Questions and Answers

Ask the Contractor
Evaluation and Management
Office or Other Outpatient Services
January 1, 2021 and after
Additional Questions from 10/14/20, 11/17/20, and 12/09/20 Teleconferences

These questions and answers apply to Evaluation and Management (E/M) Office or Other Outpatient Services codes provided January 1, 2021 and after. The procedure codes are 99201 – 99215. These questions and answers (other than the telehealth question) are not valid in 2020. These questions and answers do not apply to other procedure codes.

Question and Answer Categories

Search Tip

To find a specific word or phrase on this page, use the find tool. Use the magnifying glass in the upper left corner. Entering the key word and hitting the enter key will take you to any highlighted matches.

Category 1 – Time

Question 1 – If we document time, would any auditing just look at time? For example, if time met the 99213, but the MDM met the 99214, which would WPS GHA allow?

- Answer 1 – Choose your procedure code based on the medical record. WPS GHA will review the medical record under both the time and MDM guidelines. We will choose a code that is most advantageous to the provider.

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Question 2 – Do we have to separate time into different activities? Can we include a single reference to the total time?

- Answer 2 – Medicare would not require the physician to "stop-watch" the patient. We can accept a total time. However, the best practice is to identify the activities and the time spent. Medicare must be able to verify the time reported.

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Question 3 – Do we have to identify the different activities in the patient's medical record?

- Answer 3 – The patient's medical record must support the claim submitted to Medicare. Best practice is to identify the activities and time spent.

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Question 4 – Can the non-physician practitioner (NPP) document the physician's time during a shared/split service?

- Answer 4 – Each practitioner must document his/her own time. The medical record would show both the face-to-face and non-face-to-face time with/for that patient. We would not expect the NPP to document the physician's time.

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Question 5 – The patient contacts the office the day after the encounter to ask additional questions. Can we count this time as part of the E/M service?

- Answer 5 – No. Include only the time provided on the same calendar date as the E/M service. The pre and post work is 3 days prior or within 7 days after the encounter. If the contact occurs after the three days, determine if other procedure codes apply. An example could be a virtual check-in or electronic E/M.

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Question 6 – If we decide we will document MDM, must we also document time?

- Answer 6 – The best practice is to include both. You can then use either time or MDM to choose your level of service. Choose based on which is more advantageous to you. Should Medicare contractors review your medical record, we will evaluate based on both if in the medical record.

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Question 7 – The speaker stated there would be a new procedure code for extended time. How do we use this new code?

- Answer 7 – The new procedure code is G2212. The new extended time is for at least 15 minutes of added time spent with the patient. This is only available when you use time to choose your procedure code. The medical record would show you exceeded the time for 99205 or 99215 by at least 15 minutes. This add-on code is not valid when choosing your level of service based on the MDM. There is a contrast between Medicare guidelines and the AMA published information. The time for 99205 is 60 to 74 minutes. Medicare can allow additional time when the practitioner has spent at least 89 minutes on that patient. The time for 99215 is 40 to 54 minutes. You can use the

new code when the medical record shows at least 69 minutes. If you have more than one unit of service, you can submit on one line with multiple units. (updated 12/09/20)

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Question 8 – The new extended time procedure code, G2212, is for at least 15 minutes of additional time. This is past the 99205 (74 minutes) or the 99215 (54 minutes). Can we use this code when we provided 80 or 60 minutes of time?

- Answer 8 – No. CMS published the new procedure code G2212. The extended time procedure code requires at least 15 minutes of additional time over procedure codes 99205 or 99215. You cannot round. If less than 15 minutes, you would not submit the G2212. For example, you use time to choose code 99205. You would need at least 89 minutes of time to submit the G2212 procedure code. Time would be on the same calendar date. In order to submit the G2212 code twice, the total time would be at least 104 minutes or more. (updated 12/09/20)

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Question 9 – We are choosing a level 99205 or 99215 based on MDM. Can we use the new extended time procedure code, G2212?

- Answer 9 – No. This code (G2212) is an add-on code to 99205 or 99215 when choosing the level of service using time. (updated 12/09/20)

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Question 10 – Our doctors do the review of charts the day before the visit. Can we count this time toward the total time of the patient encounter?

- Answer 10 – No. Use only time spent on the calendar date of the patient encounter. (added 10/14/20)

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Question 11 – Previously, Medicare required more than 50% of the face-to-face time spent in counseling and/or coordination of care. Is this rule still correct?

- Answer 11 – No. Choosing your level of service based on time does not require counseling and/or coordination of care. This is for procedure codes 99202 – 99215 provided after January 1, 2021. (added 10/14/20)

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Question 12 – How do you count time when the physician and non-physician practitioner are providing a shared/split service?

- Answer 12 – You can count the time spent by each practitioner. If both practitioners were providing services during the same physical time, (10:00 – 10:15), count that time once. (added 10/14/20)

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Question 13 – We provided more than 7.5 minutes of extended care. Can we round up to use an additional unit of extended time?

- Answer 13 – No. You have to meet the exact times. For example, 99205 is 60 to 74 minutes. For Medicare, you must provide 89 minutes or more to submit the G2212. In order to submit a second unit, you would have to document at least 104 or more minutes. (updated 12/09/20)

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Question 14 – Our physicians do not always document on the date of the encounter. Does this mean they cannot use time to choose the level of service?

- Answer 14 – Choose your level of service based on the time spent on the date of the encounter. You can complete documentation on a later date. You would not count the time spent documenting on the later date to choose your level of service. (added 10/14/20)

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Question 15 – Our electronic medical record requires/records a start and stop time for the face-to-face service. How would we document the time spent on the non-face-to-face care?

- Answer 15 – Your physicians and practitioners can notate this time in the medical record. We would be unable to count non-face-to-face time without notation in the medical record. (added 10/14/20)

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Question 16 – One doctor in my practice spends approximately 25 minutes on each patient. Another physician spends 35 total minutes on each patient. How do we choose the correct code choice based on these differences?

