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Documentation and Coding Update for 2021

AAO Convocation 2021

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Conflict of interest

- Panel member, AMA CPT Editorial Panel
- No financial conflicts

Objectives

- Review the recent history of evaluation and management revisions
- Review 2021 changes in E/M office outpatient visit coding guidelines
- Practice cases to demonstrate how to choose level of service
  - Medical decision making
  - Total time
  - Prolonged service code 99417 unique to 99205 and 99215

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How did we get here? It all began in 2018

- Medicare Proposed 2019 Fee Schedule (Released July 2018) stated goals:
  - **administrative simplification** and
  - to **update E/M codes** to reflect current medical practice
- Simplify code level selection and remove unnecessary history and examination elements
  - Update Documentation Guidelines which have not been updated in 20 years
- Physicians may choose method of documentation
  - CMS 1995/1997 Documentation Guidelines (ie, current standards)
  - MDM only, or
  - Total physician time on the date of a face-to-face encounter
- Simplification included elimination of payment differentials between services

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CMS proposed condensing visit-payment amounts

- CMS calls the system of 10 codes for new and established office visits "outdated" and proposes to retain the codes but simplify the payment by applying a single-payment rate for level 2 through 5 office visits
- CY 2019 Proposed new patient non-facility payment rate
  - 99201: $43 99202-99205: $134
- CY 2019 Proposed established patient non-facility payment rate
  - 99211; $24 99212-99215: $92

CMS identified issues with new payment proposal

- CMS projected that the payment groups created significant impact (positive or negative) on specialties as a whole and might not address complexity adequately
- CMS proposed solutions to address this with a specialty add-on code ($14) and prolonged services add-on ($67)
- Adjustments created budget issues, which CMS addressed by reducing payment for perceived overlap when E/M is performed the same day as a procedure (50% reduction)

CMS tries to ‘fix’ problems in payment proposals

- CMS identifies several specialties that often report higher level office visits
  - Allery/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, Urology
- CMS proposes offsets via the addition of $14 to each office visit performed by these specialties with a new code:
  - GCG0X,*Visit complexity inherent to evaluation and management associated with these specialties*

Major concerns with the 2019 Proposed Rule voiced in comment letter

- Comments from 170 organizations called upon CMS to finalize proposals to streamline required documentation by:
  - Only requiring documentation of interval history since previous visit
  - Eliminating requirement to re-document information from practice staff or patient
  - Removing need to justify home visits in place of office visits
- CMS should not implement proposed collapsed payment rates and add-on codes
- CMS should not reduce payment for office visits on same day as other services
- CMS should set aside office visit proposal, work with medical community on mutually agreeable policy to achieve shared goal and avoid unintended consequences

CPT Editorial Panel and RUC form a workgroup to address E/M issues and provide CMS with guidance

- CPT/RUC Workgroup is charged to capitalize on the CMS proposal:
  - The Workgroup solicits suggestions and feedback on the best coding structure to foster burden reduction, while ensuring appropriate valuation.
  - Act quickly to present CMS with a tangible alternative
- A coding proposal was submitted November 2018 for consideration at the February 7-8, 2019 CPT Editorial Panel meeting
- Demonstrate the effectiveness of and follow the CPT and RUC processes

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CPT/RUC E/M Workgroup Guiding Principles

- The CPT/RUC Workgroup on E/M is committed to changing the current coding and documentation requirements for office E/M visits to **simplify** the work of the health care provider and **improve the health** of the patient.
- To **decrease administrative burden** of documentation and coding
- To **decrease the need for audits** through the addition and expansion of key definitions and guidelines
- To **decrease unnecessary documentation** in the medical record that is not needed for patient care
- To **ensure that payment for E/M is resource based** and has no direct goal for payment redistribution between specialties.

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Administrative burden reduction builds on those established in 2019

- Elimination of the requirement to document medical necessity of furnishing visits in the home rather than office.
- Elimination of the requirements for clinicians to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

Provides burden reduction

- Simplifying code selection criteria and making them more clinically relevant and intuitive
- Creating consistency across payers by adding detail within the CPT E/M Guidelines
- Alignment with current documentation guidelines from Medicare and the CPT code set to ensure minimal disruption to practices.

