namas national alliance of medical auditing specialists

Overview of 2023 AMA Documentation Guidelines

Shannon O. DeConda

CPC, CPMA, CEMA, CEMC, CRTT

President NAMAS

Partner DoctorsManagement

DOCTORS MANAGEMENT
Leave the business of medicine to us

Disclaimer

- ✓ Only the LIVE broadcast is pre-approved for 1 AAPC CEU. A recording of the training will be available on our website, unfortunately, the CEU is not approved for the on-demand option
- ✓ The handout is available in your GoTo controller
- ✓ Due to our audience size today, our event has been scheduled as a webcast which, unfortunately does not have the Q&A
- ✓ The content of this webinar is valid as of the date of the live broadcast
- ✓ This webinar has been created for a live FREE broadcast via NAMAS. Recording or rebroadcast of this event is prohibited without the expressed written consent of NAMAS
- ✓ It is important to note that further CPT Editorial Panel (Panel) or Executive Committee actions may affect CPT codes and/or descriptors. For this reason, code numbers and/or descriptor language in the CPT code set may differ at the time of publication

Shannon O. DeConda

CPC, CPMA, CEMA, CEMC, CRTT

Auditor, Coder, Consultant, Trainer, National Speaker

Partner, DoctorsManagement

President, National Alliance of Medical Auditing Specialist

Always worked in healthcare

Trained as a Respiratory Therapist and practiced for 8 years

Onboarded with DM 19 years ago | Partner 13 years ago

Founded NAMAS 17 years ago

Established the CPMA & CEMA credential

Currently reside in Merritt Island, Florida

Married with 3 kids (25, 24, and 23) 3 dogs (Goose, Noodle, and Flo), and 1 cat (Maxx)

namas national alliance of medical auditing specialists

DOCTORS MANAGEMENT

Leave the business of medicine to us

Make sure your TEAM is 2023 READY!

Effective CUSTOMIZED Training

NAMAS is Meeting Your Needs: Remote or Onsite Training | Audits & Coding Validation | Bootcamps & Workshops | Memberships for the Team

For information and pricing email us at **namas@namas.co**

Session Expectations: Today's Audience

- Over 2,000 attendees
- Provider-based service professionals
- Insurance Carrier Professionals
- Dynamically we all make up an audience that includes:
  - Providers and clinical team members
  - Practice Managers
  - Auditors and Coders
  - Compliance professionals
  - Health Law Attorneys
  - Others…
- A truly diverse audience in one webinar training event

Session Flow & Expectations:

- There are 2023 updates that pertain to ALL places and types of services
- Then there are specifications that must be divided into 4 service line types
  - Office | Clinic
  - Inpatient
  - Emergency Department
  - Nursing Facility | Home | Other
- As we move through the training, each concept will be addressed as the general principle and then addressed across the 4 service line areas

Definitions | Abbreviations

- Providers - This term references physicians, nurse practitioners, and physician assistants for purposes of today's training. Those recognized by CMS in the category as non-physician providers and/or qualified health care professionals.
- 2021 DG: 2021 Documentation Guidelines - The new set of documentation guidelines released for implementation 1-1-2021, revised in March 2021, and again for future implementation 1-1-2023

Universal Updates

It is important to understand what changes have a universal impact regardless of place or type of E&M service

Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Inpatient Hospital Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s).

There are two sets of guidelines: one for office or other outpatient services and another for the remaining E/M services. There are sections that are common to both (ie, Guidelines in Common). These guidelines are presented as Guidelines Common to all E/M Services, Guidelines for E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home) and Guidelines for Office or Other Outpatient Services.

The main differences between the two sets of guidelines is that the office or other outpatient services use medical decision making (MDM) ***or*** time as the basis for selecting a code level, whereas the other E/M codes use history, examination, ***and*** MDM and only use time when counseling and/or coordination of care dominates the service. The definitions of time are different for different categories of services.

Summary of Guideline Differences

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use key components (history, examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use key components (history, examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service. *Time is **not** a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

Start at the Beginning

E/M Guidelines Overview: The Revision

►The E/M guidelines have sections that are common to all E/M categories and sections that are category specific.

Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory.

Where these are indicated, e.g., “Hospital Inpatient and Observation Care,” special instructions are presented before the listing of the specific E/M services codes.

It is important to review the instructions for each category or subcategory.

These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service.

These guidelines do not establish documentation requirements or standards of care.

The main purpose of documentation is to support care of the patient by current and future health care team(s).

These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver.

For 99211 and 99281, the face-to-face services may be performed by clinical staff.

****more to come on this later in the presentation with MDM***

Classification of Evaluation and Management (E/M) Services

►The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs.

> ***For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code***.◄

Episode of Care Revisions

New and Established Patients

►Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.◄

Patient Categories Applicable:

- 99242 – 99245: **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination, and MDM or TIME as the Key component
- 99252 – 99255: **Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination, and MDM or TIME as the Key component
- 99341 – 99350: **Home or residence visit** for a new or established patient, which requires a medically appropriate history and/or examination, and MDM or TIME as the Key component

Initial Services

►Some categories apply to both new and established patients (eg, hospital inpatient or observation care).

These categories differentiate services by whether the service is the initial service or a subsequent service.

For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.

An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

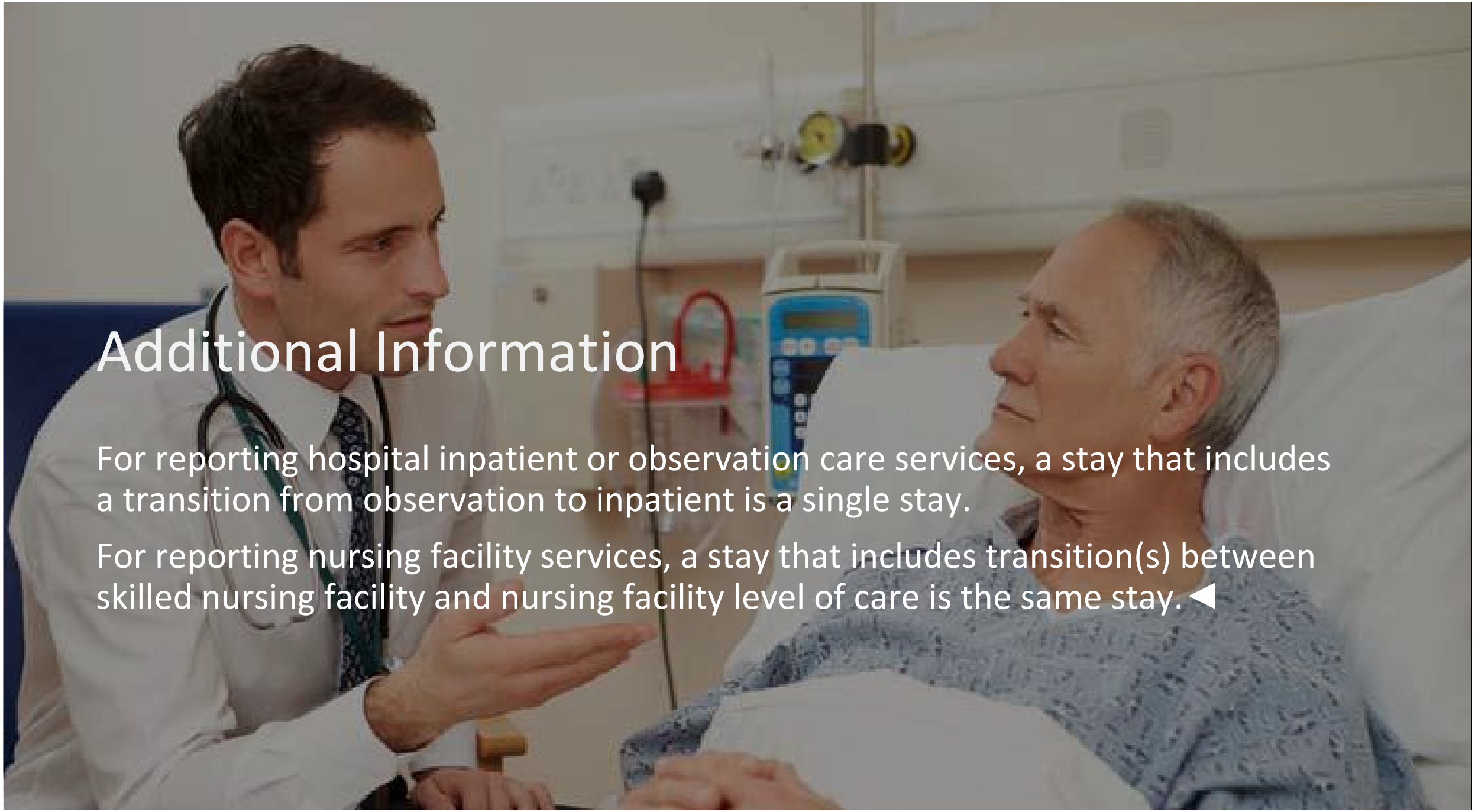
Subsequent Services

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

Additional Information

When a physician or other qualified health care professional is on call for or covering for another, the patient's encounter will be classified as it would have been by the **ORIGINAL PROVIDER** who is not available.

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.



Additional Information

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay.

For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.◄

Patient Categories Applicable:

99221 – 99233: **Initial – or – Subsequent hospital inpatient or observation care**, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and MDM or TIME as the Key component

99304 – 99309: **Initial – or – Subsequent nursing facility care**, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and MDM or TIME as the Key component

Emergency Services

No additional of varying guidance here as patients seen in the ED are not:

- New or Initial
- Initial or subsequent
- And, the rule regarding covering providers would not be applicable

Services Reported Separately

►The ordering and 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 the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service.

Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code.

