Trinity Health

Integrity & Compliance Professional Services Team
2021 E/M Office or Other Outpatient Visit Changes

Frequently Asked Questions (FAQs)

General

1. **Q: Are these changes in documentation effective immediately in 2021?**

   A: Yes, the E/M office or other outpatient visit changes are effective January 1, 2021**.**

2. **Q: Do we have to worry about the history and physical exam elements for inpatient coding or is this strictly office codes?**

   A: History and physical exam elements will still be counted for other applicable code sets. The E/M changes are only for Office or Other Outpatient Services, CPT code set 99202 – 99215.

3. **Q: Will Medicare Administrative Contractors (MACs) be able to dictate that providers should not use their own audit tool?**

   A: Audit tools are acceptable if the 2021 office or other patient visit guidelines are followed.

4. **Q: Is 99211 still valid? Will codes 99202 and 99212 now be used for nurse visits?**

   A: Yes, while 99211 will still be valid, 99201 will be deleted. No, CPT codes 99202 and 99212 are for services rendered by physicians/APPs.

5. **Q: Is Medical Necessity still the over-arching criteria when selecting the level of service? Does Time supersede Medical Necessity?**

   A: Per the Medicare Claims Processing Manual, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. 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." The method of leveling the service does not play a part in determining medical necessity.

6. **Q: Please clarify if this is for Medicare only or for all payers?**

   A: We would expect that all payors will be following the 2021 CPT E/M guideline changes. However, Payer Strategy expects that commercial payers will be publishing guidance in the next few months.

7. **Q: Do you expect hospital codes to change eventually to follow these new guidelines?**

   A: It's possible that other E/M code sets may have their guidelines changed in the future. No specific announcement on other code sets has been made at this time by the AMA or CMS.

8. **Q: If insurance does not accept consultation codes, and a provider is consulted to see a patient in Observation status, would we use this new process as well?**

   A: The new 2021 Office/Outpatient E/M guidelines should be utilized to level the encounter whenever a CPT code from the codes set 99202-99215 will be reported on the claim.

9. **Q: If provider states they spent 15 minutes (99212), but based off MDM they can get a higher code (99214), are we able to just code off MDM and not time?**

   A: Yes, the Office/Outpatient E/M may be leveled on time or Medical Decision Making. It is the provider's prerogative to select which methodology to use for a given encounter.

10. **Q: Will the 2021 E/M changes apply to AWVs, physicals, physical therapy, consultations, emergency department visits?**

    A: The new 2021 Office/Outpatient E/M guidelines should be utilized to level the encounter whenever a CPT code from the codes set 99202 – 99215 will be reported on the claim.

11. **Q: How do the 2021 changes affect how outpatient and inpatient consultations are leveled?**

    A: For the payers that recognize/reimburse outpatient consultation codes, 99241-99245, or inpatient consultation codes 99251-99255, you would use the continue to use the current 1995 or 1997 Documentation Guides.

    Below is the "Summary of the Guidelines Differences" from the AMA's 2021 CPT book.

Component(s) for Code Selection	Office or Other Outpatient Services CPT Codes 99202-99205 and 99211-99215	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, ED, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use key components (history, examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use key components (history, examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service. *Time is **not** a descriptive component for the emergency department levels of E/M services*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complication and/or morbidity or mortality

12. Q: Are the coding requirements for documentation of counseling for smoking, obesity changing at all?

A: No, the new 2021 Office/Outpatient E/M guidelines should be utilized to level the encounter whenever a CPT code from the codes set 99202 – 99215 will be reported on the claim.

Medical Decision Making

13. Q: The level of service is based on Medical Decision Making (MDM) or time, not both, correct?

A: Yes, the level of the Office/Outpatient visit code may be based on time spent by the provider or the level of Medical Decision Making (MDM).

14. Q: If the provider performs a test in the office that can be coded and billed separately, do they get credit in Data MDM?

A: No, per the AMA, "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. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making."

