QUESTIONS AND ANSWERS

Evaluation and Management (E/M) Office or Other Outpatient Services

Services January 1, 2021 and After

Medical Review/Provider Outreach & Education A/B Medicare Administrative Contractor (MAC) Collaboration Workgroup

Questions from Educational Events

The A/B MR/POE Collaboration Team provides this document to assist providers in submitting correct claims to Medicare. The team's effort ensures more consistent responses to questions across the nation. Information assists the provider community in receiving proper payment in a timely manner.

These questions and answers apply to Evaluation and Management (E/M) Office or Other Outpatient Services codes provided January 1, 2021 and after. The procedure codes are 99202: 99215. These questions and answers do not apply to other categories or procedure codes.

The American Medicare Association (AMA) update information contained in their document on March 9, 2021. The questions and answers in this document reflect these changes. The AMA document (https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf) details the changes for Office or Other Outpatient procedure codes 99202-99215. This document includes multiple definitions of the terms they use in the Medical Decision-Making (MDM) table (https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.) Evaluate the definitions when evaluating the question-and-answer document.

We will use the term "practitioner" to include the physician or other qualified health care professional (QHCP). This is a person who can submit claims to Medicare for E/M services.

QUESTION AND ANSWER CATEGORIES

SEARCH TIP

To quickly find a specific word or phrase on this page, use the find tool. Use the magnifying glass in the upper left corner. Enter the key word and hit the enter key to be taken to any highlighted matches.

TIME

- **Question 1:** Must the patient medical record show the specific times and activities for each encounter?

  Answer 1: There are no specific requirements. You do not have to "stop-watch" your activities. The best practice is to show the activities and the time you spent doing those activities. Recording the start and stop times of your activities is the most complete document, but not absolutely necessary. The medical record must support the level of service chosen. An encounter includes both face-to-face and non-face-to-face time between you and the

CGS A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

patient. The AMA document includes a description of the non-face-to-face activities you can use to account for time. When using time, only time spent on the calendar date of the face-to-face service counts toward choosing your level of service. CMS includes these instructions "Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit." https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

- **Question 2:** I spent time reviewing charts and results prior to or answering questions after the date of the face-to-face encounter. Can I count this time in choosing my level of service?

  Answer 2: No. When using time to choose your level of service, use only the time you spent on the date of service.

- **Question 3:** Must I provide counseling or coordination of care to use time to choose my level of service?

  Answer 3: No. The AMA does not require you to provide counseling or coordination of care to choose your procedure code based on the time you spent.

- **Question 4:** If I do not document on the date of the encounter, does this mean I cannot use time to choose my level of service?

  Answer 4: You can still use the time spent face-to-face and for appropriate non-face-to-face activities on the date of the encounter to choose your procedure code. If documenting the service on a different calendar date, do not include the time spent documenting.

- **Question 5:** The electronic medical record requires/records a start and stop time for the face-to-face service. How would I document the time spent on the non-face-to-face care?

  Answer 5: Notate this time in the medical record. Medicare would be unable to count non-face-to-face time without notation in the medical record.

- **Question 6:** I spend approximately 25 minutes on each patient. Another physician spends 35 total minutes on each patient. How would we choose the correct code choice based on these differences?

  Answer 6: If choosing your level of service based on time, code to the time documented. This could result in different levels of service. Medicare would evaluate the time you documented.

- **Question 7:** I see a new patient and spend 12 minutes on that patient on that calendar day. Can I choose a subsequent patient procedure code?

  Answer 7: No. The patient is still a new patient. The 99202 new patient visit code requires at least 15 minutes of time. If providing a new patient service and you do not meet the time, you would code using the MDM.

- **Question 8:** Can I count time spent by ancillary staff providing face-to-face or non-face-to-face services?

  Answer 8: No. Only count time spent by you and the QHCP to choose your level of service.

- **Question 9:** How do I document to receive reimbursement for the new extended time procedure code?

  Answer 9: The new procedure code is G2212. The medical record should show you exceeded the time for 99205 or 99215 by at least 15 minutes. This is only available when you use time to choose your procedure code. There is a contrast between Medicare guidelines and the AMA published information. The time for 99205 is 60 to 74 minutes. Medicare can allow additional time when the practitioner has spent at least 89 minutes on that patient. The time for 99215 is 40 to 54 minutes. You can use the new code when the medical record shows at least 69 minutes. If you have more than one unit of service, you can submit on one line with multiple units. You could have an additional unit of service when meeting the next unit of service of 104 or 84 minutes. Once you meet the threshold of time you can submit this code. Medicare does not require you to meet the half-way point prior to submitting.

- **Question 10:** My level of service is a 99205 or 99215 based on MDM. Can I use the new extended time procedure code, G2212?

  Answer 10: No. This code (G2212) is an add-on code to 99205 or 99215 only when choosing the level of service using time.

RETURN TO LIST OF CATEGORIES

- **Question 11:** Do we have to document start and stop times for the prolonged service?

