2021 E/M Changes

Brenda T. Griffin, MHSA, CPC, CPMA

Overview of Changes

- **On Jan. 1, 2021, new CPT guidelines for outpatient Evaluation & Management (E&M) services will take effect.** The AMA is launching these guidelines in conjunction with corresponding measures from CMS.
- **CPT vs. CMS guidelines?** The AMA has worked closely with CMS to align their guidance for 2021. CMS necessarily focuses on reimbursement and compliance; the AMA focuses on the official CPT text and guidelines.

Overview of Changes

- **On Jan. 1, 2021, new CPT guidelines for outpatient Evaluation & Management (E&M) services will take effect.** The AMA is launching these guidelines in conjunction with corresponding measures from CMS.
- **CPT vs. CMS guidelines?** The AMA has worked closely with CMS to align their guidance for 2021. CMS necessarily focuses on reimbursement and compliance; the AMA focuses on the official CPT text and guidelines.

Overview of Changes

- **Easing the documentation burden. (Patients Over Paperwork Initiative)** The push to change E&Ms "strived to reduce the significant burden associated with documentation for payment purposes by eliminating the payment rules associated with the current primary means of varying payment among office/outpatient visits."

Overview of Changes

- **On Jan. 1, 2021, new CPT guidelines for outpatient Evaluation & Management (E&M) services will take effect.** The AMA is launching these guidelines in conjunction with corresponding measures from CMS.
- **CPT vs. CMS guidelines?** The AMA has worked closely with CMS to align their guidance for 2021. CMS necessarily focuses on reimbursement and compliance; the AMA focuses on the official CPT text and guidelines.

Revised Guidelines

- Retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions.
- Revise the times and medical decision making guidelines for all of the codes and require performance of history and exam only as **medically appropriate.**
- Allow clinicians to choose the E/M visit level based on either medical decision making or time.
- The goal is to reduce the documentation burden.

Summary of Changes

- 99201 deleted
- Codes are based on time or decision-making.
- No required level of history or exam ("medically appropriate history and exam").
- Time will be a range and not dependent on counseling/coordination of care.
- Medical decision-making elements are more specifically defined.

Summary of Changes

- Revised work RVUs for these codes that were recommended by the AMA Relative Update Committee (RUC), which conducted a national survey on appropriate RVUs in 2018.

Summary of Changes – Revisions to the MDM Table

- **Column 1** is now titled "Number and Complexity of Problems Addressed".
- **Column 2** is now titled "Amount and/or Complexity of Data to be Reviewed and Analyzed". This is the column that has changed the most significantly with how elements in this section are written and what they actually say…
- **Column 3** is now titled "Risk of Complications and/or Morbidity or Mortality of Patient Management".
- https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Work Relative Value Changes Comparison

2020		2021	
• 99202	0.93	• 99202	0.93
• 99203	1.42	• 99203	1.60
• 99204	2.43	• 99204	2.60
• 99205	3.17	• 99205	3.50
• 99212	0.48	• 99212	0.70
• 99213	0.97	• 99213	1.30
• 99214	1.50	• 99214	1.92
• 99215	2.11	• 99215	2.80

Summary of Changes

- **History and exam were easy targets.** "Based on … feedback, it also seems that the history and exam portions of the guidelines are most significantly outdated with respect to current clinical practice." However, documentation and history should still be "medically appropriate".
- **Outpatient codes are just the beginning. "**We may consider expanding our efforts more broadly to address sections of the E/M code set beyond the office/outpatient codes in future".

E/M Changes & Medical Necessity

- "While the proposed change addresses who may document services in the medical record, subject to review and verification by the furnishing and billing clinician, it would not modify the scope of, or standards for, the documentation that is needed in the medical record to demonstrate ***medical necessity*** of services, or otherwise for purposes of appropriate medical recordkeeping."

MDM vs. Medical Necessity

- 1862(a)(1)(A) of the [Social Security] Act, requires services paid under Medicare Part B to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Medical necessity is a prerequisite to Medicare payment for E&M visits. The Medicare Claims Processing Manual states:
- 'Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.'

