2021 Evaluation and Management Changes

December 2020

VHA Program Office

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Integrated Veteran Care

Who, What, When, Why… Changes in Evaluation and Management for New and Established Outpatient Code Selection

CMS's "Patients over Paperwork" initiative to administrative simplification as a key goal.

- Effective Jan 1, 2021

Primary objectives:

- Decrease that administrative burden of documentation and coding
- Decrease the need for audits
- Decrease unnecessary documentation
- Ensure that payment for E&M office visits are resource based.

- ***Allows physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time***
- Changes in the definitions of MDM and time when used to report these codes
- Deleted CPT code 99201
- Created a shorter prolonged service CPT code
- Increased Relative Value Units (RVU)

New RVUs for 2021

Code	2020 RVU	2021 RVU	Increased By
99201	0.48	N/A	N/A
99202	0.93	0.93	0%
99203	1.42	1.6	13%
99204	2.43	2.6	7%
99205	3.17	3.5	10%

Code	2020 RVU	2021 RVU	Increased By
99211	0.18	0.18	0%
99212	0.48	0.7	46%
99213	0.97	1.3	34%
99214	1.5	1.92	28%
99215	2.11	2.8	33%

Prolonged Service – 99417 – 0.61

Changes in Time Requirements – Office/Outpatient Only

- Time alone may be used to select appropriate code level and **must be documented in in the progress note**
- Includes face-to-face and non face-to-face time on the date of service
- A range of time is now used
- Shared or Split Visits
  - Time personally spent by the physician and other qualified health care professional on the same day
  - If time is used for code assignment, the cumulative time spent is used to determine the level of service
  - Can only be counted toward one provider
- Prolonged Time – new code, can only be assigned to 99205 or 99215 when the amount of time spent exceeds the time outlined by the office visit code

Time Included Activities – Day of Visit ONLY

- Physician/other qualified health care professional time includes the following activities, when performed:
  - preparing to see the patient (eg, 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 to 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)

Reporting Time

E/M Office or Other Outpatient Code	Typical Face-to-Face Time (Before 2021)	Total Time on the day of the encounter: Face-to-Face and Non-Face-to-Face Time* (2021)
New Patient		
99201	10 minutes	Code deleted
99202	20 minutes	15-29 minutes
99203	30 minutes	30-44 minutes
99204	45 minutes	45-59 minutes
99205	60 minutes	60-74 minutes
Established Patient		
99211	5 minutes	Time component removed
99212	10 minutes	10-19 minutes
99213	15 minutes	20-29 minutes
99214	25 minutes	30-39 minutes
99215	40 minutes	40-54 minutes

- Includes face to face and non face to face time
- Same day as encounter
- Total time must be documented in the health record when it is used as the basis for code selection
- Physician and QHP time

* Only on the date of the encounter. There are typical activities that take place before and after the date of the encounter that are not reported separately.

Prolonged Service

- New CPT code (99417) with UNITs as quantity per 15-minute increments
  - May only be used in conjunction with 99205 and 99215
  - Time spent is 15 or more minutes **beyond what is allowed by the E&M**

Encounter Form for ANC MHS SMH SW 03 (Jul 16,2018@12:59)

Visit Type | Diagnoses | Procedures | Vitals | Immunizations | Skin Tests | Patient Ed | Health Factors | Exams | GAF

Procedure Section

CASE MANAGEMENT SERV
COMMUNITY RESIDENTIAL
EDUCATION/TRAINING
HEALTH AND BEHAVIOR AS
HOME HEALTH VISIT
OTHER
PSYCHIATRIC THERAPY
SMOKING/TOBACCO USE C
SUBSTANCE USE D/O
TEAM CONFERENCE
Prolonged Svc

Other Procedure...

