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2020 CODING BOOTCAMP WEB SERIES

2021 Evaluation and Management (E&M) Coding - Part 1

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December 14, 2020

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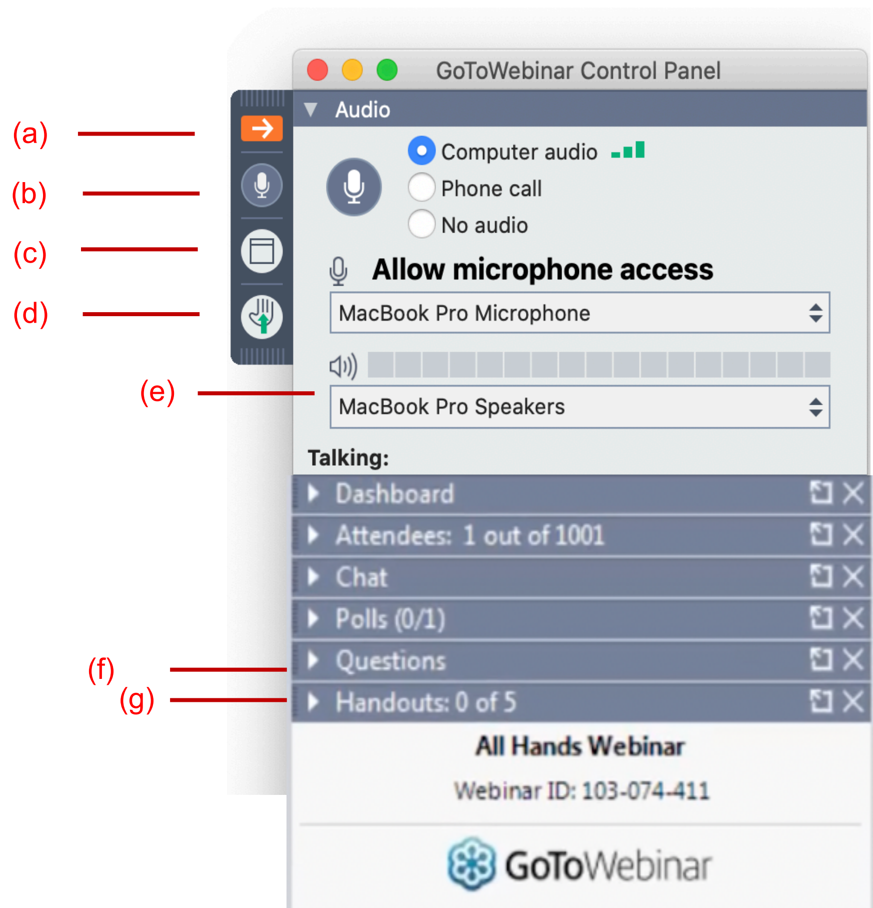

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Overview

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Final E/M Changes

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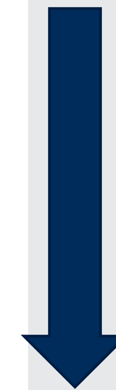
CMS accepted the full AMA E/M code definitions starting Jan. 1, 2021 – decrease documentation burden.

Per AMA survey 100% of the major commercial payors said they would be adopting new E/M guidelines

CMS finalized the adoption of revised and increased wRVUs for E/M services based on recommendations from the AMA (RUC).

Guiding AMA Principles:



- burden of coding & documentation.
- need for audits
- unnecessary documentation not needed for pt. care
- + Ensure payment for E/M is resource based.

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SUMMARY OF CODES AND WORK RVUs FINALIZED IN THE CY 2020 PFS FINAL RULE FOR CY 2021

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Table 20

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
~~99201~~	~~17~~	~~0.48~~	~~N/A~~	~~N/A~~
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

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Final E/M Revisions

Eliminate history and physical as elements for driving code selection for office and outpt E/Ms.

Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time

Modifications to the criteria for MDM and Time

Deletion of CPT code 99201

New add-on codes for visit complexity & additional time

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PROVIDER SELECTION OFFICE/OUTPT E/M SERVICE

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The level of the medical decision making (MDM) as defined for each service.

OR

The total time for E/M services performed on the date of the encounter.

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WHAT ABOUT NEW VS ESTABLISHED PATIENT?