Major revisions for 2021:
Office or Other Outpatient Services

- Extensive E/M guideline additions, revisions, and restructuring
  - Deletion of code 99201 as codes 99201 and 99202 currently both require straightforward MDM
  - Revision of codes 99202-99215
- Code selection is based on:
  - Medically appropriate history and/or examination and
  - MDM or
  - Total time spent on the date of the face-to-face encounter—including time spent conducting nonface-to-face activities.

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History and Physical

- **Eliminate history and physical as elements for code selection**:
- Physician work in capturing pertinent history and performing a relevant physical exam contributes to both
  - time and
  - medical decision making,
- History and physical alone should not determine the appropriate code level.
  - The workgroup revised the code descriptors to state providers should perform a "**medically appropriate history and/or examination**"

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Physicians choose whether their code selection is based on Medical Decision Making (MDM) or Total Time:

- **MDM:** three current MDM sub-components,
  - number and complexity of problems, document diagnosis being addressed during that visit
  - amount and complexity of data to be reviewed,
  - risk of complications or morbidity of problems/treatment including social determinants of health, and reasons behind decisions not to admit a patient or intervene in some way
- **Time:** The definition of time is minimum time, not typical time
  - Represents total physician/qualified health care professional (QHP) time on the date of service face-to-face and non-face-to-face.
  - The use of date-of-service time better recognizes the work involved in non-face-to-face services like care coordination.
  - These definitions only apply when code selection is primarily based on time and <u>not</u> MDM.

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Creation of a shorter prolonged services code

- The shorter prolonged services code **99417** (each additional 15 mins) captures physician/QHP total time in a more realistic increment
- It is used with office or other outpatient service codes 99205 and 99215
- Be used when **time** is the primary basis for code selection
- This code would only be reported with
  - 99205 and 99215 for physician work on the date of face-to-face encounter
  - 99205 when total physician time exceeds 74 mins
  - 99215 when total physician time exceeds 54 mins

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CY 2021 Physician Fee Schedule Final Rule Provisions

- Reduce documentation burden
- Recognize clinicians for the time they spend taking care of patients
- Remove unnecessary quality measures
- Make it easier for clinicians to move toward value-based care by
  - Extending telehealth and licensing flexibilities beyond the public health emergency
  - Updating Evaluation and Management (E/M) coding guidance
  - Updating the Quality Payment Program and Merit-based Incentive Payment System Value Pathways
  - Updating opioid use disorder and substance use disorder provisions

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Effective January 1, 2021 CMS Physician Fee Schedule changes

- Retains 99211-99215 coding for established patients
- Reduces the number of levels to 4 new patient office/outpatient visits 99202-99205
- Revises the times and medical decision-making process for all of the codes
- Requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level based on either medical decision making or time

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Levels of Medical decision making (MDM) for Outpatient Visits

New /Established Patient Code	99202 99212	99203 99213	99204 99214	99205 99215
Medically Appropriate History and Physical	XXX	XXX	XXX	XXX
Medical Decision Making	Straightforward	Low	Moderate	High

Components of MDM for Outpatient Encounters

- Number and complexity of problems addressed on the date of the encounter
- Amount and/or complexity of tests, orders, documents or data to be reviewed and analyzed on the date of the encounter
- Risk of complications and/or morbidity or mortality of patient management on the date of the encounter

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Number and complexity of problems

- Added clarifying definitions to the MDM table
  - Stable, chronic illness
  - Acute, uncomplicated illness or injury
- Removed some table of risk examples
  - Examples placed in the guidelines to make it less complex
- Clarified number and complexity of problems addressed in the visit
  - Straightforward –self limited problem(s)
  - Low- stable, uncomplicated, single problem
  - Moderate- Single with exacerbation, multiple problems or significant illness
  - High- very ill

Amount and/or complexity of data to be reviewed or analyzed

- Accounts for quantity of documents ordered or reviewed with counting rules
  - Each unique test, order, or document is counted to meet the threshold number
- Data divided into 3 categories
  - Tests, documents, orders or independent historians
  - Independent interpretation of tests not separately reported
  - Discussion of test interpretation and/or management with external physician not separately reported

Risk of complications and/or morbidity or mortality of patient management

- Risks of patient management options at the time of the visit
  - Patient problems
  - Testing and imaging
  - Treatment options
- Includes management options not selected but considered
- Considers risk associated with social determinants of health
  - Economic and social conditions that influence the health of people and communities
    - Food insecurity
    - Housing insecurity and living conditions
    - Access to services or treatment