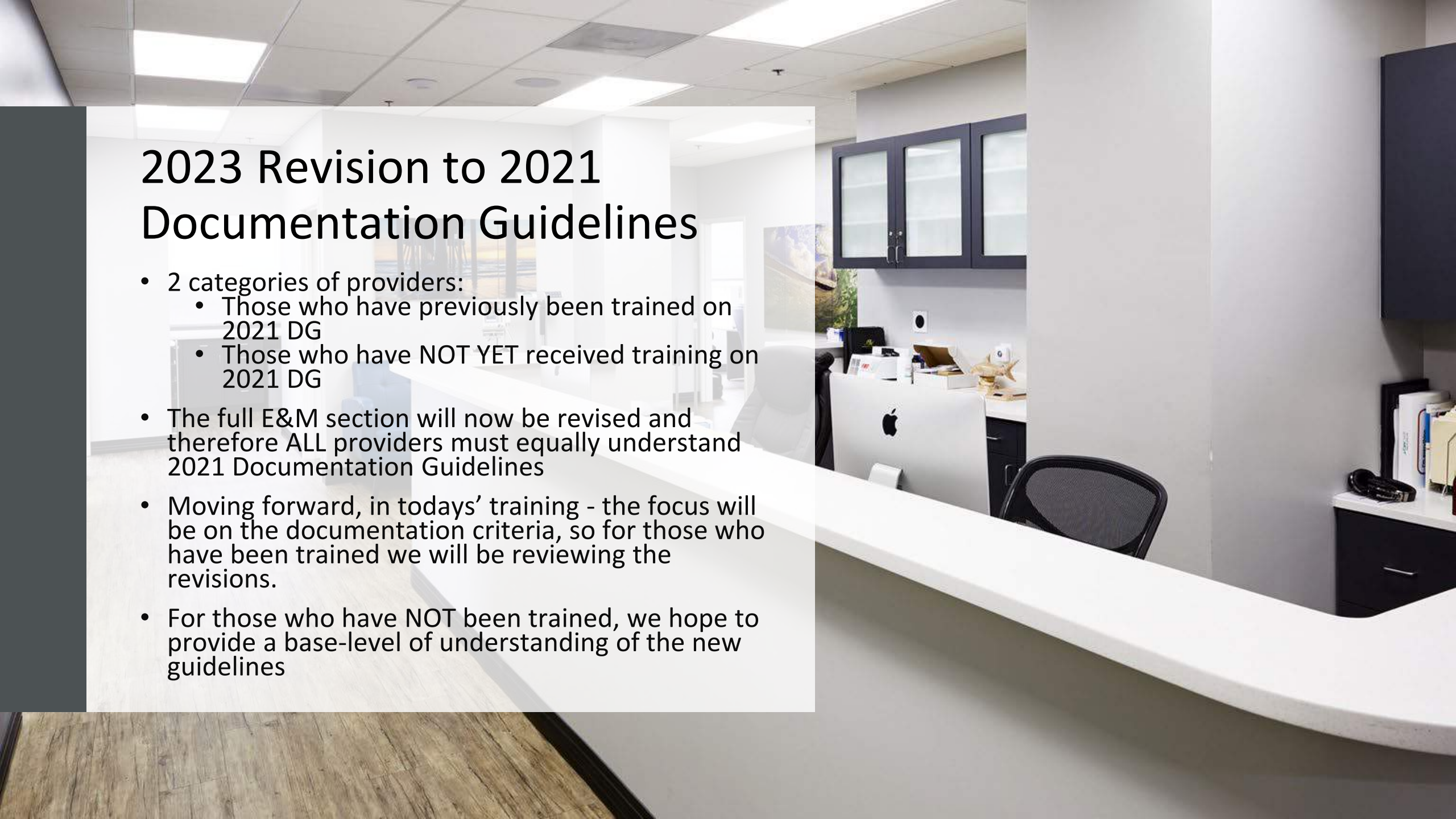
The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.◄

Services Reported Separately

- Wording Deleted: *If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but it not separately reported, it is part of MDM.*
  - By deleting, does this infer that AMA no longer allows this?
  - By deleting, does this merely mean, this guidance was not placed well in the guidelines?
  - Should we just not read it into it, but understand it's all the same allowed, and now let's discuss why?

2023 Revision to 2021 Documentation Guidelines

- 2 categories of providers:
  - Those who have previously been trained on 2021 DG
  - Those who have NOT YET received training on 2021 DG
- The full E&M section will now be revised and therefore ALL providers must equally understand 2021 Documentation Guidelines
- Moving forward, in todays' training - the focus will be on the documentation criteria, so for those who have been trained we will be reviewing the revisions.
- For those who have NOT been trained, we hope to provide a base-level of understanding of the new guidelines



History and/or Examination

►E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed.

The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service.

The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.

The extent of history and physical examination is not an element in selection of the level of these E/M service codes.◄

Implication of removing history | exam…

- Regardless of your specialty, the previous slide impacts you as moving forward that directive on history and exam applies to all places and types of E&M services
- Therefore, all details on history of present illness, review of systems, past family social history, leveling history, and references to bullets vs. organ systems on exam have been deleted

What is History under 2021 DG?

History is the interview with the patient

The ONLY requirement now is to communicate what is pertinent, relevant, and communicates the complexity (or lack of complexity) of the encounter today.

Description of the patient's problem.

Revision To: Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, or

2. The total time for E/M services performed on the date of the encounter.

►Within each category or subcategory of E/M service based on MDM or time, there are **three to five levels of E/M services** available for reporting purposes.

Levels of E/M services are **not interchangeable** among the different categories or subcategories of service.

For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

Each level of E/M services may be used by all **physicians or other qualified health care professionals**.◄

Guidelines for Selecting Level of Service Based on Medical Decision Making

- ►Four types of MDM are recognized:
- straightforward
- low
- moderate
- high

- The concept of the level of MDM does not apply to 99211, 99281.
- MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements.

Medical Decision Making

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to Be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward 99202: 15 - 29 | 99212: 10 - 19	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low OR Time: 99203: 30 - 44 99213: 20 - 29	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	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)*	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate OR Time: 99204: 45 - 59 99214: 30 - 39	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate *(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)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High OR Time: 99205: 60 - 74 99215: 40 - 54	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive *(Must meet the requirements of at least 2 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)	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor

Number and Complexity of Problems Addressed at the Encounter

►One element used in selecting the level of service is the number and complexity of the problems that are addressed at the encounter.

Multiple new or established conditions may be addressed at the same time and may affect MDM.

Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

Number and Complexity of Problems Addressed at the Encounter

The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.

Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid.

The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.◄

Defining the Problem Addressed

►Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.

This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

Focus on the Column One

Number and Complexity of Problems Addressed
N/A
Minimal • 1 self-limited or minor problem
Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury
Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury
High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function

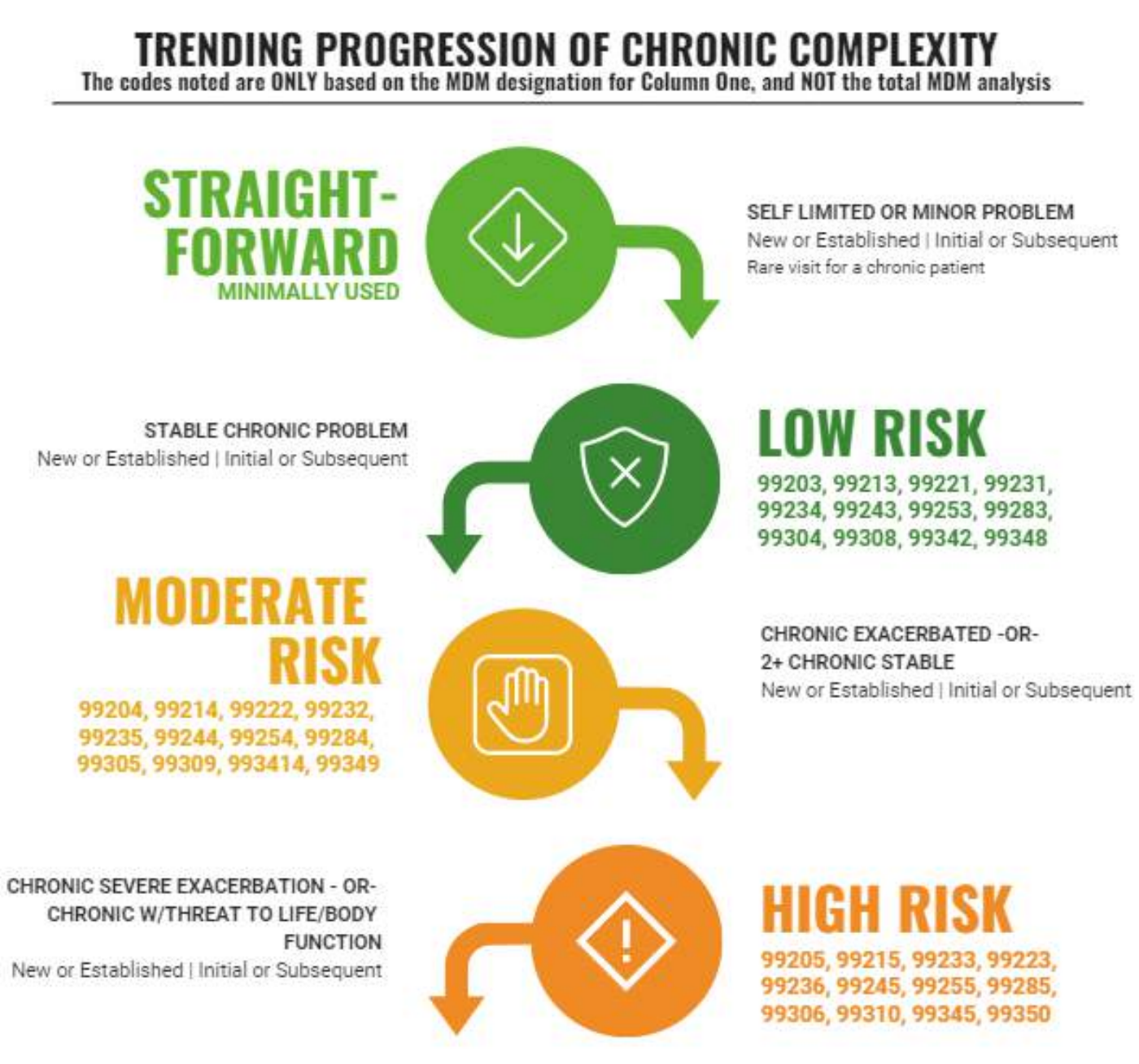
Number and Complexity of Problems Addressed at the Encounter

- Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281). ◄
- Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Number and Complexity of Problems Addressed at the Encounter

- Within this column, the problems are categorized:
  - Acute
  - Chronic
  - Undiagnosed
- These categories apply to all types and places of services

Chronic Problems



Low Complexity Level

►Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient.

