LCMC HEALTH
2021 E/M Changes

Natalie Sartori, M.Ed., RHIA, CCS
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Natalie is the Corporate Trainer with United Audit Systems, Inc. and has over 30 years of professional experience in the healthcare industry. Natalie specializes in coding management and education. She possesses extensive experience in ICD-10-CM/PCS and CPT/HCPCS coding. She has planned and implemented numerous coding training programs in a variety of healthcare organizations and professional settings. Natalie has received professional achievement awards from AHIMA, NJHIMA and SCHIMA for her efforts in coding education. She has conducted numerous ICD-10 coding and documentation quality assessments in a variety of settings including inpatient, same day surgery, ER and physician office practices. She has worked extensively with physicians, coders, billers and executives in acute care hospitals to improve the quality of clinical documentation and ensure compliant coding.
2021 E/M Changes

Objectives:
• Provide overview of 2021 E/M changes
• Explain medically appropriate History & Physical Exam
• Review and apply updated Medical Decision Making criteria
• Examine and apply Total Time criteria
• Understand new prolonged service codes
Overview of 2021 E/M Changes
Introduction:

• Between July 2018 and July 2019, the AMA worked with CMS and convened specialty societies and other health professionals to simplify and streamline the coding and documentation for E/M office visits, making them clinically relevant, and reducing excessive administrative burden.

• This transition provides simpler and more flexible guidelines.

• The new E/M Office visit guideline changes apply to all payers.
Key Elements

• Applies to New and Established clinic/outpatient E/M codes only
• Eliminates the patient history and physical exam as elements for level selection
• Removes E/M code 99201
• Allows physicians to choose whether E/M code selection is based on medical decision-making or total time
• New shorter prolonged services code that will capture physician/Qualified Health Professional (QHP) time in 15 minute increments
What’s Different?

Effective 1/1/2021 the level of office E/M services is based on:
• The level of MDM as defined for each service; or
• The total time for E/M services performed on the date of the encounter.

Note: The requirement for history and physical exam for office visits is “medically appropriate”.
Sample documentation for FY2020 E/M level

Chief complaint: Sore throat and body aches

History of Present Illness: 34 year old female presents to clinic today with 2 day history of sore throat with body aches. Patient reports that she has not had any fever, nausea, vomiting or shortness of breath. No chest discomfort at this time. Patient also reports that she has had sick contacts at home including her child who was recently checked for sore throat and was negative for group A strep but positive for group F strep. She has had step throat in the past.

Physical Exam

• Vitals Signs: Temperature tympanic 36.8 DegC BMI 24.37
• General: Alert, no acute distress, Not ill-appearing.
• Skin: Warm, dry, pink
• Head Normocephalic
• Neck Supple trachea midline
• Cardiovascular: Regular rate and rhythm, no murmur
• Eyes: Pupils are equal round and reactive to light, normal conjunctiva
• ENT: tympanic membranes clear, oral mucosa moist mild posterior pharyngeal erythema. Uvula is midline. No sign of peritonsillar abscess.
• Respiratory Respirations are non-labored
• GI: Soft, Nontender Non distended
• Skin: warm and dry,
• Neuro: Alert and oriented to person, place, time and situation.
• Psych: Cooperative, appropriate mood and affect.
• Musculoskeletal: Normal ROM
• Back Non-tender

Sample documentation for FY2021 E/M level

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Physical Exam

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• Respiratory Respirations are non-labored
E/M Level Based on: Medical Decision Making
Table: Level of Decision Making

• Guide to assist in selecting the level of MDM
• Used for office and other outpatient E/M services only
• Includes 4 levels of MDM:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Level of MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201/99211</td>
<td>N/A</td>
</tr>
<tr>
<td>99202/99212</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203/99213</td>
<td>Low</td>
</tr>
<tr>
<td>99204/99214</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205/99215</td>
<td>High</td>
</tr>
</tbody>
</table>
MDM Defined by 3 Elements

<table>
<thead>
<tr>
<th>2020 MDM</th>
<th>2021 MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Diagnoses or Management Options</td>
<td>Number and Complexity of Problems Addressed at the Encounter</td>
</tr>
<tr>
<td>Amount and/or Complexity of data to be Reviewed</td>
<td>Amount and/or Complexity of data to be Reviewed and Analyzed</td>
</tr>
<tr>
<td>Risk of Complications and/or Morbidity or Mortality</td>
<td>Risk of Complications and/or Morbidity or Mortality of Patient Management</td>
</tr>
</tbody>
</table>