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	2020	2021	Comments/Clarifications
New Patient Definition	Has not received any professional services from the provider or a provider of the same specialty who belongs to the same group in the previous 3 years • "Group" – defined per Tax ID • IM and FP are same for WPS • Face to face service – ie interp only would not count	Adds "exact same specialty and subspecialty"… same group etc.	FP and IM now different? AMA per 2021 – confirm CMS agrees
Established Patient Definition	As above, but has been seen in past 3 years	SAME	
Miscellaneous	APP and MD working together considered to be same specialty and subspecialty If on call – consider yourself same as who you are covering for	SAME - APP and MD working together considered to be same specialty and subspecialty SAME - APP and MD working together considered to be same	

AMA adds "Exact" same specialty and subspecialty.

This should distinguish FP from IM
As well as FP and Peds

This is NOT new and is consistent with how this has previously been interpreted and applied

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History Elements - Chief Complaint

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Chief Complaint is not specifically addressed in the new guidelines (reminder: office based)

1995 & 1997	
Chief Complaint	Concise statement that describes the reason for encounter. i.e. symptom, problem, condition, diagnosis - Reason for visit • Typically in the patient's own words • Not ok to just say F/U • Required for all visits

2021

Chief complaint, as well as ROS and Past family and social history can currently be documented by others. There is no indication this will change

Reminder: These changes are for BILLING purposes and do not supersede good documentation habits

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HISTORY ELEMENTS – HPI NOW SAYS “MEDICALLY APPROPRIATE”

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	1995 and 1997
HPI	• **Brief or extended** • **Brief – 1-3 elements** • **Extended – 4 or more** • **Elements include:** • **<u>Location</u> – i.e. left leg** • **<u>Quality</u> – aching, burning, radiating** • **<u>Severity</u> – 2 on a scale to 10** • **<u>Timing</u> – constant, comes and goes** • **<u>Context</u> – Lifted a large object, while walking** • **<u>Modifying factors</u> – better with heat, rest** • **<u>Associated signs and symptoms</u> – numbness in toes**

2021 – Medically Appropriate

Provider decides, but consider communication to other providers, malpractice, HCC/RAF coding, etc.

Could also help to support a “problem addressed”

Consider examples where we will need to support modifier 25 – info to show a significant and separate E/M from whatever else is billed

ISSION

HISTORY ELEMENTS – ROS, PFSH

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1995 and 1997	2021 – Medically Appropriate
ROS – No longer a set number required for each level – document what is medically appropriate PFSH - No longer a set number required for each level – document what is medically appropriate These were two of our biggest problem areas with a comprehensive history – having less than 10 in a comprehensive ROS, missing a family or social history with comprehensive especially with an acute presentation	These all default to what is medically appropriate/pertinent - Clinician decides nature and extent Keep in mind with the new medical decision-making credit is given for "problems addressed", ROS could come into play There is also a new element in MDM for "social determinants", as well as quality metrics that may need social history comments

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Exam Components

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1995 & 1997 – prescribed elements per level

Exam	Body Areas: Head • Neck • Chest, including breasts and axilla • Abdomen • Genitalia, groin, buttocks • Back, including spine • Each extremity Organ Systems • Constitutional (3 vital signs) • Eyes • Ears, nose, throat • Respiratory • Genitourinary • Skin • Psychiatric • Cardiovascular • Gastrointestinal • Musculoskeletal • Neurologic • Hematologic Lymphatic/Immunologic

2021 – Medically Appropriate

Exam defaults to whatever elements are medically pertinent in the professional opinion of the Clinician

Keep in mind with the new medical decision-making credit is given for "problems addressed", exam could come into play

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TIME – COUNTED DIFFERENTLY

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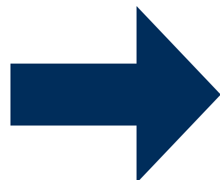
E&M 1995 & 1997 Guidelines

- Only the face-to-face time spent in counseling and coordination of care.
- Count only when greater than 50% of service is in counseling.
- No credit for any time to collect history, exam, etc.



