

## E/M Office or Other Outpatient Services: Top Practitioner Questions

A Joint A/B MAC Medical Review Collaboration Workgroup Publication

The A/B MACs partnered together to answer practitioners' top questions related to evaluation and management (E/M) office and other outpatient services (procedure codes 99202-99215) effective on January 1, 2021. Our goal is to provide consistent communication so that you have the information you need to submit claims appropriately and receive proper payment in a timely manner.

Note: This educational product reflects the American Medical Association's (AMA) code and guideline changes published on March 9, 2021, and includes multiple definitions of the terms they use in the Medical Decision-Making (MDM) table. Please review the definitions when evaluating this document. We also use the term "practitioner" to include the physician or other qualified health care professional (QHCP). This is a person who can submit claims to Medicare for E/M services.

### Question and Answer Categories

#### Search Tip

To quickly find a specific word or phrase on this page, use CTRL + F, enter the key word and hit the enter key to be taken to any highlighted matches.

#### Time

1. How should the patient's medical record indicate the specific times and activities for each encounter when time is relied upon for coding and payment?

The best practice is to document the activities and the time the practitioner spent. Recording the start and stop times of your activities is the most complete document, but not necessary. The medical record must support the level of service chosen. An encounter includes both face-to-face and non-face-to-face time between the practitioner and the patient. The AMA document includes a description of the non-face-to-face activities the practitioner can use to account for time. When using time, only time spent on the calendar date of the face-to-face service counts toward choosing your level of service. CMS includes these instructions: "Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start or stop time or documentation of total time) if time is relied upon to support the E/M visit." (Source: <https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf>.)

2. The practitioner spent time reviewing charts and results or answering questions on a different date than the face-to-face encounter (e.g., activities occurring before or after the date of the encounter). Can the practitioner count this time in choosing the level of service?

No. When using time to choose the level of service, use only the time spent on the date of the encounter.

3. Should the practitioner provide counseling or coordination of care to use time to choose their level of service?

No. The AMA does not require the practitioner to provide counseling or coordination of care to choose the procedure code based on the time spent.

4. If the practitioner does not document on the date of the encounter, does this mean the practitioner cannot use time to choose my level of service?

The practitioner can still use the time spent face-to-face and for appropriate non-face-to-face activities on the date of the encounter to choose the procedure code. If documenting the service on a different calendar date, do not include the time spent documenting.

5. The electronic medical record requires/records a start and stop time for the face-to-face service. How would the practitioner document the time spent on the non-face-to face care?

Notate this time in the medical record. Medicare would be unable to count non-face-to-face time without notation in the medical record.

6. The practitioner spends approximately 25 minutes on each patient. Another physician spends 35 total minutes on each patient. How would we choose the correct code choice based on these differences?

If choosing the level of service based on time, code to the time documented. This could result in different levels of service. Medicare would evaluate the time the practitioner documented.

7. The practitioner sees a new patient and spends 12 minutes on that calendar day. Can the practitioner choose an established patient procedure code?

No. The patient is still a new patient. The 99202 new patient visit code requires at least 15 minutes of time. If providing a new patient service and the time requirement is not met, the practitioner would code using the MDM.

8. Can the practitioner count time spent by ancillary staff providing face-to-face or non-face-to face services?

No. Only count time spent by the practitioner to choose the level of service.

9. How does the practitioner document the new prolonged time procedure code?

The new procedure code is G2212. The medical record should show the practitioner exceeded the time for 99205 or 99215 by 15 minutes. This is only available when the practitioner uses time to choose your procedure code. There is a contrast between Medicare guidelines and the AMA published information. The time for 99205 is 60 to 74 minutes. Medicare can allow additional time

when the practitioner has spent at least 89 minutes on that patient. The time for 99215 is 40 to 54 minutes. The practitioner can use the new code when the medical record shows at least 69 minutes. If you have more than one unit of service, you can submit on one line with multiple units. You could have an additional unit of service when meeting the next unit of service of 104 or 84 minutes. Once the practitioner meets the threshold amount of time, they can submit this code. Medicare does not require the practitioner to meet the half-way point prior to submitting.

10. My level of service is a 99205 or 99215 based on MDM. Can the practitioner use the new prolonged procedure code, G2212?

No. This code (G2212) is an add-on code to 99205 or 99215 only when choosing the level of service based on time.

11. Do we have to document start and stop times for the prolonged service?

The current instructions in the CMS Internet-Only Manual (IOM) 100-04, Chapter 12, Section 30.6.15.D indicate the practitioner must document start and stop times for prolonged services.

12. The practitioner codes the E/M based on time and performs a procedure on the same date. Does the practitioner subtract the actual time performing the procedure or the fee schedule “normal time”?

The practitioner would subtract the actual time spent on the activities relating to the procedure from the time for the E/M service. The identified “fee schedule” time is time used for pricing the service.

13. Can the practitioner count both the resident’s and their time, as the teaching physician, to choose the level of service? Under the primary care exception, does the practitioner count both their time, as a teaching physician, and the resident’s time?