Billing Provider Responsibility

- CMS deliberately uses language placing the emphasis on the billing provider; the responsibility of ensuring an accurate history is theirs, and when they sign a note, they are accepting more responsibility than before if someone else captured the history.
- Don't let a time-saving regulatory flexibility result in compliance problems (inaccurate history, contradictory history, history that could be interpreted as having been copy-pasted).

MDM vs. Medical Necessity

- It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

Billing Based On Time

EngageMED

E/M Changes & Medical Necessity

- Medical necessity is closely correlated with the nature of the problems addressed
- Compliance-focused; asks whether the problems addressed justify the services billed
- Not easily quantifiable; not based on a numerical metric like "points"
- Remember that while the concept of quantifying MDM only applies to E&M services, ***medical necessity is a concept that applies universally***: every single service, diagnostic test, therapy session, and piece of medical hardware provided must be medically necessary.

Billing Based on Time

- Revisions have been made to both the **definitions** of time and the **criteria** for using time as an element in the code selection process.
- **Previously** time was only used when determining level of service when counseling and/or coordination of care dominated more than 50% of the encounter.
- For 2020, pre and post non-face-to-face work performed on same calendar day as the encounter are **included in the total time reported** but does not include clinical staff time.

Billing Based on Time

- Requires a face-to-face encounter with the physician or other qualified health care professional (QHP) (APRN, PA, CNM).
- It includes both the face-to-face **and non-face-to-face** time personally spent by the provider on the day of the encounter
  - Includes time in activities that require the physician or other qualified health care professional (QHP)

Time Ranges

- **99202 15-29** minutes of total time is spent on the date of the encounter.
- **99203 30-44** minutes of total time is spent on the date of the encounter.
- **99204 45-59** minutes of total time is spent on the date of the encounter
- **99205 60-74** minutes of total time is spent on the date of the encounter.
- (For services 75 minutes or longer, see Prolonged Services
- **99212 10-19** minutes of total time is spent on the date of the encounter.
- **99213 20-29** minutes of total time is spent on the date of the encounter.
- **99214 30-39** minutes of total time is spent on the date of the encounter.
- **99215 40-54** minutes of total time is spent on the date of the encounter.
- For services 55 minutes or longer, see Prolonged Services

Reportable Elements of Time

- Preparing to see the patient (eg, review of tests, notes)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)

Example - Time

- This is a 55 year old male who presents today for evaluation. He was diagnosed with diverticulitis approximately 3 years ago. He completed a 10 day course of antibiotics for LLQ pain. One year later he was hospitalized in Searcy for the same symptoms. In early August 2019 he again developed LLQ pain and felt he had a fever.
- 10/14/19 Colonoscopy noted diverticulosis, hyperplastic polyps and hemorrhoids. It is of note CT abd/pelvis on 8/5/16 noted diverticulitis of descending colon at the left lower quadrant. No perforation or abscess. At today's appointment, patient reports experiencing a persistent "dull ache" of the left lower abdomen, that does not resolve with oral antibiotics.

Reportable Elements of Time

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

Example - Time

He took 7 days of Flagyl. He sees Dr. Cardiology every six months for CAD with questionable history of CVA or TIA. CT and MRI of head last year were unremarkable. Dr. Cardiology would like to perform cardiac stenting in the near future, per patient; Dr. Cardiology has encouraged him to undergo colon resection first, as he will be on anticoagulation therapy for 6 months following stents. 8/29/19 CT abd/pelvis noted.

Example - Time

- We discussed the situation at length. I spent given **45 minutes discussing the case** with the patient face-to-face. I personally **reviewed radiologic images**. Patient has recurrent diverticulitis. We discussed treatments would be a laparoscopic/robotic sigmoidectomy. I discussed some of the risks including bleeding, infection, scarring, pain, damage to arteries, nerves, veins, recurrence, need for further surgery, need for ostomy, cardiac failure, respiratory failure, hernia, anastomotic leak, fistula, deep vein thrombosis, pulmonary embolism and even death. Patient understands all this and wants to proceed. I answered all questions and concerns.