2021 – "Total Time Day of Visit"

- Preparing to see the patient (review of tests, records, etc.)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam and or evaluation
- Counseling and educating the pt./family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately billed i.e. TCM, CCM)
- Documenting clinical information in the record
- Independently interpreting results (not separately reported)
- Communicating results to the pt/family/caregiver
- Care coordination (not separately billed i.e. TCM, CCM)

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TIME DEFINITIONS & COMPARISONS

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- MPFS finalized adoption of actual total times, defined as the sum of component times rather than total times recommended by RUC
- Component time – includes pre, intra and immediate post time
- AMA CPT 2021 coding book as range definitions of time

CPT Code	Short Description	RUC Recommended Total Time	AMA CPT 2021 Time Day of Encounter	CMS Final Rule Actual Total Time (Sum of Component Times - Pre, Intra and Immediate Post)
99202	Level 2 NP Office/Outpt Visit	22 mins	15-29 mins	20 mins
99203	Level 3 NP Office/Outpt Visit	40 mins	30-44 mins	35 mins
99204	Level 4 NP Office/Outpt Visit	60 mins	45-59 mins	60 mins
99205	Level 5 NP Office/Outpt Visit	85 mins	60-74 mins	88 mins
99212	Level 2 Established Office/Outpt Visit	18 mins	10-19 mins	16 mins
99213	Level 3 Established Office/Outpt Visit	30 mins	20-29 mins	30 mins
99214	Level 4 Established Office/Outpt Visit	49 mins	30-39 mins	47 mins
99215	Level 5 Established Office/Outpt Visit	70 mins	40-54 mins	70 mins

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Whose Time Can Count?

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- AMA comments – "A shared or split visit is when a physician and one or more other qualified healthcare professionals perform the face-to-face and non-face-to-face work for the E/M visit. When you're coding these visits based on time, sum the time spent by the physician and other qualified healthcare professionals to get a total time. Any time that the providers spend together to meet with or discuss the patient should be counted only once (like you're counting the time of one individual)"
- **Confirmed "qualified healthcare professional" is someone who can separately bill for their services – MAs, LPN, RN, etc. do NOT count**

Questions where we are expecting additional information:

- Can teaching providers count time spent by student and or resident?
- Can teaching providers count "staffing" time. (we are anticipating that this will count)
- How would we count time in a multi-disciplinary clinic where multiple clinicians are discussing patient at end of day?

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Documenting Time EMR Example

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- The current text macro that prompts for documentation of total time and time spent in counseling and coordination of care – will no longer be valid
- Clinicians who choose to bill based on time will need to document time.
- A brief statement discussing elements counted in support of time billed is recommended.
- Possible macro "[] minutes were spent in preparation for the clinic visit, reviewing records, tests, counseling and education of the patient and parent, ordering medications, tests and procedures, coordinating care and documenting clinical information in the electronic health record.

- If using time-based coding documenting time is essential.
- Documenting time is NOT needed if using medical decision making
- Recommendation from the clinician work group is a brief statement to clarify you are only counting time on the day of the visit
  - Total time
  - Include components that make up that time – i.e. review pre and post visit, etc.
  - Each component does not need specific time noted

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PROLONGED OFFICE/OUTPT 99417

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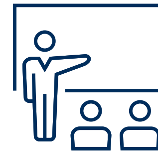

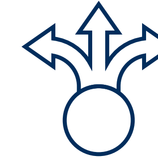

Definition

Prolonged office or other outpatient E/M **(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 additional 15 minutes

Guidelines

- ✓ List separately in addition to CPT codes 99205, 99215 for office or other outpatient E/M
- ✓ Only reported when time is used to select E/M
- ✓ Only time of the physician and QPP is counted

CMS Final Rule

- Created own code to resolve discrepancies – G2212
- CMS changed the code definition to clarify the max time must first be met – then each add'l 15 minutes

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CMS APPROVES SEVERITY CODE – G2211

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Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

(Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."

"Recognize the resources inherent in engaging the patient in a management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience.

Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals."

G2211 is not billable with an E/M service **reported with modifier 25**

Monitor payers and local MACs.

Have not implemented any additional policies that restrict the billing of this code, and so we are assuming that **utilization will be 90 percent of office/outpatient E/M visits** instead of the 100 percent that we assumed in the proposed rule.

1 Definition

2 Specialty Care

3 Modifier 25

4 Utilization

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Prolonged Time Vs Prolonged NFTF Code

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CMS Prolonged Code G2211

- CMS was concerned about the lack of clarity with the AMA code referencing "total time" and "usual service"
- They also did not want the greater than half the time threshold to apply
- CMS created their own code and revised the code description was
- "Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) "(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))."

