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Cloud EHR, PM and Billing in One

2021

An Essential Guide to E/M Coding

The AMA Initiative

The AMA prompted CMS to give them time to develop new documentation guidelines.

AMA workgroup was created to achieve the following goals:

- Decreased administrative burden of documentation & coding.
- Decreased need for audits.
- Decreased unnecessary documentation in the medical record not needed for patient care.
- Ensure that payment for E/M is resource based and has no
- direct goal for payment redistribution between specialties.

Doctors created their own guidelines and CMS accepted these in full in the Final Rule for 2020. AMA involvement means these guidelines will be industry-wide for all payers.

Summary of Changes

- E/M documentation will now be focused on MDM (medical decision making) or time.
- History and Exam elements are only to be captured when clinically appropriate.
- Code 99201 will be eliminated as the requirements for MDM are the same as 99202.
- CPT 99211 still exists, but there are no specific MDM or time requirements. This is a "minimal" visit.
- CPT guidelines were substantially revised to remove the gray areas and provide accurate code selection.
- Provider can use either time-based or MDM method, whichever is the most beneficial for the visit.

Bottomline

Documentation should be sufficient for a subsequent provider treating the patient and a proper legal defense.

Criteria of MDM

- Created sufficient detail in CPT code set to reduce variation between contractors/payers.
- Attempted to align criteria with clinically intuitive concepts .
- Used existing CMS and contractor tools to reduce disruption in coding patterns.
- Removed ambiguous terms (e.g., "mild") and defined previously ambiguous concepts (e.g., "acute or chronic illness with systemic symptoms").

While similar, this is not the MDM calculation we have today.

- All code descriptors state a "medically appropriate" history and/or examination and MDM.
- Amount of history and exam performed and documented up to the provider will not be a consideration in code selection.

CPT	MDM
99202	Straightforward
99203	Low
99204	Moderate
99205	High
99212	Straightforward
99213	Low
99214	Moderate
99215	High

Levels of MDM

New Medical Decision-Making Tree

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CODE/MDM		Elements of Medical Decision Making		
Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be reviewed and Analysed. **each unique test, order or document contributes to the combination of 2 or combination of 3 in category 1*	Risk of Complication and/or Morbidity or Mortality of Patient Management
99211	**N/A**	**N/A**	**N/A**	**N/A**
99202 **99212**	**Straightforward**	**Minimal.** 1 self-limited or minor problem	**Minimal or none**	**Minimal** risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	**Low**	**Low** 2 or more self-limited or minor problems; *OR* 1 stable chronic illness; *OR* 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1/22 categories)* **Category 1 : Test and documents** Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* *OR* **Category 2 : Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test*	**Low** risk of morbidity from additional diagnostic testing or treatment

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99204 **99214**	**High**	**Moderate** 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment; *OR* 2 or more stable chronic illnesses *OR* 1 undiagnosed new problem with uncertain prognosis; *OR* 1 acute illness with systemic symptoms; *OR* 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 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**	**Moderate** risk of morbidity from additional diagnostic testing or treatment ***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

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99205 **99215**	**High**	**High** 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment; *OR* 1 acute or chronic illness that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2/3 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) **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	**High** risk of morbidity from additional diagnostic testing or treatment **Examples:** • 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

Elements of MDM

While similar, this is not the MDM calculation we have today.

1. Number of complexity of problems addressed.
2. Amount and/or complexity of data to be reviewed and analyzed
3. Risk of complications and/or morbidity or mortality of patient management

Guidelines are the same for new and established patients.

Number and Complexity of Problems Addressed

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare 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 healthcare professional reporting the service.
- Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified healthcare professional reporting the service.

Problems Addressed	Condition evaluated at the encounter by the reporting provider
Self-limited or minor	Transient and runs a definite and prescribed course
Minimal	Problem that runs a defined & prescribed course, is transient, and not likely to permanently alter health status
Acute	Recent or new short-term problem
Chronic	Expected duration of at least a year or until death of the patient
Uncomplicated	Treatment considered but low risk of morbidity
Complicated	Extensive injury that requires evaluation of body systems that are not part of the injured organ
Stable	Patient has met treatment goals
Systemic symptoms	Symptoms cause a high risk of morbidity without treatment
Exacerbation	Worsening but does not require hospitalization
Severe exacerbation	Progression with significant risk of morbidity and may require hospitalization
Undiagnosed	Differential diagnosis that likely results in a high risk of morbidity without treatment
Threat to life or bodily function	Poses a threat in near term without treatment

Summary of Definitions

Number and Complexity of Problems Addressed

- *No consideration given for new conditions*
- *Problems addressed should be "clinically relevant"*

Level	Problems Addressed
Straightforward	Self-limited
Low	Stable, uncomplicated, single problem
Moderate	Multiple problems or significantly ill
High	Very ill

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

Data are divided into three categories:

1. Tests, documents, orders, or independent historian(s)—each unique test, order, or document is counted to meet a threshold number
2. Independent interpretation of tests—not to be reported separately
3. Discussion of management or test interpretation with external physician/other QHP/appropriate source—not to be reported separately)

Emphasizes clinically important activities. Accounts for quantity of documents ordered/reviewed and creates "counting rules".

Example of Elements of Medical Decision Making

Code	Level of MDM	Amount and/or Complexity of Data to be reviewed and Analysed. **each unique test, order or document contributes to the*
99204 **99214**	**High**	**Moderate** *(Must meet the requirements of at least 1/3 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) **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 (not separately reported)

The AMA Takes Over

The AMA asked CMS to give them time to develop new documentation guidelines.

