Disclaimer

This material is designed to offer basic information for the billing and coding of medical services, using common coding systems. The information presented here is based on the experience, training and interpretation of the authors. Although the information has been carefully researched & checked & re-checked for accuracy and completeness, neither the author, the instructor, or the companies for which they work for accept any responsibility nor liability with regard to errors, omissions, misuse or misinterpretation.
Caveats

- The new guidelines being implemented on January 1, 2021 only applies to outpatient E&M encounters 99202-99215 as part of the “Patients over Paperwork” Initiative
- 99201 will be deleted since 99201 and 99202 have the same MDM currently.
- Current E&M guidelines (‘95 or ‘97) apply to all other E&M services
10 Tips from AMA

1. Identify a project lead
   The transition to the revised E/M office visit coding guidelines will require staff education, review of internal policies and procedures and financial tracking.

2. Schedule team preparation time
   Practices should schedule time for in-person gatherings to review the changes and to surface and address questions.

3. Update practice protocols
   Practice procedures and protocols must be updated to be consistent with the new guidelines.

4. Consider coding support
   There are significant changes to the codes and documentation for office visits.

5. Be aware of medical malpractice liability
   Although the requirements around E/M documentation may have lessened or become more flexible, physicians should still carefully document the work that is being done and how to protect themselves from medical malpractice suits.

6. Guard against fraud & abuse law infractions
   The False Claims Act and other federal and state fraud and abuse laws remain in effect. Although the new E/M office visit coding guidelines allow greater flexibility, practices should continue to document appropriately and guard against inadvertent overbilling.

7. Update your compliance plan
   As your practice undergoes the transition to the new E/M guidance, ensure that your updated protocols and procedures remain consistent with your current compliance plan.

8. Check with your electronic health record (EHR) vendor
   Practices should communicate with their EHR vendor to confirm their schedule for implementing these E/M office visit code changes.

9. Assess financial impact
   Guard against an unanticipated financial impact by understanding the rules in advance and performing a prospective financial analysis.

10. Understand additional employer or payer or medical liability coverage requirements
    Employers or payers may still require documentation of additional information above and beyond the new E/M office visit coding guidelines. Physicians should carefully evaluate the flexibilities allowed under the new guidelines and ensure that their documentation will satisfy any other obligations and requirements that they may be expected to fulfill.
Which Codes Fall Under The 2021 Guidelines

New Guidelines:
- New patient visit
  - 99201 - DELETED FOR 2021
  - 99202
  - 99203
  - 99204
  - 99205
- Established patient visits
  - 99211
  - 99212
  - 99213
  - 99214
  - 99215
- Initial inpatient visits 99221-99223
- Subsequent inpatient visits 99231-99233
- Initial Observation care 99218-99220
- Observation care and discharge 99234-99236
- Subsequent Observation care 99224-99226
- Discharge visits 99238-99239, 99217
- Nursing home visits, home visits, critical care, etc

1995/1997 Documentation Guidelines
- Initial inpatient visits 99221-99223
- Subsequent inpatient visits 99231-99233
- Initial Observation care 99218-99220
- Observation care and discharge 99234-99236
- Subsequent Observation care 99224-99226
- Discharge visits 99238-99239, 99217
- Nursing home visits, home visits, critical care, etc

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services
- E/M level of service for office or other outpatient services can be based on:
  - MDM
    - Extensive clarifications provided in the guidelines to define the elements of MDM
  - Time: Total time spent on the date of the encounter
    - Including non-face-to-face services
    - Clear time ranges for each code
- Addition of a shorter 15-minute prolonged service code (99417)
  - To be reported only when the visit is based on time and after the total time of the highest-level service (i.e., 99205 or 99215) has been exceeded by at least 15 minutes
Office or Other Outpatient Services: New Patient

- **Office or Other Outpatient Services/New Patient**

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

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

  Counseling and/or coordination with other physicians, other qualified health care 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.

Source: AAMA 2019 CPT® Symposium Presented by Peter Holtz, MD and Christopher Jagnin, MD

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Office or Other Outpatient Services: Established Patient

- **Office or Other Outpatient Services/Established Patient**

  99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these key components: a medically appropriate history and/or examination and low level of medical decision making.

  - An expanded problem focused history;
  - An expanded problem focused examination;
  - Medical decision making of low complexity.

  Counseling and/or coordination with other physicians, other qualified health care 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, 15 minutes are spent face-to-face with the patient and/or family.

  When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

Source: AAMA 2019 CPT® Symposium Presented by Peter Holtz, MD and Christopher Jagnin, MD

Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, CMCS © 2020
### Guideline Comparative Analysis

<table>
<thead>
<tr>
<th>Key Components</th>
<th>1995</th>
<th>1997</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint</td>
<td>Used to define the presenting problem of the patient</td>
<td>No Change</td>
<td>CC not specifically address Presumed as part of the history-as medically appropriate History Change: No specific criteria required. &quot;As medically appropriate&quot;</td>
</tr>
<tr>
<td>History</td>
<td>1-8 HPI Elements</td>
<td>Option to use in lieu of one of the 8 elements, the management status of multiple problems (3)</td>
<td>E₀xam Change: No specific criteria required. &quot;As medically appropriate&quot; Revised wording ONLY the MDM component is scored</td>
</tr>
<tr>
<td></td>
<td>1-10 Review of Systems</td>
<td>Single system exams based on bullet scoring of findings. (General system also included)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-3 PFSH Areas Reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>1-12 organ systems of findings noted through the work of the exam. Max requirement 8</td>
<td>No Change</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>3 Elements to analyze: Diagnoses, Data &amp; Complexity Table of Risk</td>
<td>No Change</td>
<td>Time used in lieu of MDM, and is the cumulative time on the day of the encounter. Typical times changed and are now ranges of time</td>
</tr>
<tr>
<td>Time</td>
<td>Greater than half of the encounter was spent counseling/coordinating. Typical times assigned by AMA CPT</td>
<td>No Change</td>
<td></td>
</tr>
</tbody>
</table>

