FAQ: 2021 Evaluation and Management Guideline Changes

General Questions

1. **What is changing?**

   Beginning January 1, 2021, code selection for Outpatient Services will be selected by using time or medical decision making. HPI and Exam will no longer be considered when assigning codes for outpatient services.

2. **Are the guidelines changing for Emergency Medicine, Inpatient, Consultations, and Observation Services?**

   No, the guidelines for these services remain the same.

3. **Do I still need to document History of Present Illness and perform and document an Exam?**

   Yes. A medically appropriate history and exam are still required to be documented.

4. **Is there an impact to wRVU's with this change?**

   Yes. There will be an increase to wRVU's for this code set beginning on January 1, 2021.

CPT Code	2020 wRVU	2021 wRVU	CPT Code	2020 wRVU	2021 wRVU
NEW PATEINT VISITS			ESTABLISHED PATEINT VISITS		
99201	Code Deleted		99211	.18	.18
99202	.93	.93	99212	.48	.70
99203	1.42	1.60	99213	.97	1.30
99204	2.43	2.60	99214	1.50	1.92
99205	3.17	3.50	99215	2.11	2.80

Coding by Medical Decision Making

1. **What are the 3 components of Medical Decision Making (MDM)?**

   - Number and Complexity of Problems Addressed
   - Amount and/or Complexity of Data to be Reviewed and Analyzed
   - Risk of Complications and/or Morbidity or Mortality of Patient Management

     ➢ 2 of the 3 components must be met in order to support the code selected

2. **Our Primary Care group added social workers to help with social and behavioral issues. If the physician discussed a case with our social worker, does that count as discussion of management?**

   No. In order to receive credit for discussion of management, the other physician, qualified health care professional or appropriate source *must be external to the practice.*

3. **On the day you see the patient you may plan to confer with another provider but the other provider may not get an answer back to you until later. Does this count?**

   No, the only way that a discussion with another provider counts is if it is done on the same date of service.

4. **If I order a MRI at a visit on Sept 20th, and review it with the patient at a follow up visit on Sept 27, do I count the order on the 20th and the review on the 27th? I didn't bill for the MRI or the interpretation.**

   No. You would only count ordering for the test on the Sept 20th visit.
   - CPT says, "Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter."
   - AMA is consistent in this instruction. If you order a diagnostic test, for example a CBC at a patient visit, reviewing the results a day later is part of the order. When the patient returns to the office two weeks later you do not get credit for reviewing the CBC results that you ordered. Count the data for the test once, at the encounter when it was ordered.

5. **What does "external" mean for purposes of reviewing data as part of MDM?**

   "External" means records, communications and/or test results from an external physician or qualified health care provider, or external facility or health organization. An external physician or QHP is an individual who is not in the same group practice as you, or is in a different specialty or subspecialty. This is similar to the rules defining who qualifies as a "new patient".

6. **If I review a previous A1C and order a new A1C during the same encounter, does this count as two points under data reviewed?**

   No. Each unique test will count as one point and a unique test is defined by its CPT code. Since this is the same test with the same CPT code, the reviewing of the previous test and ordering of the new one will together count only as one point.

7. Who is considered an independent historian?

An individual who provides a history in addition to a history provided by the patient, who is unable to provide a complete or reliable history or because confirmatory history is judged to be necessary.

*Note: Language interpreters are NOT considered independent historians.

8. Is the social determinant of health documentation needed for the day of the visit or the year?

Social determinant of health should be documented at each encounter.

Coding by Time

1. What is the NEW criteria to bill using TIME to determine the level of service?

The new time requirements are as follows:

CPT Code	2021 Total Time(minutes)	CPT Code	2021 Total Time(minutes)
NEW PATEINT VISITS		**ESTABLISHED PATIENT VISITS**	
99201	Code Deleted	99211	N/A
99202	15 – 29	99212	10 - 19
99203	30 – 44	99213	20 - 29
99204	45 – 59	99214	30 - 39
99205	60 – 74	99215	40 - 54

Total physician/other qualified health care professional time **on the day of the encounter** includes the following:

- Both face to face and non-face to face time personally spent by the physician and/or other qualified healthcare provider (QHP).
- Preparing to see the patient (example: review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, test, procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record

- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

*Note: services that are separately reported cannot be counted towards total time.

2. Am I still required to meet the 50% counseling and coordination of care when using time to select a code?

No. With the 2021 guidelines there is no requirement for counseling and/or coordination of care. Time is now billed using the total time calculated on the date of the visit. Total time includes both face-to-face time personally spent by the physician and/or other qualified healthcare provider (NP, PA) on the date of the encounter. It does NOT include time spent by clinical staff.

*Please note: for other services (Consults, Inpatient, and Observation), when using time for code selection, you will still be required to meet the 50% of counseling and coordination of care requirement.

3. How is time calculated when an APP is involved in the visit?

When both an APP and physician jointly provide face-to-face and non-face-to-face care on the same encounter, the time would be added together for total time. Overlapping time by both the physician and APP can only be counted once.

4. Is there a new Prolonged Service Code and how is it used?

99417	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 service)

- This code can ONLY be used with 99205 and 99215
- Prolonged service of less than 15 min should not be reported
- 99417 is an add on code and may be used more than once either by listing the code twice or reporting multiple units

5. If I am leveling the visit based on total time, do I still need to document an assessment and plan (A/P)?

Yes, an A/P should always be documented for each visit. The A/P may provide additional information that will allow your visit to be leveled if the time statement does not have enough information. If the A/P is not documented and the total time is ambiguous or missing, the visit may ne unbillable. If you document both MDM and time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.

6. **If I am leveling the visit based on total time and have also provided additional time-based services (e.g. advanced care planning, tobacco cessation counseling, etc.) how do I document time for those services?**

   Make sure to document the time separately for each of those services in order to bill for them separately. The time for each service must be carved out of the total time. Example: *A total of 25 minutes was spent on this visit, with 20 minutes spent reviewing previous notes, counseling the patient on DM and HTN, ordering tests, refilling meds, and documenting the findings in the note. An additional 5 minutes was spent on tobacco cessation counseling, discussing the importance of quitting, options for medications and a quit plan.* For this example, codes 99213-25 and 99406 would be used for billing.