  Answer 11: The current instructions in the CMS Internet-Only Manual (IOM) 100-04, Chapter 12, Section 30.6.15.D https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf indicate you must document start and stop times for prolonged services. CMS has not yet updated the IOM to detail the new requirements.

- **Question 12:** I code the E/M based on time and perform a procedure on the same date. Do I carve out the actual time performing the procedure or the fee schedule "normal time"?

  Answer 12: You would carve out the actual time spent on the activities relating to the procedure from the time for the E/M service. The identified "fee schedule" time is time used for pricing the service.

- **Question 13:** Can I count both the resident's and my time (the teaching physician) to choose the level of service?

  Answer 13: Medicare pays for the services of the teaching physician. Therefore, you would count the time spent by you, the teaching physician.

- **Question 14:** Under the primary care exception, do I count both my time as the teaching physician and the resident's time?

  Answer 14: Under the primary care exception, you would count the time spent by both you as the teaching physician and the resident time. Only count the time once for the time you and your resident spend discussing patient care.

- **Question 15:** I requested and reviewed all records from the patient's numerous stays at a facility (one unique source). Can I use the time required to review all the records?

  Answer 15: You can count the time you spent in both face-to-face and non-face-to-face time for that patient on the date of the encounter. The AMA document includes the specific activities.

MEDICAL DECISION-MAKING

- **Question 1:** Under the 1995 or 1997 Documentation Guidelines (DG), a new patient had to meet the level for three out of three: history, exam, and medical decision-making. Is that still valid for the new instructions?

  Answer 1: The AMA requirements are the same for the new and established patients. You must meet or exceed the level for two out of the three categories of the MDM. The revised 2021 MDM categories are number, and complexity of problems addressed, amount and complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management.

- **Question 2:** My office uses a commercially available tool or electronic medical record (EMR) functionality to choose the level of services. Can I continue to use this for services after January 1, 2021?

  Answer 2: There are multiple tools available to assist you in choosing your level of service. The choice of a using a separate tool or using your EMR to assist you in choosing your level of care is yours. However, for Medicare patients, your documentation must support either time as described by CPT code or AMA MDM table to choose your level of service. The EMR may make a code choice but is the billing provider's responsibility to code correctly.

- **Question 3:** The MDM table states you must meet two out of the three categories. What does this mean?

  Answer 3: The levels of service are Straightforward, Low, Moderate, and High. Documentation must support the level in at least two out of the three categories.

  - For example:
    - » Low Number and Complexity of Problems addressed
    - » Low Amount and Complexity of data, and
    - » Straightforward Risk of Complications
      - ~ The level of service would be low 99203 or 99213

RETURN TO LIST OF CATEGORIES

- Another example:
  - » Low level of Number and Complexity of Problems addressed,
  - » Moderate level of Amount and Complexity of Data, and
  - » High level of risk
    - ~ The level of service would be moderate 99204 or 99214.

- **Question 4:** My documentation using MDM shows a level 99205 or 99215. Our time supports a 99202 or 99212. What will Medicare do?

  Answer 4: When Medicare evaluates documentation, we will evaluate based on both. We would accept your level of service when your documentation supports a level 99205 or 99215. We would not compare the time spent against the MDM.

- **Question 5:** Will the medical record still require history and an exam? Will the MDM now establish medical necessity?

  Answer 5: Documentation must show the medical necessity of the service. This is the diagnosis or treatment of an illness or injury or treatment of a malformed body member. The guidelines indicate you perform the history and exam as clinically appropriate. Your documentation must support the medical necessity of the service and the level of service chosen.

- **Question 6:** The patient's problem today results in a referral to another specialty. When using MDM to choose the level of service, how would we count this?

  Answer 6: You are addressing or managing a problem when evaluating or treating during the encounter. A notation in the medical record indicating another practitioner is treating without additional assessment or care coordination does not qualify for MDM. Referral without evaluation (by history, exam, or diagnostic study(ies) or consideration of treatment does not qualify for MDM as nothing is being addressed or managed. If you address the problem, utilize the level of the problem, amount and complexity of data, and risk to patient from the referral to assign your category of MDM.

- **Question 7:** Currently, I document my review of previous history or exam documentation in the patient's medical record. Will I be able to do that for office or other outpatient services provided in 2021?

  Answer 7: CMS allows a review of the history and exam in the patient's medical records. This applies to all categories of E/M services. You can identify what you reviewed and any updates. The review of your previous notes, or notes from a member of the same group with the same specialty do not contribute to the level of MDM. For office or other outpatient services, you only need to perform the history and exam when you believe clinically appropriate. If so, then you can indicate your review of information contained in the medical record.

- **Question 8:** The AMA document implies staff providing incident to services can use a higher level of care. This would include nursing, ancillary staff, pharmacists, etc. Is this an accurate statement?