New Prolonged Services Code

- 99XXX Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; **each 15 minutes** (List separately in addition to codes **99205, 99215** for office or other outpatient Evaluation and Management services) (Use 99XXX in conjunction with 99205, 99215)
- Work RVU .61 per unit of service

2020 vs 2021 Time

- Before 2021 we could only bill on the 45 minutes face-to-face (99204)
- In 2021 we can count **all** of physician's time
  - Review of records
  - Review of images
  - Ordering tests/scheduling surgery
- This would go from a 99204 (pre 2021) to at least a 99205 (60 to 75 min) in 2021.

Prolonged Services Table

Total Duration of New Patient Office or other Outpt . Services (use with 99205)	**Code(s)**
Less than 75 minutes	Not reported separately
75-89 Minutes	99205 x 1 & 99XXX x 1
90-104 Minutes	99205 x 1 & 99XXX x 2
105 or more minutes	99205 x 1 & 99XXX x 3 or more for ea. Add'l 15 min
Total Duration of New Patient Office or other Outpt . Services (use with 99215)	**Code(s)**
Less than 55 minutes	Not reported separately
55-69 minutes	99205 x 1 & 99XXX x 1
70-84 minutes	99205 x 1 & 99XXX x 2
85 or more minutes	99205 x 1 & 99XXX x 3 or more for ea. Add'l 15 min

New Prolonged Services Code

- Creation of a Prolonged Services code (99*XXX*) with a shorter time increment of 15 minutes*. (code numbers not yet assigned)
- This code **is only reported with 99205 and 99215 in increments of 15 minutes and used when time is the primary basis for code selection** (code not yet released)
- May be reported for additional time spent on the date of the encounter to include non-face-to-face time.
- Non-face-to-face Prolonged Service (99358 and 99359) will no longer be allowed to be reported on the same calendar day of the encounter.

Prolonged Services And Billing Based on Time

Coding on Time - Disclaimer

When using prolonged service or time based coding, time should add up to around a usual work day.

- If twenty (20) patients were seen in one day, all had a 99215 reported, this would reflect 13-18 hours of work in one day
- Don't bill more than one person can do in a day

Medically Appropriate History & Exam

Brenda T. Griffin, MHA, CPC, CPMA

EngageMED

Visit Complexity- add-on Code Revised

- **G2211** Visit complexity inherent to evaluation and management 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)This code is designed to capture the additional resources that a practice expends in caring for patients in a primary care environment beyond the average E/M visit.

Medically Appropriate History And Exam

- "Medically appropriate" means that the physician or other QHP reporting the E/M determines the nature and extent of any history or exam for a particular service.
- Remember that code selection does not depend on the level of history or exam.
  - Guidelines don't quantify these elements.

Visit Complexity-Medicare add-on Primary Care

- This code may be used by primary care and certain other specialties who are addressing health needs with a consistency and continuity over a long period of time
- G2211 has a wRVU of .33 with a national payment rate of $15.88
- The code may be reported for new and established patients, but may not be reported with any codes but 99202–99215

Medically Appropriate History And Exam

- Don't skip these as there is still a medical-legal reason for documenting history & exam.
- A well-constructed HPI will help determine medical decision-making.
- HPI elements in the assessment will help determine level of decision-making.
- Don't continue using "normal" exam templates Document what is needed and indicated in history elements

Medical Decision-Making Number of Diagnoses

Brenda T. Griffin, MHA, CPC, CPMA

EngageMED

Medical Decision-Making

- Same 3 Elements:
  1. Number of diagnoses & treatment options
  2. Amount & Complexity of Data Reviewed
  3. Risk of Morbidity & Mortality (Table of Risk)
- Definitions have changed

Options Not Selected Example Continued

Patient is not convinced that she wants the full surgery and would be more convinced if we had a full diagnosis of cancer after treatment. We will proceed with full-thickness transanal resection. If this does show cancer and it is abutting the sphincters patient will need an abdominal perineal resection. I again discussed the gravity of the situation with the patient. She verbalizes understanding.

- Can bill based on time OR MDM – elective major surgery is Moderate, but risk is high.
- If billing based on time add total time not just face-to-face

Medical Decision-Making: Number of Diagnosis and Problems Addressed

- The provider must evaluate or treat the problem.
- Consideration of further testing that is **decided against** because of risks involved or patient choice counts as addressed.
- But a simple note that another professional is managing a problem does **not** count as addressed.
- There must be additional assessment or care coordination.
- Referral without evaluation does **not** qualify as addressing the problem (using history, exam, or diagnostic studies) or considering treatment.

