The Society of Thoracic Surgeons

STS Webinar Series

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Update on Office/Outpatient Evaluation/Management CPT Coding

On behalf of the STS Workforce on

Coding & Reimbursement

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EFFECTIVE on January 1, 2021: CHANGES for these CPT Codes

New Patient Office/Outpatient Visit	Established Patient Office/Outpatient Visit
~~99201~~ (deleted in 2021)	**99211**
99202	**99212**
99203	**99213**
99204	**99214**
99205	**99215**

UNCHANGED

REPORTING GUIDELINES NOT CHANGED for these E/M codes—continue to apply 1995 & 1997 E/M documentation guidelines
Hospital inpatient visits (99221-99223 & 99231-99233)
Hospital observation services (99218-99220 & 99224-99226)
Outpatient & inpatient consultations (99241-99245 & 99251-99255)
Emergency department visits (99281-99285)
Domiciliary, rest home & custodial care/home visits/ nursing facilities

NO DISCLOSURES

KEY CODING CHANGES for these E/M CODES

New Patient Office/Outpatient Visit		Established Patient Office/Outpatient Visit	
~~99201~~ (deleted in 2021)		99211	
99202		99212	
99203	**4 codes**	99213	**5 codes**
99204		99214	
99205		99215	

- Based on **MEDICAL DECISION MAKING** *or* **TOTAL TIME** of the Physician/QHP on the date of the encounter
- History & Examination --> NO LONGER REQUIRED COMPONENT for selecting CODE Level

LEVELS OF SERVICE

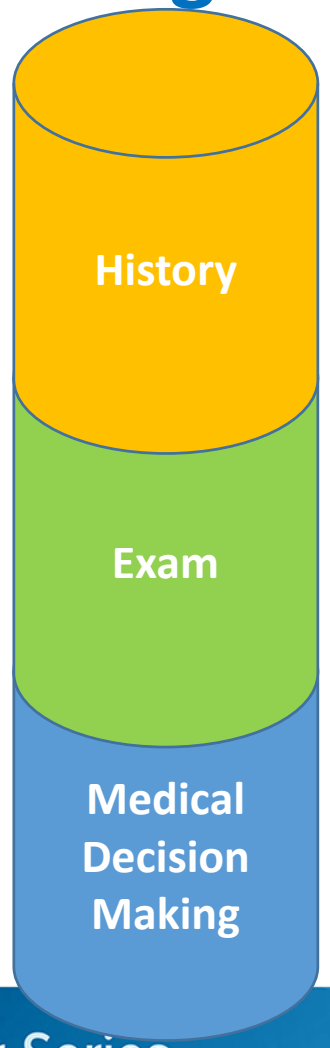
	New Patient Office/Outpatient E/M				
CPT	99201	99202	99203	99204	99205
H&P	Deleted	Medically Appropriate			
MDM Level		Straightfwd	Low	Moderate	High
Total Time		15-29min	30-44min	45-59min	60-74min

	Established Patient Office/Outpatient E/M				
CPT	99211	99212	99213	99214	99215
H&P	No Physician/QHP	Medically Appropriate			
MDM Level	N/A	Straightfwd	Low	Moderate	High
Total Time	N/A	10-19min	20-29min	30-39min	40-54min