The next several slides will examine each of the 3 elements individually and provide examples of specific documentation required in the note.
<table>
<thead>
<tr>
<th>Code</th>
<th>Level</th>
<th>Number &amp; Complexity of Problems Addressed at Encounter</th>
<th>Documentation Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>No further treatment necessary for resolution (e.g. cold, insect bite, tinea corporis)</td>
</tr>
<tr>
<td>99202</td>
<td>Straight-forward</td>
<td>Minimal:</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>• 1 self limited or minor problem</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low:</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>• 2 or more self limited or minor problems; OR</td>
<td>Document chronic conditions as stable when condition is controlled and/or treatment goals are being met (e.g. controlled diabetes mellitus, stable HTN, stable COPD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 stable chronic illness; OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 acute uncomplicated illness or injury</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Moderate:</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>• 1 or more chronic illnesses with exacerbation, or side effects of treatment; or</td>
<td>Document when chronic conditions are exacerbated, poorly controlled worsening or progressing (e.g. out of control diabetes mellitus, hypertensive crisis, COPD exacerbation, CKD stage progression)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2 or more stable chronic illnesses; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 undiagnosed new problem with uncertain prognosis; or</td>
<td>Document treatment plan changes to stabilize or control chronic condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 acute illness with systemic symptoms; or</td>
<td>For undiagnosed new problems identify potential/differential diagnoses (elevated PSA, r/o BPH vs. Prostate CA, lung nodule, breast mass)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 acute complicated injury</td>
<td>Document associated systemic symptoms such as fever, body aches or fatigue</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td>High:</td>
<td>Document potential life-threatening exacerbation or disease progression necessitating immediate life-saving intervention (e.g. inpatient admission for diagnoses such as acute respiratory failure, MI/unstable angina, suspected CVA)</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>• 1 or more chronic illness with severe exacerbation, progression or side effects of treatment; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td></td>
</tr>
</tbody>
</table>
Sample documentation for FY2020 E/M level

**Diagnosis**
- ETD (eustachian tube dysfunction) H69.90
- Serous otitis media H65.90

OR
- Diabetes Mellitus E11.22
- CKD N18.9

OR
- Congestive Heart Failure I50.9

Sample documentation for FY2021 E/M level

**Diagnosis:**
- ETD (eustachian tube dysfunction), **right ear** H69.91
- **Acute** Serous otitis media, **right ear** H65.191

OR
- Diabetes Mellitus E11.22
- CKD, **stage 4 progressing to ESRD** N18.6

OR
- **Decompensated Diastolic** Heart Failure I50.33
**MDM - Element 2: Amount and/or complexity of data to be reviewed & analyzed**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>MDM Level</th>
<th>Amount and/or Complexity of Data to be Reviewed &amp; Analyzed</th>
<th>Documentation Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99202 99212</td>
<td>Straight-forward</td>
<td>Minimal or none</td>
<td></td>
</tr>
<tr>
<td>99203 99213</td>
<td>Low</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Category 1:</strong> Tests and documents - Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review of prior external note(s) from each unique source*;</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ordering of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Or</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Category 2:</strong> Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Document each individual lab test reviewed (e.g., CBC, BMP, Urinalysis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Document each individual radiological reports reviewed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Document each external medical report from physician or QHP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Document source of information for medical history other than patient (e.g., Parent guardian, spouse)</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>MDM Level</td>
<td>Amount and/or Complexity of Data to be Reviewed &amp; Analyzed</td>
<td>Documentation Tips</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>----------------------------------------------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| 99204    | Moderate  | 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) | • Document each individual lab test reviewed (e.g. CBC, BMP, Urinalysis)  
• Document each individual radiological reports reviewed  
• Document each external medical report from physician or QHP  
• Document source of information for medical history other than patient (e.g. Parent, guardian, spouse)  
• Document any independent interpretation performed (e.g. reading radiology film, performed and billed elsewhere)  
• Document phone consultation with surgeon  
• Document phone conversation with legal representation regarding competency |
| 99214    | Moderate  | 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) | |
| 99205    | High      | Extensive (Must meet the requirements of at least 2 out of 3 categories) | |
Sample documentation for FY2020 E/M level

- Patient presents for follow-up for continued monitoring of diabetes mellitus. During previous encounter, completed lab work and patient here to review at this time.

