University Health Partners of Hawai'i

The faculty practice of the University of Hawaii John A. Burns School of Medicine

677 Ala Moana Blvd. Suite 1001, Honolulu, HI 96813 · (808) 469-4900

2021 E&M Changes Outpatient

WHAT YOU NEED TO KNOW FOR OUTPATIENT OFFICE VISITS

AS OF DECEMBER 18, 2020

What You Need To Know

Significant changes for **Outpatient** E/M coding for 2021:

Changes are specific to outpatient office evaluation and management (E/M) services only.

History and Exam not counted towards the level of service (LOS) (but should still be documented)

LOS selected will be based on **time** or **medical decision making**

New codes for Prolonged Service Codes for Outpatient

Affected CPT Codes – Outpatient only

New guidelines apply only to codes:

- 99202 - 99205 – **New Patient** Office and other outpatient visit
  - 99201 has been deleted (under utilization)
- 99212 – 99215 – **Established Patient** Office and other outpatient visit
  - 99211 does not require the presence of the MD or other NPP (AKA nurse visit / incident too visit)

What The Changes Do – Less bullets

Reduces the burden of documentation

Eliminates the “bean counting” of **History** and **Exam**

- Still document a **visit pertinent** history and exam (less pressure to document for points).

Puts the focus on Medical Necessity and **MDM**

Provides a new way to determine medical necessity

Updates the definition/range of time

Documentation Requirements

- Chief complaint not required to be re-entered by MD
  - Provider can indicate “reviewed”
  - Document any changes or additional information regarding visit
- Medically appropriate history and exam for visit
  - Performed when clinically appropriate
  - Number of systems reviewed will no longer apply

Coding based on Medical Decision Making

The overarching criteria for selecting MDM is still medical necessity

What is Medical Necessity?

- The requirement that a service is “reasonable and necessary”
- Met when a service “is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition (Medicare Program Integrity Manual, Chap 3, Sec 6.2.2)

Coding based on Medical Decision Making

Four levels of MDM (unchanged from current levels of MDM)

- 99202/99212 = Minimal/Straightforward
- 99203/99213 = Low
- 99204/99214 = Moderate
- 99205/99215 = High

Coding based on Medical Decision Making

Three categories in determining the level of MDM:

- **A - Number of complexity of problems addressed at the encounter.** Only need to count diagnoses being addressed at the encounter.
- **B - Amount and/or complexity of data to be reviewed and analyzed**. This reduces cut-and-paste, not requiring physicians to enter "voluminous," repetitive test data that is irrelevant or ancillary to the purpose of the visit
- **C - Risk of complications and/or morbidity or mortality of patient management**. We can now include social determinants of health and reasons behind decisions not to admit a patient or intervene in some way

Coding based on Medical Decision Making

- Level requirements for **Category A** - **Number of Complexity of Problem(s) Addressed at the encounter**:
- **L2 Straightforward/Minimal** – Self-limited problem
- **L3 Low** – Stable, uncomplicated, single problem
- **L4 Moderate** – Multiple problems or significantly ill
- **L5 High** – Very ill

Category A Decision Table Number of Problems

Minimal	☐	1 Self-limited / minor problem
Low	☐	2+ Self-limited / minor problem
	☐	1 Stable chronic illness
	☐	1 Acute uncomplicated illness / injury
Moderate	☐	1+ Chronic illness w/ exacerbation, progression, or Tx side effects
	☐	2+ Stable chronic illness
	☐	Undiagnosed problem w/ uncertain prognosis
	☐	Acute illness w/ systemic symptoms
	☐	Acute complicated injury
High	☐	Chronic illness w/ severe exacerbation, progression or Tx side effects
	☐	Acute / chronic illness / injury that pose threat to life or bodily function

Coding based on Medical Decision Making

- **Category B - Amount and/or complexity of data to be reviewed and analyzed.** It is the data reviewed. It is divided into **three sub-categories**
  - **#1** Tests, documents, orders or independent historian(s) – **each unique test**
  - **#2** Independent interpretation of tests **not reported separately** (by the provider)
  - **#3** Discussion of management/test interpretation with external physician/other QHP appropriate source **not reported separately** (by the provider)

Coding based on Medical Decision Making

- Level requirements for **Category B** - **Amount and/or complexity of data to be reviewed and analyzed**
- **L2 Straightforward/Minimal** – Minimal or none
- **L3 Low** (one category) – Two documents or independent historian; **or** independent interpretation
- **L4 Moderate** (one category) – Count: Three items between: tests, documents and independent historian; **or** Interpretation; **or** Discussion
- **L5 High** (two categories) – Same concepts as moderate