New vs Established Patient- the 3 year rule

- New Patient
  - Has not received services by same group in 3 years
  - Has not been seen by exact same specialty in 3 years
  - Has been seen by exact same specialty but has not been seen by exact same subspecialty in 3 years
- Established Patient
  - Has been seen by same group with in the last 3 years
  - Has been seen by exact same specialty and has been seen by the exact same subspecialty in the last 3 years

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Straightforward medical decision making

Code	Level of MDM Based on 2/3 elements of MDM	Number & Complexity of Problems	Amount and Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Management
99202 99212	**Straightforward**	**Minimal** 1 self limited or minor problem	**Minimal or None**	**Minimal risk** associated with additional testing or treatment

Example of Straightforward 99212

- 18 year old female patient presents with low back pain after shoveling snow. Medically appropriate history and physical are taken and a diagnosis of uncomplicated low back strain with lumbar somatic dysfunction is made. No testing or medication is needed. OMT is ordered.
- **Number and complexity of problems:** *minimal***:** 1 self limited or minor problem
- **Lab/imaging ordered or reviewed:** *none*
- **Risk of Complications and/or Morbidity or Mortality of Management:** *low*

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Low medical decision making

Code	Level of MDM (Based on 2 of 3 elements of MDM)	Number & Complexity of Problems	Amount and Complexity of Data to be Reviewed and Analyzed (Must meet the requirement of at least 1 of 2 categories)	Risk of Complications and/or Morbidity or Mortality of Management
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** **Cat 1**: **tests and documents** **2 of the following:** *Review* of prior external notes from unique sources *Review* of results of each unique test *Ordering* each unique test **OR** **Cat 2**: *assessment* requiring an independent historian(s)	**Low risk** of additional testing or treatment *Example*: PT/OT OMT

Example of Low medical decision making 99203

- 52 year old male patient presents with pain and stiffness that has progressed over time to include neck, low back and sacrum affecting weightbearing activities. Working from home during COVID 19 has contributed to lack of exercise and poor posture working at dining room table. Patient brought in xrays of the low back taken a year ago by another physician. No neurologic symptoms.
- Medically appropriate history and physical are taken and review of outside xray is performed. A diagnosis of lumbar disc disease, sacroiliac joint pain, neck pain, somatic dysfunction cervical, lumbar, and sacrum are made.
- Discussed with patient back pain causes, interpretation of xray and how disc disease is affected by posture and inactivity, and ordered an xray of the cervical spine for further evaluation. OMT is ordered to address somatic dysfunction.

Coding for 99203 based on 2 of 3 elements

- **Number and complexity of problems:** *Moderate*
  - 1 or more chronic illness with exacerbation: lumbar disc disease
  - 1 undiagnosed new problem with uncertain prognosis: neck pain
- **Lab/imaging ordered or reviewed:** *Limited*
  - tests and documents any 2:
    - review of external xray: low back,
    - ordered xray: cervical spine
- **Risk of Complications and/or Morbidity or Mortality of Management:** *Low*
  - Cervical xray,
  - OMT
  - Discussed proper work station set up

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Code	Level of MDM (Based on 2 of 3 elements of MDM)	Number & Complexity of Problems	Amount and Complexity of Data to be Reviewed and Analyzed (Must meet the requirement of at least 1 of 3 categories)	Risk of Complications and/or Morbidity or Mortality of Management
99204 99214	**Moderate**	**Moderate** **1** or more chronic illness with exacerbation, progression or side effect 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** **Cat 1**: **tests and documents or independent historian** **Any combination of 3 of the following:** *Review* of prior external notes from unique sources *Review* of results of each unique test *Ordering* each unique test *Assessment* requiring an independent historian(s) **OR** **Cat 2:** Independent interpretation of tests performed by another physician/qhp not separately reported **OR** **Cat 3:** Discussion of management or test interpretation with external physician/qhp not separately reported	**Moderate risk** of additional testing or treatment *Examples*: Prescription drug management Decision regarding minor surgery with patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health

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Example of Moderate medical decision making 99214