15. Q: Regarding history and exam as medically appropriate: If we see encounters without an exam and/or history component documented; does Trinity Health have recommendation on this? I expect we would query the provider about whether the note is complete, but ultimately would an E/M service be considered not billable if it is missing the history and/or exam?

A: We would not consider an office/outpatient E/M not billable without a history or physical exam. The AMA states, "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 is determined by the treating physician/APP reporting the service." The documentation should reflect the medical necessity and actions taken during the encounter.

Per the General Principles of Medical Record Documentation:

- The medical record should be complete and legible
- The documentation of each patient encounter should include:
    - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
    - Assessment, clinical impression, or diagnosis
    - Medical plan of care
- Date and legible identity of the observer.
- If the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified

- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record

16. **Q: Can you clarify the difference between "Low" and "Moderate" when the patient has a stable chronic illness?**

    A: The Number and Complexity of Problems Addressed element in the Level of Medical Decision Making Table, identifies "Low" as 1 stable chronic illness and "Moderate" as 2 or more stable chronic illnesses. The difference in the complexity is the number of stable chronic illnesses.

17. **Q: Would a refill of medication or dose adjustment be considered moderate risk in the MDM risk element?**

    A: Yes, the AMA has identified prescription drug management as moderate risk in the Risk of Complications and/or Morbidity or Mortality of Patient Management element.

18. **Q: Does prescription drug management only apply to new medications and medication changes or does it apply to refilling prescriptions for chronic illnesses?**

    A: Prescription drug management applies to new medications, changes in medications, and refilling medication as documented.

19. **Q: If the diagnosis is managed and followed by someone else but in my visit it is noted if the condition is stable or not, meds on related to this, last labs related to this, last or next visit, etc. will that count as being addressed for PCP seeing patient?**

    A: Documentation of your assessment, management and/or care coordination during the patient visit would count as problem addressed.

20. **Q: What is the definition of a unique test?**

    A: The definition of a test is each unique procedure code (CPT code).

21. **Q: Does a letter back to a referring physician count as the "Discussion or management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)" bullet?**

    A: No, interactive communication between providers would be the expectation for this bullet. A letter back to the PCP would not be considered as "discussion of management."

22. **Q: Can an "independent interpretation of a test performed by another provider" be another provider within your same practice?**

    A: If the diagnostic testing and interpretation was billed by another provider of the same specialty with the same Tax ID number, you would not be able to count this interpretation towards the level of Data to be Reviewed and Analyzed for the current visit. Medicare considers physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

23. Q: Under the Amount and/or Complexity of Data to be Reviewed and Analyzed component for the bullet "Review of prior external note(s) from each unique source," does this have to be from an outside clinic? Another specialty? What if you are reviewing two notes, is this counted twice?

A: If the diagnostic testing and interpretation was billed by another provider of the same specialty with the same Tax ID number, you would not be able to count this interpretation towards the level of Data to be Reviewed and Analyzed for the current visit. Medicare considers physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Time

24. Q: Will payers be reviewing time-based claims against the diagnoses, i.e. reject 99205 as too much time for a diagnosis of only I10?

A: As of today, we are not aware of any time-based edits against specific diagnosis codes. However, the government looks at "impossible day" in which the physician's claims appear to represent more than 24 hours in a day. We have seen this with high level coding that was not based on time.

25. Q: Having a staff huddle about the day's patients, would this count in the time of the visit?

A: Per the AMA's CPT® Evaluation and Management (E/M) Office or Other Outpatient Code and Guideline Changes: "For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff)."

In staffing huddles, time spent preparing by the provider for a specific patient encounter may be counted. Documentation should delineate the time spent per patient when attributing huddle time for a specific patient encounter. So, we would expect that if the huddle comprises at total of 20 minutes; then only the time spent discussing a specific patient (i.e. 5 minutes prepping for Mr. Jones) should be attributed when billing Mr. Jones' visit (based on time).

26. Q: If I am preparing and pre-charting the day before the visit, can this be counted to the total time?

A: No, per the AMA's CPT® Evaluation and Management (E/M) Office or Other Outpatient Code and Guideline Changes: "For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff."