  Answer 8: Physician and QHCP can submit the full range of codes. Clinical, ancillary, pharmacist, etc., can only submit the 99211 level of service. The services must also meet the incident to requirements. This applies to your Medicare patients. Incident to guidelines did not change. This is in the CMS Internet-Only Manual (IOM) Publication 100-02, Medicare Benefits Policy Manual, Chapter 15, Section 60 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

- **Question 9:** I believe the nature of the presenting problem deserves a higher level of service than the time or MDM table would indicate. Can I submit the higher level of service?

  Answer 9: Code your level of service based on time or the MDM table. The nature of the presenting problem is merely one component of the MDM. It does not choose the level of service. Reimbursement is for the work and expertise you provide to the patient during the encounter.

- **Question 10:** The 99417/G2212 is for extended time when choosing the level of service based on time. I choose the level of service based on MDM. Can I use the 99354/99355 codes to report additional time?

RETURN TO LIST OF CATEGORIES

Answer 10: No. When choosing your level of service based on MDM, you would not submit additional time codes. You may only use these codes when using time to choose your level of service.

- **Question 11:** I provided a procedure on the same date as the E/M. Do I have to choose my level of service based only on MDM? Can I use time?

  Answer 11: E/M services and surgery on the same date are subject to the global surgery guidelines. The IOM 100-04, Chapter 12, Section 40 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf) contains more information. If the E/M is separately payable, you can use time or MDM to choose your level. If using time, carve out the time spent performing all the activities for the procedure.

- **Question 12:** The patient presents with what appears to be a self-limited or minor problem. I order lab tests. I receive the results a week later. The results show an acute illness that poses a threat to life. Can I go back and amend my documentation to increase my level of service?

  Answer 12: No. The test results would not alter the service previously provided to the patient.

- **Question 13:** Must I document history taken or exam performed to submit an E/M service?

  Answer 13: The AMA document states in part "Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional." The document goes on to state "The extent of history or physical examination is not an element in selection of the level of office or outpatient services." While Medicare would expect some form of history or exam to assist in the MDM, we would not use the information to support your choice of the level of service.

NUMBER OF PROBLEMS ADDRESSED

- **Question 1:** If the patient has more than one problem, can I increase the number of problems addressed to a higher level?

  Answer 1: No. Some of the bullets under the number of problems addressed indicate "1 or more". This would mean that additional problems in that bullet would still count for one bullet. Some of the bullets indicate "1". Choose your level based on the problem(s) addressed and the highest level or problem(s) indicated. Look to the other two elements, data, and risk, to determine if a higher level of service is appropriate.

- **Question 2:** How would a diagnosis of obesity or overweight count in the Number and Complexity of problems?

  Answer 2: Base your choice of the level on how you are addressing this issue. Documentation must support the AMA definition of a problem addressed. This could be a self-limited or minor problem. This could be a stable chronic condition if the patient is at your goal. This could be 1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment. Notation in the patient's medical record without additional assessment or care does not qualify as being addressed by the practitioner.

- **Question 3:** I'm seeing the patient for one of the following. Under which level of problem addressed or analyzed would this fall?

  - Resolved problem where the patient is asymptomatic
  - History of cancer
  - Family history of diabetes or cancer

  Answer 3: For Medicare reimbursement, the documentation must show the medical necessity for the service. Use your documentation to determine the reason for the encounter and under which AMA definition the problem addressed would fall. This would be your clinical decision. Below are two examples.

  - A patient previously seen for headaches and found to be hypertensive, with medication prescribed, now returns symptom-free for blood pressure evaluation. This visit would be medically necessary to evaluate the patient's response to medication.
  - A patient previously seen for an ear infection returns for a follow-up visit with no complaints. Since the original visit was for a self-limiting condition, the medical necessity for a follow-up visit is questionable.

RETURN TO LIST OF CATEGORIES

- **Question 4:** How do I choose a level when I only have sign/symptoms and no diagnosis?

  Answer 4: The AMA defines a problem as "a problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter." The documentation must ultimately support the level of code chosen. You would determine where the signs/symptoms fall for the number and complexity of problems addressed.

- **Question 5:** Under which level of problem addressed would a patient encounter to renew birth control fall?

  Answer 5: There are several things to consider. The first is medical necessity. Does the service meet the definition of medical necessity: to diagnose or treat an illness or injury or to treat a malformed body member. The second is whether there are other procedure codes rather than E/M that would more accurately reflect the service provided. The third is your determination of the problem addressed and the AMA definitions of the problem based on the individual patient.

- **Question 6:** The patient's medical record contains several chronic conditions that I am not addressing during the encounter. Can I count these additional conditions to choose my level of service?

  Answer 6: The AMA defines a problem addressed in part as "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 services." Diagnoses contained in the medical record do not count toward choosing your level of care unless you are evaluating or treating the diagnosis. The chronic condition could also assist in choosing your level of care if you are evaluating or treating this in connection with the specific disease/illness/injury you are addressing during today's encounter.

- **Question 7:** What is the difference between "acute, uncomplicated illness or injury" and "acute, complicated injury"?

