CaroMont Health

HOT TOPIC 2021 E/M Updates Frequently Asked Questions – updated 02/02/2021

Time

Q: Can documentation be counted as part of "total time"?

A: Documenting clinical information in the health record can be counted as part of total time when performed **on the date of the encounter. Time spent the day before or after cannot be counted in the total time.** Time spent by supporting and clinical staff is **not included in the total time.**

Q: Does the provider have to document the exact time or can they use the time ranges?

A: The exact total time would need to be documented (i.e. Total time of 40 minutes).

Q: Does the provider need to separately document the time spent reviewing labs, test results, etc. or do they just need to document total time and as a coder we take that at face value?

A: AMA does not give any specific guidance on how the time should be documented. This would indicate that the physician may separately document time based on individual items performed (ex. Review labs – 5 mins., examining and evaluating the patient – 20 mins., review test results – 5 mins, etc.) or combine into total time (ex. Total time of 35 minutes examining and evaluating the patient, completing orders and counseling).

Q: With total time, if the provider documents a time level for either a 99205 or 99215 and the total time is more than 15 minutes, can the coder add the prolonged service CPT code?

A: The prolonged office or other outpatient service code of 99417 would be added only after the **minimum** time required to report the highest E/M level of service has been exceeded by 15 minutes. For example, the minimum time for 99205 is 60 minutes. Prolonged service code initiates when 15 minutes beyond 60 minutes has been met (i.e. at 75 minutes). Notice the time range for 99205 ends at 74 minutes to indicate that the prolonged service is not utilized until 75 minutes is met.

CMS has approved the use of G2212 for prolonged services for Medicare beneficiaries. Therefore, the prolonged office or other outpatient service code of G2212 would be added only after the **maximum** time required to report the highest E/M level of service has been exceeded by 15 minutes. For example, the maximum time for 99205 is 74 minutes. Prolonged service code initiates when 15 minutes beyond 74 minutes has been met (i.e. at 89 minutes). Notice the time range for 99205 ends at 74 minutes to indicate that the prolonged service is not utilized until 89 minutes is met.

Continue to document time based on the guidelines for CPT code 99417. The code will be adjusted by the coding team to match to the appropriate payer and definition.

Q: If the visit is 1 minute past the 99215 or 99205 threshold (i.e. 99205 – 75 minutes) can the prolonged code (99417) be billed?

A: Prolonged services less than 15 minutes is not billable. The minimum time for 99205 is 60 minutes. The prolonged service code is added when 15 minutes beyond 60 minutes has been met, which will be 75 minutes. Notice the time range for 99205 ends at 74 minutes to indicate use of the prolonged service is not applicable until 75 minutes (i.e.1 minute past) is attained.

Q: How should the "with or without direct contact" need to be documented by the provider?

A: AMA does not give any specific guidance on how the time should be documented. This would indicate that the physician may separately document their time based on individual items performed or combine in one documented area with the total time indicated.

Q: On the first prolonged service example in the CBL part 1, the patient was there for a physical exam which would have been the reason for such a detailed exam and ROS. Should it not have been coded as a physical exam CPT code? The A&P would not have met medical necessity for that extensive of an exam.

A: The example was showing the detail for an extended visit by using that documentation. Since that was the intent, medical necessity was not taken into effect. However, when reviewing documentation for coding it must meet medical necessity in order to be coded. According to CMS, medical necessity is the overarching criteria criterion for payment in addition to the individual requirements of a CPT code.

Q: Does the use of time to code for an office visit require counseling?

A: Counseling and/or coordination of care will no longer need to dominate the service for these codes.

Q: Is coding for completing a full chart review and note for patients without seeing them appropriate?

A: No. A visit must be performed on that day. Documenting clinical information in the health record can be counted as part of total time when performed **on the date of the encounter.**

Q: Does the use of a language interpreter count as a part of time?

A: This can be counted in time if using the interpreter to communicate with the patient. It is not one of the options when coding based on Medical Decision Making.

Medical Decision Making

Q: Regarding "independent interpretation of tests" category. If I review all X-rays that I order and interpret them and compare with the Radiologists interpretation, is that considered independent?

A: If billing for the x-ray or have billed for the x-ray in the past, this is not considered independent interpretation. If you are not or have not billed for the x-ray in the past, and you reviewed and interpreted the test it would be considered independent interpretation.

Q: If a patient was seen for a follow up visit, for example - chest pain, and an EKG was done at the last visit and billed for, if the provider reviews that EKG at today's visit would that count towards Data in the medical decision making (MDM)? The same question would be for labs that were ordered at the last visit but the patient comes in for review and medication changes.

A: If the physician documents that they reviewed the test results this would count towards data points under category 1 for tests in the MDM table.

Q: Will we be provided examples of what Social Determinants of health would be?

A: Social determinants are economical and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. If documentation indicates that the diagnosis or treatment of the patient is significantly limited by social determinants of health it can be counted as a moderate risk for the medical decision making (MDM).

Q: If providers do not document the problem as chronic stable or acute complicated/uncomplicated would it be appropriate to query the provider?

A: Start by reviewing the medical decision making (MDM) definitions to ensure if the criteria is met for the complexity of the problem(s) addressed. If you still are unable to determine complexity of the problem, code at the lower level of care (i.e. uncomplicated or stable) unless indicated in the documentation that it is complicated.

Q: On a few of the note examples vitals were not taken for the exam portion. If the patient has high blood pressure that is addressed at the visit and stated as stable, how would that be counted if a blood pressure was not taken at the visit?

A: The examples in the CBL did not include all of the details of a real note and some details were eliminated for purposes of preserving space in the CBL screens. However, if documentation throughout the note does not support a diagnosis coded by the provider a coder can query the provider to request additional clarification of that diagnosis.