For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition).

"Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient.

A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. ***For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic.***

The risk of morbidity without treatment is significant.

Moderate Complexity Level

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

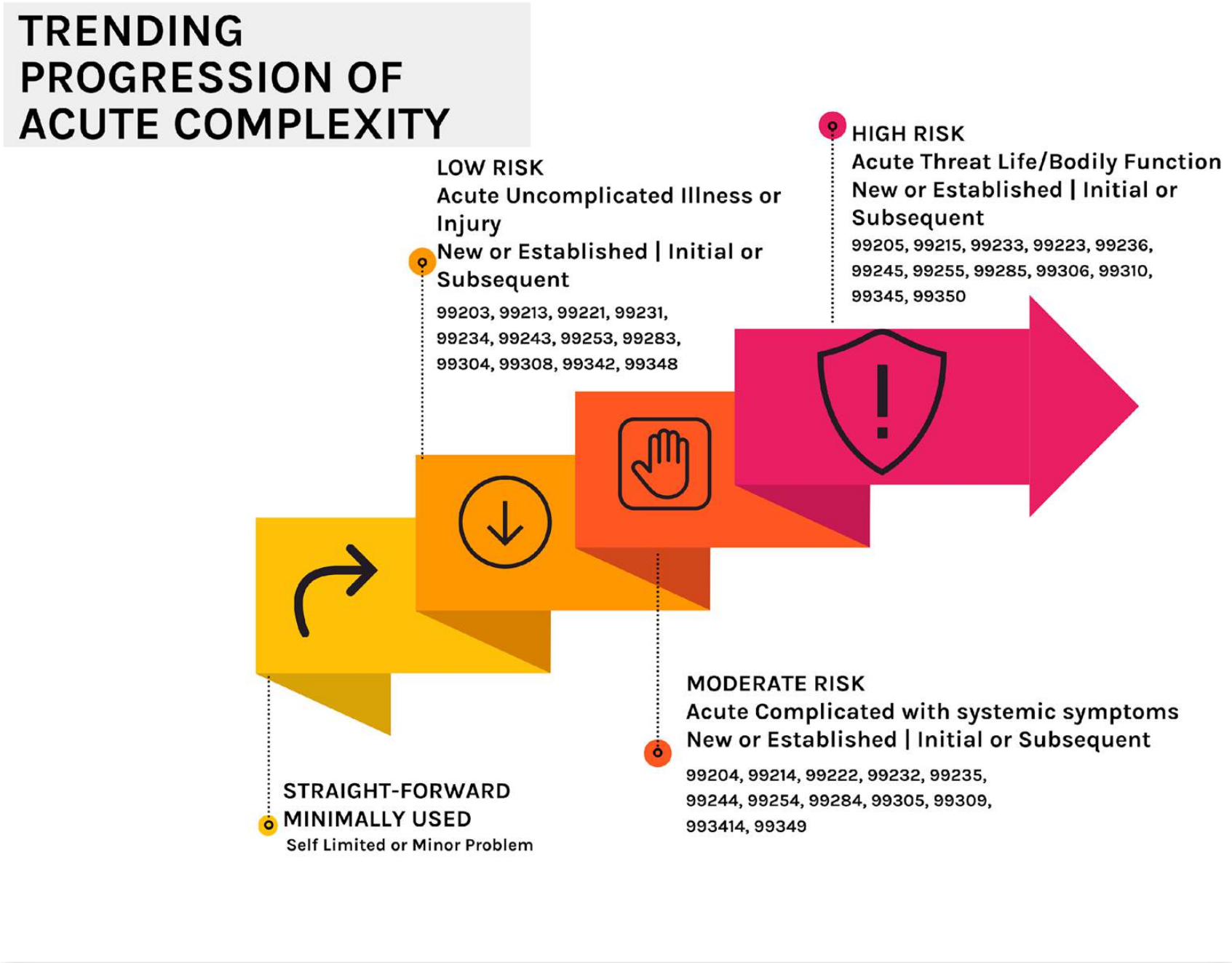
Revision: Deletion of the phrase- ***but that does not require consideration of hospital level care.***

High Complexity Level

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Revision: Deletion of the phrase- ***and may require hospital level care.***

Acute Problems



Low Level Complexity

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. ***Revision: Examples removed***

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Moderate Level Complexity

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system.

Revision: Examples deleted

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Revision: Examples deleted

High Level Complexity

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and ***may require escalation in level of care***.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. ***Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity***.◄

Column 2 of the MDM

Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*
N/A
Minimal or none

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)

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)

Extensive
(Must meet the requirements of at least 2 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)

Complications Created by Column 2

Column 1 & Column 3 have NO SCORING. Rather, a review of the column for the highest level of complexity is made.

In contrast, Column 2 REQUIRES scoring. Therefore, this column contains 3 different “Categories” each of which are comprised of work components

Each record is reviewed, and the work components are “tallied” within this column to finalize the overall complexity of Column 2

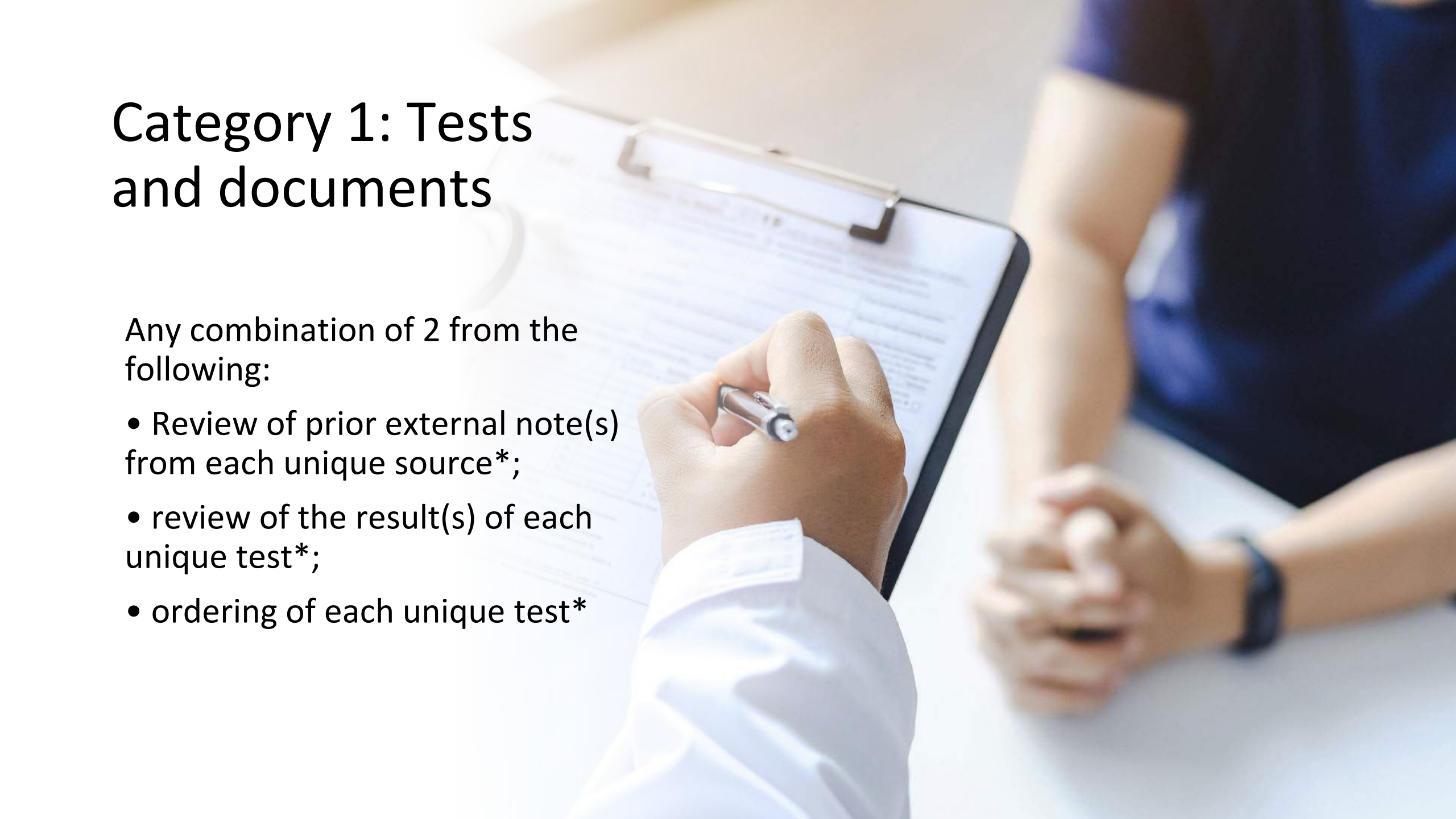
Complications Created by Column 2

- Additionally, there are some billing nuances that must be considered to properly reconcile Column 2 as well
  - 2021 DG wants to ensure that order and/or review is not performed for financial gain
  - 2021 DG want to ensure that order and/or review is not performed to artificially inflate the E&M service
  - Therefore, when we analyze the medical record, there must be an understanding of financial impact

Category 1: Tests and documents

- According to the AMA 2021 Documentation Guidelines this category is labeled as Test and Documents. More appropriately it could probably be labeled as work commonly performed in an encounter.
- What we find in this category includes: review of notes, ordering and reviewing of tests, and assessment requiring an independent historian (although this is sometimes credited Category 2 as we will discuss later).
- Common occurrences during the average encounter
- But of course, it’s not just that simple

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*

Review of prior external note(s) from each unique source

- It seems this will be a very straightforward review within the documentation. However, it becomes quite complex when you understand the complexities within the 2021 AMA Guidelines.
- External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.
- Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.
    - Example: Dr. Cardiologist is seeing Dan Murphy for uncontrolled HTN. Dr. Cardiologist reviews a previous admission with 46 pages that includes admission notes, labs, EKGs, ECHO, and stress test results.
    - In this example, the provider would receive credit for this ONE component of work within Category One, of Column Two.