Source: NAMAS 8-14-20
History – What’s New for 2021

Old 1995/1997 Documentation Guidelines (Still apply to all other E&M Codes)
- History
  - HPI
    - History of Present Illness
    - 1-3 elements vs 4 elements
  - PFSH
    - Past Family Social History
    - All mentioned vs, 1, 2 or 3 mentioned
- ROS
  - Review of Systems
  - 1, 2-9 Systems or 10-14 Systems

New 2021 Outpatient E&M Documentation Guidelines
- History
  - HPI
    - Nature & severity of presenting problem
    - Used to establish medical necessity
  - PFSH
    - Appropriate historical data as determined by physician or APP
    - Not used toward the level of service
- ROS
  - Appropriate as determined by physician or APP
  - Not used toward the level of service

Exam – What Changes

Old 1995/1997 Documentation Guidelines (Still apply to all other E&M Codes)
- 1995
  - Specific number of organ systems/body areas
- 1997
  - Certain number of bullets and systems

New 2021 Outpatient E&M Documentation Guidelines
- Exam
  - Should be medically appropriate as defined by the physician/APP.
  - The components are not longer counted and scored to determine the level of service.
  - Medically necessary
2021 OFFICE VISIT MDM - CHANGE

2021 E&M Components for 99202-99215

<table>
<thead>
<tr>
<th>History and Exam</th>
<th>Document only as medically appropriate but not used for code selection. CC &amp; HPI needed for Medical Necessity</th>
</tr>
</thead>
</table>
| Medical Decision Making (MDM) | One of the components for code selection 2 of 3 Elements Include:  
- Number and complexity of problems addressed during encounter  
- Amount and/or complexity of data reviewed and analyzed  
- Risk of complications and/or morbidity or mortality of patient management  
| OR |  |
| Time | One of the components for code selection |
1995/1997 MDM Criteria

- Number of management options (diagnosis codes)
- Amount of data to be reviewed
- Calculation of risk
  - Interpreting risk
  - Subjective component of MDM
  - Risk table

MDM 1995/1997 Guidelines

- 1995 and 1997 documentation guidelines
  - MDM
    - Based on point structure
    - Number of Diagnoses or Management Options
      - Established problem improving or worsening
      - New problem with or without workup
    - Amount and/or Complexity of Data to be Reviewed
      - Labs, radiology, medical testing, review of records, reports, discussions with other providers or care-givers, independent visualization of films
    - Risk of Complications and/or Morbidity or Mortality
      - Table of Risk
      - Straightforward, Low Moderate and High
        - Presenting problem
        - Diagnostic Procedures Ordered
        - Management Options Selected
Medical Decision Making (MDM)

Modifications to the criteria for MDM:
- CMS Table of Risk used as a foundation to create the Level of Medical Decision Making Table
- CMS Contractor “audit tools” also consulted to minimize disruption in MDM level criteria
- Removed ambiguous terms (e.g., “mild”) and defined previously ambiguous concepts (e.g., “acute or chronic illness with systemic symptoms”)

Medical Decision Making (MDM)

Effective January 1, 2021
Level of Medical Decision Making Table
- Guide to assist in selecting the level of MDM
- Used for office or other outpatient E/M services only
- Includes four levels of MDM (unchanged from current levels of MDM)
  - Straightforward
  - Low
  - Moderate
  - High
Medical Decision Making Table

<table>
<thead>
<tr>
<th>MDM 2020</th>
<th>MDM Effective Jan. 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Diagnoses or Management Options</td>
<td>Number and Complexity of Problems Addressed at the Encounter</td>
</tr>
<tr>
<td>Amount and/or Complexity of Data to be Reviewed</td>
<td>Amount and/or Complexity of Data to be Reviewed and Analyzed</td>
</tr>
<tr>
<td>Risk of Complications and/or Morbidity or Mortality</td>
<td>Risk of Complications and/or Morbidity or Mortality of Patient Management</td>
</tr>
</tbody>
</table>

Source: AMA 2019 CPT® Symposium Presented by Peter Hollmann, MD and Christopher Jagemie, MD

MDM for 2021 Outpatient E&M

- MDM is driving from a table that has been issued by the AMA
- Elements in the Table of the Risk that were more open to interpretation were removed for the 2021 MDM Table
- Similar to current MDM, to qualify for a level of MDM, two out of three elements for that level must be met or exceeded.
- But do not make assumptions because elements have been changed in the new MDM table

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDMP</th>
<th>Number of Problems Addressed</th>
<th>Elements of Medical Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA/NA</td>
<td>NA/NA</td>
<td>NA/NA</td>
<td>NA/NA</td>
<td>NA/NA</td>
</tr>
<tr>
<td>2000</td>
<td>High</td>
<td>3 or more chronic diseases</td>
<td>Medical</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with exacerbations,</td>
<td>(2) Tests, procedures, or independent factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>progression, or side effects of treatment, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 or more stable chronic diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or 1 uncontrolled new problem with uncertain prognosis, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 or 2 chronic diseases with systemic symptoms, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 or 2 complicated injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>High</td>
<td>1 or 2 chronic diseases with severe exacerbations,</td>
<td>Medical</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>progression, or side effects of treatment, or</td>
<td>(2) Tests, procedures, or independent factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 or 2 stable chronic diseases or injury that poses a threat to life or bodily function</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23
MDM – New Guidelines for 2021
Outpatient E&M