- 70 year old female complains of SOB after COVID 19 infection 4 weeks ago. Hospitalized for 2 weeks and staying at home with family. History is obtained from both the patient and daughter. Patient is fatigued and has had more joint and back pain with headaches on and off. No falls. Known osteoarthritis of knees, low back and neck is causing difficulty with ADLs. Daughter is concerned about depression. Patient is seeing a pulmonologist for lung care.
- Medically appropriate history and physical are taken. Non-face-to -face review of hospital records, pulmonologist notes and medication reconciliation are preformed. Diagnoses are: Post COVID 19 COPD, osteoarthritis of knees, lumbar spondylosis, cervical spondylosis, situational depression, somatic dysfunction head, cervical, thoracic, lumbar, ribs and lower extremities.
- Discussed with patient and daughter diagnoses and management options. OMT is ordered to address somatic dysfunction and support pulmonary function, continue to follow up with pulmonologist. Considered anti-depressant and daughter wished to wait to see if reducing pain with OMT will help with activity level and depression. She is concerned due to the many medications her mom is on now. This will be re-evaluated on the next visit. Home PT/OT is ordered.

Coding for 99214 based on 2 of 3 elements

- **Number and complexity of problems:** *Moderate*
  - 1 or more chronic illness with exacerbation: osteoarthritis multiple sites, post COVID19 COPD
  - 1 undiagnosed new problem with uncertain prognosis: depression
- **Lab/imaging ordered or reviewed:** *Moderate*
  - Any combination of 3: tests, documents or independent historian:
    - Review of external notes: hospital and pulmonologist
    - Review of results of multiple imaging and tests
    - Assessment requiring an independent historian
- **Risk of Complications and/or Morbidity or Mortality of Management:** *Low*
  - OMT
  - Discussed medication but did not prescribe
  - Home physical and occupational therapy ordered

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Code	Level of MDM (Based on 2 of 3 elements of MDM)	Number & Complexity of Problems	Amount and Complexity of Data to be Reviewed and Analyzed (Must meet the requirement of at least 2 of 3 categories)	Risk of Complications and/or Morbidity or Mortality of Management
99205 99215	**High**	**High** **1** or more chronic illness with *severe* exacerbation, progression or side effect of treatment **OR** **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** **Cat 1**: **tests and documents or independent historian** **Any combination of 3 of the following:** *Review* of prior external notes from unique sources *Review* of results of each unique test *Ordering* each unique test *Assessment* requiring an independent historian(s) **OR** **Cat 2:** Independent interpretation of tests performed by another physician/qhp *not separately reported* **OR** **Cat 3:** discussion of management or test interpretation with external physician/qhp *not separately reported*	**High risk** of morbidity from additional testing or treatment *Examples*: Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery with 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

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Example of High medical decision making 99205

- 30 year old male was referred by family physician with pain and loss of motion of lumbar and sacrum aggravated by weightbearing. Recent fall on the ice has caused a radiation of pain into left leg and numbness of the foot. He notes that his bowel habits have changed and urination is more difficult. Aggravation of periodic pain and swelling in knees, ankles and wrists affecting ADLs. A scaly rash is always at the elbows and intermittently in different areas of extremities and torso since childhood. He has not had any recent imaging of his back. Referral notes from the family physician accompanied the patient.
- Medically appropriate history and physical are taken. Significant neurologic deficits in the lower extremity and pain on palpation and percussion of lumbar spine and sacrum are noted. Hallmarks of psoriasis on the skin is also noted. Old xray report from 2 years ago reveals mild inflammation of left SI joint and no significant lumbar disease. Reviewed FP referral note with acute lumbar strain. Diagnoses are: acute herniated disc with lumbar radiculopathy and neurogenic compromise, inflammation of sacroiliac joint, psoriasis with joint involvement, concern for fracture sacrum.
- Discussed with patient concern for spinal cord compression with possible need for surgery, fracture of sacrum or lumbar spine, aggravation of psoriatic arthritis. Xray of lumbar spine done in the office demonstrates compression of L4 and early fusion of SI joint left. I spoke with the neurosurgeon and they accepted admission to the hospital for emergent evaluation through the ER. I spoke with his family physician to inform them of his condition and sending him to the hospital and about the need to pursue rheumatology evaluation for psoriatic arthritis and dermatology evaluation for skin care in the future. Due to the emergent need of the patient, he was sent to the hospital from the office by ambulance.

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Coding for 99205 based on 2 of 3 elements

- **Number and complexity of problems:** *High*
  - 1 acute injury that poses a threat to bodily function: lumbar fracture, radiculitis, neurogenic compromise
- **Lab/imaging ordered or reviewed:** *Extensive* (2 out of 3 categories)
  - Any combination of 3: tests, documents:
    - Review of results of prior external imaging: lumbar xray
    - Ordered and reviewed xray lumbosacral
    - Reviewed referral note from family physician
  - Discussion of management with external physician (not reported separately)
    - Neurosurgeon
    - Family physician
- **Risk of Complications and/or Morbidity or Mortality of Management:** *High*
  - Discussion of hospitalization and possible surgery and sent to the ER from the office.