- Answer 16 – If choosing your level of service based on time, code to the time documented. This could result in different levels of service. Medicare would evaluate the time as documented. (added 10/14/20)

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Question 17 – Medicare states you can only count the time on the date of the encounter. How does the statement "three days prior or 7 days after" apply to choosing the level of service?

- Answer 17 – This statement concerns the payment amount for the procedure code. This is separate from choosing the level of service based on time. (added 10/14/20)

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Question 18 – Can we count the time spent by an interpreter separately?

- Answer 18 – The time spent between the patient, the interpreter and the physician/NPP counts only once. This would be part of the physician/NPP time. (added 11/17/20)

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Question 19 – My practitioner sees a new patient. He/she documents 12 minutes spent on that patient on that calendar day. Can we choose a subsequent patient procedure code?

- Answer 19 –The 99202 new patient visit code requires at least 15 minutes of time. If providing a new patient service and you do not meet the time, you would code using the MDM. The 99212 subsequent patient code requires at least 10 minutes of time. If you do not have at least 10 minutes documented, you would also code using the MDM. (added 11/17/20)

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Question 20 – Do we have to meet the mid-point to bill prolonged care (7.5 minutes)?

- Answer 20 – No. You can submit the code when your time exceeds the 99205 or 99215 by more than 15 minutes. You can only use the prolonged care when using time to choose your level of service. (added 11/17/20)

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Question 21 – Do we have to document start and stop times for the prolonged service?

- Answer 21 – The current instructions in the CMS Internet-Only Manual (IOM) 100-04, Chapter 12, Section 30.6.15.D https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf indicates you must document start and stop times. CMS has not yet updated the IOM to detail the new requirements. (added 12/09/20)

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Question 22 – The CMS Physician Fee Schedule Final Rule has a section providing times. These are different from the CPT. Which time do we use?

- Answer 22 – The Final Rule lists times as part of the Relative Value Unit (RVU) development. These times are for pricing the service. Use the time listed in the descriptor of the procedure code. (added 12/09/20)

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Category 2 – Medical Decision-Making (MDM)

Question 1 – Will the medical record still require a chief complaint? Will the MDM now establish medical necessity?

- Answer 1 – The guidelines indicate you perform the history and exam as clinically appropriate. Medicare must be able to determine the medical necessity of the service. This does not have to be a distinct statement. Medicare will review the medical record looking for the medical necessity. The review will look to support the level of service chosen.

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Question 2 – Currently, a new patient service must meet three out of three sections - history, exam and MDM under the 1995 or 1997 documentation guidelines. Are the requirements the same for 99203 and 99213 for services January 1, 2021 and after?

- Answer 2 – The requirements are the same for 99203 and 99213. You must meet or exceed two of the three categories. The categories are number of problems addressed, amount and complexity of data, and risk. (updated 12/09/20)

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Question 3 – Would we submit the following scenario as a 99212 or a 99213? Patient comes in with an earache, there is no testing performed, and the physician prescribes an antibiotic.

- Answer 3 – From the data given, the correct code is 99212. You must meet or exceed the requirements for two of the three categories in the MDM table. The patient has a minimal level of Number and Complexity of Problems Addressed. The patient has no information for the Amount and Complexity of Data to be Reviewed or Analyzed. The patient has a moderate level of Risk based on the prescription. Therefore, the appropriate procedure code is a 99212. (updated 10/14/20)

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Question 4 – We use a commercially available tool to choose our level of service (Marshfield Clinic). Can we continue to use this for services January 1, 2021 and after?

- Answer 4 – There are multiple tools available to assist you in choosing procedure codes for E/M services. The choice of using a separate tool is up to you. However, choose the level of service based on time or the AMA MDM table. This is for codes 99202 – 99215 provided January 1, 2021 and after.

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Question 5 – The MDM table states you have to meet two out of the three categories. What does this mean?

- Answer 5 – To choose a level of service, you must meet or exceed two of the three categories. For example:
  - Low level of Number and Complexity of Problems addressed,
  - Low level of amount and complexity of data, and
  - Straightforward level of risk, you can choose the 99203 or 99213.
- Another example
  - Low level of Number and Complexity of Problems addressed,
  - Moderate level of Amount and Complexity of Data, and
  - High level of risk, you would have 99204 or 99214. (added 10/14/20)

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Question 6 – Our documentation using MDM shows a level 99205 or 99215. Our time supports a 99202 or 99212. What will Medicare do?

- Answer 6 - When Medicare evaluates documentation, we will evaluate based on both. We would accept your level of service when your documentation supports a level 99205 or 99215. We would not compare the time spent against the MDM. (added 10/14/20)

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Question 7 – Patient encounter is for yearly physical exam and treatment of ongoing condition. How do we carve out the two services?

- Answer 7 – When using time, document time spent in services to treat the medical condition. Carve out time spent performing the services related to the yearly exam. When using MDM, choose based on number and complexity of problems addressed for the ongoing condition. (added 10/14/20)

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Question 8 – How would the provider document a shared/split visit using MDM rather than time? Previously, the physician would simply document either history, exam, or medical decision-making.

- Answer 8 – The documentation must show both practitioners provided a portion of the E/M MDM elements. Each would document their service to the patient. (added 11/17/20)

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Question 9 – If we have more than one problem, can we increase that element to a higher level?

- Answer 9 – No. Some of the bullets under the number of problems addressed indicate “1 or more”. This would mean that additional problems in that bullet would still count for one of the bullets. Some of the bullets indicate “1”. Look to the other two elements, data and risk, to determine if a higher level of service is appropriate. (added 11/17/20)

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Question 10 – We will use the MDM to choose our level of code. Our physician reviews a lab test the day before the service. We have not counted the order/review of this lab test previously. Can we count this for today’s encounter?

- Answer 10 – If you have not previously counted the order/review of the test, you may count this for today’s encounter.

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Category 3 – Amount and Complexity of Problems Addressed

Question 1 – Another grey area for our organization is in the risk category. Can we use high risk for "psychiatric illness with potential threat to self or others"? Could we only use this when the patient is suicidal with a plan? How would we address the potential threat?