CASE MANAGEMENT SERVICES

Prolonged Svc 15 min 99417

Modifiers

Quantity | Selected Procedures

Comments

Provider: Quantity Select All Remove OK Cancel

Prolonged Services

- New CPT code (99417) with quantity for each additional 15-minute increment spent above what is allowed for the 99205 and 99215
  - May only be used in conjunction with 99205 and 99215

New Patient Encounters (Total Time)	
Documentation	**Codes and Quantity**
60-74 minutes total time documented	99205
75-89 minutes as total time documented	99205 x 1 and 99417 x 1
90-104 minutes as total time documented	99205 x 1 and 99417 x 2
105 minutes or more of total time documented	99205 x 1 and 99417 x 3 (or more) for each additional 15 minutes

Established Patient Encounters (Total Time)	
Documentation	**Codes and Quantity**
40-54 minutes total time documented	99215
55-69 minutes total time documented	99215 x 1 and 99417 x 1
70-84 minutes total time documented	99215 x 1 and 99417 x 2
85 minutes or more total time documented	99215 x 1 and 99417 x 3 (or more) for each additional 15 minutes

Exception to the Rule:

- E&M with Psychotherapy codes 90833, 90836, 90838
- When psychotherapy is performed with an Evaluation and Management service, time may NOT be used as the basis for the E/M code.
  - Psychotherapy code is time based so time must be documented in the note for that service.
  - E/M service must be coded based on MDM.

Elements of Medical Decision Making (MDM)

- MDM Includes
  - Establishing reason for visit / diagnoses, assessing the status of a condition and/or selecting a management option
  - Defined by three elements
    - Number and complexity of the problem
    - Amount and/or complexity of the data
    - Risk of complications, morbidity and/or mortality
  - Four levels of MDM
    - Straight forward
    - Low
    - Moderate
    - High

Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021: ***Note: this content will not be included in the CPT 2020 code set release***

Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 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*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 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)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **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
			Extensive
			(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)
				High risk of morbidity from additional diagnostic testing or treatment
				
				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

Items NOT considered….UNLESS

- Comorbidities and/or under-lying diseases, in and of themselves, are not considered in selecting a level of E/M service unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- Situations that do not qualify as being addressed or managed by the physician or other QHP reporting the service include:
  - Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination.
  - Referral **without** evaluation (by history, examination, or diagnostic study or consideration of treatment). Or
  - Other diagnoses or conditions that the patient has but that are not addressed in the encounter.

Services Reported Separately

- Any specifically identifiable procedure or service performed on the date of E&M services may be reported separately
  - Physician performance of diagnostic tests/studies
  - Physician interpretation of results with preparation of a separate distinctly identifiable signed written report

Documentation MUST support the ENCOUNTER

- Documentation Requirements in progress notes include:
  - History (medically appropriate)
  - Physical Exam (medically appropriate)
  - Medical Decision Making
- The main purpose of documentation is to support care of the patient by current and future health care team(s)
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- 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
- Documentation must support the level of service reported, **especially when coding by time**
- Should be documented during, or as soon as practicable, after it is provided in order to maintain an accurate medical record

Documentation Examples

Basic Documentation

- Active Problems: COPD followed by pulmonary, DM getting A1C today, OA continue NSAIDs.
- A/P: Annual exam, encounter for vaccines. RTC in 1 year or PRN

Appropriate Documentation

- Active Problems: COPD followed by pulmonary, DM getting A1C today, OA continue NSAIDs.
- Exam: breath sounds decreased on respiratory exam, O2 sats 82% RA, pedal pulses intact, normal capillary refill
- A/P: annual exam, encounter for vaccines. COPD is stable on current Rx, patient sees pulm quarterly; consider supplemental O2 for low room air saturations. DM is stable on metformin, patient to continue regular BS checks, will call with A1C results. RTC in 1 year or PRN.

Test Case 1

- A 70-year-old female **new patient** presents to the office with her daughter, **complaining of being depressed**. Patient **and daughter** report increasing distress due to the patient **repeatedly losing or misplacing small objects** over the past several months. The patient has also noticed **intermittent, mild forgetfulness of other people's names** and what she intends to say during conversation, and the daughter confirms. No additional stressors are reported, although the patient reports mild sadness when thinking about it. The physician performs an **appropriate neurologic exam** and finds no remarkable findings beyond that the patient is unable to focus on the serial 7s and that she exhibits mild struggle with telling history. She remembers only one of three objects. The physician notes these findings in the medical record and, after shared decision making with the patient and her daughter, **provides a prescription for a selective serotonin reuptake inhibitor** for the patient's diagnosis of depression, recommending a return visit in one month. The patient also likely has dementia. A **vitamin B12 test, TSH test** are ordered. They discuss ordering a brain MRI. It is decided that it is likely low yield and can wait so that the patient does not feel overwhelmed. In addition to 55 minutes with the patient and daughter an additional 8 minutes are spent on documentation. Records are requested and upon receipt a week later an additional 20 minutes is spent in review.