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Effective January 1, 2021 CMS definition of Time has changed

- It includes nonface-to-face work on the day of the encounter.
- Clearly defined ranges of minutes for new and established patients.
- Time is an option whether or not counseling and coordination of care predominates the visit.
- MDM-related codes are expected to be used most often,
- Time-related codes can reflect
  - longer patient encounters that are low on the MDM scale,
  - involve significant pre-visit and post-visit physician work on the date of the face-to-face encounter

Activities that may count toward time-related E/M coding on the day of the visit.

Reviewing tests and records in preparation for a patient's visit.

- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling or educating a patient, family or caregiver.
- Ordering medications, tests or procedures.
- Independently interpreting results (not separately reported)
- Communicating results to the patient, family or caregiver
- Review of medical records from and communicating with other health care professionals after a visit on the same date of service (when not separately reported).
- Documenting clinical information in the electronic or other health record including work done at home.

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Caveat

- Time allocated to a service or procedure performed and billed with a separate CPT code on the date of the face-to-face encounter is not included in the total time
- Time to provide the procedure of OMT on the same day is not counted toward the total time
- A separate procedure note for OMT is suggested to underscore that it is separate and distinct from the E/M
- Staff time on date of face-to-face encounter does not count towards total time
- Time associated with services not provided on date of face-to-face encounter does not count towards total time

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New Patient E/M Code Total Time (2021)

Code	Total time on date of face-to face encounter
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Example of Low medical decision making 99203 MDM and Total Time 99203

- 52 year old male patient presents with pain and stiffness that has progressed over time to include neck, low back and sacrum affecting weightbearing activities. Working from home during COVID 19 has contributed to lack of exercise and poor posture working at dining room table. Patient brought in xrays of the low back taken a year ago by another physician. No neurologic symptoms. **10 mins**
- Medically appropriate history and physical are taken and review of outside xray is performed. A diagnosis of lumbar disc disease, sacroiliac joint pain, neck pain, somatic dysfunction cervical, lumbar, and sacrum are made. **15 mins**
- Discussed with patient back pain causes, interpretation of xray and how disc disease is affected by posture and inactivity, and ordered an xray of the cervical spine for further evaluation. OMT is ordered to address somatic dysfunction. **10 mins**
- **Total time: 35 mins 99203**
- *Time involved in providing OMT is not counted toward total time and is billed separately*

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Example of High medical decision making 99205 and Total Time: 99204

- 30 year old male was referred by family physician with pain and loss of motion of lumbar and sacrum aggravated by weightbearing. Recent fall on the ice has caused a radiation of pain into left leg and numbness of the foot. He notes that his bowel habits have changed and urination is more difficult. Aggravation of periodic pain and swelling in knees, ankles and wrists affecting ADLs. A scaly rash is always at the elbows and intermittently in different areas of extremities and torso since childhood. He has not had any recent imaging of his back. Referral notes from the family physician accompanied the patient. **10 mins**
- Medically appropriate history and physical are taken. Significant neurologic deficits in the lower extremity and pain on palpation and percussion of lumbar spine and sacrum are noted. Hallmarks of psoriasis on the skin is also noted. Old xray report from 2 years ago reveals mild inflammation of left SI joint and no significant lumbar disease. Reviewed FP referral note with acute lumbar strain. Diagnoses are: acute herniated disc with lumbar radiculopathy and neurogenic compromise, inflammation of sacroiliac joint, psoriasis with joint involvement, concern for fracture sacrum. **20 mins**
- Discussed with patient concern for spinal cord compression with possible need for surgery, fracture of sacrum or lumbar spine, aggravation of psoriatic arthritis. Xray of lumbar spine done in the office demonstrates compression of L4 and early fusion of SI joint left. I spoke with the neurosurgeon and they accepted admission to the hospital for emergent evaluation through the ER. I spoke with his family physician to inform them of his condition and sending him to the hospital and about the need to pursue rheumatology evaluation for psoriatic arthritis and dermatology evaluation for skin care in the future. Due to the emergent need of the patient, he was sent to the hospital from the office by ambulance. **20 mins**
- **Total time: 50 mins 99204**