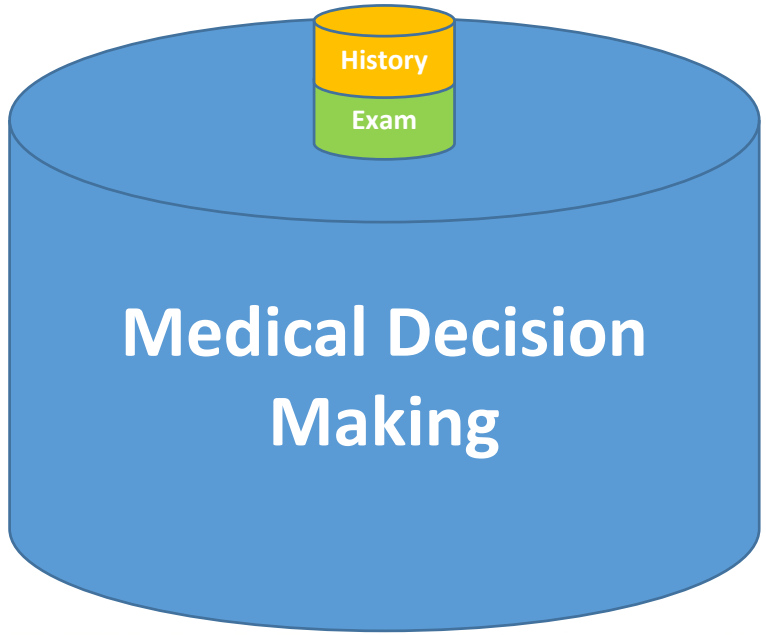
Outpatient/Office Visit CODING based on Medical Decision Making

Prior to 2021

Code Selection based reporting of all 3 required COMPONENTS of History, Exam, and Medical Decision Making based on 1995/1997 documentation guidelines



Effective Jan 1, 2021



Code Selection based only on reporting of redefined MEDICAL DECISION MAKING elements *(with History/Exam documented as medically appropriate)*

Medical Decision Making: 3 ELEMENTS

(*2 of 3 Elements required to meet selected level for both NEW & ESTABLISHED OFFICE VISITS*)

MDM ELEMENT 1	MDM ELEMENT 2	MDM ELEMENT 3
PROBLEM(S) ADDRESSED	DATA REVIEWED & ANALYZED	RISK
Number & Complexity of Problems Addressed	Amount &/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications &/or Morbidity/Mortality of Patient Management

MDM: Element 1—Problem(s) Addressed

New	Established	MDM Element 1: Problem(s) Addressed
~~99201~~	**99211**	**N/A**
99202	**99212**	**Minimal** 1 self-limited or minor problem
99203	**99213**	**Low** ➢ 2 or more self-limited minor problems *or* ➢ 1 stable chronic illness *or* ➢ 1 acute, uncomplicated illness or injury
99204	**99214**	**Moderate** ➢ 1 or more chronic illness w/ exacerbation, progression, or side effects of treatment *or* ➢ 2 or more stable chronic illness ➢ 1 undiagnosed new problem with uncertain prognosis *or* ➢ 1 acute illness with systemic symptoms *or* ➢ 1 acute complicated injury
99205	**99215**	**High** ➢ 1 or more chronic illness w/ **SEVERE** exacerbation, progression, or side effects of treatment *or* ➢ 1 acute/chronic illness or injury w/ threat to life or bodily function

CPT DEFINITION of PROBLEM ADDRESSED as *"a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter **addressed at the encounter**, w/ or w/o a diagnosis being established at the time of the encounter"*

MDM: Problem(s) Addressed Descriptors

Category	Subcategory	Descriptor
SELF-LIMITED/MINOR		Transient, unlikely to permanently alter health status
ACUTE		Recent or New short-term problem
	Uncomplicated	Treatment is considered with little to no risk of mortality with treatment—full recovery expected
	Complicated	Extensive or multiple treatment options, or risk of morbidity with treatment
	w/ Systemic Symptoms	HIGH RISK of morbidity without treatment in near term
CHRONIC		Expected duration of at least a year or until death
	Stable	Specific treatment goals have been achieved
	w/ Exacerbation, progression or side effects of treatment	Treatment goals have not been reached; Illnesses worsening. Does not require consideration of hospitalization
	w/ Severe exacerbation, progression or side effects of treatment	Significant risk of morbidity; may require hospitalization
UNDIAGNOSED		New problem with uncertain diagnosis; differential diagnosis includes condition with high risk of morbidity without treatment

MDM: Element 1—Problem(s) Addressed

NUMBER of PROBLEMS ADDRESSED at the VISIT ENCOUNTER
COMPLEXITY of PROBLEMS ADDRESSED at the VISIT ENCOUNTER

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99211	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99204 99214	Moderate	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