- Answer 1 – The statement in quotes above comes from the AMA definitions. This example is in the "acute or chronic illness or injury that poses a threat to life or bodily function" definition. This is under the "Number and Complexity of Problems Addressed" category of MDM. WPS GHA is unable to respond as to whether the patient would have to be "suicidal with a plan". Your specialty society would be better able to respond to this question. If WPS GHA reviews the medical record, we would be looking at all the information contained within the record.

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Question 2 – Please explain the definition of "systemic symptoms".

- Answer 2 – The term systemic is part of the moderate complexity of Number and Complexity of Problems addressed. This is in the definition of "acute Illness with systemic symptoms." The patient's acute illness could be whole body or a single system. Systemic conditions would include problems affecting the whole body. We would also include "constitutional" conditions when related to the problem addressed.

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Question 3 – Our question concerns the number and complexity of problems addressed in the MDM table. How would we categorize a personal history of cancer?

- Answer 3 – Base the decision on the reason for the encounter today. Is the patient having symptoms? Determine how those symptoms fall into the bullet points. Is the patient still within the medical protocols as having the disease? This could be a chronic stable illness.

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Question 4 – Our question concerns the number and complexity of problems addressed in the MDM table. How would we count a family history of diabetes or cancer?

- Answer 4 – Base the decision on the reason for the encounter today. The patient has a family history of a disease, but does not have any signs or symptoms. Medicare looks for the medical necessity of the service. Medicare does make payment for some preventive services. Physicians and NPPs should look to the procedure code that most accurately describes the service.

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Question 5 – Can you provide an example of diabetes with a comorbid condition?

- Answer 5 – We would not provide specific clinical examples of situations a patient may face. The patient's medical record would determine whether it meets the AMA definition of the types of problems addressed. The AMA has specific definition for the bullet points as part of the problems addressed.

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Question 6 – The patient has both a stable chronic illness and an acute uncomplicated illness or injury. Since they have both, can I move the number and complexity of problems addressed to the Moderate level?

- Answer 6 – No. Both of the descriptions above are in the low category of the Number and Complexity of Problems Addressed category. More than one description in a level would not move the level of service to a higher category. You would use all three elements (number of problems, data, and risk) to choose your level of service. You must meet or exceed two of the three elements to choose your level. (updated 11/17/20)

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Question 7 – The patient has on ongoing diagnosis, but the problem is new to the practitioner. Can we count this as "undiagnosed new problem with uncertain progress?" This is under the moderate category of Number and Complexity of Problems Addressed.

- Question 7 – No. The definition states "undiagnosed." The patient already knows the diagnoses. (updated 11/17/20)

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Question 8 – The patient has a chronic condition. The condition has not changed, but they are not at goal. How do I count this?

- Answer 8 – This would fall into the Moderate category of the number of diagnosis and management options. Chronic illness with exacerbation, progression, or side effects of treatment include a patient who is not at goal. Good documentation would include the goal and the patient's status toward that goal. (added 10/14/20)

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Question 9 – Previously, we were able to code based on sign/symptoms. This is when we did not have a differential diagnosis. Can we still use the signs/symptoms?

- Answer 9 – The documentation must ultimately support the level of code chosen. Your practitioner/coder would determine where the signs/symptoms fall for the number and complexity of problems addressed. Documentation must meet or exceed two of the three categories. (added 10/14/20)

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Question 10 – The patient has an encounter with symptoms and no diagnosis. Can we count this as undiagnosed problem? The physician does testing, but does not have a diagnosis by the end of the encounter?

- Answer 10 – You could. Utilize your documentation to determine the most appropriate bullet to which your encounter applies. (added 11/17/20)

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Category 4 – Amount and Complexity of Data to be Reviewed and Analyzed

Question 1 – I am with a specialty practice. When we see the patient today, my practitioner orders labs for two weeks before the next encounter. The practitioner reviews the results of the lab with the next encounter. How do we count this?

- Answer 1 – You can count the order. The review of the test is part of the order. You would not count the review as part of a subsequent encounter. This is part of the AMA instructions. (updated 12/09/20)

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Question 2 – My physician ordered a complete blood count, chemistry panel, and lipid test for the patient today. Can I count this as three unique tests under the amount and complexity of data?

- Answer 2 – The AMA MDM table indicates “each unique test”. Therefore, you could count each order separately to meet the requirements of Category 1 “Tests and documents”. Low level of MDM would require 2. Moderate and High levels would require 3. The definition of tests is each unique procedure code.

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Question 3 – My physician ordered a test at today’s encounter. The physician provided the results and any instructions in an e-mail. Can we count the review of those tests in today’s encounter?

- Answer 3 – The review of the test results is part of today’s encounter. The order and review of the same unique test count once. (updated 12/09/20)

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Question 4 – My physician ordered a complete blood count during today’s encounter. Can I count the order and review separately to meet the requirement of 2 for Category 1?

- Answer 4 – No. Count the order and review of the same test as one bullet for requirement 2 of Category 1. The review is part of today’s encounter not a subsequent encounter. AMA instructions state, “The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.” (updated 12/09/20)

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Question 5 – The physician reviews his/her previous notes on the day of the encounter. Does this review count toward Category 1 in the Amount and Complexity of Data section of the MDM?

- Answer 5 – Category 1 includes the review of "external notes." The AMA definition states, "External records, communications and/or test results are from an external physician, other qualified health care profession, facility or health care organization." The AMA definition of external physician or other health care professional is "An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organization provider such as a hospital, nursing facility, or home health care agency." A physician's review of his/her previous notes are not "external" notes. (updated 12/09/20)

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Question 6 – There was a question on the review of self-administered tests, particularly depression screening. Would we count this as a "unique test" when our practitioner reviews the information.

- Answer 6 – The AMA definition is "Tests are imaging, laboratory, psychometric, or physiologic data." Please evaluate the definition of "psychometric" to determine if you believe the self-administered test falls into this category. In addition, determine whether there are specific procedure codes for the review of a self-administered test. This may be the more appropriate service. (updated 11/17/20)

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Question 7 – We ordered multiple labs or x-rays. Must the diagnoses be different for the test to count as "unique"?