Prolonged NFTF 99358 & 59

- CMS Comments: "Regarding prolonged visits, we finalized separate payment for a new prolonged visit addon CPT code (CPT code 99XXX), and discontinued the use of CPT codes 99358 and 99359 (prolonged E/M visit without direct patient contact) to report prolonged time associated with O/O E/M visits"
- "We also note that we are not opposed in concept to reporting prolonged office/outpatient visit time on a date other than the visit. However, we continue to believe there should be a single prolonged code specific to office/outpatient E/M visits that encompasses all related time"
- "For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203,99204, 99205, 99211, 99212, 99213, 99214, 99215), see 99358, 99359…Do not report 99XXX in conjunction with…99358, 99359".

We believe if you want to report time on day of E/M use the add on code. For time on a day other than E/M use prolonged NFTF do not count time on day of visit. We anticipate add'l info.

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SEVERITY CODE WITH “25” MODIFIER

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From CMS Final Rule”

- “As we noted above, while we would not expect that HCPCS add-on code G2211 would be reported when the office/outpatient E/M visits is reported with a payment modifier, such as a modifier -25, we are not establishing any policies that prohibit reporting the add-on code under those circumstances.”
- “Thus, we will continue to include office/outpatient visits reported with a modifier -25 in our utilization assumptions for HCPCS code G2211 as part of calculating the budget neutrality adjustment for the policies we are finalizing in this rule. As we noted above, we would not expect HCPCS add-on code G2211 to be reported when the visit is reported with a modifier -25, and will consider whether to establish an explicit prohibition in future rulemaking.”
- “We continue to believe that separately identifiable visits occurring on the same day as minor procedures (such as zero-day global procedures) have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment. We are also analyzing our data to determine if separately identifiable visits occurring on the same day as another visit have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment.”

We are reviewing services where our Medicare MAC requires the 25 modifier and the potential impact. Examples: office visit with an EKG, Device check, Med Administration, split billing EM & AWV, bladder cath,

We have alerted specialty societies to our concerns, and inconsistent requirements between payors.
We will be reviewing situations where the modifier is being attached by charge entry when it is NOT required. I.E. when the only other service is venipuncture

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MDM REQUIREMENTS

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To Qualify for MDM Must Meet **2** of the **3** Elements

Existing Guidelines (1995 &1997)

1. Diagnosis and management options (max of 4 points)
2. The amount or complexity of data to review (max of 4 points)
3. Table of Risk (2 out of 3)
   1. Presenting problem (s)
   2. Diagnostic procedure (s) ordered
   3. Management options selected

2021 Proposed Office and Outpt

Each element has specific options and unique requirements.

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

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LEVEL OF MDM

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

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 of the 2 categories)
			Category 1: Tests 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 interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	Moderate
		• 1 or more chronic illnesses with 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 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• Any combination of 3 from the following:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				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

Complete table available from resource link to the AMA Items shown in red are now defined

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LEVEL OF MDM

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99205
99215
	High	High
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				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

Complete table available from resource link to the AMA Items shown in red are now defined

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DIAGNOSIS AND/OR MANAGEMENT

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#1

Number & Complexity of Problems Addressed at the Encounter

- Multiple new or established conditions may be addressed at the same time and impact MDM
- Symptoms may cluster around a specific dx and each sx is not necessarily unique.
- Comorbidities/underlying diseases unless addressed do not increase complexity
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.
- Final dx for a condition does not in itself determine the complexity or risk – extensive eval necessary to reach a conclusion.

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Number and Complexity of Problems Addressed