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99205 99215	High	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

MDM: Element 1—Problem(s) Addressed

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99204 99214	Moderate	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 Complexity-Considerations

- Problem(s) Addressed requires additional intervention (treatment, diagnostic evaluation, etc.) for appropriate management
- Problem(s) Addressed will cause (or potential) of causing significant functional impairment/morbidity without further intervention
- Affect of the Problem(s) Addressed on the patient does not necessarily require hospitalization→however, further intervention may require hospitalization (e.g. surgical treatment)

Examples of MODERATE complexity

- Mediastinal mass noted on CT imaging
- Early-stage lung cancer
- Refractory reflux symptoms despite optimal medications
- Mitral regurgitation with decreased LVEF by ECHO
- Asymptomatic 5.8 cm ascending aortic aneurysm
- Multi-vessel CAD with stable angina symptoms

MDM: Element 1—Problem(s) Addressed

Shifting from Moderate Complexity to High Complexity

Patient Co-Morbidities

- **Does not directly "count" toward complexity of this element unless co-morbid condition(s) is also appropriately addressed at the encounter**

- **May "drive" the overall complexity of MDM**
  - **Necessary additional workup (ELEMENT 2)**
  - **Increased Risk of Management (ELEMENT 3)**
- **Co-Morbidity can increase the clinical severity of the Problem Addressed on an individual patient**

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99205 99215	High	**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

Poses threat to life in the "near term" without treatment

Examples of HIGH Complexity

- Mediastinal mass causing dyspnea from compressive airway symptoms while supine or exertion
- Endobronchial tumor causing post-obstructive lobar pneumonia
- Reflux with silent aspiration causing recurrent hospitalization for bronchitis in frail COPD patient
- Severe aortic stenosis with worsening CHF episodes in chronic renal failure patient
- 7.5 cm ascending aortic aneurysm noted in asymptomatic patient
- Severe left main stenosis with depressed LVEF

Medical Decision Making: 3 ELEMENTS
(*2 of 3 Elements required to meet selected level*)

MDM ELEMENT 1	MDM ELEMENT 2	MDM ELEMENT 3
PROBLEM(S) ADDRESSED	DATA REVIEWED & ANALYZED	RISK
Number & Complexity of Problems Addressed	Amount &/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications &/or Morbidity/Mortality of Patient Management

MDM Element 2- Data Reviewed & Analyzed

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	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.*
99211	N/A	N/A
99202 99212	Straightforward	Minimal or none

99203
99213
	Low	**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)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	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.*

99204
99214
	Moderate	**Moderate**
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	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.*

99205
99215
	High	**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)

Category 1: Tests, documents, or independent historian(s)

- 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)

Category 2: Independent interpretation of tests

- **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**

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)

MDM Element 2- Data Reviewed & Analyzed

This ELEMENT accounts for the AMOUNT and/or COMPLEXITY of information provided by Tests (Docs & Studies) that a provider may incorporate into her medical decision making for the patient's PROBLEM ADDRESSED at the encounter.

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)

- Order & Review of unique test/study result counts as ONE single entity toward Category 1 on day of encounter
  - If test/study ordered outside of patient encounter, count only ONCE as single entity when test/study result is reviewed/analyzed
  - Test that have overlapping elements are not UNIQUE even if they have distinct CPT codes
  - Ordering a test may include those considered <u>but not selected</u> after shared decision making or due to patient risk (if reason to forego test is documented)

- Recurrent order/tests: Each new subsequent result may be counted in the subsequent encounter in which they are analyzed
  - Review of previous results for comparison to new result only counts as ONE UNIQUE test/study for that encounter

- Review of external notes: Unique source includes QHP **not in same group practice**, different specialty/subspecialty, or unique entity
  - Review of materials from unique source counts ONCE

- Information for independent history does not need to be obtained in person but must be obtained directly from the independent historian

- Any combination of unique tests ordered/reviewed <u>or</u> unique source external notes reviewed, <u>or</u> independent history obtained can be summed

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)

