MCA *News Bulletin…*

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Having questions about the 2021 E&M guideline changes for office visits?

Here is an assortment of FAQ's on the matter.

Question: Since history and physical exam are no longer required to level the visit, should I still document these elements?

> **Answer**: Yes. Although history and physical exam are no longer required to level the visit, they are still important components in establishing medical necessity, supporting medical decision making, and providing high-quality care. Documenting these components helps maintain continuity of care and assists other care team members.

Question: If I am leveling the visit based on total time, do I still need to document an assessment and plan (A/P)?

> **Answer**: Yes, an A/P should always be documented for each visit. The A/P may provide additional information that will allow your visit to be leveled if the time statement does not have enough information. If the A/P is not documented and the total time is ambiguous or missing, the visit may be unbillable. If you document both MDM and total time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.

Question: What does "external" mean for purposes of reviewing data as part of MDM?

> **Answer**: "External" means records, communications and/or test results from an external physician or QHP, or external facility or health care organization. An external physician or QHP is an individual who is not in the same group practice as you, or is in a different specialty or subspecialty. This is similar to the rules defining who qualifies as a "new patient."

Question: If I order an MRI at a visit on Sept. 20, and review it with the patient at a follow up visit on Sept 27, do I count the order on the 20th and the review on the 27th? I didn't bill for the MRI or the interpretation.

Answer: No, count it once, at the order. CPT says,
"Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter."
The AMA is consistent in this instruction. If you order a diagnostic test, say a CBC at a patient visit, reviewing the results a day later is part of the order. When the patient returns to the office two weeks later, you do not get credit for reviewing the CBC results that you ordered. Count the data for the test once, at the encounter when it was ordered.

Question: In a cardiology practice, what if my cardiology partner did the official echo report and billed for it, but then I see a patient and view the echo. Can I count that as an independent interpretation?

Answer: No. If your same specialty partner, in your practice, reported the professional component, do not credit an independent interpretation when you see the patient.

Question: If I order and bill for an EKG test in my office, do I count the order, the review or both?

Answer: Neither. The AMA has stated if billed separately you cannot use this in data element 2 toward selecting your level.
The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately.

Question: Does a parent count as an independent historian? If so, up to what age child?

Answer: A parent does count as an independent historian. The AMA doesn't put an age limit on the age of the child. But, the clinician must need to obtain the history because the patient is unable to provide a complete and reliable history "eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary."

Question: Can we still bill 99202-99205 and 99211-99215 based on the 1995 and 1997 guidelines for dates of service on and after January 1, 2021?

Answer: Office/outpatient visits prior to January 1, 2021 may still be billed using the 1995 or 1997 guidelines. Providers must bill office/outpatient visits provided on or AFTER January 1, 2021 using the CPT E/M code and guideline changes for 2021.

Note: Based on the CPT changes, code 99201 is no longer valid for dates of service on and after January 1, 2021.

Question: Can the independent visualization of a test be counted in the medical decision making if the physician is also billing for the test?

Answer: Per the AMA, the actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the level of E/M service when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service but is not separately reported; it is part of medical decision making.

Question: Many patients have problems that pose a threat to life or bodily function at some point in time. Is there any framework for time?

Answer: Yes. The guidelines say "in the near term." In the first element, the number and complexity of problems addressed there is "acute or chronic illness or injury that poses a threat to life or bodily function." The definition of that in the guidelines adds detail. "…that poses a threat to life or bodily function in the near term without treatment."

Question: Can we use these new definitions for other E/M services?

Answer: No. Other E/M services (outside of code set 99211-99205) defined by the key components of history, exam, and medical decision making and time will continue to use the existing 1995/1997 guidelines.

Question: If using time, do I need to list all of the activities and the time spent doing each one?

Answer: According to the AMA, list total time and describe what activities were done. For example, "I spent 40 minutes performing the exam, reviewing and counseling the patient on their conditions and treatment plan, writing prescriptions, and documenting this encounter."

Question: If reviewing records the day before the patient encounter or test results the day after, can this time be counted toward total time?

Answer: No, only time on the date of service encounter can be counted.

Question: What is an example of social determinants of health?

Answer: Homelessness, food insecurity, lack of access to clean water, unable to afford medications. These diagnosis codes start at Z55-Z65.

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf - guidelines

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf - MDM table

I hope these are helpful in answering questions you may have, of course as always please feel free to reach out to myself with any questions or concerns.

-Laura Conlan, CPC

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