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<table>
<tr><th>CPT Code</th><th>Level of MDM
(Based on 2 out of 3 MDM)</th><th colspan="5">#1 - Number and Complexity of Problems Addressed</th></tr>
<tr><td>**99211**</td><td>**N/A**</td><td colspan="5">N/A</td></tr>
<tr><td>**92202 or 99212**</td><td>**Straightforward**</td><td colspan="5">Minimal – 1 self-limited or minor problem</td></tr>
<tr><td>**99203 or 99213**</td><td>**Low**</td><td colspan="2">2 or > self-limited or minor problems</td><td>1 stable chronic illness</td><td colspan="2">1 acute, uncomplicated illness or injury</td></tr>
<tr><td>**99204 or 99214**</td><td>**Moderate**</td><td>1 or > chronic illnesses w/exacerbation, progression, or side effects of treatment</td><td>2 or > stable chronic illnesses</td><td>1 undiagnosed new problem w/uncertain prognosis</td><td>1 acute illness w/systemic sxs,</td><td>1 acute complicated injury</td></tr>
<tr><td>**99205 or 99215**</td><td>**High**</td><td colspan="3">1 or > chronic illnesses w/severe exacerbation, progression, or side effects of tx</td><td colspan="2">1 acute or chronic illness or injury that poses a threat to life or bodily function</td></tr>
<tr><td colspan="7"></td></tr>
</table>

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Now Defined: “Problem Addressed”

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"The number and complexity of problem(s) that are addressed during the encounter."

- "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 due to 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.*
- 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 health care professional reporting the service."

“Addressed” is how we have treated this all along. Just because a problem appeared in a problem list, it wasn’t considered for auditing purposes unless there was some indication it was addressed or taken into consideration.

For HCC purposes this WOULD qualify as MEAT

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Application Of “Problems Addressed”

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If it is a problem you want credit for as a “problem addressed” then there should be something in your note beyond the comment that the condition is being followed by another clinician

Consider adding the “problem addressed” as a diagnosis in your assessment and plan

When reviewing notes we do note examples that would support a “problem addressed” within the HPI/ROS, etc. - it is unknow how the audit criteria might be applied to these situations. While this would count for HCC/RAF purposes and adding the diagnosis codes, it is unclear if this would support level of service without additional comments.

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AMA – DEFINITIONS OF MDM ELEMENTS

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Low –Level 3

- 2 or more self-limited or minor problems; OR
- 1 stable chronic illness; OR
- 1 acute, uncomplicated illness or injury

Self-Limited/ Minor Problem	Stable, Chronic Illness	Acute, Uncomplicated Illness/Injury
• Runs a definite and prescribed course. • Transient in nature • Not likely to permanently alter	• Expected duration of at least 1 yr or death • Chronic conditions whether or not stage or severity changes. • Stable = specific tx. Goals. • ‘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. • Risk of morbidity w/o tx is significant	• Recent or new short-term problem w/ low risk w/treatment. • Full recovery w/o functional impairment. • Not resolving consistent with a definite and prescribed course

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AMA – DEFINITIONS OF MDM ELEMENTS

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Moderate – Level 4

- **1** or more chronic illnesses with 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

Chronic illness w/ exacerbation, progression, or side effects of treatment

- Acutely worsening, poorly controlled or progressing
- Intent to control, may require add'l supportive care.
- Require attention to tx for side effects.
- Does not need hospitalization

Undiagnosed new problem w/ uncertain prognosis

- Differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness w/ systemic sxs

- Systemic sxs.
- High risk w/o tx.
- Systemic sxs may not be general but may be single system.

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AMA – DEFINITIONS OF MDM ELEMENTS

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High – Level 5

- **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **OR**
- 1 acute or chronic illness or injury that poses a threat to life or bodily function

Acute, complicated injury	Acute or chronic illness or injury that poses a threat to life or bodily function	Chronic illness w/ severe exacerbation, progression, or side effects tx
• Requires tx includes eval of body sxs that are not directly part of the injured organ • Injury is extensive, or the tx options are multiple and/or associated with risk	• Acute illness w/ systemic symptoms • Acute complicated injury • Chronic illness or injury w/ exacerbation, progression or side effects • Threat to life or bodily function in the near term w/o tx.	• Severe exacerbation or progression of a chronic illness or severe side effects of tx • Significant risk of morbidity • May require hospitalization

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#2 Counting Data Reviewed

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1995/1997 – Counted per "category" for points

1 Lab or 10 labs equaled one point	
Review and summary of old records, and or obtaining hx from other than pt, discuss with other	2
Review and or order labs	1
Review and or order radiology	1
Review and or order medicine section	1

2021 - Will count per CPT and/or "Unique source"

Review results each unique test 1 lab = CPT code – I.e. CMP is 1, CBC is another one, Lipid profile is another, U/A another – Total 4

Review "prior external note(s) from each unique source"