Counting Problems

- Rectal Cancer example - Assessment

1. Rectal cancer - C20 (Primary)
2. Hypertension - I10
3. Asthma - J45.909
4. Pulmonary emphysema, unspecified emphysema type - J43.9

- The only problem addressed is rectal cancer. Can't count others UNLESS he asks for pulmonary clearance prior to surgery
- If pulmonary "addressed" we could count that diagnosis

Options Not Selected Example

Assessments

1. Rectal cancer - C20 (Primary)
2. Hypertension - I10
3. Asthma - J45.909
4. Pulmonary emphysema, unspecified emphysema type - J43.9

This is a 71-year-old female here for discussion. Patient completed radiation on 8/23/19 and last chemo was on 10/09/19. Flexible sigmoidoscopy on 11/11/19 noted residual tumor effect. Patient will likely need an abdominal perineal resection. We discussed the situation at length. I spent greater than 45 minutes discussing the case with the patient and family

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Minimal problem:** 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. (99211)
- **Self-limited or minor problem:** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. (99202 & 99212)

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Stable, chronic illness:** A problem with an expected duration of at least a year or until the death of the patient.
- Conditions are treated as chronic whether or not stage or severity changes (eg, 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.

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Chronic illness with exacerbation, progression, or side effects of treatment:** 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.

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **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.

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Undiagnosed new problem with uncertain prognosis:** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
  - An example may be a lump in the breast.

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **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 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.

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Acute illness with systemic symptoms:** 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.'

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Acute illness with systemic symptoms:**
- Systemic symptoms may not be general, but may be single system.
  - Examples may include pyelonephritis, pneumonitis, or colitis.

Number of Diagnosis and Problems Addressed

- Unchanged from previous:
- Low (99213/99203)
  - 2 or more self-limited or minor problems OR
  - 1 stable chronic illness (See definition change)
  - 1 Acute uncomplicated illness or injury

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Number of Diagnosis and Problems Addressed

- 99204/99214 – **Moderate**
- 1 or more chronic illness with exacerbation, progression or side effect of treatment
- 2 or more stable chronic illness
- 1 undiagnosed new problem with uncertain prognosis
- 1 acute illness with systemic symptoms
- 1 acute complicated injury

Number of Diagnosis and Problems Addressed – Presenting Problems Definitions

- **Acute or chronic illness or injury that poses a threat to life or bodily function:** 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
- Examples may include acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Number of Diagnosis and Problems Addressed

- **High** (99205/99215)
- 1 or more chronic illness with severe exacerbation, progression or side effect of treatment
- **OR**
- 1 acute or chronic illness that poses a threat to life or bodily function

Diagnoses & Treatment Options - Example

- This 64-year-old female presents for Get established. Has an appointment with CIG for and EGD on 04/11/18. Refill medication. Diabetes and back pain.
- **History of Present Illness:**
- Get established.
- Has an appointment with CIG for and EGD on 04/11/18.
  - Was seen here earlier this week for belching and vomiting. Has been taking medication for GERD for years. Also reports dysphagia with foods.
- Medication refill. Requesting refills on vitamin D through mail order. Dose was 1,000 units twice a week.

Diagnoses & Treatment Options - Example

- Essential hypertension (I10). BP controlled, continue current medication plan
- Mixed hyperlipidemia (E78.2). Tolerating statin, lipid panel pending.
  - LIPID PANEL to be performed Today.
- Vitamin D deficiency (E55.9).
  - Dosing inaccuracy. Unclear what dose she needs. Await results to determine prescription. Will need sent to Express

Diagnoses & Treatment Options - Example

- Diabetes
- The problem is getting worse. Risk factors include: obesity, over age 45 years old and sedentary lifestyle. Patient is compliant with using medication. She Has been managed with oral medications. Average BS = 200. Comorbidity: hypertension. Associated symptoms include: constant hunger, heartburn, increased fatigue and weight gain. Additional information: Trouble following diet and keeping away from sugars. Does not exercise due to chronic low back pain.