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Established Patient E/M Code Total Time (2021)

Code	Total time on date of face-to-face encounter
99212	99212: 10-19 minutes
99213	99213: 20-29 minutes
99214	99214: 30-39 minutes
99215	99215: 40-54 minutes

Example of and coding for Straightforward 99212 MDM and Total Time 99212

- 18 year old female patient presents with low back pain after shoveling snow. Medically appropriate history and physical are taken and a diagnosis of uncomplicated low back strain with somatic dysfunction is made. No testing or medication is needed. OMT is ordered. **10 mins**
- Documentation time: **6 mins**
- **Total time: 16 mins 99212**
- *Time involved in providing OMT is not counted toward total time and is billed separately*

Example of Moderate 99214 MDM and Total Time 99215

- 70 year old female complains of SOB after COVID 19 infection 4 weeks ago. Hospitalized for 2 weeks and staying at home with family. History is obtained from both the patient and daughter. Patient is fatigued and has had more joint and back pain with headaches on and off. No falls. Known osteoarthritis of knees, low back and neck is causing difficulty with ADLs. Daughter is concerned about depression. Patient is seeing a pulmonologist for lung care. **25 mins**
- Medically appropriate history and physical are taken. Non-face-to -face review of hospital records, pulmonologist notes and medication reconciliation are preformed. Diagnoses are: Post COVID 19 COPD, osteoarthritis of knees, lumbar spondylosis, cervical spondylosis, situational depression, somatic dysfunction head, cervical, thoracic, lumbar, ribs and lower extremities. OMT is ordered. **35 mins**
- Discussed with patient and daughter diagnoses and management options. OMT is ordered to address somatic dysfunction and support pulmonary function, continue to follow up with pulmonologist. Considered anti-depressant and daughter wished to wait to see if reducing pain with OMT will help with activity level and depression. She is concerned due to the many medications her mom is on now. This will be re-evaluated on the next visit. Home PT/OT is ordered. **10 mins**
- **Total time: 70 mins* (16 mins above 54 min max for 99215)**
- *Time involved in providing OMT is not counted toward total time and is billed separately*

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Prolonged Service code 99417

- Unique to outpatient services 99205 and 99215
  - Used as an add-on code with E/M using total time only
- Meant to capture more realistic outpatient extended times
  - Includes physician non face-to-face time on same date of face-to-face service
  - Time value is 15 mins
- May be used in multiples to report higher total time
- Prolonged direct patient contact in outpatient setting
  - Does not include physician non face-to-face time
  - 99354 first 60 mins
  - 99355 each additional 30 mins

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Prolonged Service new patient in the outpatient setting 99205

Total duration of new patient service 99205	Code(s)
Less that 75 mins	Not reported separately
75-89 mins	99205 and 99417 x 1
90-104 mins	99205 and 99417 x 2
105 mins or more	99205 and 99417 x 3 or more for each additional 15 mins

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Prolonged services established patient in the outpatient setting 99215

Total duration of established patient service 99215	Code(s)
Less than 55 mins	Not reported separately
55-69 mins	99215 and 99417 x 1
70-84 mins	99215 and 99417 x 2
85 mins or more	99215 and 99417 x 3 or more for each additional 15 mins

Example of Moderate 99214 MDM and Total Time 99215 with Prolonged services

- 70 year old female complains of SOB after COVID 19 infection 4 weeks ago. Hospitalized for 2 weeks and staying at home with family. History is obtained from both the patient and daughter. Patient is fatigued and has had more joint and back pain with headaches on and off. No falls. Known osteoarthritis of knees, low back and neck is causing difficulty with ADLs. Daughter is concerned about depression. Patient is seeing a pulmonologist for lung care. **25 mins**
- Medically appropriate history and physical are taken. Non-face-to -face review of hospital records, pulmonologist notes and medication reconciliation are preformed. Diagnoses are: Post COVID 19 COPD, osteoarthritis of knees, lumbar spondylosis, cervical spondylosis, situational depression, somatic dysfunction head, cervical, thoracic, lumbar, ribs and lower extremities. OMT is ordered. **35 mins**
- Discussed with patient and daughter diagnoses and management options. OMT is ordered to address somatic dysfunction and support pulmonary function, continue to follow up with pulmonologist. Considered anti-depressant and daughter wished to wait to see if reducing pain with OMT will help with activity level and depression. She is concerned due to the many medications her mom is on now. This will be re-evaluated on the next visit. **10 mins**
- **Total time: 70 mins* (16 mins above 54 min max for 99215) use 99215 & 99417 x 2**
- *Time involved in providing OMT is not counted toward total time and is billed separately*