Sample documentation for FY2021 E/M level

- Patient presents for follow-up for continued monitoring of diabetes mellitus. During previous encounter, completed lab work, including BMP, Urinalysis, CBC and A1C. Patient is here to review lab findings at this time.
MDM - Element 2: Amount and/or complexity of data to be reviewed & analyzed

Straightforward
  • Minimal or None

Low (one category only)
  • Two documents or independent historian

Moderate (one category only)
  • Three items between documents and independent historian; or
  • Independent Interpretation of a test performed by other MD/QHP; or
  • Confer with external MD/QHP

High (two categories)
  • Same concepts as moderate
Decisions made at this visit, associated with the patient’s problem(s), treatment(s)

- Includes possible management options selected and those considered, but not selected
- Addresses risks associated with social determinants of health - Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>MDM Level</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
<th>Documentation Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
| 99202    | Straight-forward | Minimal risk of morbidity from additional diagnostic testing or treatment | • Document orders for lab draw specimen via venipuncture and/or clean-catch UA  
• Document orders for plain x-rays (e.g. no contrast)  
• Document orders for EKG/EEG |
| 99212    | Straight-forward | Low risk of morbidity from additional diagnostic testing or treatment  | • Document orders for radiology or other imaging using contrast  
• Document orders for lab draw via arterial puncture  
• Document orders for, or performance of, superficial or needle biopsy |
| 203      | Low       | Low risk of morbidity from additional diagnostic testing or treatment  |                    |
| 99213    | Moderate  | Moderate risk of morbidity from additional diagnostic testing or treatment | • Document any additions, deletions or change in dosage of prescription drug management  
• Document treatment option including minor surgery including patient or procedure risk factors  
• Document decision for elective major surgery without identified patient or procedure risk factors  
• Document any significant social determinants (e.g. financial hardship, homelessness, interpersonal stressors) |
| 99204    | Moderate  | High risk of morbidity from additional diagnostic testing or treatment | • Document decision for elective major surgery with identified patient or procedure risk factors  
• Document any plans for inpatient hospitalization and/or emergency major surgery  
• Document DNR discussions and decisions. |
| 99214    | Moderate  | High risk of morbidity from additional diagnostic testing or treatment |                    |
| 99215    | High      | High risk of morbidity from additional diagnostic testing or treatment  |                    |
Sample documentation for FY2020 E/M level

Pilonidal disease L98.8
Ordered:
• External Referral
• Referral Ambulatory
Orders:
• doxycycline hyclate 100 mg oral capsule, (100 mg) 1 cap(s), Oral, Daily, x 14 day(s), # 14 cap(s), 0 Refill(s), 03/24/20, Pharmacy: Walmart Pharmacy 2121, Cap
You have been referred to follow-up with a general surgeon, please call to schedule appointment at your convenience for discussion of revision of the surgical area. Gave after visit summary to the patient. Use medications as directed. Work note was granted from the ninth through the 11th. Patient indicated all questions have been answered

Sample documentation for FY2021 E/M level

Pilonidal disease L98.8
Ordered:
• External Referral
• Referral Ambulatory
Orders:
• doxycycline hyclate 100 mg oral capsule, (100 mg) 1 cap(s), Oral, Daily, x 14 day(s), # 14 cap(s), 0 Refill(s), 03/24/20, Pharmacy: Walmart Pharmacy 2121, Cap
You have been referred to follow-up with a general surgeon, please call to schedule appointment at your convenience for discussion of revision of the surgical area. Gave after visit summary to the patient. Use medications as directed. Work note was granted from the ninth through the 11th. Patient indicated all questions, including risk factors, have been answered
MDM - Element 3: Risk of complications and/or morbidity or mortality of patient management

- **Straightforward**
  - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)

- **Low**
  - Low risk (ie, very low risk of anything bad), minimal consent/discussion

- **Moderate**
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management

- **High**
  - Need to discuss end of life or other significant medical or legal issues for which physician or other qualified health care professional will watch or monitor
Medical Decision Making Table
Medical Decision Making Table

• To be used as a guide to assist in selecting the level of medical decision making for reporting an office or other outpatient E/M service code.