  Answer 7: The AMA defines acute, uncomplicated illness or injury as "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 with functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribe course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simply sprain." The AMA defines acute, complicated injury as "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 mortality. An example may be a head injury with brief loss of consciousness." Evaluate your documentation to determine how the problems addressed compare to the definitions.

- **Question 8:** The patient has had a cough for three months. Is this a chronic stable condition?

  Answer 8: The AMA definition for a stable chronic condition is "A problem with an expected duration of at least one year or until the death of the patient." "A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function." Your documentation on the expected duration and goal would determine whether the problem is a chronic stable condition.

- **Question 9:** If the patient has systemic conditions such as fever, body aches, or fatigue, can I count this as "acute illness with systemic conditions".

  Answer 9: The AMA definition of acute illness with systemic conditions is "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 problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be a single system. Examples may include pyelonephritis, pneumonitis, or colitis." A patient with systemic conditions does not necessarily correspond to a Moderate level of problems addressed. Documentation must support the level chosen.

- **Question 10:** The patient's problem is new to me. Can I use the moderate level "undiagnosed new problem"?

RETURN TO LIST OF CATEGORIES

Answer 10: The complete AMA problem definition is "undiagnosed new problem with uncertain prognosis." This is a new problem to the patient not the practitioner. If the patient was aware of the diagnosis before the specific encounter, this is not a new problem. In addition, the AMA definition is "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." Documentation must support the new diagnosis and how the problem would likely result in a high risk of morbidity without treatment. A patient may have a new problem that could fall into one of the other categories such as a sinus infection.

- **Question 11:** The patient has a chronic condition. The condition remains the same, but they are not at goal. How do I count this?

  Answer 11: This would fall into the Moderate category of the number and complexity of problems addressed. Chronic illness with exacerbation, progression, or side effects of treatment includes a patient who is not at goal. Documentation would include the goal and the patient's status toward that goal.

- **Question 12:** Does the patient have to be "suicidal with a plan" to use the "acute or chronic illness that poses a threat to life or bodily function."

  Answer 12: Documentation must support the threat to life or bodily function. The AMA gives an example of psychiatric illness with potential threat to self or others. The AMA does not specific "suicidal with a plan."

- **Question 13:** I am seeing the patient to start or renew birth control. Where would this fall under the level of problem addressed?

  Answer 13: Base the level of problem addressed on the patient condition. An otherwise healthy patient would fall into the "self-limited or minor problem." Documentation must support the patient condition and how a pregnancy, as well as the choice of contraception, would be harmful to the patient.

AMOUNT AND COMPLEXITY OF DATA

- **Question 1:** Can we count an action in one of the three Categories provided the day before the patient encounter?

  Answer 1: Yes, verify you have not previously used the order of the test(s) in choosing a level of service for a previous encounter. Verify you have not previously billed for a professional service. The time used to determine the pricing for the E/M service is three days before or seven days after the patient encounter.

- **Question 2:** The column of amount and complexity of data mentions "(not separately reported)". What does this mean?

  Answer 2: The practitioner cannot submit a separate charge for the professional service when using that as a data element. You can look to other procedure codes that accurately reflect the service. Examples can include billing for

  - Professional interpretation of test/studies
  - Charges for interprofessional consultations
  - Physiological testing and/or monitoring

- **Question 3:** The patient brings a log of their food intake, blood pressures, blood sugars, etc. Can I count this as "external notes"?

  Answer 3: No. Reviewing notes from another unique source (data category 1) would be notes from another health care professional or organization. You may want to look to other procedure codes. These could include physiological monitoring. Those codes may be more appropriate for that review. When choosing your level of service based on time, you can count the time spent reviewing the log.

- **Question 4:** When reviewing external notes, how do I indicate my review? Must I provide a summary of the notes?

  Answer 4: When incorporating external notes into the patient medical record, a notation of reviewed is sufficient. This can include a signature and date of the review. The medical record will need to show the notes reviewed. If not incorporated, then document a summary of the

RETURN TO LIST OF CATEGORIES

external notes. Your medical record should indicate how you are using the information to treat the patient.

- **Question 5:** I reviewed notes from a previous ER visit. The notes included lab test results. Can I count the review of the note and the review of the tests separately?

  Answer 5: No. The AMA document states "Review of all material from any unique source counts as one element toward MDM." Reviewing the notes and tests results for the ER encounter counts once. Reviewing two previous ER encounters from the same ER would count only once.

- **Question 6:** The patient provides verbal results of tests ordered by another practitioner. Can I count this as a review of unique tests?

  Answer 6: No. A patient's verbal reporting of test results is not the same as reviewing test results.

- **Question 7:** Can we count the order and the review of the testing separately to meet Category 1 requirements for a moderate level of service?

  Answer 7: The order and review of the test is only counted once. The AMA states in the definition of Analyzed states in part "Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter."

- **Question 8:** Can I count my review of my previous notes for the patient as part of Category 1?