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E/M and OMT on the same date of service

- Document medically appropriate history and exam and diagnosis with treatment and management plan
  - Document somatic dysfunction and choose appropriate ICD 10 codes
  - Document decision to provide OMT
- Select level of E/M using either
  - MDM or Total Time and append -25 modifier
- If a patient is scheduled for assessment or reassessment after previously receiving OMT
  - Avoid documenting patient is here for follow-up OMT
  - Avoid documenting patient is here for a treatment in a scheduled series

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Clearly document indications for OMT

- Document findings of somatic dysfunction
  - Physical findings support somatic dysfunction areas coded
  - Provide rationale for treating areas of somatic dysfunction found on physical exam and not noted in the presenting problems
  - Provide rationale for providing OMT to support system and organ function such as
    - Respiratory
    - Lymphatic
- Document OMT in the treatment plan and patient agreement to treatment
- Code appropriate OMT CPT code for areas documented and treated

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OMT procedure documentation

- Document a separate procedure note considering:
- Pre-service work
  - Explanation of procedure and answer questions
  - Verbal or written consent obtained
  - Determine type and order of technique application, order of regions treated and position patient
- Intra-service work
  - Body regions, techniques applied and adjusted as needed in response to patient feedback
- Post-service work
  - Post treatment instructions related to the OMT procedure
  - Any side effects, treatment reactions and self-care
  - Document in procedure note

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Modifier -25 appropriate use

- Modifier -25 alerts the payer that a significant, separately identifiable E/M service is provided by the same physician on the same date as a procedure
- It is appended to the E/M service
- Applies to new and established patients
- Requires documentation of appropriate diagnosis and medically necessary care to support E/M that stands alone
  - Is there a different diagnosis that supports the E/M?
  - If diagnoses the same, is the work supporting the E/M above and beyond the usual pre and post operative work associated with the OMT?

When not to report E/M and OMT on same date of service

- There is no documented medical necessity for OMT
- Based on todays E/M, a patient is scheduled to return on a different date specifically for OMT
- Preplanned OMT
  - Creating a schedule of successive treatments similar to PT

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Are commercial payers required to adopt the E/M office-visit code revisions?

- Yes.
- HIPAA requires that health plans use the most recent version of the medical data code set
  - Current CPT code set
  - Department of HHS HCPCS code set
  - ICD 10 code set

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Can an EHR's automatic coding application still be used?

- Yes.
- Confirm with your EHR vendor that their system's code-selection application conforms to the revised codes and descriptors
- Remember that the billing provider has the ultimate responsibility for appropriate coding.

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Tips

- **Be aware of medical malpractice liability**
- Physicians should still carefully document the work that is being done to protect themselves from medical malpractice suits.
- **Guard against fraud & abuse law infractions**
- The False Claims Act and other federal and state fraud and abuse laws remain in effect.
- Although the new E/M office visit coding guidelines allow greater flexibility, practices should continue to document appropriately and guard against inadvertent overbilling.

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Tips

- **Assess financial impact**
- Guard against an unanticipated financial impact by performing a prospective financial analysis.
- Review and self audit use of MDM vs Time for accuracy
- **Understand additional employer or payor or medical liability coverage requirements**
- Employers or payors may still require documentation of additional information above and beyond the new E/M office visit coding guidelines.
- Physicians should ensure that their documentation will satisfy any other obligations and requirements that they may be expected to fulfill.

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Resources

- The AMA offers free tools and resources to keep physicians current on critical updates, including:
- Step-by-step videos on using MDM criteria or total time to select a code.
- A table illustrating the MDM revisions.
- A detailed document with the E/M code and guideline changes.
- An interactive, educational module, “Office Evaluation and Management (E/M) CPT Code Revisions.”

Resources

- CMS Patients Over Paperwork Initiative
  - https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork
- See the AMA's resources on ancillary staff E/M documentation and the AMA STEPS Forward™ module on team documentation.
- Visit the AMA's E/M office visit educational website to learn more about the changes and take the module to see how the revisions will help reduce administrative burden.
- AOA Physician Services Department
  - 312 202-8194
  - physicianservices@osteopathic.org