- Number and Complexity of Problems Addressed at the Encounter
  - Only the actively treated diagnoses are credited to the level of service
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Level</th>
<th>Problems</th>
<th>Data Analysis</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td>High</td>
<td>Extensive</td>
<td>High</td>
</tr>
<tr>
<td>99211</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>99212</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>99213</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>High</td>
<td>High</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

MDM: Number and Complexity of Problems Addressed at the Encounter: Clinically Relevant

- Straightforward
  - Self-limited
- Low
  - Stable, uncomplicated, single problem
- Moderate
  - Multiple problems or significantly ill
- High
  - Very ill
### 2021 - MDM – Number & Complexity of Problems Addressed

#### ‘95/’97 Guidelines Still used for other E&M services

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
</tr>
<tr>
<td><strong>Problem(s) Status</strong></td>
</tr>
<tr>
<td>Self-limited or minor</td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
</tr>
<tr>
<td>New prob. (to examiner); add. workup planned</td>
</tr>
</tbody>
</table>

#### New

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

#### ‘95/’97 Guidelines

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A minor self-limited or minor problem; or</td>
</tr>
<tr>
<td>2</td>
<td>1 Stable chronic illness</td>
</tr>
<tr>
<td>3</td>
<td>1 Acute uncomplicated illness; injury</td>
</tr>
<tr>
<td>4</td>
<td>1 Chronic illness w/ exacerbation; progression, or Tx side effects; or</td>
</tr>
<tr>
<td>5</td>
<td>2 Stable chronic illness</td>
</tr>
<tr>
<td>6</td>
<td>1 Unresolved problem w/ uncertainty or ambiguity; or</td>
</tr>
<tr>
<td>7</td>
<td>2 Unresolved problem w/ uncertain diagnosis; or</td>
</tr>
<tr>
<td>8</td>
<td>3 Acute complicated injury; or</td>
</tr>
<tr>
<td>9</td>
<td>4 Chronic illness w/ severe exacerbation, progression or Tx side effects; or</td>
</tr>
<tr>
<td>10</td>
<td>3 Unstable severe or critical condition; or</td>
</tr>
</tbody>
</table>

#### New

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

#### Risk of Complications and/or Morbidity or Mortality of Patient Management

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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CRN Healthcare Solutions
Definition of “A Problem”

A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, and/or other matters addressed during the visit, with or without a diagnosis being established at the time of the visit.

Problem Addressed / Managed

A problem is addressed or managed when it is:

- Evaluated or treated at the visit by the physician
- Includes consideration for further testing or treatment that may not be elected by reason of risk/benefit analysis or patient/parent/guardian/surrogate choice.

Does not qualify when:

- Notation in the patient’s medical record that another professional is managing the problem without additional assessment or coordination of care documented
- Referring a patient to another provider without additional assessment or coordination of care documented
### Problem – Minimal

**Minimal - Self-limiting or Minor Problem**
- A problem that may not require the presence of a physician
- A problem that is temporary and runs a definite prescribed course

### Problem – Low

**Chronic Stable Illness**
- Expected duration of at least one (1) year or until the death of the patient
- Patient is at their specific treatment goal(s)
- A patient that is not at their treatment goal is not stable even if the condition has not changed

**Acute, Uncomplicated Illness or Injury**
- Recent or short-term problem with low risk of morbidity based on the treatment considered
- Full recovery is expected w/o deterioration
- A problem that is normally minor, self-limiting but not resolving
Problem – Moderate

Number/Complexity of Problems Addressed (Table #1)

Chronic w/ exacerbation
- Illness that is acutely worsening, poorly controlled, uncontrolled or progressing,...requiring additional supportive care, or attention to side effects but does not require hospital level of care

Undiagnosed w/ Uncertain Prognosis
- A differential diagnosis represents a condition likely to result in a high risk of morbidity without medical intervention

Problem – Moderate

Number/Complexity of Problems Addressed (Table #1)

Acute Illness w/ Systemic Symptoms
- Illness that causes systemic symptoms AND has high risk for morbidity w/o medical intervention

Acute Complicated Injury
- Injury requiring medical intervention that includes evaluation of other body systems that are not directly related to the injured organ
- Injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity
### Problem – High

#### Number/Complexity of Problems Addressed (Table #1)

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Elements of Medical Decisions Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9032</td>
<td>High</td>
<td>35 high</td>
<td>36 high</td>
<td>36 high</td>
</tr>
</tbody>
</table>

#### Acute or Chronic or Injury w/ severe exacerbation, progression or side effects of Tx

- Illness or injury w/severe progression or severe side effects of treatment that have a significant risk of morbidity and may require hospitalization
- Or that pose a threat to life or bodily function in the short-term w/o treatment

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**CRN Healthcare Solutions**

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MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