  Answer 8: Category 1 includes the review of "external notes." The AMA defines external as "External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization." The AMA definition of external physician or other health care professional is "An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organization provider such as a hospital, nursing facility, or home health care agency." Your review of your previous notes are not "external" notes.

- **Question 9:** Can I count my review of the PHQ-9, PHQ-2, and GAD-7 responses as psychometric tests?

  Answer 9: Your documentation of your review of the results of the patient completed tests can count as a psychometric testing.

- **Question 10:** I reviewed the uploaded results of tests ordered by an external entity into the patient's medical record. Can I count the review of this unique test?

  Answer 10: Since your practitioner or a member of your group with the same specialty did not order the service, you could count this as a review of a test. If the test was part of an external note, you would only count the review of the external note. Documentation must show you reviewed the results and used those results in the medical decision-making for the patient.

- **Question 11:** I checked the state's automated prescription system to verify patient is taking opioids as prescribed. Would this fall into Category 3: discussion of management or test interpretation?

  Answer 11: This would fall into Category 1 under the "review of external notes from each unique source."

- **Question 12:** My staff checked the state's automated prescription system to verify the patient is taking opioids as prescribed. The staff provided me the results verbally. Can I include this under "review of external notes from each unique source"?

  Answer 12: No. The staff performed the review.

- **Question 13:** The medical record contains the test results. Does this mean I can count the review of the tests?

  Answer 13: Document your review/analysis of the test results. Your documentation should show your review and use for your medical decision for that patient encounter. If you submit a separate charge for the professional component of the test or use the independent interpretation as a data element, do not count the review.

RETURN TO LIST OF CATEGORIES

- **Question 14:** I ordered a lab test during today's encounter. Based on the results, I want to repeat the test in one month. Can I use the analysis of the second test as a data element for the next encounter?

  Answer 14: Yes. You did not include the review of the second test as a data element for today's encounter.

- **Question 15:** Discuss the difference between analyzed, review, and independent interpretation.

  Answer 15: the AMA definition for analyzed includes: "The process of using the data to make a medical decision for the patient. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment." A review evaluates the test or results in determining the medical decision for that patient for that encounter. The AMA defines an independent interpretation as "The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test."

- **Question 16:** During the last four encounters with the patient, I've ordered a particular diagnostic test. The patient has yet to comply. Can I use the additional orders as a data element in the subsequent encounters?

  Answer 16: Yes. If you determine you need the test and provide the order, you can use the order/review of the test as one data point for the individual encounter. Ordering a test includes those considered but not selected after shared decision-making. The patient may request a test, but the practitioner may decline to order. The physician may order, but the patient may decline. The practitioner may consider, but due to risk to the patient, may determine not to perform. Document the considerations and discussion.

- **Question 17:** I requested the patient get labs done two weeks from today. I will analyze the results during the next encounter. How do I use this data element?

  Answer 17: Include the order of the test in today's encounter. The review of the test is part of the order and not counted separately.

- **Question 18:** I ordered a complete blood count, chemistry panel, and lipid test for the patient today. Can I count this as three unique tests under the amount and complexity of data?

  Answer 18: The AMA defines unique in part as "A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count." The AMA does not require each unique test to be in a separate category of CPT codes.

- **Question 19:** Must I ordered tests in different categories (e.g., labs and radiology) to count more than one test?

  Answer 19: No. You must have separate tests, but they do not need to be in different categories of service.

- **Question 20:** I ordered screening services (e.g., AIC, Cholesterol, mammogram, screening colonoscopy, etc.) Will Medicare use screening services as a unique test data element?

  Answer 20: Tests ordered, but not covered by Medicare could still count as a unique test when part of the practitioner's medical decision for the patient.

- **Question 21:** My documentation did not include a notation of a request for a test. My staff has the requisition. Can I use this as a data element?

  Answer 21: Your documentation must show your need for the results of the test in making medical decisions for the patient. You would not count this as one of your data elements.

- **Question 22:** I ordered two tests with the same procedure code (right and left elbow x-ray). Would we use this as one or two data elements?

  Answer 22: You can use this as two. Even though the procedure code is the same, this really is two unique tests for the patient.

RETURN TO LIST OF CATEGORIES

- **Question 23:** During today's encounter, I ordered one lab test for the patient to repeat quarterly. Can I count the order today and the review of the subsequent tests in the next encounter?

  Answer 23: In the case of recurring orders, you can count each new result in the encounter in which you analyze the result. For example, an encounter that includes an order for monthly prothrombin times could count for one test ordered and reviewed. Additional future results, if analyzed in subsequent encounters, can count as a single test in that encounter.

- **Question 24:** I ordered an electromyography (EMG) and a colonoscopy for the patient. Do I use this under the Data or Risk element?

  Answer 24: Medicare would consider these services as procedures rather than tests. However, the determining factors would be the reason for the order. If ordering to determine results for further medical decision-making, you can count this as a test. If you order or perform the test, this could be part of the Risk element. If also performing the test, the E/M is subject to the global surgery guidelines.