Review of the result(s) of each unique test and/or Order of each unique test

- 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.
- Ordering a test may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required.
- Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented.

Review of the result(s) of each unique test and/or Order of each unique test

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Review of the result(s) of each unique test and/or Order of each unique test

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported.

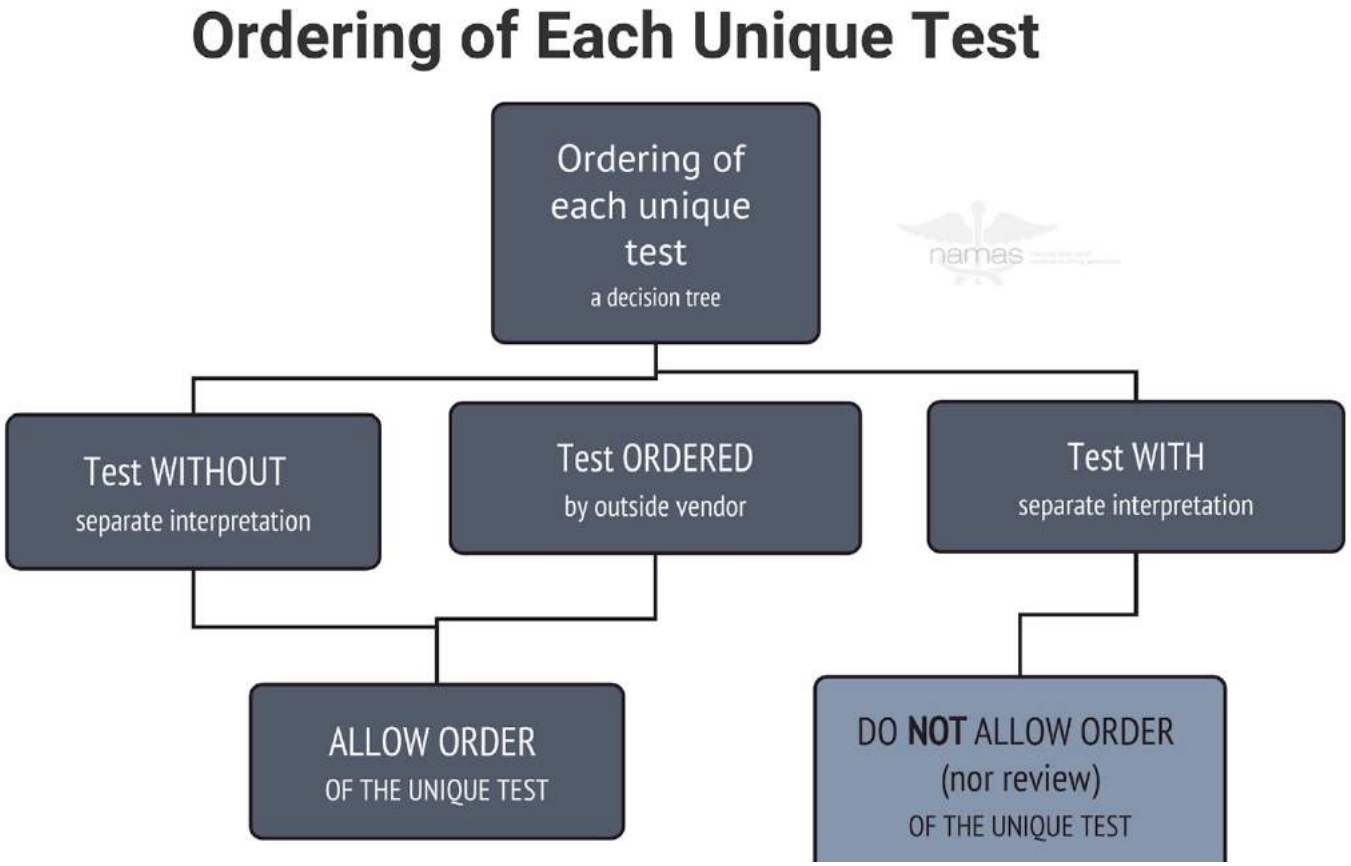
Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed.

For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.

Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Here is decision chart to visually make this process a bit easier:

Even though the chart does make it easier, at times organizational structure can make these decisions more complex. This always becomes complex within the sphere of health systems. The specifications around order/review were put into place by AMA in order to ensure that the organization who is ordering and performing is not profiting to prevent erroneous “gaming” of the system. But as stated- there are complex pitfalls, at no fault of the health system.



Let’s consider an example:

Health System: Sweetwater Health system

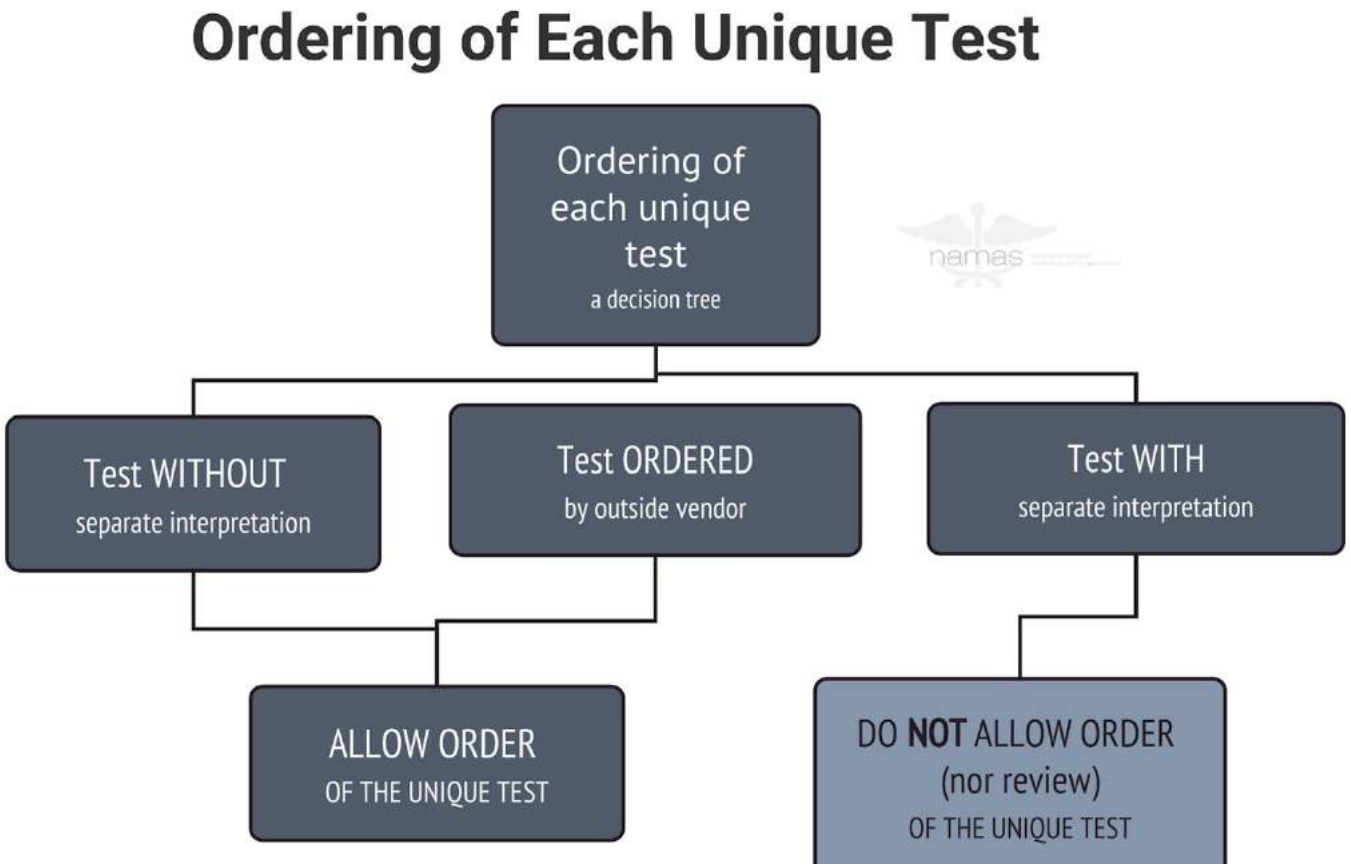
Radiology Department: Part of the Facility

Physician Group: Part of a separate Tax ID, Physician Associates of Sweetwater Health system

Dr. Spine sees Mark and decides that advanced imaging is required in order to make the best decision on a treatment plan. The patient will be having the imaging studies performed in the radiology department at Sweetwater Health system.

Is the health system in this scenario considered an “outside vendor”?

What is the outcome?



Assessment Requiring an Independent Historian

- The values that we score in MDM are always assessing the workload and/or risks associated with the patient encounter. When we consider the involvement of the independent historian, this area is no different, as it both creates more work and also has the potential of increasing risk.

- Independent historians are used when the patient cannot be relied upon to provide a complete or reliable history. Within 2021 DG we are provided with examples of illness/injury that could be the cause and other criteria, but what an auditor is looking for in the medical record to qualify the use of an independent historian is what information did they provide and did it have relevance to the encounter.

- This information is validated by the documentation of course, and therefore if these findings cannot be abstracted from the documentation, then credit cannot be provided for this component.

Assessment Requiring an Independent Historian

At the low level of complexity, this component of work is “rated” as Category 2, but once we move to Moderate and High it shifts to Category 1

However, the concept and guidelines do not change

►Independent historian(s): An individual (eg, 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 (eg, 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 is needed, the independent historian requirement is met. ***It does not include translation services.*** The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent Historian

- Prior to 2021 there was much controversy as to whether a parent/guardian could qualify as an independent historian of a child during every encounter within pediatric medicine. 2021 DG states that the parent for reasons of developmental stage may be the independent historian, relieving further controversy. However, the provider must not rely on an implied attendance of the parent/guardian as the historian. The reader of the note cannot assume that since the child is only 6 months that someone else provided the current symptomology and automatically provides credit for this component. The provider should document in a way that this information is clear, such as, “The mother reports…”

- Controversy can arise when we see a patient who appears to be of sound mind, of reasonable age and reason, but there is an add-in within the documentation of the encounter from another source.

