2021 E/M updates

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Coding and Billing Compliance

Agenda

- New Patient E/M 2021 Guidelines
- Established Patient E/M 2021 Guidelines
- Medical Decision Making explained
- Data categories new in 2021
- Categories and Codes
- Billing according to Time
- Prolonged time
- History and exam

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New Patient E/M 2021 Guidelines

Code	Medical Decision Making	Time
99202	Straightforward	15-29 minutes
99203	Low	30-44 minutes
99204	Moderate	45-59 minutes
99205	High	60-74 minutes

*For encounters lasting longer than 74 minutes there is a prolonged services code

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Established Patient E/M 2021 Guidelines

Code	Medical Decision Making	Time
99212	Straightforward	10-19 minutes
99213	Low	20-29 minutes
99214	Moderate	30-39 minutes
99215	High	40-54 minutes

*For encounters lasting longer than 54 minutes there is a prolonged services code

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Medical Decision Making explained

- Straightforward
  - 1 self limited or minor problem
  - Minimal or not data to review
  - Minimal risk of morbidity
- Low
  - 2+ self limited or minor problem or 1 stable chronic illness or 1 acute uncomplicated illness
  - Limited data to review (see categories next slide)
  - Low risk of morbidity

Medical Decision Making explained cont.

- Moderate
  - 1+ chronic illness with exacerbation or 1 undiagnosed new problem with uncertain prognosis or 1 acute illness or 1 acute complicated injury
  - Moderate data to review(see next slide for categories)
  - Moderate risk of morbidity
- High
  - 1+ Chronic illness with severe exacerbation or 1 acute/chronic illness/injury that poses a threat to life
  - Much data to review(see next slide for categories)
  - High risk of morbidity

Data categories as part of MDM 2021

- New to the table of risk in 2021 are data categories

Category	Included in category
Category 1	**tests and documents** *Any combination of 2 from following* • Review of prior external note from each unique source • Review of the result(s) of each unique test • Ordering of each unique test
Category 2	**Assessment requiring and independent historian (moderate or high)** • Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported)
Category 3	**Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/ or other qualified health care professional\ appropriate source(not separately reported)

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Categories and codes

- 99203/99213- meet 1 of Category 1 or Category 2
- 99204/99214- meet 1 of Category 1 or Category 2 or Category 3
- 99205/99215- meet 2 of Category 1 or Category 2 or Category 3

Time based coding

- In 2021 the provider may choose whether to bill according to time or according to MDM

- How to bill according to time
  - Document everything that happens in the encounter to substantiate medical necessity
  - Document the start time and end time for the encounter
  - Document how time was spent in the encounter

Time based coding

- In 2021 we can now count both face-to-face time as well as non-face to face time What does this mean?
  - Time spent with the patient during the encounter (face-to-face time)
  - Any time spent reviewing labs/tests prior to encounter(non face-to-face time)
  - Any time spent getting prepared for the encounter(non face-to-face time)
  - Any time spent documenting or finishing up the encounter after the patient leaves(non face-to-face time)
- Total time counted during the Date of Service only

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Prolonged time

- When billing according to time and the time exceeds the level 5 time you can add on a code for prolonged time spent

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

History and Exam

- In 2021 The History and Exam elements are not being used to calculate the level of E/M service provided

- What does this mean?
  - The History and exam component should still be documented
  - The history and exam helps to prove the medical necessity of the E/M level chosen
  - 2021 guidelines state that ancillary staff may collect information from patient/ family(from portal or questionnaire) and the provider must review the information collected

If you have any questions please feel free to call Anastacia Chapman

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