- **Question 25:** Under Amount and Complexity of Data, I don't have the independent historian or discussion of management. Does this mean I have to order testing the patient does not need to meet the requirements?

  Answer 25: You would not order testing just to meet a certain level of service. All testing and activities as part of the E/M service must be medically necessary for the patient. To meet a level of service, you must meet two out of the three elements.

- **Question 26:** What documentation is required to support the independent historian?

  Answer 26: The AMA defines independent historian as "An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to development stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. The independent historian does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information." Documentation must support the reason the patient is unable to provide the complete or reliable history, and from whom you obtained the additional history.

- **Question 27:** Can I count the use of an interpreter as an independent historian?

  Answer 27: No. An interpreter is not the same as an independent historian. The patient is providing the information. The interpreter is translating the information from the patient to you.

- **Question 28:** My staff performs a pulse oximetry (procedure code 94760) to gather the vitals for the patient. Can I use this as a data element?

  Answer 28: This is not a data element. The AMA states "For purposes of data reviewed and analyzed, pulse oximetry is not a test." This would be part of the clinically appropriate exam.

- **Question 29:** I ordered a radiology test. The radiologist in my group will provide and bill for the professional component. Can I perform and use my independent interpretation as a data element?

  Answer 29: The first consideration is whether you performed a review or an independent interpretation of the test. Your documentation would determine what you performed. The AMA defines an independent interpretation as "The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test." The practitioner providing the E/M and the practitioner providing the formal interpretation must be different specialties.

- **Question 30:** Does "Discussion of Management or Test Interpretation" include other professionals in the office? An example could be a pharmacist or mental health provider. Does the patient's previous Family Medicine doctor from outside practice count? Can we count the discussion between the resident and the teaching physician?

  Answer 30: The "Discussion of Management or Test Interpretation" is part of Amount and Complexity of Data reviewed and analyzed. This is category 3 in the moderate and high level.

RETURN TO LIST OF CATEGORIES

This is a discussion of management or test interpretation with external physician/other health care professional/appropriate source (not separately reported.) The discussion would be on the date of the encounter or within a day or two. This is an individual (doctor/non-physician practitioner) not in the same group or with a different specialty. This can also include other licensed professionals practicing independently. It may also be a facility such as hospital, nursing facility, or home health care agency. A pharmacist or mental health provider could be appropriate. A practitioner with a different specialty could be appropriate. A provider with the same specialty, but in a different group could also be appropriate. The definition of "appropriate source" includes professional sources who are not health care professionals, but are involved in patient management (e.g., Lawyer, parole officer, case manager, or teacher). This would not include a discussion between a resident and teaching physician. Document must show how the discussion played a part in the medical decision for the patient.

- **Question 31:** Another physician provided a letter explaining his/her previous care of the patient. I indicated I would request medical records from another practitioner. Can I use this as a Category 3: Discussion of management or test interpretation?

  Answer 31: No. Category 3 is a discussion between practitioners. A letter or an indication of future activity would not satisfy this requirement. Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries. Sending chart notes or written exchanges within the progress notes do not qualify as interactive exchanges.

- **Question 32:** I texted or messaged another physician concerning the patient care. Would this text or message count as "discussion of management or test interpretation"?

  Answer 32: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries. Sending chart notes or written exchanges within the progress notes do not qualify. The discussion does not need to be on the date of the encounter. However, count only once and only when used in the decision making of the encounter. It may be asynchronous, and you must initiate and complete within a short period, within a day or two.

RISK AND COMPLICATIONS OF PATIENT MANAGEMENT

- **Question 1:** I discussed possible surgery, hospitalization, etc. as listed in the risk category. Can I consider these discussions when the final decision is no to those options?

  Answer 1: Yes, as you discussed and came to a decision on those options

- **Question 2:** How will Medicare determine "minor" or "major" surgery?

  Answer 2: Base your determination of minor or major surgery on your clinical determination for that specific patient. We would also review any medical record data that is specific to that patient. The type of anesthesia is also a consideration, examples include local anesthesia, conscious sedation, or general anesthesia. The AMA document includes the following:

  - "Surgery: Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by surgical package classifications."
  - "Surgery, Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures."
  - "Surgery: Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk."

- **Question 3:** I ordered a CT with contrast. Can I use this as an order in the data category and the same test under the risk category?

  Answer 3: You can count the order of the test under the amount and complexity of data. You could also document the associated risk and use the resulting level in choosing your level of service.

RETURN TO LIST OF CATEGORIES

- **Question 4:** What documentation would Medicare require to meet the substantial duration as part of the definition of morbidity?

  Answer 4: The AMA document defines morbidity as "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 in nature." A good rule of thumb would be at least one year

- **Question 5:** The MDM table does not have examples of straightforward or low in the Risk category. Can we use examples provided in the 1995 and 1997 Documentation Guidelines (DG)?