Standard
STILL USED FOR OTHER E/Ms

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

New
Amount /complexity of Data Reviewed & Analyzed – Table #3

<table>
<thead>
<tr>
<th>Tests &amp; Documents (T&amp;D)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of final external second opinion report</td>
<td>1</td>
</tr>
<tr>
<td>Review of the final internal review report</td>
<td>1</td>
</tr>
<tr>
<td>Ordering of test specimen</td>
<td>1</td>
</tr>
<tr>
<td>Assessment requiring an independent historian(s) (IHs)</td>
<td>2-9</td>
</tr>
<tr>
<td>In consultation or statement (IC): any statement made by another physician who is not directly involved in treating the patient</td>
<td>0 or 1 max</td>
</tr>
<tr>
<td>Independent interpretation of a test performed by another qualified health care professional (separately reported)</td>
<td>0 or 1 max</td>
</tr>
<tr>
<td>Discussion of management or test interpretation (DUC)</td>
<td>0 or 1 max</td>
</tr>
<tr>
<td>Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)</td>
<td>0 or 1 max</td>
</tr>
</tbody>
</table>

MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Simplified and standardized contractor scoring guidelines
- Emphasized clinically important activities over number of documents
- Need to account for quantity of documents ordered/reviewed (as it is MDM work) and create “counting rules”
- Data are divided into three categories:
  - Tests, documents, orders, or independent historian(s)—each unique test, order, or document is **counted** to meet a threshold number
  - Independent interpretation of tests not reported separately
  - Discussion of management or test interpretation with external physician/other QHP/appropriate source (not reported separately)
Definition of External Document

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

Definition of Test

• Tests are laboratory services, diagnostic imaging, psychometric, or physiologic data
• The differentiation between single or multiple unique test is defined in accordance with the CPT® code set
• A clinical laboratory panel (e.g. 80047 Basic Metabolic Panel is a single test, 71046, chest x-ray 2 views is a single test)
Data - Tests & Documents

Amount/complexity of Data Reviewed & Analyzed – Table #2

<table>
<thead>
<tr>
<th>Tests &amp; Documents (T&amp;D)</th>
<th>T&amp;D Total Category points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of prior external note(s) from each unique source*</td>
<td>x1 =</td>
</tr>
<tr>
<td>Review of the result(s) of each unique test*</td>
<td>x1 =</td>
</tr>
<tr>
<td>Ordering of each unique test*</td>
<td>x1 =</td>
</tr>
</tbody>
</table>

Each unique test, order or document counts as 1 point and contributes to the combination of the T&D total category points.

- Example: BMP ordered; chest x-ray reviewed from another provider = 1 point each, for a total category points of 2

Data – Independent Historian

Amount/complexity of Data Reviewed & Analyzed – Table #2

<table>
<thead>
<tr>
<th>Assessment requiring an independent historian(s) (Hx)</th>
<th>Hx Total Category points</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to patient</td>
<td>0 or 1 max =</td>
</tr>
</tbody>
</table>

- 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
- Patient is unable to provide a complete or reliable history (e.g., due to developmental stage of the patient, or another mental condition(s) or because a confirmatory history is determined to be necessary
- Maximum coding point is 1 regardless of the # of historians
## Data – Independent Interpretation

### Amount/complexity of Data Reviewed & Analyzed – Table #2

<table>
<thead>
<tr>
<th>Independent interpretation of tests (Interpr)</th>
<th>Interpr Total Category points</th>
</tr>
</thead>
</table>

- The interpretation of a test for which there is a CPT® code and an interpretation or report is expected
- 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
- Maximum coding point is regardless of the # of interpretations done

---

## Data – Discussion w/External Provider

### Amount/complexity of Data Reviewed & Analyzed – Table #2

<table>
<thead>
<tr>
<th>Discussion of management or test interpretation (DISC)</th>
<th>DISC Total Category points</th>
</tr>
</thead>
</table>

- An external physician is an individual who is in a different group practice or who is of a different specialty or subspecialty
- An appropriate source includes individuals who are not health care professionals but may be involved in the management of the patient. It does not include discussion with family or informal caregivers
- Maximum coding point is 1 regardless of the # of external discussions
## Data Calculation: By Category Points

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Level</th>
<th>Category</th>
<th>Data Level</th>
<th>Category</th>
<th>Data Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 T&amp;D</td>
<td>Minimal</td>
<td>2 T&amp;D / 1 IHx</td>
<td>Moderate</td>
<td>2 T&amp;D / 1 IHx / 1 Intpr</td>
<td>High</td>
</tr>
<tr>
<td>2 T&amp;D</td>
<td>Limited</td>
<td>1 T&amp;D / 1 IHx</td>
<td>Moderate</td>
<td>1 T&amp;D / 1 IHx / 1 Intpr</td>
<td>High</td>
</tr>
<tr>
<td>1 IHx</td>
<td>Limited</td>
<td>2 T&amp;D / 1 DISC</td>
<td>Moderate</td>
<td>3+ T&amp;D / 1 IHx / 1 Intpr</td>
<td>High</td>
</tr>
<tr>
<td>1 T&amp;D / 1 IHx</td>
<td>Limited</td>
<td>2 T&amp;D / 1 DISC</td>
<td>Moderate</td>
<td>3+ T&amp;D / 1 IHx / 1 Intpr</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3+ T&amp;D</td>
<td>Moderate</td>
<td>3 T&amp;D / 1 IHx / 1 DISC</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Intpr</td>
<td>Moderate</td>
<td>1 Intpr / 1 DISC</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 DISC</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Elements of Medical Decision Making

- **Category 1: T&D**
  - Level: Minimal
  - Problem: 1 T&D
  - Condition: No significant findings

- **Category 2: T&D**
  - Level: Limited
  - Problem: 2 T&D
  - Condition: Significant findings