- ORDER, REVIEW, and INDEPENDENT INTERPRETATION (not separately reported) of a unique STUDY/TEST for MDM by the PROVIDER counts as single element
  - Count toward Category 2—should not double-count toward Category 1
    - CPT/CMS→ interpretation of a study/test toward MDM <u>includes review</u> of result/report

Separately Reportable Services

- Any specifically identifiable procedure or service performed on the date of an E/M service may be reported separately
  - This includes procedures/services that can be identified with separate specific CPT code
  - When the professional interpretation of a separately reportable test or study is performed (billed) by the provider or qualified health professional, the associated work of ordering, reviewing, or performing the test/study does not count toward Category 1 (order/review) of this MDM element for the office visit
  - If a test/study is independently interpreted in order to manage the problem addressed by the provider at the E/M Visit **AND is not separately reported by the provider**, then the test/study interpretation can count toward Category 2 (interpretation) of this MDM element

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)

- Discussion of management requires interactive exchange between provider and external physician/QHP—must be direct and not through intermediary
  - Sending notes or written exchanges within progress notes do not qualify (e.g. letters to referring QHP)
- Does not need to occur on DATE of patient encounter but only counts once
  - Can be asynchronous but must be initiated/completed within short time period (e.g. EMAIL exchange counts)

Medical Decision Making: 3 ELEMENTS
(2 of 3 Elements required to meet selected level)

MDM ELEMENT 1	MDM ELEMENT 2	MDM ELEMENT 3
PROBLEM(S) ADDRESSED	DATA REVIEWED & ANALYZED	RISK
Number & Complexity of Problems Addressed	Amount &/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications &/or Morbidity/Mortality of Patient Management

MDM: Element 3—RISK of MANAGEMENT

New Patient	Established Patient	Element 3: Risk(s)
~~99201~~	**99211**	**N/A**
99202	**99212**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203	**99213**	**Low risk of morbidity from additional diagnostic testing or treatment**
99204	**99214**	**Moderate risk of morbidity from additional diagnostic testing or treatment**
99205	**99215**	**High risk of morbidity from additional diagnostic testing or treatment**

CPT DEFINITION of RISK is *"the probability and/or consequence of an event. The assessment of level of risk is affected by the nature of the event under consideration. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified HCP 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 MDM—the 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

MDM: Element 3
RISK of MANAGEMENT

New Patient	Established Patient	Element 3: Risk(s)
~~99201~~	**99211**	**N/A**
99202	**99212**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203	**99213**	**Low risk of morbidity from additional diagnostic testing or treatment**
99204	**99214**	**Moderate risk of morbidity from additional diagnostic testing or treatment**
99205	**99215**	**High risk of morbidity from additional diagnostic testing or treatment**

RISK FACTORS in SURGICAL TREATMENT

- Risk(s) inherent to nature and type of surgical procedure under consideration to diagnosis/treat the PROBLEM ADDRESSED at the encounter
- Risk(s) of the surgical procedure/test(s) on the specific patient→ consider effects patient's co-morbid conditions on surgical outcome

MDM: Element 3—RISK of MANAGEMENT

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A
99202 99212	Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low risk of morbidity from additional diagnostic testing or treatment

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	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

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	High	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

MDM: ELEMENT 3-RISK of MANAGEMENT & SURGERY

- **MINOR or MAJOR**
  - CMS/CPT does not provide list of surgical procedures or defined specific criteria to separate MINOR from MAJOR surgery (e.g. not based on GSP period)
  - Classification as MINOR or MAJOR based on *common meaning of such terms when used by trained clinicians*
- **ELECTIVE or EMERGENT/URGENT**
  - ELECTIVE→ Timing of procedure related to the patient's condition is PLANNED in ADVANCED (e.g. scheduled for weeks later)
  - EMERGENT/URGENT→ Timing of procedure is performed immediately (or with minimal delay to allow patient stabilization)

