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LCMC HEALTH
2021 E/M Changes –Live Q&A

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LCMC Health

Guideline Question

Question:

- Do the new E/M Guidelines apply to ER and inpatient encounters too?

Answer:

- No. The new guidelines apply only to Office and Other Outpatient Visits. The AMA has discussed plans to expand these changes to other E/M services areas but these is no definitive time frame.

Reference:

- CPT 2021 Evaluation and Management (E/M) Services Guidelines
- CPT Assistant. Volume 30 Issue 11 November 2020. P. 11

Guideline Question

Question:

- Is the E/M code assigned based on Medical Decision Making (MDM) or Total Time or both?

Answer:

- Physicians may choose whether E/M code selection is based on medical decision-making **or** total time but not both.

MDM Question

Question:

- What does assessment requiring an independent historian mean?

Answer:

- Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.
- Documentation should identify the independent historian and the information provided.

Reference:

- CPT 2021 Evaluation and Management (E/M) Services Guidelines

MDM Question

Question:

- How specific do you need to document information provided by an independent historian. For example do you need to specify the HPI, PMH, ROS, Family/Social History were provided by an independent historian.

Answer:

- No. Documentation should include the reason an independent historian is needed and who provided the history. For example: Due to the patient's (age, developmental delay, dementia etc.) the patient's history is provided or supplemented by (parent, spouse, son/daughter, guardian, caregiver etc.).

MDM Question

Question:

- In Pediatrics, H&P from the parent would always qualify as a level 3 right?

Answer:

- No not necessarily. Use of an independent historian is applicable to low (level 3), moderate (level 4) and high (level 5) levels of MDM and is only 1 element that impacts the E/M level. The E/M level will also depend on what other data is reviewed, the complexity of diagnoses and risk.

MDM Question

Question:

- Define independent interpretation of a test.

Answer:

- Independent interpretation of a test performed and billed by another physician/other qualified health care professional. For example a chest X-ray is performed and read by a hospital radiologist. During the encounter a pulmonologist reviews the film and performs his/her own interpretation of the test.

Reference:

- CPT 2021 Evaluation and Management (E/M) Services Guidelines

MDM Question

Question:

- If I review a report, such as a chest X-ray, and then perform an independent interpretation of the film can I count both when selecting my E/M level.

Answer.

- No, not normally.
- In the unusual circumstance that upon reviewing the test result and based on your clinical judgement along with the patient's medical condition that the test needs to be independently reviewed both could be counted. For example if a pulmonologist reviews a chest X-ray reported as "normal" but based on the patient's symptoms and abnormal PFTs the films require his/her interpretation it would be appropriate to count both. The documentation will be key in supporting counting both the review of the test and the reason your independent interpretation was required based on your clinical judgement.

MDM Question

Question:

- What is the definition of each unique source in the context or prior external notes review?

Answer:

- An external note is from an external physician or other QHP who is not in the same group practice or is of a different specialty or subspecialty. Each unique document from external source(s) can be counted.

Reference:

- CPT 2021 Evaluation and Management (E/M) Services Guidelines

MDM Question

Question:

- Would reading a referral from a physician requesting a referral and why be counted?
- Answer:
- Yes if it includes the clinical information needed in managing the patient and your medical decision making this can be counted. If reporting by E/M level by total time the spent on this activity can be counted.

MDM Question

Question:

- If there is an underlying condition that increases the risk of a poor outcome and/or patient management but one that is not being treated directly by you – how does this affect your MDM? For example you are treating a diabetic foot ulcer but provide education and counseling on the effect of diabetes on healing.

Answer:

- A problem is considered “addressed” when it is evaluated or treated during the encounter. In the above example the physician would use diabetes and the counseling as a elements when selecting the level of MDM.

Reference:

- CPT Assistant. Volume 30 Issue 11 November 2020. P. 5

MDM Question

Question:

- Can you clarify “acute illness with system symptoms”.

Answer:

- An illness that causes systemic symptoms and has a high risk of morbidity without treatment.
- Examples of acute illness with systemic symptoms include: pyelonephritis, pneumonitis, or colitis.

- For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for ‘self-limited or minor’ or ‘acute, uncomplicated.’

MDM Question

Question:

- Will the provider receive MDM credit for both ordering and reviewing and reviewing the same test?