- Answer 7 – The diagnosis for each test must reflect why the practitioner is ordering the test. The diagnoses do not have to be different. (updated 10/14/20)

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Question 8 – The patient is a child and the parent provides the history. Do we meet the independent historian requirement?

- Answer 8 – Yes. This is part of the definition of an independent historian. (updated 11/17/20)

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Question 9 – The office staff uploaded test results ordered by an outside source into the patient's medical record. Can we count this as "review of results of each unique test"?

- Answer 9 – You can count this when the documentation shows the practitioner's review. Medicare requires documentation of the review of the test results. If no documentation, you would not use

this in choosing the level of service. Medicare would look to see documentation of the review, not just a practitioner signature on the total note. The physician can indicate his/her review by signing and dating the test results. (updated 12/09/20)

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Question 10 – Does "Discussion of Management or Test Interpretation" include other professionals in the office? An example could be a pharmacist or mental health provider. Does the patient's previous Family Medicine doctor from outside practice count?

- Answer 10 – The "Discussion of Management or Test Interpretation" is part of Amount and Complexity of Data reviewed and analyzed. This is category 3 in the moderate and high level. This is a discussion of management or test interpretation with external physician/other health care professional/appropriate source (not reported separately.) This is an individual (doctor/non-physician practitioner) not in the same group or with a different specialty. This can also include other licensed professionals practicing independently. It may also be a facility such as hospital, nursing facility, or home health care agency. A pharmacist or mental health provider could be appropriate. A physician/non-physician practitioner that has a different specialty would be appropriate. A provider with the same specialty, but in a different group could also be appropriate. The definition of "appropriate source" includes professional sources who are not health care professionals, but may be involved in the management of the patient (e.g. Lawyer, parole officer, case manager, or teacher). We sent this question to our Contractor Medical Directors and here are their responses:
  - A provider in the same group with the same specialty is not "external"
  - A provider in the same group with a different specialty can be "external"
  - Reviewing notes from a member of the same group with the same specialty is not "external"
  - Reviewing notes from a member of the same group with a different specialty is "external"
  - A review of notes is not "discussion of management or test interpretation"
  - (updated 11/17/20)

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Question 11 – We have ordered a screening test (such as A1C, cholesterol, etc.). Will Medicare count non-covered screening services as a unique test?

- Answer 11 – Tests ordered, but not covered by Medicare would still count as a unique test. (added 10/14/20)

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Question 12 – The column of amount and complexity of data mentions "(not separately reportable)". What does this mean?

- Answer 12 – The physician or NPP submitting the E/M does not submit a separate charge for the service. Examples can include billing for the lab test, global, technical or professional portion of a radiology service or submitting charges for interprofessional consultations. Do not count a service as part of the amount and complexity of data if you bill a separate code for the service performed by the same physician or a member of the same group with the same specialty. (updated 12/09/20)

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Question 13 – As an ophthalmology office, there are several tests we perform as part of the E/M service. They do not have procedure codes. Can we count these tests?

- Answer 13 – Do not count as Amount and Complexity of Data if there is no unique procedure code. This would be part of your E/M service. (updated 11/17/20)

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Question 14 – Medicare states you count the order and review as one item. How would Medicare determine we had not counted the order previously when counting the review for today's encounter?

- Answer 14 – The order and review are part of the same bullet. Medicare would expect physicians and practitioners to choose the level of services based on Medicare guidelines. We can request other dates of services to verify medical necessity and correct coding if we identify a concern. We encourage providers to determine workflow process to avoid counting the order and/or review in multiple encounters. (updated 12/09/20)

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Question 15 – Our physicians check the state's automated prescription system to verify patient is taking opioids as prescribed. Would this fall into Category 3 – discussion of management or test interpretation?

- Answer 15 – This would fall into Category 1 under the "review of external notes from each unique source". (added 10/14/20)

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Question 16 – Must the patient have the test on the same day as the order?

- Answer 16 – No, Medicare does not require the test on the same day as the order. (added 10/14/20)

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Question 17 – The physician's documentation does not include a notation of a hip x-ray. However, I have the requisition. Can I count this as a test ordered?

- Answer 17 – No. You would not count this. The physician note needs to show why he/she needs the results of the hip x-ray. (added 10/14/20)

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Question 18 – The physician provided a pelvic exam and took a culture. Can we count both the exam and the order and review of the culture as separate tests?

- Answer 18 – You can count the order and review of the culture as a single unique test. The pelvic exam is not a test. (added 12/09/20)

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Question 19 – As part of the encounter, the physician performed a breast exam due to a lump. Can we count this as a unique test?

- Answer 19 – The exam of the breast is not a test. (added 11/17/20)

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Question 20 – What documentation does Medicare need to count a review of a test?

- Answer 20 – A notation showing the physician reviewed the findings and the result of his her review. This would include a signature and date. (updated 12/09/20)

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Question 21 – The patient's cardiologists provided a letter to the primary care physician. This included information on management of the patient. Can the primary care physician count this as Category 3?

- Answer 21 - No. Category 3 is a discussion between practitioners. A letter would not satisfy this requirement. (added 11/17/20)

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Question 22 – The physician for today's encounter reviewed a test ordered by a previous physician. The physician also ordered another test for 6 months after the encounter. How do we count this?

- Answer 22 – The review of the previous testing can count for one bullet. You can count the order and review of the test performed in 6 months as a separate bullets. You would not count the review of the test in 6 months as part of a separate encounter. (updated 12/09/20)

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Question 23 – Our physician ordered a radiology test. The patient had it at our facility. Our radiologist will provide the formal interpretation. Can the physician count a Category 2 bullet for the interpretation?

- Answer 23 – No. Category 2 is for independent interpretation of testing provided by another physician/practitioner. A service provided in your group would not qualify. (added 11/17/20)

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Question 24 – Our physician ordered two tests with the same procedure code (right and left elbow x-ray). Would we count this as one unique test or two?