Independent Historian

- Consider the following example we reviewed earlier in your workbook:

  Patient presents to the ED today with coughing and respiratory complaints. **His wife states** he has been coughing and having and wheezing for approximately 2 days at times waking her up. **His wife is worried** as he has been having breathing pauses and she wakes up to him gasping for air during his snoring. Husband states he is here at his wife behest. He feels bad and knows he has a cold, but doesn't think eventually he should be checked for sleep apnea as he was also told years ago that he has a deviated septum. The patient is severely obese at 425 lbs. and is compromised with normal activities due to his size and limited mobility.

- Based on the 2021 AMA's definition, how should we decide if credit for independent historian is allowed?

Independent Historian

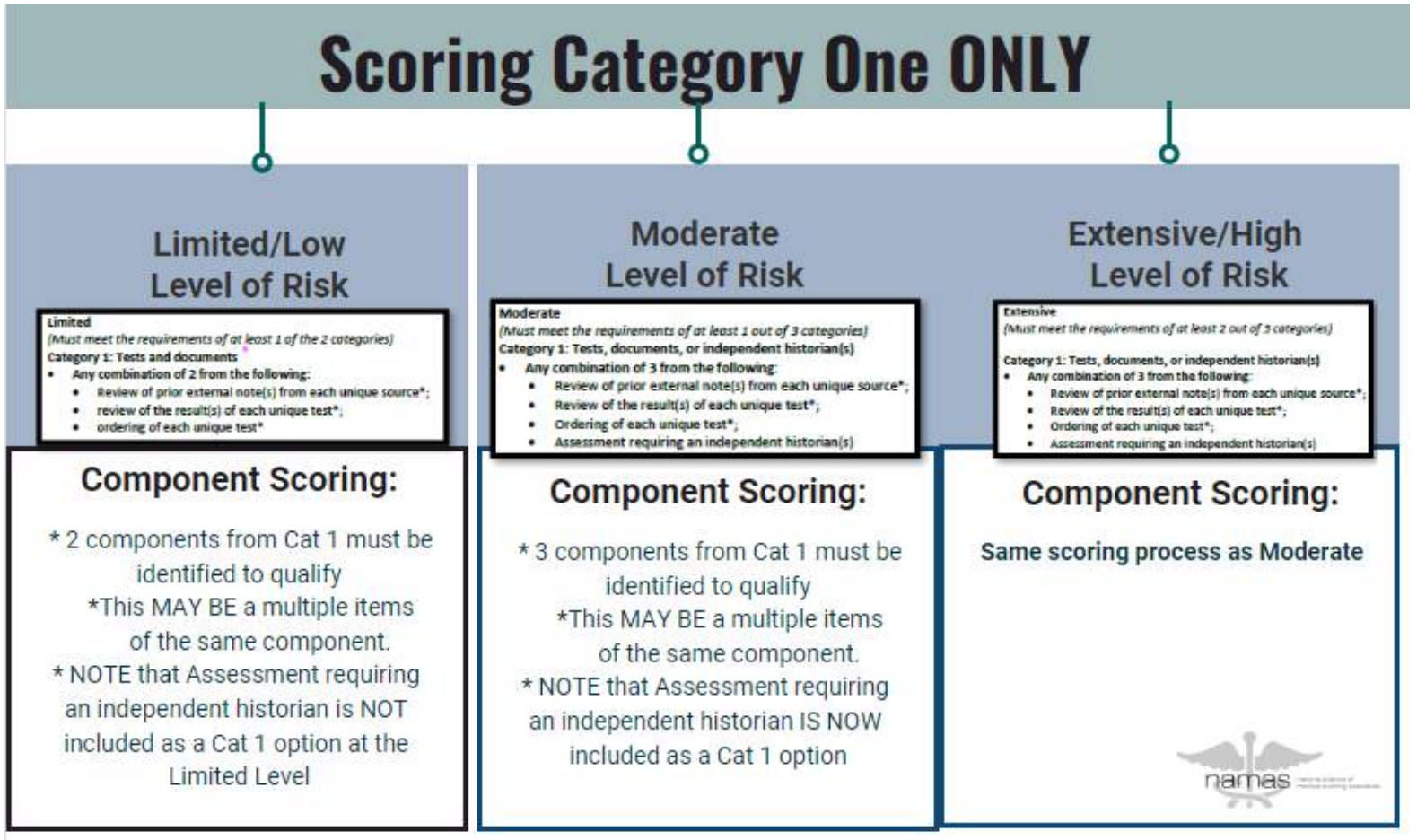
Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory 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 is needed, the independent historian requirement is met. ***It does not include translation services.*** The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

AMA does indicate that if the historian is providing supplemental history and it is judged to be confirmatory in necessary that it is allowed. If this was NOT pertinent and relevant, then it would not have been included to clearly show the complexity of the patient's problem at this stage. Therefore, it would be reasonable to count it in this instance.

An interpreter is not a historian. In no way is the interpreter supplementing or providing history for or on behalf of the patient, they are performing the act of translating one language (type/style) to another to allow the office visit to occur. This is NOT in any way the act of a historian.

One last item to note with this component, although we will discuss the scoring of these elements a bit later in this section, it is important to note that when reviewing the MDM chart, this component appears as Category 2 under the Low level of risk, but it then moves to the position of Category 1 under the Moderate level of risk. There really isn’t much of an explanation as to why found in AMA guidance, but it is worth mentioning to ensure it does not cause distraction later in this section.

Category One Overview



Category Two: Only has One Component

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. ***This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test.*** A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.◄

Category 3: Discussion of management or test interpretation

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees).

Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.

The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter.

It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Discussion Regarding the Patient

Appropriate Source:

> *For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

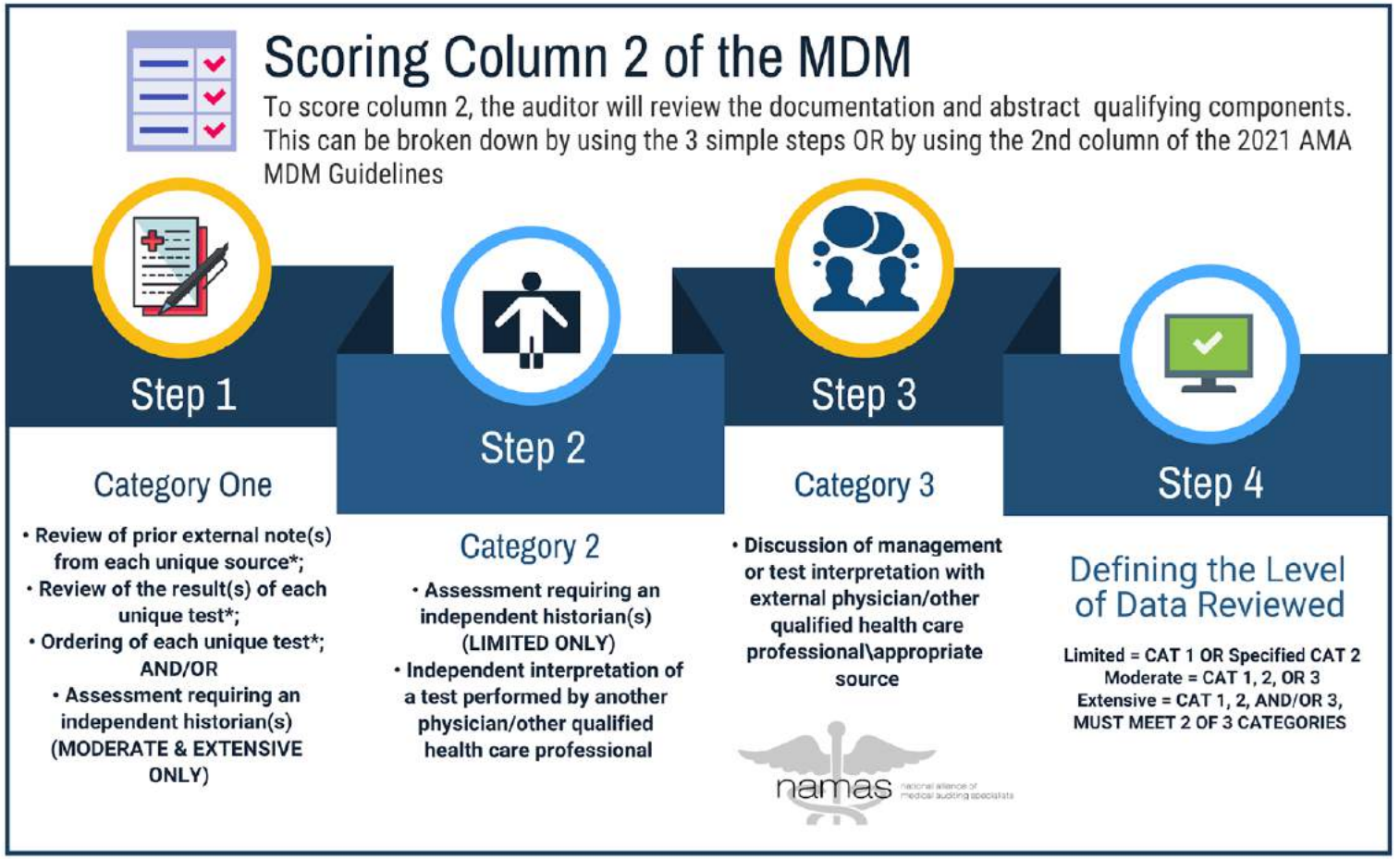
It is important to note that the guideline clearly stressed that discussion is for an expressed purpose, pointing back to the need for the documentation to identify the medical necessity and/or relevance of the discussion.

Discussion with family members would not be considered an appropriate source as this time could count toward the total time of any E&M encounter as well as the time spent in conversation with informal caregivers as well.