Test Case 1: Using Medical Decision Making

Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 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)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

E/M Office Visit Code = 99204 (New Patient)
Level of MDM = Moderate (3/3)

Test Case 1: Code Determination Using Time

"In addition to 55 minutes with the patient and daughter an additional 8 minutes are spent on documentation. Records are requested and upon receipt a week later an additional 20 minutes is spent in review."

× NO: 55+8+20 — 99205 E&M New Patient High MDM
+99417 Prolonged Service

✓ **YES: 55+8 — 99205 E&M High MDM**

Justification: While the face-to-face time in the office is less than 60 minutes, the total time on the day of the encounter is 63 minutes by including the 8 minutes spent on documentation. The record review occurred on another date which cannot be included in the time for this date of service. So it is not accurate or appropriate to report prolonged services, as the total time (63) minutes does not exceed the maximum allowed by the E&M code 99205. If the patient's records from another provider/specialty/facility and reviewed on the same date as the visit, e.g. spent the 20 minutes on the date of the encounter reviewing records from Dr. X from one month ago(and that's why no CBC and Chemistries were ordered), then correct code assignment would include both the E&M and additional code 99417 Prolonged services to represent 83 minutes total.

Test Case 1: Comparison of Methodology

99204 New Patient based on Medical Decision Making = Moderate (3/3)

Number and Complexity of Problems Addressed = **Moderate**

- *1 undiagnosed new problem with uncertain prognosis*

Amount and/or Complexity of Data to be Reviewed and Analyzed = **Moderate**
Category 1: Tests, documents, or independent historian (1 of 3 categories met)

- Review of prior external note(s) from each unique source (none);
- Review of the results(s) of each unique test (none);
- Order unique tests (two)
- *Assessment requiring an independent historian(s)*

Risk of Complications and/or Morbidity or Mortality of Patient Management = **Moderate**

- *Moderate risk of morbidity from additional diagnostic testing or treatment: Prescription-drug management*

99205 New Patient based on Time = 63 minutes

- 55 Minutes with Patient and daughter plus 8 minutes spent on documentation **(55+8) = 63 minutes 99205 E&M High MDM**

Test Case 2

- The same patient returns in follow-up 4 weeks later. For this scenario assume the requested records arrived before the new patient visit, so there is no new data beyond what the physician ordered. In the inter-visit interval, an MRI was ordered and performed. The B12 was low and the TSH returned as normal. This is documented in the progress note. The patient's daughter and the patient both provide important history information. She is less frustrated and down, but her cognition is reported as unchanged. The physician explains the diagnosis of dementia, likely Alzheimer's, and mild depression. The SSRI medication is not changed and B12 was already started when the lab returned. On the date of the encounter a total of 25 minutes were spent seeing the patient and documenting the visit.

Test Case 2: Code Determination Using Time

- "On the date of the encounter a total of **25 minutes** were spent seeing the patient and documenting the visit."
- **YES: 25 min = 99213 E&M Low Complexity 20-29 minutes MDM**
- The documentation states total time on the visit date as 25 minutes which falls in the range of 99213. If documentation of health record were completed and the documentation included the time spent reviewing and impact on the evaluation, tests ordered, or plan that would result in additional time for consideration in code assignment.