- Answer 24 – This would count as two. Even though the procedure code is the same, this really is two unique tests for the patient. (added 11/17/20)

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Question 25 – The patient brought in a log of their blood sugars or blood pressures. This could include information from where the patient is keeping track or a printout from a device. Can we count this as reviewing external notes from each unique source?

- Answer 25 – No. Reviewing notes from another unique source (data category 1) would be notes from another health care professional or organization. You may want to look to other procedure codes. These could include physiological testing and monitoring. Those codes may be more appropriate for that review. When choosing your level of service based on time, you can count the time spent reviewing the log. (added 11/17/20)

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Question 26 – Our physician texted or messaged another physician concerning the patient care. Would this text or message count as "discussion of management or test interpretation"?

- Answer 26 – A discussion requires an interaction between the two practitioners. Using technology to conduct that discussion is valid. In order for this to count, the interaction would have to be on the same day as the encounter. (added 11/17/20)

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Question 27 – Can we apply Category 2 – Independent interpretation of test, to a clinical lab? Would this be more suited to radiology services?

- Answer 27 – An independent interpretation of a test is for those services having a separate professional component. This could include radiology, some cardiology services, anatomical pathology, etc. This would not include clinical lab services. (added 11/17/20)

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Question 28 – Can the discussion between the resident and the teaching physician count as category 3 – "discussion of management or test interpretation"?

- Answer 28 – No. The discussion between the resident and the teaching physician is part of the teaching physician guidelines. (added 11/17/20)

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Question 29 – "Not reported separately" does this mean we cannot bill for the lab test we perform?

- Answer 29 – Correct. You can submit a charge for the lab test if you do not count the order and review as part of your MDM. If you submit a charge for the test, this would not be a data element for choosing the level of service. (updated 12/09/20)

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Question 30 – When reviewing external notes, does our physician just indicate his/her review? Do they need to provide a summary of the notes?

- Answer 30 – When incorporating external notes into the patient medical record, a notation of reviewed is sufficient. This can include a signature and date of the review. The medical record will need to show the notes reviewed. If not incorporated, then document a summary of the external notes. (updated 12/09/20)

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Question 31 – The patient needed an interpreter for the encounter. Can we count this as an independent historian?

- No. The patient is providing the history. (added 12/09/20)

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Question 32 – During today's encounter, the physician decided to request medical records from a previous physician. Can we count this as review of external notes or discussion?

- No. A decision to request the previous note is not a review of external notes nor would this be a discussion between the two practitioners. (added 12/9/20)

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Question 33 – Our practice uses a popular software product that can share information between multiple organizations when the patient provides consent. Can we consider our access and review of this information as review of external notes?

- Answer 33 – If the software allows you to access the medical record from different organizations, then you can count this as review of external notes. (added 12/09/20)

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Question 34 – During the last four encounters with the patient, I've ordered a particular diagnostic test. The patient has not yet taken the test. Can I count the order each time I order the test?

- Answer 34 – If part of your MDM you are determining you need to test and providing the order for the test, you can count the order and review of the test as one data point. (added 12/09/20)

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Question 35 – The patient provides verbal results of tests ordered by another practitioner. Can I count this as a review of unique tests?

- Answer 35 – No. A patient's verbal reporting of test results is not the same as reviewing test results. (added 12/09/20)

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Question 36 – My physician had a conversation with an external physician the day after the patient encounter. Can we include this when coding this service?

- Answer 36 – When using the MDM table, you could include this discussion as part of choosing your level of service. However, you would not be able to include this until it happens. An indication in the file of the expectation of this interaction would not suffice for documentation. You may choose not to include this as part of today's encounter, but instead submit a separate charge for an interprofessional consultation if you meet the time requirements. (added 12/09/20)

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Question 37 – My physician ordered a vaccine for the patient during today's encounter. Can we count this as prescription drug management?

- Answer 37 – This would not count as prescription drug management. (added 12/09/20)

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Question 38 – During today's encounter, the physician ordered one lab test for the patient to repeat quarterly. Can I count the order today and the review of the subsequent tests in the next encounter?

- Answer 38 – The order and review is one data point for each unique test as described by the CPT code. If during today's encounter, your physician orders four tests for performance on different dates, this is four unique tests. You would not count the review of the test result during the subsequent encounters. (added 12/09/20)

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Question 39 – The physician during today's encounter ordered a lab test. The test result came back a week later and based on the results, the physician wants the test repeated in one month. Can we count the review of the second test during the next encounter?

- Answer 39 – Yes, since the tests were not ordered at the same time, the review of the second test has not yet be included in the choice of your level of service. (added 12/09/20)

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Question 40 – We are providing testing in the office that does not have a separate procedure code. Can we count this as a test?

- Answer 40 – The AMA document states "Tests are imaging, laboratory, psychometric, or physiologic data". If your test does not fall into this category, it could be part of an exam and therefore not counted as a unique test. (added 12/09/20)

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Question 41 – We've ordered an electromyography (EMG) and a colonoscopy for the patient. Do we count this in the Data or Risk element?

- Answer 41 – Generally speaking, Medicare would consider these services as procedures rather than tests. However, the determining factors would be the reason for the order. If ordering to determine results for further medical decision-making, you can count this as a test. If you were performing the test and providing an E/M these would be part of the risk element. If you are performing, an E/M is part of a procedure and as such would need to meet an exception to the global surgical package rules to submit separately. (added 12/09/20)

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Question 42 – The physician performed a biopsy and sent the tissue sample to the pathologist. When the results come back, can we count the review of the report?

- Answer 42 – If billing for an E/M on the date of the biopsy, you would not count the subsequent review. If you did not submit an E/M, you can count the review of the pathology report as a data element. (added 12/09/20)

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Category 5 – Risk

Question 1 – The MDM table does not have examples of straightforward or low in the Risk category. Can we use examples provided in the 1995 and 1997 Documentation Guidelines (DG)?