  Answer 5: The 1995 and 1997 DG do not apply to procedure codes 99202: 99215 provided January 1, 2021 and after. Documentation would need to support the level of risk as listed in the new document. Do not mix the 1995 or 1997 DG with the AMA MDM table. The AMA MDM table is for office and other outpatient services provided January 1, 2021 and after.

- **Question 6:** I determine the patient needs surgery during one encounter, but the patient must meet certain qualifications such as levels in blood work or reducing weight. The patient met the qualification for a subsequent encounter. Can I count the decision for surgery in both encounters?

  Answer 6: You would only count the decision for surgery at one encounter. This would be when you made the decision for the surgery and the patient met the established criteria.

- **Question 7:** Please explain further the "prescription drug management."

  Answer 7: Prescription drug management does not require a new drug, a new dosage, or a discontinuation of a current prescription. The medical record will show the physician work to determine the medical necessity of the prescription drugs. An encounter documented as only a prescription refill without documentation of a problem addressed would not suffice. The AMA defines a problem addressed in part as "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." You can also count prescription medications considered but not given. There could be patient choice, possible drug interactions, etc. Prescription drug management does not include drugs injected during the current or subsequent encounter.

- **Question 8:** Question: Can we always give a moderate level of risk using the example of "prescription drug management" when we order an injection for the patient?

  Answer 8: Ordering an injection for the patient is not prescription drug management. There can be many different reasons for ordering injections including, but not limited to, birth control, cancer treatments, joint issues, allergies, and antibiotics. The column of risk is "Risk of Complications and/or Morbidity or Mortality of Patient Management." The MDM table includes examples of situations that could fall under that category of risk. The AMA definition of morbidity reads "A state of illness or functional impairment that is expected to be a substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment." The American Medical Association (AMA) definition of risk reads in part: "The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of event under consideration." "Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified healthcare professional in the same specialty." "For the purposes of MDM, level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter." Choose the level of risk based on the physician or other qualified health care professional's determination and documentation of the risk to that specific patient for that specific encounter for that specific treatment choice. Billing for the administration of the injection and drug show the decision for that treatment.

- **Question 9:** The high and moderate levels of risk mention decision on various surgery scenarios. Can this decision happen with the primary care physician prior to referral to the surgeon?

  Answer 9: Yes, the primary care physician could decide surgery is a treatment option. Part of the medical decision-making is to determine whether to refer the patient for surgery.

RETURN TO LIST OF CATEGORIES

- **Question 10:** I provided a sample prescription drug to the patient. Is this "prescription drug management"?

  Answer 10: This would be "prescription drug management".

- **Question 11:** How would I document "social determinants to health"?

  Answer 11: Document the social determinants and identify how these affect the MDM for that patient for that encounter. The AMA defines social determinants of health as "Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity."

- **Question 12:** Can I just document "risks discussed with the patient?"

  Answer 12: Documentation should identify the specific risks associated with that patient and that procedure. Risk factors are those relevant to the patient and procedure. You are not required to use evidence-based risk calculators.

- **Question 13:** I am instructing the patient to take an over-the-counter medication. I evaluate the possible interactions with the current prescription medications. Can I count this as prescription drug management?

  Answer 13: An order for an over the counter (OTC) drug does not count as prescription drug management. However, managing the patient's prescription drugs in connection with adding an OTC or supplement would show prescription drug management. If the patient can purchase the drug OTC, Medicare would not consider this a prescription drug. Several publications by different specialty organizations have multiple instructions. Our contractor medical directors (CMDs) looked at this question. Documentation must show the additional risk or benefit to the patient from taking this OTC drug. This can include the additional risk from off-label use, higher dosage, frequency changes, etc.

- **Question 14:** I ordered a lab with instructions to start a medication based on the result of the test. Can I use this as prescription drug management?

  Answer 14: Yes, this would count. Your documentation would describe the test and the actions to take depending on the result of the test.

- **Question 15:** The patient is refusing the advised treatment. Is this a "social determinants of health"?

  Answer 15: The AMA definition states "Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity." The patient's non-compliance would not fall into this category. However, you can use the medical decision made to determine your level of risk.

- **Question 16:** I advised the patient to start a prescription drug. The patient declined. Can I still use this data element?

  Answer 16: Yes. Your medical decision for the patient is to start a medication therapy. Documentation would show the patient's decline and any adjustments the physician made to the plan of care.

- **Question 17:** I am performing an encounter to provide a clearance for surgery at the request of the surgeon. Can I use my encounter as a "decision for surgery" in the risk column?

  Answer 17: No. You are not determining the patient risks for the surgical intervention. The surgeon already made the decision for surgery. Utilize the problem you are addressing, amount or complexity of data and the risk to the patient from your decision to determine your level of care.

- **Question 18:** I ordered compression stockings or oxygen for the patient. Is this "prescription drug management"?

  Answer 18: This is not prescription drug management. The items ordered are not drugs.

- **Question 19:** Please further explain "drug therapy requiring intensive monitoring."

  Answer 19: The AMA definition states in part "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." Monitoring is not less than quarterly. The monitoring is by lab test, a physiologic test, or imaging. Monitoring by history or exam does not qualify.