Test Case 2: Using Medical Decision Making

Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 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)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

E/M Office Visit Code = 99214 (Established Patient)
Level of MDM = Moderate (2/3)

Test Case 2: Comparison of Methodology

99214 Established Patient Medical Decision Making = Moderate (2/3)

Number and Complexity of Problems Addressed = **Moderate**
- *2 stable chronic illnesses*

Amount and/or Complexity of Data to be Reviewed and Analyzed = **Moderate**
Category 1: Tests, documents, or independent historian (1 of 3 categories met)
- Review of prior external note(s) from each unique source (none);
- Review of the results(s) of each unique test (one);
- Order unique tests (none)
- *Assessment requiring independent historian(s) (present);*

Risk of Complications and/or Morbidity or Mortality of Patient Management = **Moderate**
- *Moderate risk of morbidity from additional diagnostic testing or treatment: Prescription-drug management*

99213 Established Patient based on Time Spent on Date of the Visit = 25 minutes

- 25 minutes total time spent
- There is no documentation of additional time spent reviewing records in case scenario and impact on current evaluation and/or plan of care.

Summary

- Effective Jan 1, 2021
- Medical Decision Making (MDM) OR Total time Spent may be used to determine the level of Outpatient Office Visit codes.
- Documentation must continue to show all of the details and evidence to support the encounter.
- Total time spent ON THE DAY OF THE VISIT ONLY
- Time of the primary provider ONLY
- While using time is easier and may be more consistently applied it will not always yield the highest code assignment.
- Using either method Medical Decision Making (MDM) by using criteria outlined in the AMA table or Total Time spent.

References

- Teri Bedard (2020) Preparing for E/M Changes to Outpatient Visits in 2021, Oncology Issues, 35:2, 8-10, DOI: 10.1080/10463356.2020.1729038
- E/M Office Visit Compendium 2021: Resources for Understanding Changes to CPT Coding for Office Visits, ISBN: 978-1-64016-042-2
- CMS Evaluation and Management Services Guide, MLN Booklet, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf
- American Medical Association – https://www.ama-assn.org/practice-management/cpt
- CPT 2021 Professional Edition

Questions

Additional Examples

- The following slides provide additional examples

Test Case 3

- A 58-year-old male **established patient** who had a **bi-leaflet mechanical prosthetic aortic valve replacement nine months ago** is seen in the office with **evidence of congestive heart failure secondary to aortic insufficiency**. The physician **reviews laboratory studies** that reveal anemia secondary to hemolysis and a normal sed rate with no evidence of bacterial endocarditis. The physician **recommends an immediate cardiac catheterization study** (performed by another physician) which reveals four-plus aortic insufficiency. Based on her independent review of the images, the physician determines that this is a medical emergency. The situation was discussed with the patient and his family and he was **scheduled for emergency surgery** to repair the aortic valve. Including evaluation in the office with assessment of the patient's condition and subsequent **discussion with the patient and family** regarding his emergency situation (28 min), **arranging for the urgent cardiac catheterization** (20 min) and **arranging for the hospitalization and surgery** (20 min) the physician spent 68 minutes total time on the date of the encounter.

Test Case 3: Code Determination Using Time

- "Including evaluation in the office with assessment of the patient's condition and subsequent discussion with the patient and family regarding his emergency situation (**28 minutes**), arranging for the urgent cardiac catherization **(20 minutes)** and arranging for the hospitalization and surgery (**20 minutes**)."

✓**YES: 28+20+20 = 99215 E&M Established Patient High MDM 40 minutes**

+99417 Prolonged Service 15 Additional Minutes Quantity = 1 (28 minutes)

Test Case 3: Using Medical Decision Making

Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99205
99215
	High	**High**
		• **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
			Extensive
			(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)
				High risk of morbidity from additional diagnostic testing or treatment
				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

E/M Office Visit Code = 99215 (Established Patient)
Level of MDM = High (3/3)

Test Case 3: Comparison of Methodology

99215 Established Patient Medical Decision Making = High (3/3)

Number and Complexity of Problems Addressed = **High**

- *1 acute or chronic illness or injury that poses a threat to life or bodily function*

Amount and/or Complexity of Data to be Reviewed and Analyzed = **High**

Category 1: Tests, documents, or independent historian (1 of 3 categories met)