- Answer 1 – The 1995 and 1997 DG do not apply to office or other outpatient E/M services provided January 1, 2021 and after. Documentation would need to support the level of risk as listed in the new document. Do not mix the 1995 or 1997 DG with the AMA MDM table. The AMA MDM table is for office and other outpatient services provided January 1, 2021 and after.

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Question 2 – Please explain further the "prescription drug management."

- Answer 2 – Prescription drug management is part of the moderate Risk category of an E/M service. These drugs require a prescription. An over-the-counter drug ordered at a higher dosage is not a prescription drug. Prescription drug management does not require a new drug, a new dosage, or a discontinuation of a current prescription. The medical record will show the physician work to determine the medical necessity of the prescription drugs. An encounter documented as only a prescription refill without documentation of an E/M service would not suffice. You can also count prescription medications considered but not given based on patient interaction, possible other drug interactions, etc. as prescription drug management. (updated 12/09/20)

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Question 3 – Please further explain "drug therapy requiring intensive monitoring." This is in the Risk category for the High level.

- Answer 3 – The AMA provided a definition of this example. The therapeutic agent has the potential to cause serious morbidity or death. Monitoring is not for efficacy, but for adverse effects. Monitoring is not less than quarterly. The monitoring is by lab test, a physiologic test, or imaging. Monitoring by history or exam does not qualify.

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Question 4 – Can we count Warfarin monitoring as Drug Therapy Monitoring?

- Answer 4 - Drug therapy requiring intensive monitoring for toxicity is part of the high level in the risk category. The monitoring is for an agent that has the potential to cause serious morbidity or death. The monitoring is for assessment of the adverse effects, not primarily for the efficacy. The monitoring must be at least quarterly by a specific test – lab, physiologic or imaging test. Warfarin testing that meets these guidelines could count as intensive monitoring for toxicity. (added 10/14/20)

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Question 5 – The high and moderate level of risk mention decision on various surgery scenarios. Can this decision happen with the primary care physician prior to referral to the surgeon?

- Answer 5 - Yes, the primary care physician could decide surgery is one treatment option. Part of the medical decision-making is to determine whether to refer the patient for surgery. (added 10/14/20)

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Question 6 – We discussed possible surgery, hospitalization, etc. as listed in the risk category. Can we still count this if the final decision is no to those options?

- Answer 6 – Yes, as you discussed and came to a decision on those options (added 10/14/20)

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Question 7 – The moderate and high category of risk discusses decision for surgery. This is either minor or major and with or without patient or procedure risk factors. What would we look for in the documentation?

- Answer 7 – Risk is the probability and/or consequences of the event. The nature of the event under consideration affects the assessment of the level of risk. (added 10/14/20)

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Question 8 – The physician provided a sample prescription drug to the patient. Can we count this as "prescription drug management"?

- Answer 8 – This would count as “prescription drug management”. (added 10/14/20)

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Question 9 – How will Medicare determine “minor” or “major” surgery?

- Answer 9 – Base your determination of minor or major surgery on your clinical determination for that specific patient. If Medicare reviews, we can use the CMS identification of minor or major surgery based on the global days of 0, 10, or 90 days as a starting point. We would also review any medical record data that is specific to that patient. (updated 12/09/20)

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Question 10 – How would we document “social detriments to health”?

- Answer 10 – Document the social detriments and identify how these affect the MDM for that patient. The AMA defines social detriments of health as “”Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.” (updated 12/09/20)

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Question 11 – Can we just document “risk discussed with the patient”?

- Answer 11 – The best documentation indicate the specific risks associated with that patient and that procedure.

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Question 12 – We are instructing the patient to take an over-the-counter medication. We are evaluating the possible interactions with the current prescriptions medications. Can we count this as prescription drug management?

- Answer 12 – An order for an over-the-counter drug does not count as prescription drug management. However, managing the patient’s prescription drugs in connection with adding an over-the-counter or supplement would show prescription drug management. (added 11/17/20)

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Question 13 – We ordered a lab test. We placed instructions in the patient’s chart to provide a prescription depending on the result of the test. Can we count this as prescription drug management?

- Answer 13 – Yes, this would count. Your documentation would describe the test and the actions to take depending on the result of the test. (added 11/17/20)

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Question 14 – We provided an injection into the knee. Can we count the medication injected as prescription drug management?

- Answer 14 – No. This would not count as prescription drug management. (added 12/09/20)

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Question 15 – The patient is refusing the advised treatment. Can we count this as "social detriments of health"?

- Answer 15 – The AMA definition states "Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity." The patient's non-compliance would not fall into this category. (added 12/09/20)

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Question 16 – The doctor's decision is to send the patient to the emergency room. Does this count as a "decision regarding hospitalization"?

- Answer 16 – No. If your physician were not making a decision regarding the hospitalization of the patient, this would not fall into this element. (added 12/09/20)

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Category 6 – Miscellaneous

Question 1 – Does a facility need to decide on billing either time or MDM? Can you have a mix--one patient documented based on time and the next patient documented based on MDM?

- Answer 1 – You can choose to document based on time or MDM for each encounter. You do not have to make a choice based on a practice or a patient.

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Question 2 – Can we apply the information in the new MDM table to other category of services? This will assist my hospitalist in coding the inpatient visits.

- Answer 2 – The AMA MDM table is for procedure codes 99201 – 99215. This applies for services January 1, 2021 and after. These are office or other outpatient services. This does not apply to any other category of service. Additional categories of E/M services are subject to the 1995 or 1997 DG.

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Question 3 – The presenter stated the new 2021 E/M guidelines go into effect 1/1/2021. She also stated, "They are in effect now, during the public health emergency." I would like further information and confirmation of this.

- Answer 3 – The use of time or MDM as described in the 1995 or 1997 DG is currently in place for office or other outpatient E/M procedure codes provided through telehealth. This flexibility is not available for in-person services. This flexibility is not available for any other category of service.

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Question 4 – Would the new rules apply for observation consultations?