RETURN TO LIST OF CATEGORIES

Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect, unless severe hypoglycemia is a current significant concern.

- **Question 20:** Can we count Warfarin monitoring as Drug Therapy Monitoring?

  Answer 20: Warfarin testing could meet the AMA definition when monitoring for toxicity.

  - Examples:

    » **Example 1:** A patient with A-Fib who is chronically anticoagulated with routine laboratory testing and intermittent slight adjustments to their medication dosing would not be considered intensive monitoring or high risk.

    » **Example 2:** A patient with A-Fib has discontinued their chronic anticoagulation medication in preparation for a surgical procedure. After the procedure, the physician has restarted the patient's anticoagulation medication and performs multiple dosing titrations with laboratory testing to reach the desired effect. Significant medication adjustments with testing, or other interventions such as Vitamin K administration, would be considered intensive and high risk.

- **Question 21:** Can I count my decision to send the patient to the emergency room as a "decision regarding hospitalization"?

  Answer 21: Documentation must show your MDM. Medicare would look at the documentation to determine if you are sending the patient for evaluation by the ER physician or sending the patient to the ER to accomplish the admission.

- **Question 22:** The patient's chronic illness can cause extreme flare-ups that could lead to functional limitations or death. Can we always count this as high risk?

  Answer 22: Risk is the probability and consequences of an event. Base the level of risk on consequences of the problem(s) addressed at the encounter when treated appropriately. The diagnosis, by itself, does not determine the risk level.

MISCELLANEOUS

- **Question 1:** Does my organization have to choose whether to document using time or MDM as an organization?

  Answer 1: No. You can choose to document using time or using MDM for each patient encounter. You can choose the method most advantageous to you. Any Medicare review of documentation will look at both methods to support the level of service billed. If the medical record does not contain time, Medicare will review based on the MDM.

- **Question 2:** Patient encounter is for yearly physical exam and treatment of ongoing condition. How do we carve out the two services?

  Answer 2: When using time, document time spent in services to treat the medical condition. Carve out time spent performing the services related to the yearly exam. Choose your level of service based on the remaining time. When using MDM, choose based on number and complexity of problems addressed for the ongoing condition. Use the documentation to support the preventive service first and then use the remaining documentation to support the covered service. Information in the documentation cannot be used twice.

- **Question 3:** Can we apply the information in the new MDM table to other categories of services? This will assist my hospitalist in coding the inpatient visits.

  Answer 3: The AMA MDM table is for procedure codes 99202: 99215. This applies for services January 1, 2021 and after. These are office or other outpatient services. This does not apply to any other category of service. Additional categories of E/M services are subject to the 1995 or 1997 DG.

- **Question 4:** Would the new rules apply for observation consultations?

  Answer 4: The practitioner ordering the patient's observation care submits the observation category of services. Any other practitioner seeing the patient while in observation submits the 99201: 99215 currently. The changes described apply when you use procedure codes 99202: 99215. This applies for services for January 1, 2021.

RETURN TO LIST OF CATEGORIES

- **Question 5:** What additional information can you provide concerning the add-on G-code, G2211?

  Answer 5: This code is for additional intensity of services. The Consolidated Appropriations Act, 2021 delayed this service until January 1, 2024.

- **Question 6:** Can you provide further information on the procedure codes 99415 and 99416?

  Answer 6: Use procedure codes 99415 and 99416 when your practitioner supervises prolonged clinical staff time. The 99415 is the first hour of additional time and the 99416 is each additional 30 minutes. This could be appropriate when you are submitting a 99211 for ancillary staff incident to services. This could be appropriate when submitting for a higher level of service provided by your physicians. The ancillary staff are completing additional services with that patient.

- **Question 7:** How do I submit for the 99358? Can I connect to the office or other outpatient codes in 2021?

  Answer 7: You cannot use the 99358 and 99359 in connection with an office E/M codes starting in 2021. The code will still be available. It will need to connect to another professional service.

- **Question 8:** There are services that require a moderate or high MDM. An example is the transitional care management (TCM). Will we use the description from the 1995 or 1997 DG or the new AMA MDM table?

  Answer 8: If other procedure codes require a moderate or high MDM, use the new 1995 or 1997 DG.

- **Question 9:** When the Public Health Emergency (PHE) began, CMS issued directives that, for E/M services (99201-99215) conducted via telehealth through audio/video, the E/M level could be selected based on medical decision making or time through the end of the PHE. The times for these codes have changed with the implementation of the new 2021 guidelines. Since the PHE is still in effect, the question has arisen as to which times to use now for telehealth E/M services. For example, under 2020 times, a 99213 is met at 15 minutes. Under 2021 the time is 20-29 minutes. So which time should be used?

  Answer 9: For dates of service on or after January 1, 2021, CMS aligned with the AMA and providers should use the new guidelines for office or other outpatient services.

RETURN TO LIST OF CATEGORIES