Q: Any coding and documentation tips for psychiatry? There are not many lab testing or orders in psychiatry.

A: The review of test results and ordering of tests are not limited to laboratory test. Other test, such as psychological testing, can be counted as well.

Q: Are there any changes with MDM?

A: There were changes made to the MDM table:

“An abrupt change in neurologic status” was removed from the number and complexity of problems.

The “diagnostic procedures ordered” was changed to “amount and/or complexity of data to be reviewed and analyzed”. The complexity of data are identified by categories with each unique test ordered/reviewed contributing to the complexity of data.

“Diagnosis or treatment significantly limited by social determinants of health” was added to the moderate MDM.

Q: Can the MDM still be used based on the complexity of the patient?

A: MDM or Time can be used to determine the E/M level.

Q: If a thyroid ultrasound was completed with results, should the interpretation of those results be counted in MDM?

A: There are two areas that this could possibly be counted in the amount and complexity of data area.

Category 1: Review of the result(s) of each unique test and the ordering of each unique test.

Category 2: **“Independent”** interpretation of test performed by another physician (not separately reported) with separate documentation indicating the providers interpretation.

Q: What are recommendations for coding as it relates to high-risk medication use (i.e. opiate) and the associated required monitoring and counseling?

A: While high-risk medication drug therapy requiring intensive monitoring for toxicity is located in the high MDM, the code selection requires 2 out of the 3 elements of the MDM.

For Example:

1. **High number and complexity of problems addressed.**

   □ 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

2. **Extensive amount and/or complexity of data to be reviewed and analyzed.**

   (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)

3. **High risk of complications and/or morbidity or mortality of patient management.**

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

Q: If a provider enters "Time" but the "MDM" supports a higher level should the code be changed?

A: Yes. The higher level will be reported.

Q: Would you receive credit when outpatient labs are ordered and the results are not received until the next day and interpreted to assist with the management of the patient. Ex: Since the blood sugars are higher than at the previous visit, if the A1c is elevated then a GLP1 will be added before returning to the clinic for better diabetes control.

A: No. Credit would not be given for independent interpretation completed on a separate day.

- Credit will be given for ordering the lab in "Category 1: Test and Documents" under the amount and/or complexity of data to be reviewed and analyzed **on the date of the encounter**.

- Credit will be given for an "independent interpretation" of test(s), for which there is a CPT code and an interpretation or report is customary, when it is documented as interpreted at a follow up visit. This does not apply when the provider is reporting the service or has previously reported the service for the patient.

Q: Are vitals no longer a requirement?

A: Vitals are a part of the exam and still required as it would be medically appropriate to document this component. The exam is not used in the code selection but documentation of a medically appropriate exam is required.

Q: Give examples of minimal and low risks.

A: Minimal risk examples: rest, gargle, elastic bandages, superficial dressings; Low risk examples: over-the-counter drugs, minor surgery with no identified risk factors, PT/OT.

Q: Give definition and examples of what is considered an acute complicated and uncomplicated injury.

A: Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. ***An example may be a head injury with brief loss of consciousness.*** Acute, uncomplicated illness or injury: The problem is recent and short-term. There is a low risk of morbidity. There is little to no risk of mortality with treatment. Full recovery without functional impairment is expected. The problem may be self-limited or minor, but it is not resolving in line with a definite and prescribed course. ***An example may be Cystitis, Allergic Rhinitis, or a Simple Sprain.***

Q: Is anything changing with consult codes?

A: No. Only the office and other outpatient services codes (99201-99215) have changes.

Q: When POC tests (urinalysis, flu, strep, etc.) are performed in the office and billed with a separate CPT code, would these be counted as ordered/reviewed results of unique tests or is this considered double dipping?

A: This is considered double dipping and would not be counted in the MDM since the provider is billing for the service. Please see AMA's documentation to support this.

Services Reported Separately:

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.

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

Documentation

Q: Does information that can readily be found in the chart need to be included in the note (i.e. past medical history, past social history, family history)?

A: The guidelines indicate that the note should have a medically appropriate history and/or physical examination documented. Include history elements that are pertinent and medically appropriate for that visit.

Q: Provide an example of time-based documentation.

A: A total time 50 minutes was spent reviewing the chart, reviewing physician and nursing notes, assessing problems from last visit, review and interpretation of any labs, review of EKGs and chest x-rays, performing face-to-face time with the patient, analyzing all the permutations of the diagnosis and treatment options, formulating the current assessment, and making recommendations regarding care. Assessment and recommendations were then verbally discussed with the patient and the family.

Q: Is a Preventative Exam (physical) any different from 2020 to 2021 with regards to documentation?

A: Nothing has changed with the way you document preventative exams (physicals).

Q: When can an EPIC super user assist with smart phrases?

A: Informatics will be able to assist after completion of Part 1 and 2 of the 2021 E/M training.

Q: If reviewing external records for a new patient would the statement "reviewed external records" count as an external review?

A: No. Also indicating the external physician, other qualified health care professional, facility or healthcare organization where the external records came from is required.

Q: Does all office visit documentation need to have a statement regarding the amount of time spent, with the parameters specified, in order to be compliant for billing?

A: No. Only the cases that coding based on "Time" is selected. If utilizing the "Medical Decision Making" to select the code the time is not required.

Q: Is there a flow sheet to follow or aids to assist in determining levels of MDM?

A: There is a laminated TIP sheet that has been provided to every physician and other qualified health care professional to assist with interpreting the time and medical decision making for each office and other outpatient E/M service. **For additional copies, select**:

Full Size: https://www.caromonthealth.org/documents/em_full_size_tip_sheet.pdf

Pocket Size: https://www.caromonthealth.org/documents/EM-Pocket-Card-Tip-Sheet-2.pdf