MDM: ELEMENT 3-RISK of MANAGEMENT & SURGERY

- Risk for ELEMENT 3 of MDM applies to patient management decisions made as part of the reported encounter
  - Risk of further evaluation, diagnostics, treatment (surgery)
    - Assessment based on the consequences to specific patient for undergoing the evaluation/treatment→ Patient can be "TOO HIGH" risk to undergo surgical treatment
- Risk determination does NOT require quantification but level of risk—*high, medium, low, minimal*—would be commonly accepted by other trained clinicians
  - Documentation for ELEMENT 3 should note RISKS associated with PROCEDURE and specific patient risk factors (relevant CO-MORBIDITIES)

Cardiothoracic surgical procedures & MDM Element 3

- HIGH RISK→ Decision regarding elective major surgery identified patient or procedure risk factors
  - *Arguably, this would include nearly all major cardiac surgical procedures and most major thoracic surgical procedures*
  - *Many patients requiring cardiothoracic surgical procedures will also have identified patient risk factors*

Case Example #1

- 60 y/o NEW patient with COPD seen by CT surgeon for lung nodule in right lung found on recent lung cancer screening CT ordered by PCP
- Surgeon performs and documents following:
  - Reviews radiologist report of screening CT and also separate older report of another prior CT chest (for trauma) which did not report lung nodule finding at the time
  - Interprets images of nodule on screening CT scan as condition c/w early lung cancer and was not seen in prior CT--that may be amenable to segmental lung resection based on nodule size and location (RLL superior segment) given concerns for emphysema that is noted.
  - Orders 1) CT PET study; 2) PFTs; 3) CBC and CHEM 7
  - Discusses with patient concern that lung nodule is concerning for lung cancer, discusses treatment options which include invasive lymph node staging and lung surgery if ordered test results are acceptable for lung resection
- Patient agrees to follow-up in clinic once ordered tests complete for pre-op teaching and surgical consent

Case Example #1—MDM LEVEL of SERVICE: NEW patient visit—CPT 99205 (2 of 3 Elements: Mod, Extensive,High)

Problem Addressed:

- **Lung nodule-clinical concern for primary lung cancer given risk factors**
- **Element #1: Moderate** ***(Undiagnosed new problem with uncertain prognosis)***

Data Reviewed/Analyzed:

- **Category 1: 4 unique source/test** ***(4 unique tests ordered—CT PET, PFTs, CBC, CHEM Panel; *2 separate imaging reports (lung screen CT and old trauma CT-but 1 unique source- *reviewed but counted toward interpretation)***
- **Category 2: Interpretation of external CT images toward MDM** ***(interpretation of lung nodule noted on CT images as concerning for lung cancer—not present prior and amenable to undergo segmentectomy, emphysematous lung changes)***
- **Category 3: n/a**
- **Element #2: Extensive (2 of 3 categories met)**

Risk:

- **Procedural risk: Mediastinoscopy & Segmentectomy**
  - **Prolonged air leak, bleeding, chronic pain, infection, etc.**
- **Patient risk factors:**
  - **COPD??**
- **Element #3: High** ***(decision regarding maj. surgery with identified risk factors—depends on documentation)***

Case Example #2

- 67 y/o ESTABLISHED patient seen by CT surgeon for lung cancer surveillance after having performed lung resection 2 years earlier
- Surgeon performs and documents following:
  - Reviews newly obtained CT chest images and compares to CT scan obtained prior—no new or concerning lung/pleural/ mediastinal findings—old lung resection staple line scar is unchanged—Discusses CT images and surgeon's interpretation with a radiologist by phone.
  - Informs patient of CT interpretation. Encourages patient to stop smoking—documents that smoking cessation intervention being managed by PCP
  - Informs patient to RTC in ~ 1 yr for annual CT CHEST.
- Patient agrees to follow-up in clinic.