- Answer 4 – The physician/NPP ordering the patient's observation care can submit the observation category of services. Any other physician/NPP seeing the patient while in observation submits the 99201 – 99215 currently. The changes described apply when you use procedure codes 99202 – 99215. This applies for services for January 1, 2021.

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Question 5 – What additional information can you provide concerning the add-on G-code?

- Answer 5 – CMS publication has not yet identified the specific procedure code. This code is available for additional intensity of services. A primary care or specialty can provide care for a single, serious, or complex chronic condition. The description and discussion of this code is in the 2020 Physician Fee Schedule Final Rule. You can access this file by going to the CMS Physician Fee Schedule page https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched. Scroll down to the link under **CY 2020 Physician Fee Schedule Final Rule** paragraph. Then scroll down to Related Links. In the PDF copy, this is on page 62855.

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Question 6 – We are submitting the outpatient facility charge. Do we use this new information?

- Answer 6 – If you are submitting using the 99202 – 99215, these rules apply.

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Question 7 – Can you provide further information on the procedure codes 99415 and 99416?

- Answer 7 – Use procedure codes 99415 and 99416 when your practitioner supervises prolonged clinical staff time. The 99415 is the first hour of additional time and the 99416 is each additional 30 minutes. This could be appropriate when you are submitting a 99211 for ancillary staff incident to services. This could be appropriate when submitting for a higher level of service provided by your physicians. The ancillary staff are completing additional services with that patient. (updated 10/14/20)

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Question 8 – Is this correct? We only perform history and exam when clinically appropriate. We do not use history and exam to choose a level of service.

- Answer 8 – This is correct. Use time or the MDM table to choose your level of service for procedure codes 99202 – 99215. These are the office or other outpatient E/M services. This applies to services provided January 1, 2021 and after.

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Question 9 – Our providers are reluctant to use these new guidelines. Can we continue to use the 1995 or 1997 DG for services provided after January 1, 2021?

- Answer 9 – No. You will choose your code based on time or the AMA MDM table. This applies to procedure codes 99202 – 99215. These are office or other outpatient services. Other categories of service may use the 1995 or 1997 DG.

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Question 10 – Will all payers change to these new guidelines?

- Answer 10 – Medicare does not have a response to what other payers may choose to do.

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Question 11 – Our question is about teaching physicians. This is for procedure codes 99202 – 99215 after January 1, 2021. Would we count both the resident's and the teaching physician's time to choose the level of service?

- Answer 11 – Medicare pays for the services of the teaching physician. Therefore, you would count the time spent by the teaching physician.

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Question 12 – Under the primary care exception, do we count both the teaching physician and resident's time?

- Answer 12 – Under the primary care exception, you would count both the resident and teaching physician time.

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Question 13 – Will CMS publish new guidelines?

- Answer 13 – CMS stated they would abide by the AMA published MDM and time. This was in the Physician Fee Schedule 2020 Final Rule. CMS will determine any separate publication on the Office or Other Outpatient procedure codes.

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Question 14 – Will the new coding rules apply differently for primary care versus a specialty?

- Answer 14 – The new guidelines apply to the procedure code category of Office or Other Outpatient services.

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Question 15 – Currently, we can document we reviewed previous history or exam documentation in the patient's medical record. Will we be able to do that for office or other outpatient services provided in 2021?

- Answer 15 – CMS allows a review of the history and exam in the patient's medical records. This applies to all categories of E/M services. The physician/NPP can identify what he/she reviewed and any updates. For office or other outpatient services, the practitioner only needs to perform the history and exam when clinically appropriate. If so, then they can review and indicate their review of information contained in the medical record. Any history and exam performed does not go into choosing the level of care.

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Question 16 – The AMA document implies staff providing incident to services can use a higher level of care. This would include nursing, ancillary staff, pharmacists, etc. Is this an accurate statement?

- Answer 16 – Physician and NPPs can submit the full range of codes. Clinical, ancillary, pharmacists, etc., can only submit the 99211 level of service. The services must also meet the incident to requirements. This applies to your Medicare patients. Incident to guidelines are not changing. This is in the CMS Internet-Only Manual Publication 100-02, Medicare Benefits Policy Manual, Chapter 15, Section 60 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf (updated 11/17/20)

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Question 17 – We believe the nature of the presenting problem deserves a higher level of service than the time or the MDM table would indicate. Can we submit the higher level of service?

- Answer 17 – Code your level of service based on time or the MDM table. The nature of the presenting problem does not now and will not choose the level of service. (added 10/14/20)

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Question 18 – How do we submit for the 99358? Do we connect this to the office or other outpatient codes in 2021?

- Answer 18 – You cannot use the 99358 and 99359 in connection with an office E/M codes starting in 2021. The code will still be available. It will need to connect to another professional service. (updated 11/17/20)

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Question 19 – We are a facility. Do we have to follow the new guidelines when billing our facility charges to Medicare for outpatient clinic visits?

- Answer 19 – When submitting charges using the 99202 – 99215 procedure codes, you must follow the new guidelines for services January 1, 2021 and after. If you submit charges using the G0463 outpatient visit, follow the guidelines for that procedure code. (updated 11/17/20)

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Question 20 - There are services that require a moderate or high MDM. An example is the transitional care management (TCM). Will we use the description from the 1995 or 1997 DG or the new AMA MDM table?

- Answer 20 - If other procedure codes require a moderate of high MDM, use the new AMA MDM table. (For services that reference office or other outpatient services.) (added 10/14/20)

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Question 21 – The 1995 or 1997 Documentation Guidelines required us to meet three out of three elements for a new patient. This is history, exam, and medical decision-making. Under the new MDM table, do we have to meet three out of three for a new patient?

- Answer 21 – The MDM requirements are the same for both a new and established patient. You have to meet or exceed two out of three categories. (updated 11/17/20)

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Question 22 – We provided 90 minutes of non-face-to-face care on a day other than the encounter. How can we submit charges for this care?