Per the 2022 Final Rule, when time is used, only time spent by the teaching physician in qualifying activities can be included for purposes of visit level selection. Under the primary care exception, time cannot be used to select the visit level – only MDM may be used to select E/M visit levels in this scenario, to avoid possible inappropriate coding that reflects residents inefficiencies.

14. The practitioner requested and reviewed all records from the patient’s numerous stays at a facility (one unique source). Can the practitioner use the time required to review all the records?

The practitioner can count the time they spent in both face-to-face and non-face-to-face time for that patient on the date of the encounter. The AMA document includes the specific activities.

[Back to Categories](#)

## Medical Decision-Making

1. Under the 1995 or 1997 Documentation Guidelines (DG), a new patient had to meet the level for three out of three – history, exam, and medical decision making. Is that still valid for the new instructions?

The AMA requirements for office or outpatient service level determination are the same for the new and established patients. The practitioner must meet or exceed the level for two out of the three categories of the MDM. The revised 2021 MDM categories are number, and complexity of problems addressed, amount and complexity of data to be reviewed and analyzed, and risk of complications and morbidity or mortality of patient management.

2. My office uses a commercially available tool or electronic medical record (EMR) functionality to choose the level of services. Can the practitioner continue to use this for services after January 1, 2021?

There are multiple tools available to assist you in choosing the level of service. The choice of using a separate tool or using an EMR to assist in choosing the level of care is yours.

3. The MDM table states the practitioner must meet two out of the three categories. What does this mean?

The levels of MDM are Straightforward, Low, Moderate, and High. Documentation must support the level in at least two out of the three categories. For example:

Low Number and Complexity of Problems addressed,

Limited amount and complexity of data to be reviewed and analyzed, and

Low risk of morbidity from additional diagnostic testing or treatment

The level of service would be low 99203 or 99213

Another example:

Low level of Number and Complexity of Problems addressed,

Moderate level of Amount and Complexity of Data to be reviewed and analyzed, and

High level of risk of morbidity from additional diagnostic testing or treatment

The level of service would be moderate 99204 or 99214.

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

When Medicare reviews documentation, we will evaluate based on MDM or time to support the level 99205 or 99215.

5. Will the medical record still require history and an exam? Will the MDM now establish medical necessity?

Documentation must show the medical necessity of the service. This is the diagnosis or treatment of an illness or injury or treatment of a malformed body member. The guidelines indicate you perform the history and exam as clinically appropriate. Your documentation must support the medical necessity of the service and the level of service chosen.

6. The patient's problem today results in a referral to another specialty. When using MDM to choose the level of service, how would we count this?

You're addressing or managing a problem when evaluating or treating during the encounter. A notation in the medical record indicating another practitioner is treating without additional assessment or care coordination does not qualify for MDM. Referral without evaluation (by history, exam, or diagnostic study(ies) or consideration of treatment does not qualify for MDM as nothing is being addressed or managed. If you address the problem, utilize the level of the problem, amount and complexity of data, and risk to patient from the referral to assign your category of MDM.

7. Currently, the practitioner documents the review of previous history or exam documentation in the patient's medical record. Will the practitioner be able to do that for office or other outpatient services provided in 2021 and beyond?

CMS allows a review of the history and exam in the patient's medical records. This applies to all categories of E/M services. You can identify what you reviewed and any updates. The review of your previous notes or notes from a member of the same group with the same specialty do not contribute to the level of MDM. For office or other outpatient services, the practitioner only needs to perform the history and exam when they believe it's clinically appropriate.

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

The practitioner can submit the full range of codes. Clinical and ancillary staff, pharmacist, etc., can only submit the 99211 level of service. The services must also meet the incident to requirements. This applies to your Medicare patients. Incident to guidelines did not change. This is in the CMS IOM Publication 100-02, Medicare Benefits Policy Manual, Chapter 15, Section 60

9. The practitioner believes the nature of the presenting problem deserves a higher level of service than the time or MDM table would indicate. Can the practitioner submit the higher level of service?

Code the level of service based on time or the MDM table. The nature of the presenting problem is merely one component of the MDM. It does not choose the level of service. Reimbursement is for the work and expertise provided to the patient during the encounter.

10. The G2212 is for prolonged time when choosing the level of service based on time. The practitioner chooses the level of service based on MDM. Can the practitioner use the 99354 or 99355 codes to report additional time?

No. When choosing the level of service based on MDM, don't submit additional time codes. These codes should only be used when time is chosen for the level of service.

11. A procedure was provided on the same date as the E/M. Does the practitioner have to choose the level of service based only on MDM or time?

E/M services and surgery on the same date are subject to the global surgery guidelines. The IOM 100-04, Chapter 12, Section 40 contains more information. If the E/M is separately payable, utilize time or MDM to choose the level. If using time, subtract the time spent performing all the activities for the procedure.