Case Example #2—MDM LEVEL of SERVICE: ESTABLISHED patient visit—CPT 99213 (2 of 3 Elements: Low, Extensive, Minimal)

Problem Addressed:

- **Lung cancer surveillance**
- **Element #1: LOW** ***(Chronic stable condition; *smoking cessation encouraged but not managed: deferred to PCP—*does not count as problem addressed)***

Data Reviewed/Analyzed:

- **Category 1: n/a (CT image counted toward Cat #2)**
- **Category 2: Interpretation of CT images toward MDM**
- **Category 3: Discussion of CT images with radiologist**
- **Element #2: Extensive (2 of 3 categories met)**

Risk:

- **Follow-up in one year with repeat CT scan**
- **Element #3: Minimal** ***(minimal risk of morbidity from additional diagnostic testing or treatment)***

Case Example #3

- 70 y/o ESTABLISHED patient with ischemic cardiomyopathy s/p CABG (performed by partner), chronic kidney disease seen by you for LVAD implantation—destination therapy
- Surgeon performs and documents following:
  - Reviews of reports and views images of 1) RHC & LHC and 2) ECHO
  - Discusses patient mgmt. and treatment options with heart failure cardiologist by phone
  - Reviews nephrology outpatient clinic notes and discusses chronic kidney disease with nephrologist by email regarding ordering CT angio and risk of further renal injury from additional contrast load and LVAD surgery—prior to clinic visit, in preparation.
  - Discusses with patient and spouse, the risks of undergoing LVAD surgery and CT angio needed redo sternotomy
- After discussion with patient, shared-decision making to not undergo surgery due to risks, including undesired high likelihood of permanent dialysis--CT angio not ordered

Case Example #3—MDM LEVEL of SERVICE: ESTABLISHED patient visit—CPT 99215 (3 of 3 Elements: High, Extensive, & High)

Problem Addressed:

- **End-stage ischemic cardiomyopathy, severe progression**
- **Element #1: High** ***(acute/chronic condition that poses threat to life/bodily function)***

Data Reviewed/Analyzed:

- **Category 1: 4 unique source/test** ***(2 unique imaging reports reviewed (caths/echo); 1 nephrology note reviewed; CT angio considered but not ordered due to undesirable risk to patient)***
- **Category 2: n/a** ***(no interpretation documented)***
- **Category 3: Discussion of management** ***(discussion with heart failure cardiologist and nephrologist)***
- **Element #2: Extensive (2 of 3 categories met)**

Risk:

- **Procedural risk: LVAD**
  - **Stroke, post-cardiotomy shock, bleeding, renal failure, infection, etc.**
  - **Redo sternotomy**
- **Patient risk factors:**
  - **CAD/CABG, CKD-dialysis**
- **Element #3: High** ***(De-escalate care because of high risk/poor prognosis)***

Case Example # 4

- 35 y/o NEW patient referred for posterior mediastinal mass noted on CT scan ordered by PCP for workup of sternochondral pain
- Surgeon performs relevant hx/exam, and reviews and documents following:
  - Reviews images of CT imaging—interprets as paravertebral mass, likely a neurogenic tumor, difficult to determine if there is widening of neural foramen→ Orders MRI of thoracic spine for better imaging of spinal column
  - Discusses management with patient—location of tumor does not correlate anatomically with location chest pain, but recommends surgical resection with combined approach with neurosurgery
- Patient to agrees to surgery and will return for pre-op teaching after MRI completed

Case Example #4—MDM LEVEL of SERVICE: NEW patient visit—CPT 99204 (2 of 3 Elements: Mod, Mod, High)

Problem Addressed:

- **Paravertebral tumor**
- **Element #1: Moderate** ***(Undiagnosed new problem with uncertain prognosis)***

Data Reviewed/Analyzed:

- **Category 1: n/a (*MRI ordered but not analyzed/interpreted yet*)**
- **Category 2: Interpretation of CT images toward MDM *(review of CT images)***
- **Category 3: n/a (no discussion with neurosurgeon documented)**
- **Element #2: Moderate (1 of 3 categories met)**

Risk:

- **MRI study—minimal**
- **Surgical management—High *(Decision regarding elective major surgery with procedure risk factors—risk of spinal canal injury)***
- **Element #3: High**