L4 Moderate: Must meet the requirements of at least **1** out of 3 categories

L5 Extensive: Must meet the requirements of at least **2** out of 3 categories

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)

Category B Decision Table for Data

Category	Data Level
1 T&D	Minimal
2 T&D	Limited
1 IHx	Limited
1 T&D and 1 IHx	Limited
2 T&D and 1 IHx	Moderate
1 T&D and 1 Intpr	Moderate
1 T&D and 1 DISC	Moderate
2 T&D and 1 Intpr	Moderate
2 T&D and 1 DISC	Moderate
3+ T&D	Moderate

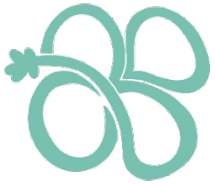
Category	Data Level
3 + T&D and 1 IHx	Moderate
1 Intpr	Moderate
1 DISC	Moderate
2 T&D and 1 IHx and 1 Intpr	High
2 T&D and 1 IHx and 1 Disc	High
3+ T&D and 1 Intpr	High
3+ T&D and 1 DISC	High
3+ T&D and 1 IHx and 1 Intpr	High
3+ T&D and 1 IHx and 1 DISC	High
1 Intpr and 1 DISC	High

Coding based on Medical Decision Making

- Level requirements for **Category C** - **Risk of complications and/or morbidity or mortality of patient management**
- **L2 Straightforward** – Minimal risk from treatment (includes no treatment) or testing (Most consider effectively as no risk)
- **L3 Low** – Low risk (very low risk of severity problems),minimal consent/discussion
- **L4 Moderate** – Typical review with patient/surrogate, obtain consent and monitor/or management of complex social factors
- **L5 High** – Need to discuss high risk problems that could happen for which physician or other QHPs will watch or monitor

Coding based on Medical Decision Making

- Determined at the visit, associated with the patient's problem(s), treatment(s)
  - Includes possible management options selected and those not selected
  - Addresses risk associated with social determinants of health



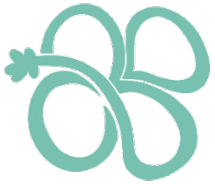
Category C – Decision Table for Risk

Minimal	☐ Minimal risk of morbidity from additional diagnostic testing or Treatment *Examples: Rest, gargles, elastic bandages, superficial dressings*
Low	☐ Low risk of morbidity from additional diagnostic testing or Treatment *Examples: OTC drugs, minor surgery w/o identified risk factors, PT OT therapy, IV fluids w/o additives*
Moderate	☐ Moderate risk of morbidity from additional diagnostic testing or Treatment *Examples: Prescription drug management. Decision regarding minor surgery w/identified patient or Tx risk factors, Decision regarding elective major surgery w/o identified PT or Tx risk factors, Diagnosis or Tx significantly limited by social determinants of health*
High	☐ High risk of morbidity from additional diagnostic testing or Treatment *Examples: Drug therapy requiring intensive monitoring for toxicity, Decision regarding elective major surgery w/identified Patient or treatment risk factors, Decision regarding emergency major surgery, Decision regarding hospitalization, Decision not to resuscitate or to de- escalate care because of poor prognosis*

Calculating the overall MDM

The overall MDM is determined by:

- Calculating the level of each of the three categories (A, B & C)
- Select the **two** categories with the highest level.
- Of the two categories with the highest levels, the lowest of those two levels will be your MDM category.



Draw a line down the column with 2 or 3 circles and circle the Overall MDM level OR draw a line down the column with the Center circle and circle the Overall MDM level

A	Number/Complexity of problems - NPP	Minimal	Low	Moderate	High
B	Data to be Reviewed and Analyzed	None or Minimal	Limited	Moderate	High
C	Risk of Patient Management	Minimal	Low	Moderate	High
Overall MDM Level		Straightforward Level 2	Low Level 3	Moderate Level 4	High Level 5

Revised Coding Based on Time

Selecting MDM based on Time:

- Time is defined as the minimum time spent on all tasks related to patient care **on the date of service**
- Select the LOS based on the total time spent with/on the patient **ON THE DATE OF SERVICE**
- Face to face and non face to face time personally spent counts
- >50% spent on counseling and coordination of care is no longer the criteria
- Does not count staff time (Resident time still not counted)

What Counts as Time?

Face to Face & Non Face to Face activities include:

- 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)

What Counts as Time?

(Con’t)

- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Medical necessity must be evident for the documented time spent with/on the patient

What Time does not count?