However, if you are basing the level of service on **MDM**, per the AMA's CPT and RBRVS 2021 Annual Symposium, "The data review does not need to occur on the date of the encounter, but it does have to be part of the analysis that is within the encounter. We also believe it is appropriate to count discussion of management or test interpretation as a data element, even if it occurs on

a separate date, when it is part of the MDM of the encounter. Presumably, this would be on the date of the encounter or very shortly thereafter, as a practical matter to be part of the MDM of the encounter".

27. Q: What are the requirements for billing prolonged services time?

A: CPT code 99417 is used to report prolonged total time, combined time with and without direct patient contact, provided by the physician/APP on the date of office or other outpatient services (99205, 99215). Code 99417 is only used when the office or other outpatient service has been selected using **time** alone as the basis and only after the total time of the highest-level service (99205 or 99215) has been exceeded. To report a unit of 99417, 15 minutes of additional time must have been met. Do not report 99417 for any additional time increment of less than 15 minutes.

Total Duration of new Patient or Other Office or Other Outpatient Services (use with 99205)	**Code(s)**
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 x 1
90-104 minutes	99205 X 1 and 99417 x 2
105 or more	99205 X 1 and 99417 x 3 or more for each additional 15 minutes.
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 x 1
70-84 minutes	99215 X 1 and 99417 x 2
85 or more	99215 X 1 and 99417 x 3 or more for each additional 15 minutes.

In the 2021 CMS Final Rule, CMS published that they will not be accepting 99417. They have created code G2212 for billing prolonged services. To report prolonged services for a Medicare beneficiary, the provider must meet 15 additional minutes beyond the ***maximum*** 99205 or 99215 time threshold.

CPT Code(s)	**Total Time Required for Reporting**
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes.	119 or more

CPT Code(s)	Total Time Required for Reporting
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

28. Q: Will you provide a Trinity approved dot phrase to use when billing by time; do you need start/stop times or is total time acceptable?

A: Both the AMA and CMS have indicated to document the total time (both face-to-face and non-face-to-face) spent on the **calendar date**. However, best practice would be to identify the activities and the time spent.

A SmartPhrase has been created and is available in TogetherCare. It is named .TOTALTIME. It states, "I spent a total of *** minutes on the day of the visit for this patient." You click on the *** and fill in the total time spent on the date of service.

29. Q: Would one bill on time if treating with IV fluids in office that may take over an hour?

A: No, there are specific CPT codes to report for infusion services.

30. Q: Is the requirement that >50% of time must be spent on counseling and/or coordination of care still valid for office and other outpatient visits in 2021?

A: No, time may be used to select a code level in office or other outpatient services based on total time spent by the provider on the date of the encounter.

31. Q: Does the review of records and time spent need to be documented to be counted?

A: Yes, you need to document the time spent if you're going to use time to select your level of service.

32. Q: What activities count when billing based on time?

A: Physician/APP time includes the following activities, when personally performed on the same calendar date as the office visit:

- preparing to see the patient (e.g., 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, tests, or 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)

33. Q: Is there a maximum amount of time allowed for the above activities?

A: The AMA and CMS have not published maximum amount of times allowed for the above. It is recommended that documentation be detailed on the services provided if an extraordinary amount of time is spent providing the above services.

34. Q: Can we bill for only non-face-to-face time if there was no face-to-face time on that date?

A: No, the physician/APP would have to see the patient to report CPT code set 99202-99215.

35. Q: Do these new guidelines offer the opportunity to bill for time when responding to patient advice requests/e-communication from patients?

A: No, these guidelines are specific to CPT code set 99202-99215.

36. Q: Are procedures included when selecting a level of service based on time?

A: 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.

37. Q: Does CMS and AMA agree on the total time elements?

A: CMS and AMA are aligned when using total time for code selection of CPT code set 99202-99205. Please see Question 26 for prolonged services time requirements for AMA and CMS.

38. Q: Does face-to-face and non-face-to-face time have to be documented separately?

A: No. However, it is recommended to include detailed information on the time spent to support the level of service if an unusual amount of time spent.