A great example here is recalling the communication between consultant and referring physician. The obligation of the consultant is to send an overview of the encounter with the patient back to the referring physician. This is active communication, and it is regarding management of the patient, but it is NOT discussion and therefore would NOT support this component according to the guidelines.

This discussion does not need to occur on the date of the encounter. The discussion could happen at a later time or may have even occurred prior to the date of the encounter as a pre-service conversation. Restraints on the same date of service only apply when time-based billing is utilized in lieu of work-based billing with MDM.

Overall Column 3



Column 3:
Risk of Complications and/or Morbidity or Mortality of Patient Management

Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A
Minimal risk of morbidity from additional diagnostic testing or treatment
Low risk of morbidity from additional diagnostic testing or treatment
Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only*: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High risk of morbidity from additional diagnostic testing or treatment *Examples only*: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Risk of Complications and/or Morbidity or Mortality of Patient Management

►Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.

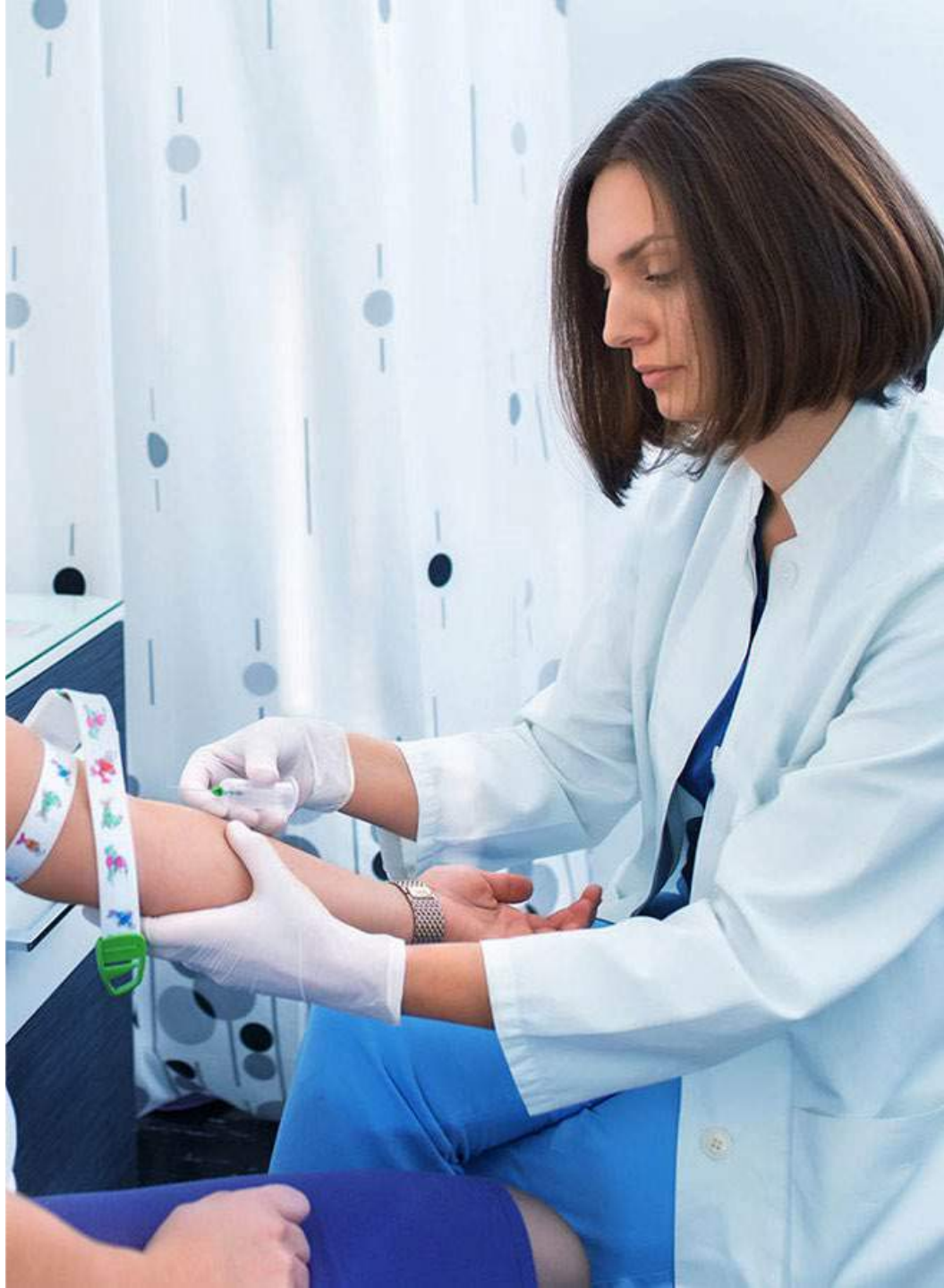
For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.

Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.

Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.◄



Risk of Complications and/or Morbidity or Mortality of Patient Management

- Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Minimal Risk: 99202 | 99212

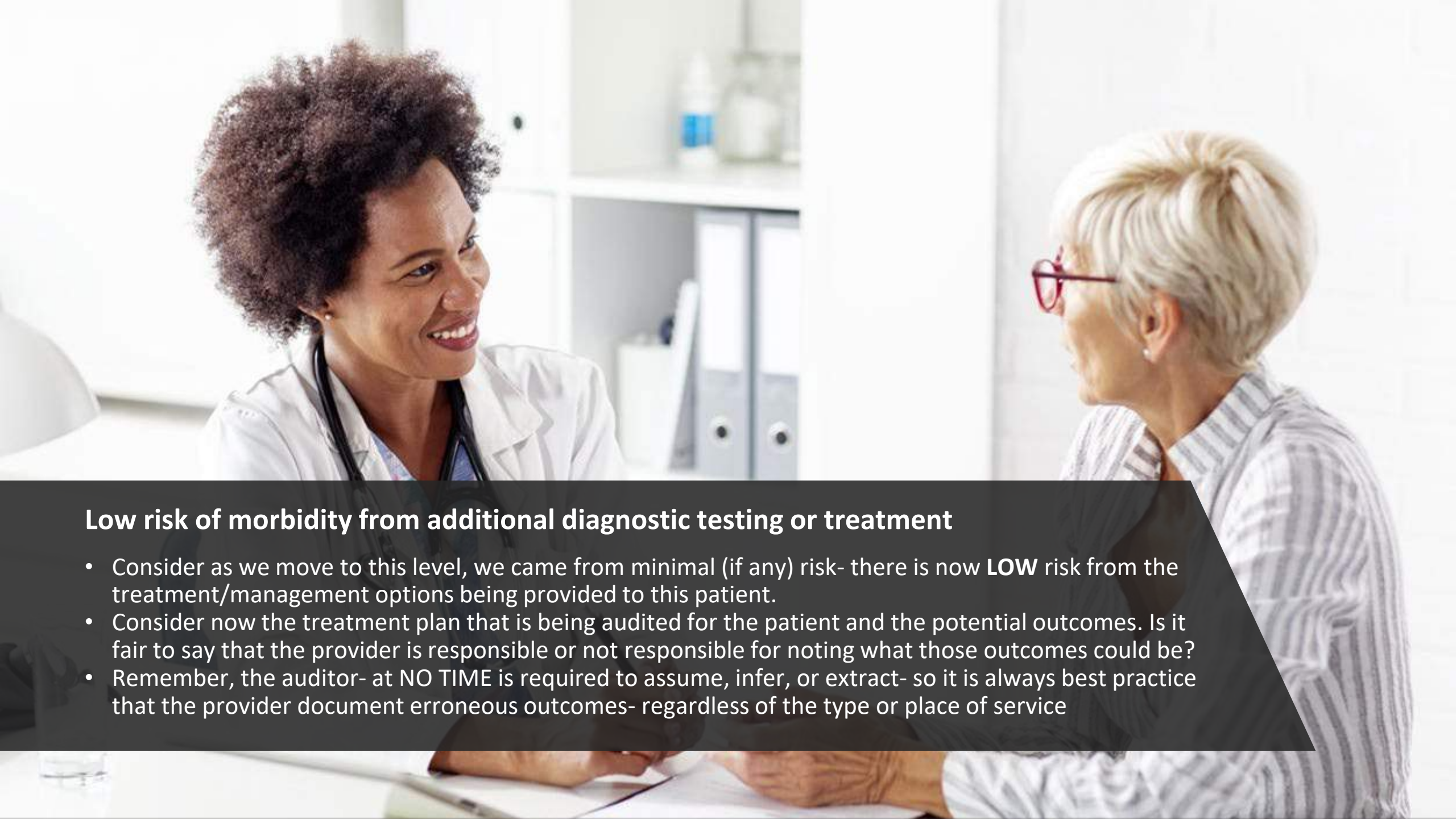
2021 DG guidance does not provide a description or definition of what the expected patient risk would be for a minimal risk.

Examples that were previously used in 1995/1997 DG included:

- Rest
- Gargle
- Elastic bandages
- Superficial dressing

Each one of these treatment options are self-performed and even self prescribed treatments for the patient. Therefore, they were of “minimal risk”.

Challenge yourself to think of **at least one** minimal risk treatment option not listed here.



Low risk of morbidity from additional diagnostic testing or treatment

- Consider as we move to this level, we came from minimal (if any) risk- there is now **LOW** risk from the treatment/management options being provided to this patient.
- Consider now the treatment plan that is being audited for the patient and the potential outcomes. Is it fair to say that the provider is responsible or not responsible for noting what those outcomes could be?
- Remember, the auditor- at NO TIME is required to assume, infer, or extract- so it is always best practice that the provider document erroneous outcomes- regardless of the type or place of service

Low risk of morbidity from additional diagnostic testing or treatment

- The examples of low-risk treatments that were provided in 1995/1997 DG were as follows:
  - Over the counter medications
  - Minor surgery (e.g.; procedure in the office) with no identified risk factors
  - Physical therapy
  - Occupational therapy

Low risk of morbidity from additional diagnostic testing or treatment

As we wrap up LOW…
FOCUS- this column is **NOT s**coring the risk of the treatment. **READ THE HEADER AGAIN.**
Low risk of morbidity from additional diagnostic testing or treatment

The key word is FROM. Consider the example of Physical Therapy (PT). PT is the treatment of disease or injury by physical methods, therefore, what are the risks associated with this form of treatment? Low.