- Time spent for activities normally performed by clinical staff
- Time spent on separately reportable services such as:
  - EKG, Xray
  - Time spent performing separately reportable minor procedures
    - Example: Pt presents has a visit totaling 20 minutes to discuss HTN. During that 20 minutes, 6 minutes was spent performing cryotherapy on 2 AK lesions. Deduct the 6 minutes from the 20 minutes to arrive at the total time to select the E/M visit. Remember to use the correct modifiers.

2021 E&M changes (cont'd)

Changes to time-based coding (99202-99215) (cont'd)

For 2021, CMS will follow CPT's "typical times" when selecting office/outpatient E/M codes based on time spent. Please note, CPT 2021 now gives a range for typical times and some of the times have been revised from CPT 2020 (for example 99214 is now 30-39 minutes vs. a single typical time value of 25 minutes in 2020).

CPT 2020 Guidelines

- **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

CPT 2021 Guidelines

- **99202:** 15-29 minutes
- **99203:** 30-44 minutes
- **99204:** 45-59 minutes
- **99205:** 60-74 minutes
- **99211:** minimal (no specific values given)
- **99212:** 10-19 minutes
- **99213:** 20-29 minutes
- **99214:** 30-39 minutes
- **99215:** 40-54 minutes

Prolonged Service Codes

New Prolonged Service add-on codes

+99417 – (CPT) Private insurance plans

+G2212 – Medicare insurance plans only

Use only with 99205 & 99215

Report when the time requirement for the highest-level office/outpatient code has been exceeded by at least 15 minutes.

PRIVATE PAYER TABLE FOR PROLONGED TIME: 99417	
CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and **99417** x 1	75 - 89 minutes
99205 x 1 and **99417** x 2	90 - 104 minutes
99205 x 1 and **99417** X3 or more for each additional 15 minutes	105 minutes or more
99215	40-54 minutes
99215 x 1 and **99417** x 1	55 - 69 minutes
99215 x 1 and **99417** x 2	70 - 84 minutes
99215 x 1 and **99417** X3 or more for each additional 15 minutes	85 minutes or more

MEDICARE PAYER TABLE FOR PROLONGED TIME: G2212	
CPT Code(s)	Total Time Required for Reporting*
99205 x 1 and **G2212** x 1	89 - 103 minutes
99205 x 1 and **G2212** x 2	104 - 118 minutes
99205 x 1 and **G2212** X3 or more for each additional 15 minutes	119 minutes or more
99215	40-54 minutes
99215 x 1 and **G2212** x 1	69-83 minutes
99215 x 1 and **G2212** x 2	84-98 minutes
99215 x 1 and **G2212** X3 or more for each additional 15 minutes	99 minutes or more

***Total time is the sum of all time, with and without direct patient contact (including prolonged time), spend by the reporting practitioner on the DOS of the visit.**

Glossary:

PROBLEM: a disease, condition, illness, injury, symptom, sign, finding, complaint, and/or other matter addressed during the visit, with or without a diagnosis being established at the time of the visit.

PROBLEM ADDRESSED: A problem is address or managed **when it is evaluated or treated** at the visit by the provider reporting the service. This includes **consideration for further testing or treatment that may not be elected** by reason 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 coordination of care documented does not qualify as being "addressed"** or managed by the provider reporting the service**. Referring a patient to another provider without evaluation (by history, exam or diagnostic study(ies) or consideration of treatment does not qualify** as being addressed or managed by the provider reporting the service.

Glossary (Con't):

MINIMAL PROBLEM: **A problem that may not require the presence of the provider**, but the service is provided under the providers supervision

SELF-LIMITED OR MINOR PROBLEM: **A problem that runs a definite and prescribed course**, is temporary in nature, and is not likely to permanently affect the patient's health status

STABLE CHRONIC ILLNESS: **A problem with an expected duration of at least one (1) year or until the death of the patient**. For the purpose of defining chronicity, conditions are treated as chronic whether or not the stage or the severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of calculating medical decision making is defined by the specific treatment goal(s) 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 bodily 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*.

Glossary (Con't):

ACUTE, UNCOMPLICATED ILLNESS OR INJURY: **A recent or new short-term problem with low risk of morbidity for which a treatment is considered**. There is little to no risk of mortality with treatment, and full recovery without functional deterioration 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.*

CHRONIC ILLNESS WITH EXACERBATION, PROGRESSION OR SIDE EFFECTS OF TREATMENT: A chronic illness that is **acutely worsening, poorly controlled, uncontrolled, or progressing with an intent of controlling 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**.