Ordering each unique test

Assessment requiring independent historian

Orders also counted per unique CPT code i.e. see lab example above

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AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED AND ANALYZED

Limited – Level 3
Note – 1 of 2

Limited (Must meet the requirements of at least 1 of the 2 categories)
Category 1: Tests 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 interpretation, see moderate or high)

Moderate – Level 4
Note - 1 of 3

Moderate (Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
Any combination of 3 from the following:

- Review of prior external note(s) from each unique source*;
- Review of the result(s) of each unique test*
- Ordering of each unique test*;
- Assessment requiring an independent historian(s)

Or Category 2:

- Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

Or Category 3:

- Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

High – Level 5
Note - 2 of 3

Extensive (Must meet the requirements of at least 2 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
Any combination of 3 from the following:

- Review of prior external note(s) from each unique source*;
- Review of the result(s) of each unique test*;
- Ordering of each unique test*;
- Assessment requiring an independent historian(s)

Or Category 2:

- Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

Or Category 3:

- Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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Data Clarifications

- "External source" – consider each unique note from a source not within the same location/office where you practice
- "Future Orders" – When placing a medically necessary order for tests and or visits in 6 months for example – this can be counted as an element of an "order" on the day this is placed.
- "Trending Labs" – seeking clarification on interpretation on how to credit this

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AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED AND ANALYZED

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Critical to this category:

- Each individual test, lab, etc. is counted
- Each review of an external note – and from each unique source is counted
- Each test ordered counts
- Speaking with an independent historian
- Having a discussion with another healthcare provider
- Independent interp of a test (that you are not billing separately for)

If making note of specifically what you review on the day of an encounter is not a part of your current documentation it will be an important if not critical element to add for 2021

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AMA Info	Application To Level Of Service Data
• Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately. • The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. • If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making.	• If you are billing for the interpretation of the test then you do not count it as data reviewed for that visit • Guidelines for the use of modifier 25 to signify a "significant and separate" E/M service in addition to a procedure still apply

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AMA – DEFINITIONS DATA

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1 Independent Historian

- ✓ Individual who provides a hx in addition to the hx provided by the pt who is unable to provide details, etc.

2 Independent Interpretation

- ✓ Interpretation of a test for which there is a CPT code and an interpretation or report is customary.
- ✓ Form of interp should be documented, but need not conform to the usual standards of a complete report
- ✓ *Does not apply when reporting the service or service was previously reported.*

3 Appropriate Source

- ✓ Professionals who are not health care professionals, but may be involved in the management of the pt.
- ✓ Does not include discussion with family or informal caregivers.

4 External

- ✓ Records
- ✓ Communications
- ✓ Test results
- ✓ From external MD, QPP, facility or organization.

5 External Physician or QPP

- ✓ Individual who is not in the same group practice or is a different specialty or subspecialty
- ✓ Licensed professional practicing independently.
- ✓ Facility or organization.

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

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1995 1997 Guidelines	2021
Provided us with a "Table of Risk" Includes examples in 3 categories: 1) Presenting problem (s) 2) Diagnostic Procedure (s) Ordered 3) Management Options Selected	The table goes away, and elements are now merged in with other areas of MDM Presenting problem – now points us to the number and complexity of problems addressed Orders – now considered with the amount and or complexity reviewed Management options – close to how we will use this now considering risk of morbidity and mortality

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CPT Code	Level of MDM (Based on 2 out of 3 MDM)	Risk of Complications and/or Morbidity or Mortality of Patient Management	
99211	**N/A**	N/A	
92202 or 99212	**Straightforward**	Minimal risk of morbidity from additional diagnostic testing or treatment	
99203 or 99213	**Low**	Low risk of morbidity from additional diagnostic testing or treatment	
99204 or 99214	**Moderate**	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**
99205 or 99215	**High**	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

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AMA – DEFINITIONS RISK

Defers to your thought process

1 Risk

- ✓ Probability and/or consequences of an event
- ✓ Assessment of the level of risk is affected by the nature of the event under consideration
- ✓ Definitions based upon the usual behavior and thought processes of a provider in the same specialty
- ✓ Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities).
- ✓ MDM risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated, testing, etc.

2 Drug therapy requiring intensive monitoring for toxicity

- ✓ Therapeutic agent that has the potential to cause serious morbidity or death
- ✓ Monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy
- ✓ Intensive monitoring may be long-term or short term
- ✓ Long-term monitoring occurs at least quarterly.