- Review of prior external note(s) from each unique source (none);
- Review of the results(s) of each unique test (two)
  - CBC
  - ESR (set rate)
- Order unique tests (one)
  - Cardiac Catheterization

Category 2: Independent interpretation of tests (one)

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported (cardiac catheterization)

Risk of Complications and/or Morbidity or Mortality of Patient Management = **High**

- *Decision regarding emergency major surgery*

99215 Established Patient based on Time Spent on Date of the Visit = 68 minutes

- 68 minutes total time spent
- All time was documented as occurring on the date of the visit thus can be included.
- Prolonged Service: Since the time beyond what is allowed for office visit is exceed an additional code for prolonged service can be reported per 15 minutes.
- A full 30 additional minutes beyond 40 allowed by 99215 was not documented only quantity of 1 must be reported.

Test Case 4

- A resident in the primary care urgent care clinic sees a new 34-year-old patient with a **foot laceration** that is 2 days old. The **patient is homeless**. The history obtained is that the patient stepped on broken glass. He did not think the wound was bad, but he is concerned it might be infected or glass might be inside. He has no past medical history. On exam, the wound does not appear infected and vital signs and foot neurovascular and extremity lymphatic exams are negative. The **resident orders a CBC, glucose, and foot x-ray** (read by radiology). His **time is 24 minutes**. He then gets **the attending who sees the patient and spends 16 minutes discussing the case with the resident and seeing the patient**. The plan is for soaks twice a day, a dry sterile dressing, and to stay off the foot as much as possible. The patient says he does not see how he could do that. They ask the **patient to meet with the social worker as the health system has recently started a temporary housing assistance service. She spends 22 minutes getting him housing near the clinic**. The situation does not qualify the patient for a visiting nurse. The **attending spends 3 minutes with the social worker** and decides that this is the best they can do for the patient. The patient is scheduled to have a recheck in 2 days.

Test Case 4: Code Determination Using Time

- "His (resident) time is 24 minutes. He then gets the attending who sees the patient and spends **16 minutes** discussing the case with the resident and seeing the patient. She (social worker) spends 22 minutes getting him housing near the clinic. The attending spends **3 minutes** with the social worker and decides that this is the best they can do for the patient."

✓ **Minutes 16 + 3 = 99202 E&M Established Patient 19 Minutes**

Test Case 4: Using Medical Decision Making

Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 **99212**	**Straightforward**	**Minimal** •**1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** •**2** or more self-limited or minor problems; **or** •**1** stable chronic illness; **or** ➡ •**1** acute, uncomplicated illness or injury	**Limited** (*Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** •**Any combination of 2 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* **or** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 **99214**	**Moderate**	**Moderate** •**1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** •**2** or more stable chronic illnesses; **or** •**1** undiagnosed new problem with uncertain prognosis; **or** •**1** acute illness with systemic symptoms; **or** •**1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 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)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* •Prescription drug management •Decision regarding minor surgery with identified patient or procedure risk factors •Decision regarding elective major surgery without identified patient or procedure risk factors ➡ •Diagnosis or treatment significantly limited by social determinants of health

E/M Office Visit Code = 99204 (Established Patient)

Level of MDM = Moderate (2/3)

Test Case 4: Comparison of Methodology

99204 New Patient Medical Decision Making = Moderate (2/3)

Number and Complexity of Problems Addressed = **Low**

- *1 acute uncomplicated illness or injury*

Amount and/or Complexity of Data to be Reviewed and Analyzed = **Moderate**

Category 1: Tests, documents, or independent historian (1 of 3 categories met)

- Review of prior external note(s) from each unique source (none);
- Review of the results(s) of each unique test (none)
- Order unique tests (three)
  - Foot Xray
  - CBC
  - Glucose

Category 2: Independent interpretation of tests (none)

Risk of Complications and/or Morbidity or Mortality of Patient Management = **Moderate**

- *Diagnosis or treatment significantly limited by social determinants of health*

1**99202 New** Patient based on Time Spent on Date of the Visit = 19 minutes

- 9 minutes total time spent
- All time spend directly by the attending was documented as occurring on the date of the visit thus can be included.
- Resident and Social worker time is not included.