Glossary (Con't):

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 medical intervention**. An *example may be a lump in the breast.*

ACUTE ILLNESS WITH SYSTEMIC SYMPTOMS: An **illness that causes systemic symptoms (symptoms affecting one or more organ systems) and has a high risk of morbidity without medical intervention. 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.*

Glossary (Con't):

ACUTE, COMPLICATED INJURY: An **injury which requires medical intervention that includes evaluation of other body systems that are not directly related to 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, multiple fractures, multiple injuries, etc*.

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 hospitalization

Glossary (Con't):

ACUTE OR CHRONIC ILLNESS ORINJURY THAT POSES A THREAT TO LIFE OR BODILY FUNCTION: An **acute illness with systemic symptoms (symptoms affecting one or more organ systems), or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment**, that poses a threat to life or bodily function in the short-term without treatment. *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.*

TEST: Tests are **laboratory services, diagnosistic imaging, psychometric, or physiologic data**. A clinical laboratory **panel** (e.g., basic metabolic panel [80047]) is a **single test**. The differentiation between single or multiple unique tests is defined in accordance with the **CPT® code set**.

Glossary (Con’t):

EXTERNAL: **External records, communications and/or test results** are from an external provider, facility or healthcare organization

EXTERNAL PHYSICIAN OR OTHER QUALIFIED HEALTHCARE PROFESSIONAL: An external physician or other qualified health care professional is an individual who is **in a different group practice** or **who is of a different specialty or subspecialty**. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency

Glossary (Con't):

INDEPENDENT HISTORIAN(S): An individual such as a **parent, guardian, surrogate, spouse, care giver, witness, who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history due to developmental stage of the patient, or another mental condition(s) or because a confirmatory history is determined to be necessary**. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

INDEPENDENT INTERPRETATION: The interpretation of a test for which there is a CPT® code and an interpretation or report is expected. This **does not apply when the provider is reporting the service or has previously reported the service** for the patient. **A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.**

Glossary (Con't):

APPROPRIATE SOURCE: For the purpose of the Discussion of Management Data Element, an **appropriate source includes individuals who are not health care professionals, but may be involved in the management of the patient** (*e.g., lawyer, parole officer, power of attorney, case manager, clergy, teacher*). **It does not include discussion with family or informal caregivers**.

RISK: **The probability and/or consequences of an event (an event is the medical intervention or treatment). The assessment of the level of risk is affected by the nature of the medical intervention or treatment 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 provider 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 calculating medical decision making, level of risk is based upon consequences of the problem(s) addressed at the visit when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization**.

Glossary (Con't):

MORBIDITY: **A state of illness or functional impairment that is expected to be long-term duration in which function is limited, quality of life is impaired, or there is organ damage** that may not be temporary despite treatment.

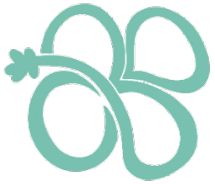
SOCIAL DETERMINANTS OF HEALTH: **Economic and social conditions that may influence the health of individuals and communities**. *Examples may include food or housing insecurity, safety and wellfare risks, unemployment, inadequate education, etc.*

Glossary (Con't):

DRUG THERAPY REQUIRING INTENSIVE MONITORING FOR TOXICITY: **A drug that requires intensive monitoring is a therapeutic agent which has the potential to cause serious morbidity or death**. Monitoring is performed for assessment of potential adverse effects, not primarily for assessment of the therapeutic effect. Monitoring should follow practice that is generally accepted for the drug, but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is performed not less than quarterly. **Monitoring may include a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in a visit in which it is considered in the management of the patient**. *Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold*

Glossary (Con't):

TOTAL TIME ON THE DATE OF THE VISIT(99202 – 99205, 99212 – 99215): For calculation purposes, time for these services is the **total time on the date of the visit**. It includes **both the face-to-face and non-face-to-face time personally spent by the provider(s)** on the day of the visit and includes time in activities that require the provider **but does not include time in activities normally performed by clinical staff.**



Resources

AMA AT A GLANCE E/M REFERENCE TOOL:

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

AMA E/M Outpatient Guidelines:

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Mahalo!

- Darcie Logan: dlogan@ucera.org (808) 469-4947
- Derek Wong: dwong@ucera.org
- Visit us at uhphawaii.org/index.php/UHPCBO
- Or Find this video on YouTube UHPCBO

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The faculty practice of the University of Hawaii John A. Burns School of Medicine

677 Ala Moana Blvd. Suite 1001, Honolulu, HI 96813 · (808) 469-4900