- ✓ Lab, imaging, and physiologic tests are possible monitoring methods. History and exam are not.
- ✓ Monitoring affects MDM level when the provider considers the monitoring as part of patient management.

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AMA – DEFINITIONS RISK

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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.

Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity

1 Morbidity

2 Social Determinants of Health

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NEW OPTION FOR LEVEL 4 MODERATE RISK: SOCIAL DETERMINANTS OF HEALTH

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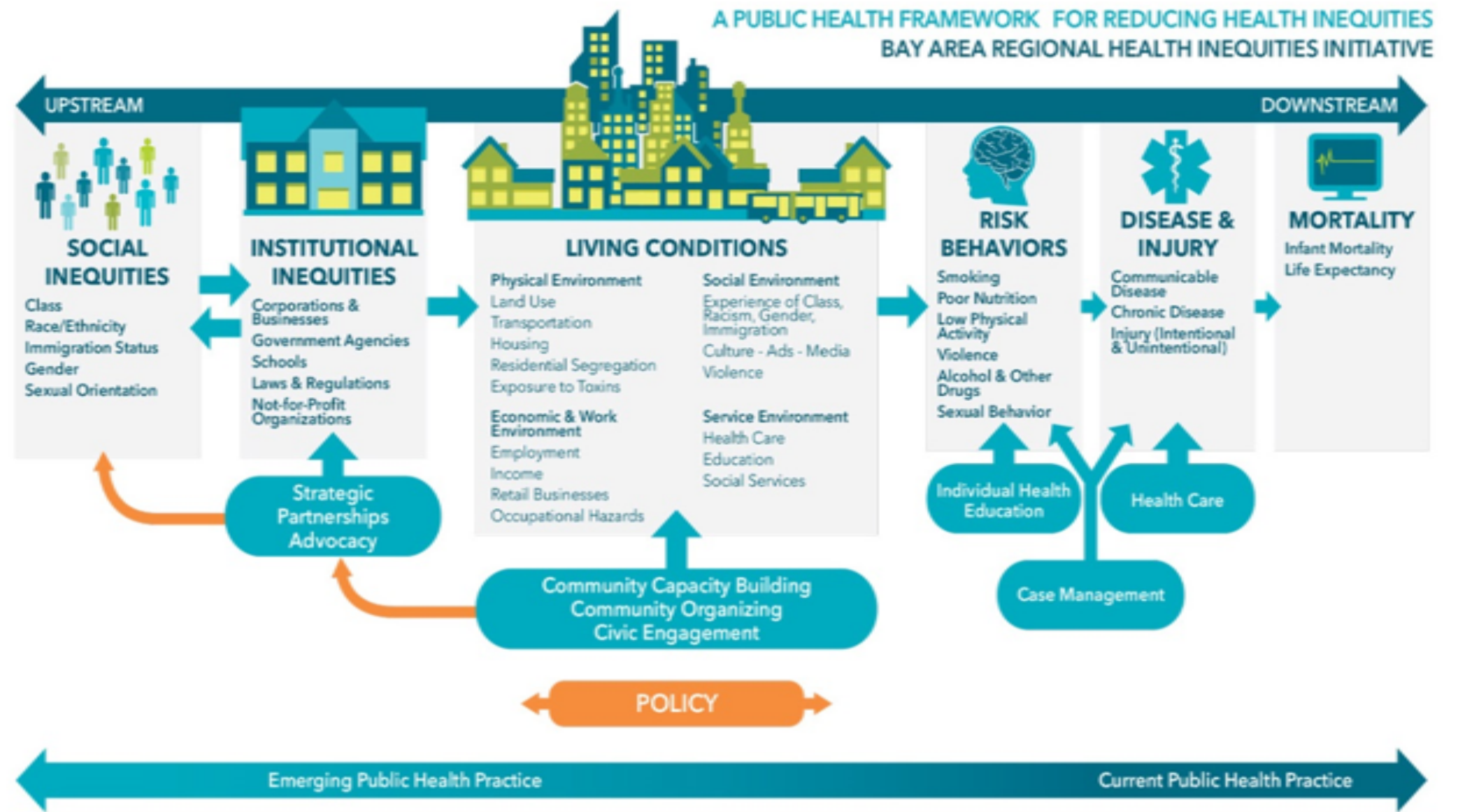
Link to AAFP Article

https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine.html



Link to ACC Article

https://www.acc.org/latest-in-cardiology/articles/2020/06/01/12/42/cover-story-health-disparities-and-social-determinants-of-health-time-for-action

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NEW CODES FOR SOCIAL DETERMINANTS

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Social Determinants of Health
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

There may be payor financial incentives for adding these codes as appropriate to our visits.

