2021 E/M FAQ's

Topics:

- Medical Decision Making
- Time
- Other

Medical Decision Making

1. **If a provider orders an over-the-counter (OTC) medication, would the Medical Decision Making score as Low Risk?**
   Over- the-counter (OTC) medications are not always without risk and therefore are not always considered low risk for purposes of MDM.
   For example, recommending an OTC medication to a patient with several co-morbidities (example: a patient with diabetes, hypertension, and renal failure) may lead to a detailed discussion of risk, therefore each encounter should be evaluated individually and not necessarily characterized as low risk.

2. **If a patient returns to a Rheumatology office, and lab tests are imported and reviewed from the prior years. For example, three years of elevated erythrocyte sedimentation rate (ESR) results. Would the rheumatologist/provider count each ESR test result?**
   No, if the provider reviews multiple lab results for the same test that were performed in prior years (like the above example: three separate ESR results) this is counted only once.

Time

1. **How should a provider consider coding by time regarding the day of the encounter? By the calendar date or a 24- hour period?**
   When coding by time, only the time spent on the date of the encounter is acceptable.

2. **If a provider based the level of the visit on the total time, is the documentation of an assessment and plan required?**
   Yes, the assessment and plan should always be documented for each encounter so that continuity of care for a patient is established and maintained. If the total

time is not clearly documented and the medical record also lacks documentation of an assessment and plan, the visit may be unbillable. The level billed for the visit can be based on whichever is more advantageous if both the Medical Decision Making (assessment and plan) and total time is documented.

3. **How would a provider document the following additional time-based services if the billing provider is leveling the visit based on total time?**

   Examples:

   - **Advanced care planning**
   - **Alcohol and/or substance abuse structured screening**
   - **Depression screening**
   - **Tobacco cessation/counseling**

   If time is spent performing other services identified by a CPT® code during the same date of service, do not include that time in the office/outpatient E/M. The time for each service must always be clearly documented separately in the record.

   Example (billing 99214-25 and 99408): A total of 35 minutes was spent on this visit, with 30 minutes spent reviewing previous notes, counseling the patient on pancreatitis and diabetes, ordering tests, ordering/refilling medications, and documenting the findings in the note. An additional 20 minutes was for alcohol abuse instruction including the importance of quitting with options for counseling and a quit plan.

4. **What is not included in the total time?**

   - Time spent by clinical staff such as that of a medical assistant, registered nurse or other facility employed staff
   - Time spent on travel
     - Example: The time to travel for a home health visit is not included.
   - Time spent by a medical scribe/transcriptionist documenting in an electronic health record.
   - Time spent on involvement with prior authorizations with the insurance company
   - Time spent on separately reportable services that will be billed by the same provider.

Other

1. **Has the modifier 25 guidance changed effective January 1, 2021?**
   No, the guidance remains the same. Highmark follows AMA/CPT, CMS-Global Period Booklet and National Correct Coding Initiative Policy Manual for modifier 25 guidance. In addition, Highmark follows MAC (Medicare Administrative Contractor) Guidance: Novita's and Palmetto GBA Jurisdiction M Part B. There is also a Highmark Reimbursement Policy regarding modifier 25: RP-042.

   Per AMA/CPT book: Modifier 25 is defined as a significant, separately identifiable established E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.
   - Modifier 25 is used to facilitate billing of the E/M service on the day of a procedure for which separate payment may be made.
   - Modifier 25 is used to report a significant, separately identifiable E/M service by the same physician on the same day of the procedure.
   - Provider's documentation should clearly indicate on the day the procedure was performed that a significant, separately identifiable E/M service was provided. The E/M service should clearly reflect that it was performed for a reason unrelated (above and beyond the usual preoperative and postoperative care) to the minor surgical procedure performed.
   - A different diagnosis is not required for reporting the E/M service on the same date as the procedure

References:

1. AAPC: Knowledge Center2021 E/M Guidelines- May
   - https://www.aapc.com/blog/69102-begin-to-understand-2021-e-m-guidelines/
2. AMA/CPT Book 2020 and 2021
3. Novitas: FAQ 2021 EM Updates
   - https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00005056#P15_309
4. AAPC: Knowledge Center: Get Answers to the Top 10 Questions About Coding for Office and Other Outpatient Services in 2021
   - https://www.aapc.com/blog/69102-begin-to-understand-2021-e-m-guidelines/