient.
- ❑ ___ minutes to Coordinate patient care.

Consider adding as a 'pick list' to providers template, with or without minutes indicated

Appropriate time statement examples:
I spent 90 minutes obtaining the HPI, examining the patient, and counseling the patient on diagnosis "xxxxx".
I scheduled a follow up with patient in 3 months.
If new patient → LOS: 99205 and 99417 Qty:1 (prolonged code)
If established patient → LOS: 99215 and 99417 Qty:2
NOTE: AMA guidelines (published in late 2019) state that the 2021 prolonged services 99417 of **less than 15 minutes total time (over the max 99205/99215 time)** on the date of the visit **is not reported.**

I spent 40 minutes of the 66 minutes in the encounter (99205/99215) discussing the diagnosis of "xxxxx" with the patient and the remainder of the time was spent obtaining the HPI and examination of the patient.

I spent 35-minutes in the encounter (99203/99214) with the patient discussing the options of surgery versus watchful waiting regarding the diagnosis of "xxxxx".

Inappropriate time statement examples:

- I had a lengthy discussion with the patient.
- I spent 30 minutes with the patient

Providers are not allowed to include the activities performed by clinical staff members, such as taking vitals, in the time spent on the visit. The guidelines state that activities performed by clinical staff are NOT used to calculate time.

When the provider is reporting/billing for a separate CPT i.e., EKG/X-ray code that includes interpretation and/or report, the interpretation and/or report time should **not** be counted in the Time nor the MDM when selecting the LOS for the visit.

When the provider is reporting billing for a separate CPT i.e., 99452 for discussion of management with another provider, the discussion time should not be counted in the Time nor the MDM when selecting the LOS for the visit.

Documentation, coding changes for office E/M codes reported based on time

Guideline	2020	2021
Visit time is calculated based on pre-, intra- and post-encounter services on the day of the visit	No	Yes
Separately reported services may also be counted towards time	No	No
To report based on time counseling/coordination of care must dominate the visit	Yes	No
Time is included in the descriptor for **99211**	Yes	No
Time in descriptor describes the actual time for a visit	No	Yes
Physicians and other qualified health care professionals may share a time-based visit	N/A	Yes
Prolonged service with direct patient contact (**99354-99355**) maybe reported with an office visit	Yes	No
Prolonged service without direct patient contact (**99358-99359**) maybe reported with an office visit	Yes	No
Prolonged service by clinical staff (**99415-99416**) maybe reported with an office visit	Yes	Yes

Source: CPT 2020 Professional Edition, AMA code and guideline changes www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

MEDICAL DECISION MAKING (MDM) (2021 *PROPOSED* CHANGES IN RED)…

MDM of E&M codes performed in the Office and other outpatient area is defined by three elements:

- Number and Complexity of Problems Addressed *changed from*
  Number of Diagnoses or Management Options

- Amount and/or Complexity of Data to be Reviewed and Analyzed *changed from*
  Amount and/or Complexity of Data to be Reviewed

- Risk of Complications and/or Morbidity or Mortality of Patient Management *changed from*
  Risk of Complications and/or Morbidity or Mortality
  Review the linked table to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate or high:
  https://www.aafp.org/fpm/2010/0700/p10.html#fpm20100700p10-ut3.

Based on the above, there are four **types** of MDM recognized:

- Straightforward (SF) - self-limited or minor problem
- Low (L) - stable chronic illness or acute, uncomplicated illness or injury
- Moderate (M) - chronic illnesses with exacerbation, progression, or side effects of treatment; or undiagnosed new problem with uncertain prognosis; or acute illness with systemic symptoms; or acute complicated injury
- High (H) - chronic illnesses with severe exacerbation, progression, or side effects of treatment; or acute or chronic illness or injury that poses a threat to life or bodily function

A problem is **addressed** or **managed** when it is evaluated or treated at the encounter by the provider reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or due to patient, parent, guardian, surrogate choice.

NOTE: For 2021, a notation in the record that another provider is managing the problem without additional assessment or care coordination **does NOT** qualify as being 'addressed' or managed by the provider reporting the service.

MDM may be impacted by role and management responsibility. Shared MDM involves eliciting patient and/or family preferences, education, and explaining risks/benefits of management options.

Data reviewed and analyzed 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/billed. Which 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.

NOTE: For 2021, comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E&M services **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. This would include patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s), as well as the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

For purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.

Review the AMA chart outlining the updates to selecting MDM in 2021 with the appropriate type of MDM for each level:
https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

NOTE: The definitions of several terms such as 'stable, chronic illness', 'risk', 'morbidity', and 'problem' have been updated and been better defined. See the AMA CPT guidelines to familiarize yourself with the new definitions:
https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

RESOURCES…

MEDDATA previous News Blasts: https://www.medronsoftware.com

AMA Elements of Medical Decision Making: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

AMA Code and Guideline changes for 2021:
https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

NAMAS E&M changes: http://shop.namas.co/EM-Comparison-Chart_p_494.html.

NAMAS Weekly Auditing and Compliance Tips: https://namas.co/

Medical Billers and Coders, Time Based Billing for CPT E&M:
https://www.medicalbillersandcoders.com/blog/time-based-billing-for-cpt-evaluation-and-management/

E&M University: https://emuniversity.com/CodingBasedonTime.html

The Rheumatologist: https://www.the-rheumatologist.org/article/evaluation-management-code-changes-set-for-2021/

2019 Federal Register conveys 2021 changes and is available via:
https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf

2021 Proposed Final Rule (published in the Federal Register 08/17/2020):
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17127.pdf

MDS Evaluation & Management Service Guide: https://www.medtronsoftware.com/User Guides/E&M_Resources/E&M_Information_Packet_General.pdf

For assistance or any questions, contact MDS/MSI via:
From **MED**PM or **MED**EHR Sign On screens, double click on **'helpdesk@medtronsoftware.com**' to compose an email which will automatically create a ticket in our ticketing system. The ticketing system will then send an automated reply with your ticket # for all future correspondence related to your question/concern.