### Risk of Complications and/or Mortality

- **Minimal risk of mortality from additional diagnostic testing or treatment**
- **Moderate risk of morbidity from additional diagnostic testing or treatment**
- **High risk of morbidity from additional diagnostic testing or treatment**

---

**SM10**

### Elements of Medical Decision Making

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Element of MDM</th>
<th>Category 1 (1 Intpr)</th>
<th>Category 2 (1 Intpr Moderate)</th>
<th>Category 3 (1 DISC Moderate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>T&amp;D / 1 IHx</td>
<td>T&amp;D</td>
<td>Level: Minimal</td>
<td>Problem: No significant findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td>Limited</td>
<td>1 T&amp;D / 1 IHx</td>
<td>1 T&amp;D</td>
<td>Level: Limited</td>
<td>Problem: Significant findings</td>
<td>Condition: Moderate findings</td>
</tr>
<tr>
<td>Limited</td>
<td>2 T&amp;D / 1 DISC</td>
<td>2 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
<td>Problem: Moderate findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td></td>
<td>4 T&amp;D / 1 DISC</td>
<td>4 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
<td>Problem: Extensive findings</td>
<td>Condition: Significant findings</td>
</tr>
</tbody>
</table>

---

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### Elements of Medical Decision Making

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Element of MDM</th>
<th>Category 1 (1 Intpr)</th>
<th>Category 2 (1 Intpr Moderate)</th>
<th>Category 3 (1 DISC Moderate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>T&amp;D / 1 IHx</td>
<td>T&amp;D</td>
<td>Level: Minimal</td>
<td>Problem: No significant findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td>Limited</td>
<td>1 T&amp;D / 1 IHx</td>
<td>1 T&amp;D</td>
<td>Level: Limited</td>
<td>Problem: Significant findings</td>
<td>Condition: Moderate findings</td>
</tr>
<tr>
<td>Limited</td>
<td>2 T&amp;D / 1 DISC</td>
<td>2 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
<td>Problem: Moderate findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td></td>
<td>4 T&amp;D / 1 DISC</td>
<td>4 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
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<td>Condition: Significant findings</td>
</tr>
</tbody>
</table>

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**SM10**

### Elements of Medical Decision Making

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<thead>
<tr>
<th>Level of MDM</th>
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<th>Category 2 (1 Intpr Moderate)</th>
<th>Category 3 (1 DISC Moderate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>T&amp;D / 1 IHx</td>
<td>T&amp;D</td>
<td>Level: Minimal</td>
<td>Problem: No significant findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td>Limited</td>
<td>1 T&amp;D / 1 IHx</td>
<td>1 T&amp;D</td>
<td>Level: Limited</td>
<td>Problem: Significant findings</td>
<td>Condition: Moderate findings</td>
</tr>
<tr>
<td>Limited</td>
<td>2 T&amp;D / 1 DISC</td>
<td>2 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
<td>Problem: Moderate findings</td>
<td>Condition: Significant findings</td>
</tr>
<tr>
<td></td>
<td>4 T&amp;D / 1 DISC</td>
<td>4 T&amp;D / 1 DISC</td>
<td>Level: Limited</td>
<td>Problem: Extensive findings</td>
<td>Condition: Significant findings</td>
</tr>
</tbody>
</table>

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Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CPC-I, CENTC, CPCO, CMCS © 2020
MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Risk of complications and/or morbidity, or mortality of patient management decisions made at the visit, associated with the patient’s problem(s), treatment(s)
  - Includes possible management options selected and those considered, but not selected
  - Addresses risks associated with social determinants of health
## New Risk Measurement

### Risk of Complication and/or Morbidity or Mortality of Patient Management – Table #3

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or Treatment</td>
<td>Examples: Rest, gauze, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Low risk of morbidity from additional diagnostic testing or Treatment</td>
<td>Examples: OTC drugs, minor surgery w/ identified risk factors, PT/OT therapy, IV fluids w/ additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate risk of morbidity from additional diagnostic testing or Treatment</td>
<td>Examples: Prescription drug management, Decision regarding minor surgery w/uncontrolled patient w/ risk factors, Decision regarding elective major surgery w/ identified PT or Tx risk factors, Diagnosis w/ Tx significantly limited by social determinants of health</td>
</tr>
<tr>
<td>High</td>
<td>High risk of morbidity from additional diagnostic testing or Treatment</td>
<td>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</td>
</tr>
</tbody>
</table>

---

## Definition of 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**
- Definitions of risk are based upon the usual behavior and **thought processes of a provider in the same specialty**
- Level of risk is based upon consequences of the problem(s) addressed at the visit when appropriately treated
- Risk includes **medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization**
### Risk - Minimal & Low

**Risk of Complication and/or Morbidity or Mortality of Patient Management – Table #3**

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
</tr>
</thead>
</table>
| Minimal risk of morbidity from additional diagnostic testing or Treatment  
Examples: Rest, gargles, elastic bandages, superficial dressings | 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 |

**Minimal**
- Rest
- Gargles
- Superficial bandages and dressings

**Low**
- Over the counter drugs
- Minor surgery w/o risk factors
- Therapies (PT/OT, etc.)
- IV fluids w/o additives
- X-rays, simple lab tests
- CT/MRI w/o contrast

---

### Risk - Moderate

**Risk of Complication and/or Morbidity or Mortality of Patient Management – Table #3**

<table>
<thead>
<tr>
<th>Moderate</th>
</tr>
</thead>
</table>
| Moderate risk of morbidity from additional diagnostic testing or Treatment  
Examples: Prescription drug management, Decision regarding minor surgery w/identified patient or To risk factors, Decision regarding elective major surgery w/o identified PT or To risk factors, Diagnosis or To significantly limited by social determinants of health |