Why are Social Determinants of Health Important?

A person's health is determined by more than just access to health care. Social and behavioral factors contribute more than 60 percent of an individual's health status. Research shows that health behaviors such as smoking, and diet and exercise are most determinants of premature death. Whether someone is able to engage in healthy behaviors is largely determined by a range of social, economic, and environmental factors.

Problems related to education and literacy (Z55)
Z55.0 Literacy and low-level literacy
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Educational maladjustment and discord with teachers and classmates
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspecified

Problems related to social environment (Z60)
Z60.0 Problems of adjustment to life-cycle transitions
Z60.2 Problems related to living alone
Z60.3 Acculturation difficulty
Z60.4 Social exclusion and rejection
Z60.5 Target of (perceived) adverse discrimination and persecution
Z60.8 Other problems related to social environment
Z60.9 Problems related to social environment, unspecified

Occupational exposure to risk factors (Z57)
Z57.0 Occupational exposure to noise
Z57.2 Occupational exposure to dust
Z57.31 Occupational exposure to environmental tobacco smoke
Z57.39 Occupational exposure to other air contaminants
Z57.4 Occupational exposure to toxic agents in agricultural
Z57.5 Occupational exposure to toxic agents in other industries
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factor

Problems related to housing and economic circumstances (Z59)
Z59.0 Homelessness
Z59.1 Inadequate housing
Z59.2 Discord with neighbors, lodgers and landlords
Z59.3 Problems related to living in residential institution
Z59.4 Lack of adequate food and safe drinking water
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support

Risk – 4 Levels

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Level 2 – Straightforward

Minimal risk of morbidity from additional diagnostic testing or treatment

Level 3 – Low

Low risk of morbidity from additional diagnostic testing or treatment

Level 4 – Moderate

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

(New) Diagnosis or treatment **significantly** limited by social determinants of health

Level 5 – High

High risk of morbidity from additional diagnostic testing or treatment

Examples only:

Drug therapy requiring intensive monitoring for toxicity (Now defined)

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

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WHAT DOES AND DOES NOT GET INCLUDED IN A PATIENT SUMMARY – EMR EXAMPLE

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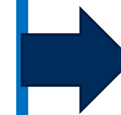
- If you want to use "risk" as an element for medical decision making you could consider documenting the level of risk
- Anything that is free text under the diagnosis in assessment and plan is NOT viewable by the patient (but if we print a copy it will show, and it would be "discoverable")
- It you type within the "discussion note" box – this will be included in the patient summary

Check your setting to be sure.

This is the "default" so you would have had to make a change in your settings for it to print



athenaNet | Calendar | Patients | Claims | Financials | Reports | Quality

No lab alarms by default

Notifications for new flagged tasks: Alert me when I receive flagged tasks

PE template layout: Enable paragraph view

Default specialty view: All / Selected
Pediatric Medicine
Addiction Medicine
Allergy/Immunology
Anesthesiologist Assistant
Anesthesiology
Applied Behavior Analyst
Audiology
Bariatric Surgery
Behavioral Health
Bone Marrow Transplant

Display ROS summary as itemized list

Include notes for diagnoses in the patient care summary

Include the assessment note in the patient care summary

Recommend patient info orders

Speech to text vendor: None

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Takeaways

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The new options allow providers to choose between time and medical decision making

Understand what can and can not be counted for your time

The levels of care are now aligned – new and established patient requirements match (MDM)

Review and familiarize yourself with the Medical Decision Making Table

Consider trends, i.e. a patient with 2 or more stable illness, with medication management is now a level 4 with appropriate documentation

These are effective January 1, 2021 – Don't wait to learn them

Keep in mind the "current" 1995/1997 guidelines remain in effect outside of the office setting (hospital, nursing home, home, etc.)

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Q&A

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