Case Example #5

- 80 y/o ESTABLISHED patient with COPD, CHF referred by PCP for ongoing chest pain after recently seen in urgent care following ground level fall. Pt accompanied by daughter. In office, patient is tachypneic with shallow, labored breathing, and confused.
- Surgeon performs relevant hx/exam, and reviews and documents following:
  - Pulse oximetry reads “85%”; history obtained from daughter due to patient agitation, confusion, and shortness of breath; therefore, unable to provide history.
  - Orders CXR→ reviews, shows moderate-sized pleural effusion, small pneumothorax, minimally displaced single rib fracture
  - Discusses management with patient & daughter→ Recommends admission to hospitalization for further management and work-up
- Patient has DNR/DNI status, but daughter (DPOA) agrees to the admission

Case Example #5—MDM LEVEL of SERVICE: ESTABLISHED patient visit—CPT 99215 (2 of 3 Elements: High, Mod, High)

Problem Addressed:

- **Symptoms/Sx: Tachypnea/Hypoxia/ Chest pain/Pleural effusion**
- **Element #1: High *(Acute injury/illness that poses threat to life/bodily function)***

Data Reviewed/Analyzed:

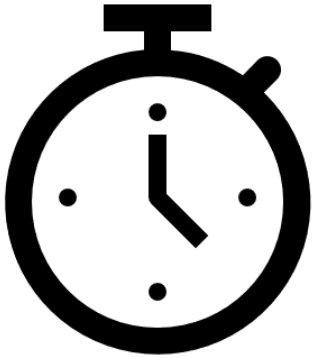
- **Category 1: n/a (*CXR ordered but counted as interpretation, Pulse oximetry reading is not a test*)**
- **Category 2: Interpretation of CXR images toward MDM *(CXR images)***
- **Category 3: n/a**

- **Element #2: Moderate (1 of 3 categories met)**

Risk:

- **Element #3: High *(Decision regarding hospitalization)***

Outpatient/Office Visit CODING based on TOTAL TIME



Effective Jan 1, 2021

TOTAL TIME of Billing Provider on Date of Encounter BOTH Face-to-Face AND Non-Face-to-Face

Using TIME for Code selection in 2021

- TOTAL TIME on DATE of ENCOUNTER may be used instead of MDM for code selection
- TIME spent in "counseling and coordination of care" **NO LONGER** needs to dominate (> 50%) the TOTAL TIME spent providing the service

NEW OUTPATIENT PATIENT CPT/HCPCS CODE
Divided into 15” intervals

CODE	Prior to 2021 (Face-to-Face TYPICAL TIME)	Effective in 2021 (TOTAL TIME-specific range)
99201	10min	**Deleted in 2021**
99202	20min	**15-29min**
99203	30min	**30-44min**
99204	45min	**45-59min**
99205	60min	**60-74min**
+G2212 (HCPCS) +99417 (CPT)	N/A	**Each additional 15min increment (report w/ 99205)**

ESTABLISHED PATIENT CPT/HCPCS CODE Divided into 10” intervals

CODE	Prior to 2021 (Face-to-Face TYPICAL TIME)	Effective in 2021 (TOTAL TIME-specific range)
99211	5min	**Time N/A**
99212	10min	**10-19min**
99213	15min	**20-29min**
99214	25min	**30-39min**
99215	40min	**40-54min**
+G2212 (HCPCS) +99417 (CPT)	N/A	**Each additional 15min increment (report w/ 99205)**

TOTAL TIME—What can count toward time:

Activities performed that may count toward TOTAL TIME if performed and NOT separately reportable:

- Preparing to see the patient (eg, 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
- Documenting clinical information in the electronic or other health record
- Documenting clinical information in the health record
- Independently interpreting results & communicating results to the patient/family/caregiver
- Care coordination

TOTAL TIME—What does NOT count toward time:

- Time spent by STAFF does NOT count
- Time spent performing procedure(s) which are separately reportable does NOT count
- Time spent in general teaching and not required for management of a specific patient does NOT count
- Time spent in travel does NOT count

Prolonged Service on the Date of an OFFICE/OTHER OUTPATIENT VISIT: Add-on Code changes: G2212 and 99417

HCPCS code +G2212 *(use for Medicare patients)*

Prolonged office or other outpatient evaluation and management service(s) beyond the ***MAXIMUM*** *required time of the primary procedure which has been selected using* ***total time on the date of the primary service****;* ***each additional 15 minutes*** *by the physician or qualified healthcare professional,* ***with or without direct patient contact***

(List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)

(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)

(Do not report G2212 for any time unit less than 15 minutes).