**Moderate**
- Prescription drug management
- Minor surgery w/ risk factors
- Major surgery w/o risk factors
- CT/MRI w/contrast
- Social determinants of health
Risk - Social Determinates of Health

Economic and social conditions that may influence the health of individuals and communities, includes:

- Food
- Housing insecurity and safety
- Welfare risks
- Unemployment
- Inadequate education
- Race

Risk - High

Risk of Complication and/or Morbidity or Mortality of Patient Management – Table #3

- Major surgery w/risk factors
- Decision regarding hospitalization, DNR, emergency major surgery
- Drug therapy requiring intensive monitoring for toxicity
**Risk - Drug Therapy w/Intensive Monitoring**

- 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.

---

To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded (concept unchanged from current guidelines).

---

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Minimal or none</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99303</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99313</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>

To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded (concept unchanged from current guidelines).
<table>
<thead>
<tr>
<th>CRN Healthcare Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CHCC</td>
</tr>
</tbody>
</table>

**99205 99215**

**High**

**High**

| **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; |
| 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 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 |

**TIME**

Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CHCC © 2020
Effective Jan. 1, 2021

- **Office or other outpatient services** - Time may be used to select the code level. Time in counseling and/or coordination of care is not a factor.
- **Other E/M services** - Time may only be used to select the code level when counseling and/or coordination of care dominates the service.

**Total Time** on the date of the encounter

- Recognizes the important non-face-to-face activities
- Uses easy to remember increments based on time data of past valuations
- Removes “closest” vs “threshold” by giving exact ranges
- Is for **Code Selection When Using Time**
  - Not a required minimum amount when using MDM
**Time: Office and Other Outpatient E/M Services**

**In order to bill the visit based on time:**
- Must have a face-to-face encounter on the date of service being reported
- Time cannot be shared or overlapped over providers
  - If an APP and an MD/DO see the patient, only their separate time can be counted. Time that overlaps cannot be counted by both clinicians

---

**What is Total Time?**

- **Total time documented includes**
  - Total time on date of encounter
  - Both face-to-face and non-face-to-face time
  - Activities by physician or qualified healthcare professional (but not clinical staff)
  - Does not include time by clinical staff
  - Use prolonged services codes if time runs over (99205 and 99215)

*Not required for code selection but still counts for total time calculation*
Time:
Office and Other Outpatient E/M Services

Example of Overlapping time:
• PA sees patient for 10 minutes
• MD comes in with the PA for 15 minutes
• MD stays with the patient for an additional 10 minutes
• Each clinician documents his/her own time appropriately
• Total time that can be billed over the two providers (assuming no other work is performed non face-to-face) is 35 minutes.

Time:
Office and Other Outpatient E/M Services

Physician/other QHP time 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 necessary 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 reported separately)
• Documenting clinical information in the electronic or other health record (Charting)
• Independently interpreting results (not reported separately)
• Communicating results to the patient/family/caregiver
• Care coordination (when not reported separately)
**Time: Office and Other Outpatient E/M Services**

**Do Not Include Time For:**
- Separate reported tests / procedures
- Staff time (any staff that does not have a NPI number to bill for their services)
- Slow charting
- Any element performed on a different date

**New Patient (Total Time on the Date of the Encounter)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 minutes</td>
<td>Code deleted</td>
</tr>
<tr>
<td>99202</td>
<td>20 minutes</td>
<td>15-29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 minutes</td>
<td>30-44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 minutes</td>
<td>45-59 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 minutes</td>
<td>60-74 minutes</td>
</tr>
</tbody>
</table>

*If less than 15 minutes, no code is supported*
## Time: Office and Other Outpatient E/M Services

### Established Patient (Total Time on the Date of the Encounter)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5 minutes</td>
<td>Time removed</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>10-19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>20-29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>30-39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>40-54 minutes</td>
</tr>
</tbody>
</table>

*If less than 10 minutes than no code supported*

---

### OFFICE VISIT PROLONGED SERVICES
**Prolonged Services (99417)**

**Effective Jan. 1, 2021**

- Shorter prolonged services code to capture each 15 minutes of physician/other QHP work beyond the time captured by the office or other outpatient service E/M code
  - Used only when the office/other outpatient code is selected using time
  - **For use only with 99205, 99215**
  - Prolonged services of less than 15 minutes should not be reported

---

**Prolonged Services (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 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 15 minutes of total time (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 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)*
- *(Do not report 99417 for any time unit less than 15 minutes)*
Conflict in Prolonged Services Usage Per AMA vs CMS

• Per AMA 99215
  - 40-54 minutes typical time
  - Per AMA New Prolonged code used after 55 minutes (55-70)
  - Start using prolonged services 15 minutes after the lower limit of the code’s time, 50 minutes
  - Prolonged services code 99417 may be used only 1 minute into maximum outer limit of time of 99215, at 55 minutes (40 minutes + 15 minutes)

Per CMS 99215
  - 40-54 minutes typical time
  - Per CMS New Prolonged code used after maximum time of 55 minutes or more
  - Start using prolonged services 15 minutes after the upper limit of the code’s time, 55 minutes
  - Prolonged service code 99417 may be used, at 69 minutes (55 minutes + 15 minutes)

The same applies to the 99205 times

How To Use The New Prolonged Services Code – AMA vs CMS (Established Patient)