A workgroup was created with the following goals:

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2. Decrease the need for audits.
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Independent Interpretation

- Tests with a CPT code that includes an interpretat
- Not if clinic is reporting the service or has reporte
- Document a form of interpretation. Does not nee of a complete report.
- *Do not confuse "interpretation" with "review of*

Independent Interpretation

- Tests with a CPT code that includes an interpretation
- Not to report if clinic is reporting the service or has reported the service.
- Document some form of interpretation. Does not need the usual standards of a complete formal report.
- "Interpretation" is often confused with "Review of Results'.'

Appropriate Source

- Includes discussion with non-healthcare professionals.
- Must be involved in the management of the patient.
- Does not include family or informal caregivers.

Examples:

- Case Manager
- Parole Officer
- Professional Caregiver
- Lawyer
- Teacher

Amount and/or Complexity of Data to be Reviewed and Analysed

Categories are not the same for each level.

Level	Data Reviewed
Straightforward	Minimal or None
Low	• 1 category only • 2 documents or independent historian
Moderate	• 1 category only • Count: 3 items between documents and independent historian; or interpret; or confer
High	• 1 category only • Same concepts as moderate

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

Decisions involved with the patient's problem(s) or treatment(s)

- Includes possible management options selected and those considered, but not selected
- Addresses risks associated with social determinants of health

Examples are included in the table for moderate or high risk only.

Example on Elements of Medical Decision Making

Code	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 **99215**	**High**	**High** risk of morbidity from additional diagnostic testing or treatment **Examples:** • 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

Social Determinants

Social determinants of health: Economic and social conditions that influence the health of people and communities

- Social determinants of health appear under moderate complexity for codes 99204 and 99214.
- Consider this as diagnosis or treatment significantly limited by social determinants of health.

Examples may include but not limited to:

- Unemployment
- Extreme poverty
- Nutrition/Food
- Housing insecurity and safety
- Welfare risks

Level	Data Reviewed
Straightforward	Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
Low	Low risk (i.e., very low risk of anything bad), minimal consent/discussion
Moderate	Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
High	Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

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

Add-on Code for Chronic Conditions

GPC1X

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

Code added by CMS for the additional work involved in chronic conditions.

- Effective January 1, 2021
- No specialty distinction
- Report whether the visit is based on MDM or time

TIME BASED CODING CHANGES

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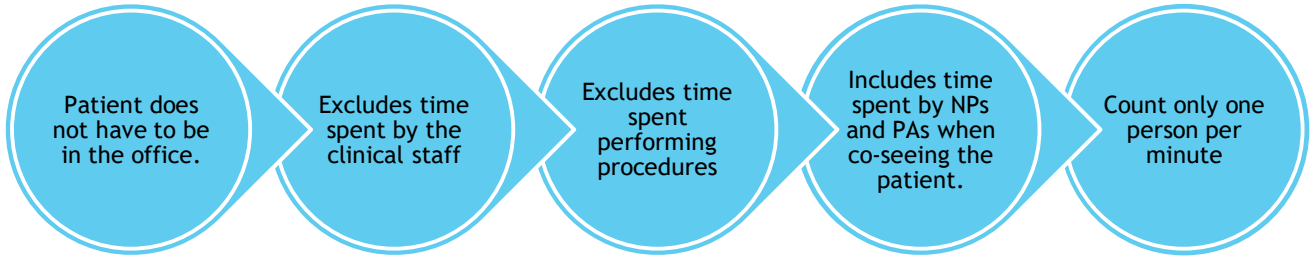
Total Time

Total time is face-to-face and non-face-to-face on the date of the encounter by the "reporting" practitioner.



To document, state the total time spent that day and summarize the services performed. No log required.

Non-Face-to-Face Time

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Physician/Other qualified healthcare professional time includes the following important 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 healthcare professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

CPT	TIME (MINUTES) SPENT ON DAY OF ENCOUNTER
99202 (New Patient)	15-29
99203 (New Patient)	30-44
99204 (New Patient)	45-59
99205 (New Patient)	60-74
99212 (Established Patient)	10-19
99213 (Established Patient)	20-29
99214 (Established Patient)	30-39
99215 (Established Patient)	40-54

Time Ranges

New CPT Code

+99417

Prolonged 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 (List separately in addition to codes 99205, 99215 for office or outpatient Evaluation and Management services).

- Report this code if the visit goes 15 minutes more than the time started for 99205 and 99215.
- Report **99417** for each 15-minute increment.
- Must be a complete 15 minutes to report. No rounding up.
- Do Not Use existing prolonged services codes on the same DOS.

Example

Time Interpretation Difference between AMA & CMS

New Patient

AMA Time in Minutes	CMS Time in Minutes	99417 Units
Less than 75	Less than 89	0
75-89	89-103	1
90-104	104-118	2
More than 105	More than 119	3

Established Patient

AMA Time in Minutes	CMS Time in Minutes	99417 Units
Less than 55	Less than 69	0
55-69	69-83	1
70-84	84-98	2
More than 85	More than 99	3

CMS Logic

- For Level 5, CMS says it needs to be 15 minutes beyond the highest time
- The AMA lets you bill 99417 if you go a minute over. Time to code for 99205 will be anywhere between 60-74 minutes.
- It is anticipated private payers may go with CMS logic.

Time to Gear for

- Start tracking your time today.
- Include items performed when not in the chart.
- Established best practices for tracking such activities and time.
- Start to case by case differentiate between type of visits that should be calculated based on time rather than MDM.

Points to Remember

- Sufficient Documentation to document complexity in medical decision making.
- Assume Not documented, not done.

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