Discharging a 10-year-old seemingly healthy child with a sprained extremity to obtain a DME splint at their local pharmacy, what is the associated risk from this treatment? Low
Even when we are considering a treatment NOT on this list- we can apply this same sort of logic.

Challenge yourself to think of **at least one** low risk treatment option not listed here.

Moderate risk of morbidity from additional diagnostic testing or treatment

The level rises again, and we now evaluate MODERATE risk FROM management/treatment plans within each encounter. Our responsibility here is to consider the “moderate risk from” and since 2021 DG does not include straight forward guidance, only examples of moderate treatment/management options, then we must break down moderate risk to better understand.

When we consider moderate risk and the fact that this is also representative of a level 4, we often, in our minds, associate this with being a more intense service. However, interestingly enough- we skip over the words use and rather focus on the placement of the service.

Moderate means **average** in amount, intensity, quality, or degree. Even more interesting are synonyms we could substitute for Moderate- and would keep the definition the same but make you as an auditor look at this quite differently.

Moderate Risk

Consider the following:

- AVERAGE risk of morbidity from additional diagnostic testing or treatment
- MODEST risk of morbidity from additional diagnostic testing or treatment
- MEDIUM risk of morbidity from additional diagnostic testing or treatment
- ORDINARY risk of morbidity from additional diagnostic testing or treatment
- COMMON risk of morbidity from additional diagnostic testing or treatment
- EVERYDAY risk of morbidity from additional diagnostic testing or treatment
- MILD risk of morbidity from additional diagnostic testing or treatment
- NEUTRAL risk of morbidity from additional diagnostic testing or treatment

Moderate Risk

When you consider some of these terms, as opposed to “moderate” , the clinical mindset of the moderate level being more relevant to many encounters makes more sense. Now, keep in mind- this is only ONE COLUMN OF THREE, and it takes 2 of 3 columns to solve for MDM.

Let’s apply this then to the common examples of treatment/management options provided by 2021 DG, and as we do so, we will also address common questions and gray are concerns within each of these components:

- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

Prescription Drug Management

It would have been helpful if 2021 DG had provided a definition within guidelines of RX management to finally put to rest much ambiguity within the auditing world, but unfortunately AMA did not. There are many MACs that do have published guidance, and that is what NAMAS promotes as it is the closest published guidance there is.

Therefore, prescription drug management is the initiation, continuation, discontinuation, or modification of any prescription medication. This does NOT include medications that are OTC and prescription that are ONLY prescribed for insurance benefits. Keep in mind that patient convenience and reimbursement rules NEVER make such determinations.

A key word in the description that causes confusion is “management”. Oftentimes, coders/auditors hear the word management and infer that this would mean a longtime use of a prescription drug, but this infers they did not look up nor understand the meaning of the word management

To 2 keys to determine RX Management:

1. Did it require prescriptive authority
2. Is the provider of record managing the RX?

Minor | Major

Within the NCCI Policy Manual, CMS clearly states *If a procedure has a global period of 090 days, it is defined as a major surgical procedure*. Also, it states, *If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure.* CMS policy clearly did NOT conform to the new AMA policy. By continuing to use global days and patient risk **only** an organization is creating a more stringent compliance policy that is offered by the AMA.

NAMAS recommendation would be to adhere to the global days policy, and the patient risk factors or risk over and above “typical” risk as noted by the provider.

Thinking outside of the box- What about a consult for a minor/major procedure? Consults are questions often asked as they are a normal treatment plan option, but not found as an “example” in the MDM table. Well, that is because in of themselves *consults* have little to no risk- but the reason for the consult would and remember it is the management/treatment that we are allocating the risk for. Therefore, if the provider documented that the patient is being sent for consultation for consideration of knee replacement (with no health risks), then we could allocate that to major surgery at moderate risk.

As we wrap up MODERATE…

FOCUS- this column is NOT scoring the risk of the treatment. READ THE HEADER AGAIN.

MODERATE risk of morbidity from additional diagnostic testing or treatment

The key word is FROM. Consider the example of Prescription Drug Management. RX management is the “average” treatment received when going to the doctor. Remember moderate meaning average.

A patient comes in with an acute uncomplicated problem and the treatment is RX management and the associated risk from this treatment is? Moderate (Average)

Even when we are considering a treatment NOT on this list- we can apply this same sort of logic.

- Challenge yourself to think of at least one moderate risk treatment option not listed here.

High Risk of Management or Treatment

Obviously, this category represents the highest risk from treatment/management as documented within the encounter being audited. As noted in other levels of complexity, 2021 DG does provide examples, but of course these examples are not an exhaustive list. The list includes components that were previously included within 1995/1997 DG as well as new components as well.

The examples are as follows:

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding elective major surgery with identified patient or procedure risk factors
- Decision regarding emergency major surgery
- Decision regarding hospitalization
- Decision not to resuscitate or to de-escalate care because of poor prognosis

Drug therapy requiring intensive monitoring for toxicity

►Drug therapy requiring intensive monitoring for toxicity: 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 performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify.

The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles.

Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.◄

Decision regarding ELECTIVE MAJOR surgery with identified patient or procedure risk factors -OR- EMERGENCY major surgery

Both surgeries in this category are major, and again if you will recall there is a difference of opinion between AMA and CMS in this description. AMA indicates that major is up to the description of the provider, and CMS states it is based on global days (your organization should certainly have a policy).

The major difference here is the difference between elective and emergent. Elective is a term used which can be misleading. When one hears the term elective, often they think of cosmetic services or those that are not necessarily for medically indicated reasons. Elective in these instances merely refers to the fact that they were not emergent. If this is confusing to you at all, then merely remove the word elective, and as in the other levels and refer to it as Major surgery.

When considering the component for Emergency surgical intervention it is important to note the difference between non-emergent and emergent. Emergent would indicate that we are going to surgery NOW as opposed to scheduling for at a later time. We would not even consider the decision to operate tomorrow as emergent. Again, emergency surgery would infer an ASAP or STAT status.

Decision Regarding Hospitalization or escalation of hospital level of care

This component, as worded, can cause confusion as it seems to imply that in order to allow the component the patient must be hospitalized, however, that is NOT the case. First, consider the term regarding, which is seemingly used A LOT in 2021 DG. The term concerning could be substituted for regarding and provide a better perspective of what this component is considering.

Decision Concerning Hospitalization: By changing the term, the component makes better sense that the provider is considering this within the treatment options, but not making this final determination.

2021 DG also states that a decision regarding hospitalization can also be seen as a decision regarding alternative levels of care. This is another view of consideration that also provides a better understanding of how best to interpret this component.

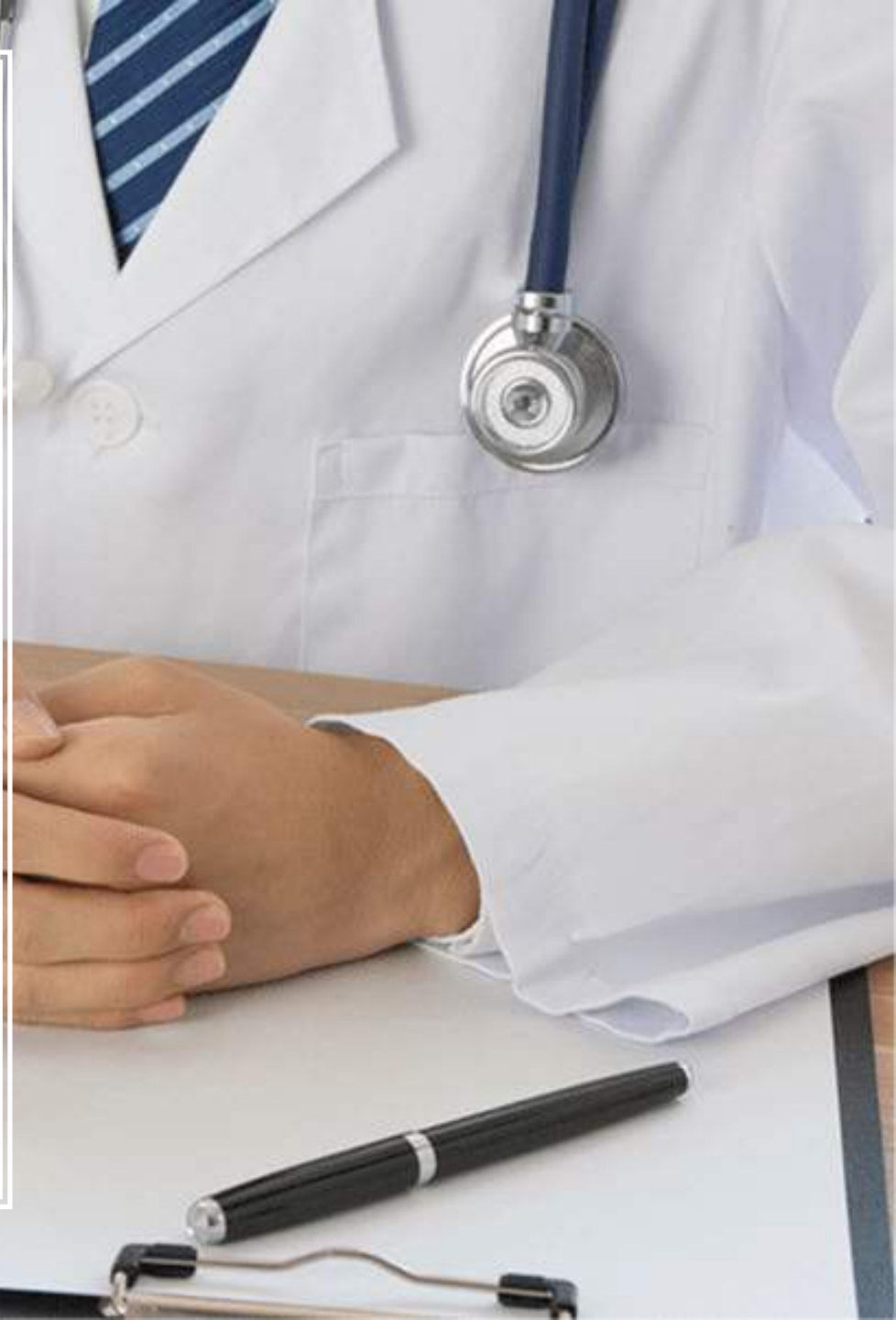
Decision not to resuscitate or to de-escalate care because of poor prognosis

This element is not new as well as it has also been part of the 3rd column of the Table of Risk for 1995/1997 DG.