CPT code +99417 *(Do not use for Medicare patients—Check with Non-Medicare Payors for rules on reporting +G2212 or +99417)*

Prolonged office or other outpatient evaluation and management service(s) beyond the **MINIMUM** required time of the primary procedure which has been selected using **total time**, requiring total time **with or without direct patient contact** beyond the usual service, **on the date of the primary service**, **each 15 minutes** of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

- (Use 99417 in conjunction with **99205, 99215**)
- (Do not report 99417 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)
- (Do not report 99417 for any time unit less than 15 minutes)

Reporting HCPCS Code +G2212 with 99205/99215 when TOTAL TIME is used to select Code

*CMS rule: Do NOT report +G2212 until **additional 15min beyond MAXIMUM** required time for primary procedure

New Patient Office/Outpatient E/M	
Total Time	**CPT/HCPCS Code**
60-74*min	99205
75-88 min	99205
89-103min	99205 x 1 +G2212 x 1
104-118min	99205 x 1 +G2212 x 2
119min or more	99205 x 1 +G2212 x 3 or more for each add' full 15min increment

Establ Patient Office/Outpatient E/M TOTAL TIME	
Total Time	**CPT/HCPCS Code**
40-54*min	99215
55-68 min	99215
69-83min	99215 x 1 + G2212 x 1
84-98min	99215 x 1 + G2212 x2
99min or more	99215 x 1 + G2212 x 3 or more for each full add' 15min increment

Reporting CPT Code +99417 with 99205/99215 when TOTAL TIME is Reported to Select Code

*AMA CPT rule: May report +99417 after additional 15min beyond the **MINIMUM** required time of the primary procedure

New Patient Office/Outpatient E/M	
Total Time	**CPT Code**
60*-74min	99205
75-89min	99205 x 1 +99417 x 1
90-104min	99205 x 1 +99417 x 2
105min or more	99205 x 1 +99417 x 3 or more for each add' 15min

Establ Patient Office/Outpatient E/M TOTAL TIME	
Total Time	**CPT Code**
40*-54min	99215
55-69 min	99215 x 1 +99417 x 1
70-84min	99215 x 1 +99417 x 2
85min or more	99215 x 1 +99417 x 3 or more for each add' 15min

- TOTAL TIME→ Documentation should reflect and capture the time spent on various “countable” activities performed by the provider

  - Example: *I spent a **total time** of 40 minutes **today** on this new patient encounter. This time was spent reviewing external records and cath and echo images prior to the visit; performing history and examination and discussing with the patient and his partner the risks and benefits of different treatment options for his coronary disease. I also discussed his case with the referring cardiologist and shared with the patient that it was both of our professional opinions that despite the invasiveness of bypass surgery over PCI, we felt with his diabetes and cardiac function, the long-term benefit of CABG would be superior. This time also includes the time I spent charting, ordering labs and vascular studies for this patient. The patient would like to consider today’s discussion with his children before deciding to proceed.*

Final thoughts… clear documentation facilitates appropriate, accurate coding

- For selection of service level based on MDM, document clearly that the billing provider personally performed services related to the DATA MANAGEMENT: e.g. “I ordered, I reviewed, I interpreted, I discussed with . . .”
- Document PROBLEM(s) ADDRESSED to help classify the problem into the defined categories of complexity based on your evaluation
- Include the RISKS associated with the surgical procedure and the RISKS of patient CO-MORBIDITIES when documenting the RISK of MANAGEMENT—*(eg. don’t assume that auditors will know that a redo aortic valve replacement in a young adult with a history of chest radiation for past lymphoma is HIGH risk if you don’t document it)*

Thank you for your participation