<table>
<thead>
<tr>
<th>AMA Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 69 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>69-83 minutes</td>
<td>99215 x 1 and 99417 x 1</td>
</tr>
<tr>
<td>84-98 minutes</td>
<td>99215 x 1 and 99417 x 2</td>
</tr>
<tr>
<td>99 minutes or more</td>
<td>99215 x 1 and 99417 x 3 or more for each additional 15 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CMS.gov Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 55 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>55-69 minutes</td>
<td>99215 x 1 and 99417 x 1</td>
</tr>
<tr>
<td>70-84 minutes</td>
<td>99215 x 1 and 99417 x 2</td>
</tr>
<tr>
<td>85 minutes or more</td>
<td>99215 x 1 and 99417 x 3 or more for each additional 15 minutes</td>
</tr>
</tbody>
</table>
How To Use The New Prolonged Services Code – AMA vs CMS (New Patient)

**AMA** Total Duration of New Patient Office Or Other Outpatient Service (use with 99205) | Codes
---|---
Less than 80 minutes | Not reported separately
89-103 minutes | 99205 x 1 and 99417 x 1
104-118 minutes | 99205 x 1 and 99417 x 2
119 minutes or more | 99205 x 1 and 99417 x 3 or more for each additional 15 minutes

**CMS** Total Duration of New Patient Office Or Other Outpatient Service (use with 99205) | Codes
---|---
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

Pitfalls of Time-based Coding

- Purpose is to allow for extenuating circumstances
- Increases chances of audit with high frequency
- Make sure time adds up!
  - Don’t code for more time than the provider has in their day
  - Have realistic time allocations
- How will CMS know if you coded based on time or MDM?
CMS – AMA DEFINITIONS

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 staged or severity changes.

Examples:
- 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 & the patient is asymptomatic. The risk of morbidity without treatment is significant.

Stable
- It is defined by the specific treatment goals for the individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed & there is no short-term threat to life or function.

Examples:
- Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract or benign prostatic hyperplasia.

Source: AMA 2019 CPT® Symposium Presented by Peter Hollmann, MD and Christopher Jagmins, MD
**CMS / AMA Definitions (continued)**

**Self-limited or minor problem:**
- A problem that runs a definite & prescribed course, is transient in nature and is not likely to permanently alter health status

**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 or no risk of mortality with treatment & full recovery without functional impairment is expected
- A problem that is normally self-limited or minor but is not resolving consistent with a definite & prescribed course
- Examples: Cystitis, allergic rhinitis, simple sprain

**Mineral problem:**
- A problem that may not require the presence of the physician or AP, but the service is provided under the physician/APP supervision

**Straightforward:**
- Self-limited
- Minimal risk from treatment or testing
- No risk

**Low:**
- Stable, uncomplicated single problem

**Moderate:**
- Multiple problems or significantly ill
- Would typically review with patient/surrogate, obtain consent & monitor or there are complex social factors in management

**High:**
- Very ill
- Need to discuss some pretty bad things that could happen for which the physician/APP will watch or monitor

---

**Independent Historian:**
- An individual (eg: parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg: due to developmental stage, dementia, psychosis, unconscious, etc) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians & more than one historian(s) is needed, the independent historian(s) requirement is met.

**External physician or other qualified healthcare professional:**
- Someone who is not in the same group practice or is classified as a different specialty or sub-specialty
  - Review of external notes is included in the office/outpatient E/M codes for levels 3 to 5
  - Discussion with an external provider is included in levels 4 and 5

---

Source: AMA 2019 CPT® Symposium Presented by Peter Hallman, MD and Christopher Jagnin, MD
CMS / AMA Definitions (continued)

Independent Interpretation:
• Independent interpretation of a test performed by another healthcare professional
• Not a separately reported interpretation

Social determinants of health (SODH)
• Economic and social conditions that influence health
• Persons with potential health hazards related to socioeconomic and psychosocial circumstances
• 2021 MDM table references SDOH as an example of moderate risk from additional diagnostic testing or treatment because SDOH, like housing insecurity, may limit those options.

Morbidity:
• 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.

Appropriate Source:
• A person involved in the care and well-being of the patient to include a teacher or healthcare agency, for example

Drug therapy requiring intensive monitoring for toxicity:
• The drug can cause serious morbidity or death.
• Monitoring assesses adverse effects, not therapeutic efficacy.
• The type of monitoring should be the generally accepted kind for that agent, although patient-specific monitoring may be appropriate also
• Long-term or short-term monitoring is ok
• Long-term monitoring occurs at least quarterly
• Lab, imaging and physiologic tests are possible monitoring methods
  • History and exam are not a monitoring method
• Monitoring affects MDM level when the provider considers the monitoring as part of the patient management

Risk:
- Risk of complications and/or morbidity, or mortality of patient management decision made at the visit, associated with the patient’s problem(s)
- Is related to probability of something happening, but risk and probability are not the same for E/M coding purposes.
- High probability of a minor adverse effect may be low risk, depending on the case
- The terms high, medium, low and minimal risk are meant to reflect the common meanings used by clinicians
- For MDM, base risk on the consequences of the addressed problems when they’re appropriately treated. Risk also comes into play for MDM when deciding whether to begin further testing, treatment or hospitalization.
  - Includes possible management options selected and those considered but not selected
  - Addresses risks associated with social determinants of health (SDOH)

Source: AMA 2019 CPEB Symposium Presented by Peter Hoffmann, MD and Christopher Jagmin, MD