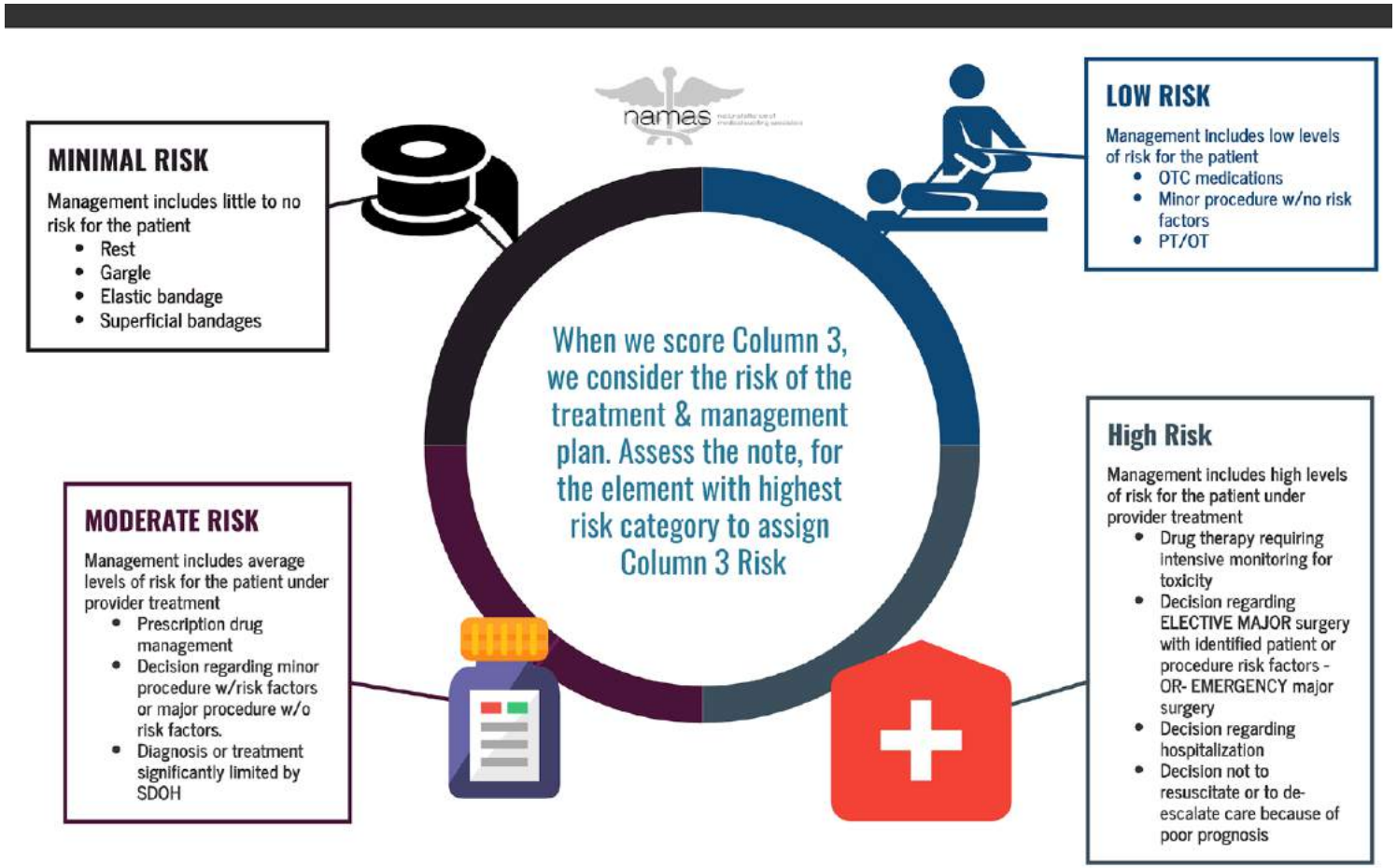
The variance to consider is that this is NOT advanced care planning and end of life discussions.

These are active discussions due to poor prognosis which is what makes the encounter high risk on the date of service.

Having a conversation about end-of-life planning is NOT high risk, omitting further intervention for a patient is a high-risk treatment decision.



Column 3


namas
MINIMAL RISK
Management includes little to no risk for the patient
Rest
Gargle
Elastic bandage
Superficial bandages
LOW RISK
Management includes low levels of risk for the patient
OTC medications
Minor procedure w/no risk factors
PT/OT
When we score Column 3, we consider the risk of the treatment & management plan. Assess the note, for the element with highest risk category to assign Column 3 Risk
MODERATE RISK
Management includes average levels of risk for the patient under provider treatment
Prescription drug management
Decision regarding minor procedure w/risk factors or major procedure w/o risk factors.
Diagnosis or treatment significantly limited by SDOH
High Risk
Management includes high levels of risk for the patient under provider treatment
Drug therapy requiring intensive monitoring for toxicity
Decision regarding ELECTIVE MAJOR surgery with identified patient or procedure risk factors - OR- EMERGENCY major surgery
Decision regarding hospitalization
Decision not to resuscitate or to de-escalate care because of poor prognosis

Time in the E&M Encounter

Time-Based E&M Services

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services.

The E/M services for which these guidelines apply **require a face-to-face encounter** with the physician or other qualified health care professional and the patient and/or family/caregiver.

For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

Time Based E&M Services

- For coding purposes, time for these services is the total time on the date of the encounter.
- It includes both the face-to-face time with the patient and/or family/caregiver 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 (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).
- It includes time regardless of the location of the physician or other qualified health care professional (eg, whether on or off the inpatient unit or in or out of the outpatient office).
- **It does not include any time spent in the performance of other separately reported service(s).**

Services Reported Separately

- ALL services performed by ANYONE in addition to the E&M service, the time MUST BE carved out of the E&M time! This would include, but is not limited to:
  - Vaccinations
  - Administration or injection of any medication
  - Performing any office-based procedure
  - Nursing services
  - Diagnostic procedures in the office (EKG, x-ray, etc…)
- Controversy has been raised as to whether the time-based statement of the provider should note the carve out of this time. Best practices indicate it should.

Split-Shared & Time

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit.

When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time.

Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

Qualification Statement

- When time is being used to report an office visit, the documentation should include sufficient information to support the amount of time reported. This would include a description of the activities personally performed by the provider on the date of the face-to-face visit.
- It is NOT enough for the provider to merely state they spent XX minutes

Qualification Statement

- The following is a list of activities as defined by the AMA and approved by CMS the physician or QHP can provide on the day of the visit and include in their calculation of total time:
    - preparing to see the patient (e.g., review of tests)
    - obtaining and/or reviewing separately obtained history
    - performing a medically appropriate examination and/or evaluation
    - counseling and educating the patient/family/caregiver
    - ordering medications, tests, or procedures
    - referring and communicating with other health care professionals (when not separately reported)
    - documenting clinical information in the electronic or other health record
    - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
    - care coordination (not separately reported)

- There is no need for a provider to have listed each of these components and the time associated with each. Furthermore, the provider's qualification statement does not micro-analyze their visit time. What it does need to do is “justify” and qualify rationally the amount of time of the encounter.

Office | Clinic Time-Based Services

New Patient Office Visits	Total Time on the Day of the Visit	Established Patient Office Visits	Total Time on the Day of the Visit
99201	Deleted in 2021	99211	Time removed
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

Each CPT has a range of time assigned, and each subsequent CPT code connects to make a rolling time to prevent any gaps.

Office or Outpatient Consult Time-Based Services

CPT Service Code	Total Time on the Day of the Visit
99242	20 minutes
99243	30 minutes
99244	40 minutes
99245	55 minutes

namas national alliance of medical auditing specialists

The CPT codes listed are for the Consult Code Category. While not all payors reimburse this code set, they are now recognized under the 2021 DG

Hospital Inpatient or Observation Care Time-Based Services

Initial Encounter	Total Time on the Day of the Visit	Subsequent Encounter	Total Time on the Day of the Visit
99221	40 minutes	99231	25 minutes
99222	55 minutes	99232	35 minutes
99223	75 minutes	99233	50 minutes

Inpatient services have a specific time as opposed to a time range
99221 - 99233

Inpatient or Observation Consult Time-Based Services

CPT Service Code	Total Time on the Day of the Visit
99252	35 minutes
99253	45 minutes
99254	60 minutes
99255	80 minutes

The CPT codes listed are for the Consult Code Category. While not all payors reimburse this code set, they are now recognized under the 2021 DG

Nursing Facility Care Time-Based Services

Initial Encounter	Total Time on the Day of the Visit	Subsequent Encounter	Total Time on the Day of the Visit
99304	25 minutes	99307	10 minutes
99305	35 minutes	99308	15 minutes
99306	45 minutes	99309	30 minutes

Nursing Facility Services have a specific time as opposed to a time range
99304 - 99309

What's next?
Visit namas.co

AT NAMAS,
WE SEE YOU.

NAMAS ANNUAL AUDITING & COMPLIANCE CONFERENCE

WELCOMING YOU THIS WINTER.

NAACC 2022

NAMAS ANNUAL AUDITING & COMPLIANCE CONFERENCE

The NAMAS 14th Annual Auditing & Compliance Conference

Get ready for a conference experience unlike any other! The NAMAS 14th Annual Auditing and Compliance Conference is redefining auditing education – and we can't wait to share it with you!

Mark your calendars for December 8th & 9th, 2022 and plan to join NAMAS in Savannah, Georgia for an event especially customized for YOU!

namas national alliance of medical auditing specialists