Diagnoses & Treatment Options - Example

8. Chronic bilateral low back pain without sciatica (M54.5).

Duration: 4 Years. Location of pain is lower back. The patient describes the pain as an ache. Symptoms are aggravated by changing positions and daily activities. Symptoms are relieved by injection: epidural injection, over the counter medication, pain meds/drugs and physical therapy. Additional information: Quit doing PT because she did not feel it was helping. Wanting to lose weight. Limits her standing and ability to cook dinner. Has seen a neurosurgeon in the past at the Hospital.

Diagnoses & Treatment Options - Example

- **Assessment:**
- Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (E11.65). Labs pending. Uncontrolled per patient. No recent blood sugar log values to review. Due for labs. Recommend annual foot and eye exams. Previous records pending. CMP to be performed Today and hemoglobin A1C to be performed today.

Diagnoses & Treatment Options - Example

- Chronic bilateral back pain
- Await records to determine previous treatment and modalities. Did not complete PT, may need new referral. consider repeating MRI and new pain management consult as well.
- Calculation: 5 problems addressed, 1 chronic disease worsening
- Moderate risk

Amount & Complexity of Data

Brenda T. Griffin, MHA, CPC, CPMA

EngageMED

Amount & Complexity of Data Reviewed Defining the Definitions!

- Independent Interpretation: the interpretation of a test for which there is a CPT code and an interpretation and/or report is necessary.
- Doesn't apply when provider is reporting or has previously reported the service for the patient.
- CT, MRI, X-rays for which a radiologist has billed the interpretation.
- Document review of images – separate written report not needed

Amount & Complexity of Data Reviewed Defining the Definitions!

- **Tests** are imaging, lab, psychometric or physiologic data
  - Lab panel is a single test
- **External:** External records, communications and/or test results from an external physician or QHP not in the same group practice or is a different specialty or subspecialty
  - Includes licensed professionals practicing independently or a facility

Amount & Complexity of Data Reviewed Defining the Definitions!

- When the physician or other QHP is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted
- **Appropriate Source** – includes professionals who are not health care professionals but may be involved in the management of the patient.
  - Lawyer, parole officer, case manager, teacher
  - Doesn't include discussion with family or care givers

Amount & Complexity of Data Reviewed Defining the Definitions!

- **Independent historian**(s) – an individual (parent, guardian, surrogate, spouse or witness who provides history in addition to that provided by the patient who is unable to provide a complete or reliable history due to developmental stage, dementia or psychosis **or**
- Because a confirmatory history is judged necessary **or**
- In the case where conflicting information or poor communication among multiple historians are needed.

Amount & Complexity of Data Reviewed

- Level 3 (99203/99213) Low MDM
- Any combination of **2** of the following (Category 1):
  1. Review of prior external note(s) from each unique source
  2. Review of the results of each unique test
  3. Ordering of each unique test
- **OR**
- Category 2: assessment requiring an independent historian
- Must meet 1 of 2 categories

Amount & Complexity of Data Reviewed

- Level 4 (99204/99214) Moderate
- **Category 1** – any combination of 3 of the following
  1. **Review of prior external note** from each unique source
  2. Review of results of each unique test
  3. Ordering of each unique test
  4. Assessment requiring an independent historian
- **OR**
- **Category 2 Independent interpretation of test** (performed by another provider) (not separately reportable)

Data Reviewed Example

- This is a 55 year old male who presents today for evaluation. He was diagnosed with diverticulitis approximately 3 years ago. He completed a 10 day course of antibiotics for LLQ pain. One year later he was hospitalized in Searcy for the same symptoms. In early August 2019 he again developed LLQ pain and felt he had a fever.

Amount & Complexity of Data Reviewed

- 99204/99214 Moderate (continued)
- **Category 3** Discussion of management or test interpretation with external providers (not separately reportable)
- For this level, must meet at least **1 out of 3 Categories**

Data Reviewed Example

- 10/14/19 Colonoscopy noted diverticulosis, hyperplastic polyps and hemorrhoids. It is of note CT abd/pelvis on 8/5/16 (**images reviewed**) noted diverticulitis of descending colon at the left lower quadrant. No perforation or abscess. At today's appointment, patient reports experiencing a persistent "dull ache" of the left lower abdomen, that does not resolve with oral antibiotics.