- Answer 22 – The 2020 Physician Fee Schedule Final Rule states that code 99358 and 99359 can no longer connect to an office or other outpatient service. Look at the possibility of other services. This could include an electronic visit if the service is through your patient portal, telephone calls during the PHE, virtual check-ins, etc. (updated 11/17/20)

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Question 23 – The patient's diagnosis would indicate the service should be a high-level procedure code. However, the time spent or the MDM table would lead to a lower level code. Can we choose the level of service based on the diagnosis?

- Answer 23 – You would not choose your level of services based on the diagnosis. Choose your level of service based on the care provided during the encounter. This is also the current rule. Your patient may have a very devastating diagnosis. However, choose your level of service on what you provided to the patient today. (added 10/14/20)

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Question 24 – We are confused on new versus established patient and "undiagnosed" problem. If the patient has never seen the physician before aren't they a new patient? If the physician has never treated the problem before, isn't it a new problem?

- Answer 24 – This question combines two rules of Medicare. A patient is a new patient when that provider or a member of the same group with the same specialty has not provided professional services within the previous three years. You can submit the 99202 – 99205. When the patient has

the diagnosis, this is not an "undiagnosed problem" in the Number of Problems addressed portion of the MDM table. (added 10/14/20)

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Question 25 – Can the facilities submit the 99415 and 99416 procedure codes along with the G0463?

- Answer 25 – No. The 99415 and 99415 is for prolonged supervision of ancillary staff under the incident to requirements. This is a professional service. (added 10/14/20)

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Question 26 – What documentation would Medicare expect to see for the 99415 and 99416?

- Answer 26 - Medicare needs documentation of the services provided by the ancillary staff. We would need the amount of time spent by the billing practitioner in supervising those services. (added 10/14/20)

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Question 27 – The 99XXX is for extended time when choosing your level of service based on time. We choose the level of service based on MDM. Can we use the 99354/99355 codes to report additional time?

- Answer 27 – No. When choosing your level of service based on MDM, you would not submit additional time codes. (updated 11/17/20)

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Question 28 – My provider performs consults for patients in observation care. We use the 99201 through 99215 since Medicare does not pay for consultations. Do these new rules apply to us?

- Answer 28 – Yes, anytime you submit the 99202 – 99215, the new rules apply.

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Question 29 – There is no separate CPT to reflect our procedure. How do we capture the work?

- Answer 29 – Choose a level of service based on either the time or the MDM table. (added 11/17/20)

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Question 30 – We provide both E/M and psychotherapy during the same encounter. How would we use time in choosing the level of both codes?

- Answer 30 – When providing both services, choose your codes based on what you provide to the patient. Documentation must show the separation between the E/M and the time spent on the psychotherapy. You can only choose your level of E/M based on the MDM table. (updated 12/09/20)

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Question 31 – We provided a procedure on the same date as the E/M. Do we have to choose our level of service based only on MDM? Can we use time?

- Answer 31 – E/M services and surgery on the same date are subject to the global surgery guidelines. If the E/M is separately payable, you can use time or MDM to choose your level. If using time, carve out the time spent performing the procedure. Follow the global surgery guidelines to determine if you should append a modifier to the E/M. (added 11/17/20)

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Question 32 – The patient presents with what appears to be a self-limited or minor problem. We order lab tests. We receive the results a week later. The results show an acute illness that poses a threat to life. Can we go back and amend our documentation to increase our level of service?

- Answer 32 – No. The test results would not alter the service previously provided to the patient. (added 11/17/20)

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Question 33 – Our physician provides a non-covered yearly exam or an initial preventive physical exam (IPPE) or annual wellness visit (AWV) at the same time as treatment for a chronic condition. How do the new changes for 2021 affect the billing?

- Answer 33 – Your documentation is crucial when performing both covered and non-covered services at the same time. To submit a charge for the IPPE or AWV, documentation will need to support those services. Documentation will need to support separate billing for treatment of a chronic condition. If billing based on time, show the total time and then the time spent specifically on the chronic condition. If billing based on MDM, documentation will have to support the level of code based on the MDM table. (added 11/17/20)

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Question 34 – The reason for the patient encounter was extreme fatigue. After my assessment, I referred the patient to the local cardiology group. How would I count the referral to the cardiology group when using MDM to choose my level of service?

- Answer 34 – The AMA MDM table does not address a referral to another practice. You would choose your level of service based on what you are doing for the patient. The number and complexity of problems is what you are addressing. Any data would be what you have ordered or reviewed for the patient. The risk would be the risk defined by what you determine and decide for your patient. When choosing a level of service, you must meet 2 out of the 3 categories for the level of service. You can also choose your level of service based on the time spent on that patient on that calendar date. (added 12/09/20)

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Question 35 – We provide a shared/split service between the non-physician practitioner and the MD/DO. Can the physician review, verify, and sign the non-physician practitioner notes to qualify?

- Answer 35 – In order to submit a shared/split visit, both parties must provide a portion of the service and both would document the service provided. (added 12/09/20)

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Question 36 – Can I use these new guidelines for other categories of E/M services?

- Answer 36 – Other categories such as inpatient or skilled nursing facility, etc. would follow the 1995 or 1997 Documentation Guidelines. Other categories such as emergency department or critical care would follow Medicare guidelines. (added 12/09/20)

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Question 37 – Can a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) use the new guidelines on non-face-to-face time when choosing the level of service?

- We do not have a response for this question at this time. We do not find any CMS publication or instruction on whether the RHC or FQHC can use non-face-to-face time to choose their level of service (added 12/09/20)

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Question 38 – Is there a frequency limitation to the new add-on code G2211 to show the visit complexity inherent to the E/M as the focal point of continuing care?

- Answer 38 – **Congress has DELAYED implementation of this code until January 1, 2024.** CMS has not published any type of frequency limitation. You can submit this service for both new and established patients. (added 12/09/20)

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Question 39 – When it is appropriate to submit the G2211 procedure code?

- Answer 39 – **Congress has DELAYED implementation of this code until January 1, 2024.** This is an add-on code to your E/M service. This code is for those patients with a single, serious condition of a complex condition when the practitioner is the focal point for needed health or medical services part of ongoing care. (added 12/09/20)

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