### Acute Illness

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Acute, uncomplicated illness or injury | - The problem is recent & short-term  
- There is a low risk of morbidity  
- There is little to no risk of mortality with treatment  
- Full recovery without functional impairment is expected.  
- The problem may be self-limited or minor, but it is not resolving in line with a definite & prescribed course. | - Cystitis  
- Allergic rhinitis  
- Simple sprain |
| Acute illness w/ systemic symptoms  | - The illness causes systemic symptoms, which may be general or single system,  
- There is a high risk of morbidity without treatment.  
- For a minor illness with systemic symptoms like fever or fatigue, consider acute, uncomplicated or self-limited/minor instead. | - Pyelonephritis  
- Pneumonitis  
- Colitis |
| Acute, complicated injury           | - Treatment requires evaluation of body systems that aren’t part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment. | - Head injury with brief loss of consciousness |
## Stable Chronic Illness

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable, chronic illness</td>
<td>This type of problem is expected to last at least a year or until the patient’s death. A change in stage or severity does not change whether a condition is chronic. The patient’s treatment goals determine whether the illness is stable. A patient who hasn’t achieved their treatment goal is not stable, even if the condition hasn’t changed and there’s no short-term threat to life or function. · The risk of morbidity is significant without treatment.</td>
<td>Well-controlled hypertension · Non-insulin dependent diabetes · Cataract · Benign prostatic hyperplasia NOT stable · Asymptomatic but persistently poorly controlled blood pressure (pressures don’t change), with a treatment goal of better control</td>
</tr>
</tbody>
</table>

## Chronic Illness

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic illness with exacerbation, progression, or side effects of treatment</td>
<td>The chronic illness is getting worse, is not well controlled, or is progressing “with an intent to control progression.” · The condition requires additional care or treatment of the side effects. · Hospital level of care is not required.</td>
<td>No examples given by CPT® guidelines</td>
</tr>
<tr>
<td>Chronic illness with severe exacerbation, progression, or side effects of treatment</td>
<td>· There is a significant risk of morbidity. · The patient may require hospital care.</td>
<td>No examples given by CPT® guidelines</td>
</tr>
<tr>
<td>Acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>There is a near-term threat to life or bodily function without treatment. · An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment may be involved.</td>
<td>Acute myocardial infarction · Pulmonary embolus · Severe respiratory distress · Progressive severe rheumatoid arthritis · Psychiatric illness with potential threat to self or others · Pertussis · Acute renal failure · Abrupt change in neurologic status</td>
</tr>
</tbody>
</table>
IMpact on Revenue

Effect on Revenue

Important: These guidelines only apply to visits in the clinic (office). Inpatient services use the 1995/1997 documentation guidelines

Final RVU assignment by CMS

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>0.93</td>
<td>0.93</td>
</tr>
<tr>
<td>99203</td>
<td>1.42</td>
<td>1.60</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
<td>2.60</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
<td>3.50</td>
</tr>
</tbody>
</table>

99417 Prolonged Services 15 min add on code: 0.61 RVUs
REFERENCES

Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, CMCS © 2020

References

• AMA Guidelines:

• CMS 2020 Proposed Rule:

• AAPC Audit Tool:
## Questions and Answers

### Definitions for the elements of MDM

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong></td>
<td>A problem is 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.</td>
</tr>
<tr>
<td><strong>Problem Addressed</strong></td>
<td>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. This 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.</td>
</tr>
<tr>
<td><strong>Minimal problem</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Self-limited or minor problem</strong></td>
<td>A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.</td>
</tr>
<tr>
<td><strong>Stable, chronic illness</strong></td>
<td>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 of 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.</td>
</tr>
<tr>
<td><strong>Acute, uncomplicated illness or injury</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
**Definitions for the elements of MDM (cont’d)**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic illness with exacerbation, progression, or side effects of treatment</td>
<td>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.</td>
</tr>
<tr>
<td>Undiagnosed new problem with uncertain prognosis</td>
<td>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.</td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td>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, pneumoconiosis, or colitis.</td>
</tr>
<tr>
<td>Acute, complicated injury</td>
<td>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.</td>
</tr>
<tr>
<td>Chronic illness with severe exacerbation, progression, or side effects of treatment</td>
<td>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.</td>
</tr>
<tr>
<td>Acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>An acute illness with systemic symptoms, 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 near 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, penticostis, acute renal failure, or an abrupt change in neurologic status.</td>
</tr>
<tr>
<td>Test</td>
<td>Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [B0047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.</td>
</tr>
<tr>
<td>External</td>
<td>External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.</td>
</tr>
</tbody>
</table>

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**Definitions for the elements of MDM (cont’d)**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>External physician or other qualified healthcare professional</td>
<td>An external physician or other qualified health care professional is an individual who is not in the same group practice or is 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.</td>
</tr>
<tr>
<td>Independent historian(s)</td>
<td>An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged 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.</td>
</tr>
<tr>
<td>Independent interpretation</td>
<td>The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional 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.</td>
</tr>
<tr>
<td>Appropriate source</td>
<td>For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.</td>
</tr>
<tr>
<td>Risk</td>
<td>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.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>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.</td>
</tr>
<tr>
<td>Social determinants of health</td>
<td>Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.</td>
</tr>
</tbody>
</table>
Definitions for the elements of MDM (cont’d)

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
<td>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. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by 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 an encounter 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.</td>
</tr>
</tbody>
</table>

Staying in Contact

Should you have any questions after the conference, you can contact me at:

(732) 739-7466 or via E-mail at: b.cobuzzi@att.net

www.CRNHealthcare.com