2021 Office and Outpatient E&M Coding Changes
Jody Ebner, CPC, CGSC
Physician Educator, himagine solutions

Kerry Ducey, CPC, CPMA
Regional Coding Manager, himagine solutions

Clinical Documentation vs Coding Rules

2021 E/M Changes apply to Office/Outpatient services only (99202-99215).
MDM or time are used to level service.

CPT guideline changes for 2021 affect the way documentation is used to score an office or outpatient E/M level, but the guidelines do not change the documentation required from a clinical perspective.

Time – new definition

- All the following activities may be included in total time used to select a CPT code.
  - Preparing to see the patient (eg, 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
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)
- Do not count staff time in performing these activities. Count activities on calendar day patient was seen.
- Documentation: AMA recommendations
  - Document total time spent (not a range)
  - Document time and describe what was done in a single statement. “I spent 30 minutes reviewing the patient’s diagnostic tests, seeing the patient, and documenting in the record.” It isn’t necessary to note how much time was spent in each activity.

Agenda

- E/M 2021 coding changes affect Office and Outpatient Services Only (99202-99215)
- E/M level will qualify based on Time or Medical Decision Making
- Time
- Medical Decision Making (MDM)
- Prolonged Services code 99417 / G2212
- Q&A
Prolonged Services

- CPT 99417, CMS G2212
  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.
  - Add-on code to 99205 or 99215 only
  - Includes prolonged services on same date of service
  - CPT and CMS differ on time thresholds for prolonged services
  - Code is for each 15 minutes. Do not report for any time unit less than 15 minutes

Provider Takeaway: Document total time spent in approved activities on the date of patient’s face to face visit along with a description of activities.

Medical Decision Making

- E/M level will qualify based on Time or Medical Decision Making
  • If time is documented, coder should evaluate both time spent and medical decision making, and code based on which is more beneficial to provider.
  - Medical Decision Making: 2 out of 3 needed to support MDM level
    • Number and Complexity of Problems Addressed
    • Amount and/or Complexity of Data to be Reviewed and Analyzed
    • Risk of Complications and/or Mortality or Mortality

First MDM Element: Number and Complexity of Problems Addressed

- What is a problem addressed?
  • AMA: 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.
  • 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 QHP reporting the service.

- How do we define "evaluated or treated"?
  • When the condition is discussed in the history of present illness and/or in the assessment and plan.
  • Mentioning patient “has a history of...” without further information in the HPI or A/P, or the inclusion of it in the problem list does not meet the criteria of evaluated and treated.

Provider Takeaway: Document all problems evaluated or treated on current date of service.
Second MDM Element - Data

Data Components

- Review of prior external note from each source
- Ordering of each unique test
- Assessment regarding an independent historian
- Independent interpretation of each test performed by another physician
- Review of results of each unique test
- Documentation requiring an independent historian
- Ordering of each unique test for a surgical or ob/gyn procedure

Provider Takeaways:
1. Document provider who ordered the test to receive credit when you review
2. Document independent historian and need for one
3. Document if you personally viewed and interpreted an image or tracing (more than review of report)

MDM Table – 2021 Office / Outpatient

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
<td>2nd</td>
<td>3rd</td>
</tr>
<tr>
<td></td>
<td>4th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11th</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12th</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References

- AMA

- CMS Physician Fee Schedule Final Rule
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

Jody Ebner, CPC, CGSC
Physician Educator, Himagine Solutions
jebner@himaginiessolutions.com
# MDM Table – 2021 Office / Outpatient

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM Based on 2 or 3 Elements</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>CPT / CMS Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1-9 (use MDM)</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal or none</td>
<td></td>
<td>Low risk or morbidity from additional testing or treatment</td>
<td>99202 15-29, 99212 10-19</td>
</tr>
</tbody>
</table>
| 99213 | Low                                  | Limited (Must meet the requirements of at least 1 of the 2 categories) | Category 1: Tests and documents  
*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)  
Category 2: Assessment requiring an independent historian(s)  
Category 3: Discussion of management or test interpretation  
Discussion of management or test interpretation with external physician/other qualified health care professional/appropria | Moderate risk of morbidity from additional testing or treatment | 99202 30-44, 99213 20-29 |
| 89204 | Moderate                             | Moderate (Must meet the requirements of at least 1 out of 3 categories) | Category 1: Tests, documents, or independent historian(s)  
*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)  
Category 2: Independent interpretation of tests  
Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)  
Category 3: Discussion of management or test interpretation  
Discussion of management or test interpretation with external physician/other qualified health care professional/appropria | Moderate risk of morbidity from additional testing or treatment | 99204 45-59, 99214 30-39 |
| 89214 | High                                | High                                        | Excessive Must meet the requirements of at least 2 out of 3 categories above  
Category 1: Tests, documents, or independent historian(s)  
Category 2: Independent interpretation of tests  
Category 3: Discussion of management or test interpretation  
Discussion of management or test interpretation with external physician/other qualified health care professional/appropria | High risk of morbidity from additional testing or treatment | 99205 60-74, 99215 40-54 |
| 89216 |                                      |                                             |                                             |                                                 |                |

---

*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  
- Decision regarding emergency major surgery  
- Decision regarding hospitalization  
- Decision not to resuscitate or to de-escalate care because of poor prognosis