• Includes:
  • Four levels of medical decision making (i.e., straightforward, low, moderate, high)
  • Three elements of medical decision making (diagnosis, data, risk)
• Two of the three elements for a particular level must be met or exceeded.
# Medical Decision Making Table

## Example of Low Level MDM

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
<th>Element 1: Number and Complexity of Problems Addressed at the Encounter</th>
<th>Element 2: Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Element 3: Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straight forward</td>
<td>Minimal • 1 self-limited or minor problem</td>
<td>Low</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury</td>
<td>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)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
E/M Level Based on: Total Time
Time – Changes for 2021

2020

• When counseling and/or coordination of care dominates (over 50%) the encounter with the patient and/or family, time shall be the key or controlling factor to qualify for a particular level of E/M service

• Only face-to-face time counted.

2021

• Time may be used to select a code level in office or other outpatient services **whether or not** counseling and/or coordination of care dominates the service.

• Time may only be used for selecting the level of the **other E/M services** when counseling and/or coordination of care dominates the service. **Examples: Consultation, Inpatient**

• For coding purposes, time 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

• If the physician’s or other QHP’s time is spent in the supervision of *clinical staff* who perform the face-to-face services of the encounter, use 99211.
Time – Physician/Other QHP Activities

- Preparing to see the patient (e.g., review of tests)
- Obtaining history or reviewing external notes
- Performing a medically appropriate history and examination
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting EMR or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)
- When more than one clinician involved simultaneously, count only 1 person per minute
# Time – Code Assignment

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Typical Time</th>
<th>Time in 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 minutes</td>
<td>Deleted for 2021</td>
</tr>
<tr>
<td>99202</td>
<td>20 minutes</td>
<td>15 to 29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 minutes</td>
<td>30 to 44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 minutes</td>
<td>45 to 59 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 minutes</td>
<td>60 to 74 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>5 minutes</td>
<td>Time component removed</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>10 to 19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>20 to 29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>30 to 39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>40 to 54 minutes</td>
</tr>
</tbody>
</table>
Sample documentation for FY2020 E/M level

• 72 year old established patient seen for lack of energy and feeling weak. She has hyperlipidemia, CAD and hypertension. Prior to the appointment the notes and lab work from previous visits were reviewed.

• The patient is seen initially by NP in the exam room who documents the history of present illness and physical exam. I spoke with the patient, along with the NP. We discussed her current issues and spent 12 minutes counseling her regarding her chronic conditions and additional diagnostics and prescription management that may be needed.

• Prior to the conclusion of the visit, the following tests were ordered: stress test, CBC, Chem7, and thyroid ultrasound.

• Total time for encounter was 20 minutes with greater than 50% spent in counseling the patient.

Sample documentation for FY2021 E/M level

• 72 year old established patient seen for lack of energy and feeling weak. She has hyperlipidemia, CAD and hypertension. Prior to the appointment the NP spent 7 minutes reviewing the notes and lab work from previous visits. The patient is seen initially by NP in the exam room who spent 5 minutes updating a medically appropriate history and physical exam. Both myself and NP spent 5 minutes with the patient counseling her regarding her chronic conditions and additional diagnostics and prescription management that may be needed. After the visit the NP spent 2 minutes ordering a stress test, CBC, Chem7 and thyroid ultrasound and documented all in the EMR.

Time calculation:

• NP 7 minutes before visit reviewing documents
• NP 5 minutes update H&P with patient
• NP/MD 5 minutes with patient counseling and coordinating care
• NP 2 minutes ordering follow-up diagnostics and documenting in EMR

Total time 19 – the 5 minutes spent simultaneously with both NP & MD in exam room can only be reported by 1 provider – it is not appropriate to report the time for both.

Documentation Example

Documentation of Total Time

Documentation by a resident still requires teaching physician attestation.
Prolonged Services
Prolonged Services – New Code

New Prolonged Visit Code – 99417

- To capture each 15 minutes of physician/other QHP work beyond the time captured by the office or other outpatient service E/M code
- Used only when the office/other outpatient code is selected using time
- For use only with 99205, 99215
- **Prolonged services of less than 15 minutes should not be reported**
- Allows for face-to-face and non-face-to-face care on the date of the encounter
Summary of 2021 E/M Changes
2021 E/M Summary

• Medically appropriate patient history and exam
• E/M code 99201 is deleted
• E/M level assignment is based on Medical Decision Making or Total Time on day of encounter
• Total time ranges revised at code level
• New prolonged service code 99417 to be used in conjunction with codes 99205 and 99215
Questions?

Provider Q&A sessions with expert educator:

- Three sessions:
  - 12/15/20 at 7:30am
  - 12/16/20 at 12:30pm
  - 12/17/20 at 5:30pm
- Three sessions to be scheduled in January