Answer:

- Ordering and reviewing a test are considered component for MDM on the date of the encounter, even if ordering the test and subsequent review are performed on different days. The 2021 guidelines state that “ordering a test is included in the category of test results and the review of the test result is part of the encounter and not a subsequent encounter.”

Reference:

- CPT Assistant. Volume 30 Issue 11 November 2020. P. 5

MDM Question

Question:

- If I'm seeing a patient every 3,6 or 12 months and I have to re-review results from previous encounters, does this count in MDM? These have been previously reviewed on an earlier encounter. I may need to compare test results from multiple previous encounters. (i.e. test ordered on day 1, f/u in 6 months, additional f/u in 6 more months).

Answer:

- Yes if you are reviewing results from a previous encounter to analyze data, look for trends or identify abnormalities you may include this in your MDM or total time.

MDM Question

Question:

- We often document past workup (chronic disease patient) and this information is important in the current encounter – can these be counted?

Answer:

- Yes review of each previous report can be counted separately. If you are using time to select the E/M level the time spent reviewing these documents can be included in total time.

MDM Question

Question:

- What constitutes prescription drug management?

Answer:

- Obviously any new medications prescribed, discontinued or dosage change would represent prescription drug management. However, the medication/dosage does not need to change – assessment of the effectiveness and/or potential side effects or other patient management issues with decision to continue mediation at its current dosage is also prescription drug management. Again documentation will be important to convey you evaluated the current medication but decided not to make any changes.

MDM Question

Question:

- What about ROS? Is it even pertinent anymore?

Answer:

- It is not pertinent to selecting the level of E/M visit. However, similar to the H&P a medically appropriate ROS should be performed.

MDM Question

Question:

- What constitutes intensive monitoring for drug toxicity?

Answer:

- A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
- The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases.
- Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly.
- The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify.
- The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient.
- **Examples of monitoring that do apply include:** monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.
- **Examples of monitoring that do not qualify include:** monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.

Time Question:

Question:

- When coding based on time is it appropriate to add the time spent performing a separately reportable procedure during the same encounter to the time calculated for an E/M visit?

Answer:

- Any time spent performing a separately reportable procedure should not be added to the time spent to calculate total time for an E/M visit. The use of modifier 25 has not changed for 2021 and should continue to be used and appropriately reported.
- The answer would be the same if you were using MDM to select your E/M level.

Reference:

- CPT Assistant. Volume 30 Issue 11 November 2020. P. 6

Time Question:

Question:

- If selecting an E/M office code based on time what is the best practice for documentation – should it document only total time or should it include documentation of time for both face to face and non-face-to-face?

Answer:

- The 2021 guidelines do not provide specific documentation best practices for reporting time – just that time must be documented in the record. Recommend you check with your EHR vendor to see if they have a smart phrase or template. If not a facility/practice policy should be developed for data consistency.

Reference:

- CPT Assistant. Volume 30 Issue 11 November 2020. P. 6

Time Question:

Question:

- For an office visit that does not meet the minimum time is it sill appropriate to report the service based on time? For example an encounter with an established patient that includes a total time of 8 minutes.

Answer

- For an office visit with a time frame that is below what is identified in the code descriptors MDM should be used the select the appropriate service level.

Reference

- CPT Assistant. Volume 30 Issue 11 November 2020. P. 6

Time Question

Question:

- Is it appropriate to count prolonged services time from multiple dates to arrive at a total time for reporting prolonged services?

Answer:

- Although the prolonged services do not have to be continuous or face-to-face it must be spent only on the date of the encounter.

Reference:

- CPT Assistant. Volume 30 Issue 12 December 2020. P. 11

Time Question

Question:

- What are the typical activities that are included in total time?

Answer:

- Preparing to see the patient (e.g., review of tests on the day of the encounter))
- 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 Question

Question:

- Can time used to **prepare the MA** for the visit with the patient count towards the time of the visit? For example, discussion of needed services to be done at the time of the visit?

Answer:

- The time spent by clinical or nursing staff performing normal activities (e.g. vitals and ROS) cannot be reported in total time. However, if the MD/QHP communicates with MA or others on the health care team regarding the patient's visit – **on the date of the encounter** - this time can be included.

Reference:

- American Medical Association. CPT Changes 2021 An Insider's View. Clinical Examples 999202-99215, pages 22-25