Amount & Complexity of Data Reviewed

- Level 5 (99205/99215) High
- "Extensive" Must meet **2 of 3** categories
- **Category 1-Any** combination of 3 of the following:
  1. Review of prior **external** note from each unique source
  2. Review of results of each unique test
  3. Ordering of each unique test
  4. Assessment requiring an independent historian

Importance of a Good HPI

- Even though history and exam are considered "medically appropriate" with no required elements.
- HPI is crucial to determining decision-making
- The example above shows how a well-constructed history is crucial to determining decision-making (diagnoses, data and risk).
- Shows that records and images were reviewed
- The example shows the work involved for this visit.

Amount & Complexity of Data Reviewed

- Level 5 (99205/99215) **High**
- **Category 2:** Independent interpretation of a test performed by another provider (not separately reportable)
- **OR**
- **Category 3:** Discussion of management or test interpretation with an external provider/appropriate source (not separately reportable)

Levels of Risk

- Four types of medical decision making are recognized:

1. Straightforward,
2. Low,
3. Moderate, and
4. High.

- The concept of the level of medical decision making does not apply to code 99211.

Risk of Morbidity & Mortality

Brenda T. Griffin, MHA, CPC, CPMA

EngageMED

Risk

- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with
- The patient's problem(s), the diagnostic procedure(s), treatment (s).
- Includes the possible management options selected and those **considered, but not selected**, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care

Risk of Morbidity and Mortality

- Based on decisions make at the visit and include:
- Presenting problems
- Diagnostic procedures
- Management options that are considered but **may not be selected by the patient**

Risk - Definitions

- The probability and/or consequences of an event.
- Affected by the nature of the event under consideration.
- 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.
- Based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
- Related to the need to initiate or forego further testing, treatment and/or hospitalization.

Risk

- 99202/99212 – risk is minimal
- 99203/99213 – risk is low
- 99204/99214 – Moderate:
  - Prescription Drug Management
  - Minor surgery w/identified risk factors (over & above the usual)
  - Decision for Major surgery weather or not pt. elects to have it
  - Diagnosis or treatment significantly limited by **social determinants of health.** (economic and social conditions that influence the health of people & communities)
  - Food or housing insecurity

Social Determinants of Health Example

During the patient visit, the physician learns that in the past year, the patient has been in homeless shelters, stayed on the couch of a family member, and sometimes even slept on the street. He had no regular access to a refrigerator in which to keep his insulin, and was not able to shop and cook in a kitchen. He doesn't always have access to laundry and clean socks. He hasn't had the money to buy his medicines.

Risk of Morbidity & Mortality

- **Social determinants of health:** economic and social conditions that influence the health of people & communities.
- Use ICD-10 Diagnosis codes to describe:
  - Homeless Z59.0
  - Food insecurity Z59.4
  - Financial Stress (unable to afford meds) Z59.9
  - Unemployment Z56.0

Social Determinants of Health Example

Arranging care and social services for this patient takes the physician three times the scheduled office visit time. But there is a way to code for it: The physician can look up ICD-10-CM codes for homelessness and food insecurity.

Social Determinants of Health Example

A physician looks at a patient's reason for a visit in her appointment schedule: *sore on foot*. The patient tells the medical assistant that the sore won't heal and keeps getting worse. The physician reviews the patient's problem and medication list and sees that the patient was prescribed insulin for his diabetes and has peripheral vascular disease, among many other problems. His most recent documented A1C was over a year old and was 14.3, and the patient missed his follow-up appointment and could not be reached to reschedule.

Risk Definitions - High

- Drug therapy requiring intensive monitoring for toxicity: 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.
- Can be long or short-term

Risk Definitions – Intensive Drug Therapy

- The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases.
- Long-term intensive monitoring is not less than quarterly.
  - 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.

Important Links

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

Risk Definitions – Intensive Drug Therapy

- 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);
  - Annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.

Place Holder – CPT MDM Table

- See Attachment1