12. The patient presents with what appears to be a self-limited or minor problem. Labs are ordered and results received a week later. The results show an acute illness that poses a threat to life. Can the medical documentation be amended to increase the level of service?

No. The test results would not alter the service previously provided to the patient.

13. Must the practitioner document history taken, or exam performed to submit an E/M service?

The AMA document states in part “Office or other outpatient services include a medically appropriate history and physical examination, when performed. The nature and extent of the history and physical examination are determined by the treating physician or other qualified health care professional.” The document goes on to state “The extent of history or physical examination is not an element in selection of the level of office or outpatient services.” While Medicare would expect some form of history or exam to assist in the MDM, the guidelines indicate the practitioner performs the history and exam as clinically appropriate. Documentation must support the medical necessity of the service and the level of service chosen.

[Back to Categories](#)

#### Number of Problems Addressed

1. If the patient has more than one problem, can the practitioner increase the number of problems addressed to a higher level?

No. Some of the bullets under the number of problems addressed indicate “1 or more”. This would mean that additional problems in that bullet would still count for one bullet. Some of the bullets indicate “1”. Choose your level based on the problem(s) addressed and the highest level or problem(s) indicated. Look to the other two elements, data, and risk, to determine if a higher level of service is appropriate.

2. How would a diagnosis of obesity or overweight count in the number and complexity of problems?

Base the selection of the level on how the issue is being addressed. Documentation must support the AMA definition of a problem addressed. This could be a self-limited or minor problem. This could be a stable chronic condition if the patient is at their goal. This could be one or more chronic illnesses with severe exacerbation, progression, or side effect of treatment. Notation in the patient’s medical record without additional assessment or care does not qualify as being addressed by the practitioner.

3. The practitioner is seeing the patient for one of the following:

resolved problem where the patient is asymptomatic

history of cancer

family history of diabetes or cancer

Under which level of problem addressed or analyzed would this fall?

For Medicare reimbursement, the documentation must show the medical necessity for the service. Use your documentation to determine the reason for the encounter and under which AMA definition the problem addressed would fall. This would be your clinical decision.

4. How does the practitioner choose a level when they only have sign or symptoms and no diagnosis?

The AMA defines a problem as “a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.” The documentation must ultimately support the level of code chosen and would determine where the signs or symptoms fall for the number and complexity of problems addressed.

5. Under which level of problem addressed would a patient encounter to renew birth control fall?

There are several things to consider. The first is medical necessity. Does the service meet the definition of medical necessity which is to diagnose or treat an illness or injury or to treat a malformed body member? The second is whether there are other procedure codes rather than E/M that would more accurately reflect the service provided. The third is the determination of the problem addressed and the AMA definitions of the problem based on the individual patient.

6. The patient’s medical record contains several chronic conditions not addressed during the encounter. Can these conditions be counted to choose the level of service?

The AMA defines a problem addressed in part as “addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the services.” Diagnoses contained in the medical record do not count toward choosing your level of care unless you’re evaluating or treating the diagnosis. The chronic condition could also assist in choosing your level of care if you’re evaluating or treating this in connection with the specific disease, illness or injury you’re addressing during the encounter.

7. What is the difference between “acute, uncomplicated illness or injury” and “acute, complicated injury”?

The AMA defines acute, uncomplicated illness or injury as “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 with functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribe course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simply sprain.” The AMA defines acute, complicated injury as “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 associated with risk of mortality. An example may be a head injury with brief loss of consciousness.” Evaluate your documentation to determine how the problems addressed compare to the definitions.

8. The patient has had a cough for three months. Is this a chronic stable condition?

The AMA definition for a stable chronic condition is “A problem with an expected duration of at least one year or until the death of the patient.” AMA further states “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.” Your documentation on the expected duration and goal would determine whether the problem is a chronic stable condition.

9. If the patient has systemic conditions such as fever, body aches, or fatigue, can the practitioner count this as “acute illness with systemic conditions”?

The AMA definition of acute illness with systemic conditions is “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, shorten the course of illness, or to prevent complications, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be a single system. Examples may include pyelonephritis, pneumonitis, or colitis.” A patient with systemic conditions does not necessarily correspond to a Moderate level of problems addressed. Documentation must support the level chosen.

10. The patient’s presents with a new problem. Is this considered an “undiagnosed new problem”?

The complete AMA problem definition is “undiagnosed new problem with uncertain prognosis.” This is a new problem to the patient not the practitioner. If the patient was aware of the diagnosis before the specific encounter, this is not a new problem. In addition, the AMA definition is “A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.” Documentation must support the new diagnosis and how the problem would likely result in a high risk of morbidity without treatment. A patient may have a new problem that could fall into one of the other categories such as a sinus infection.

11. The patient has a chronic condition. The condition remains the same, but they are not at goal. How is this counted?

This would fall into the Moderate category of the number and complexity of problems addressed. Chronic illness with exacerbation, progression, or side effects of treatment includes a patient who is not at goal. Documentation would include the goal and the patient’s status toward that goal.

12. Does the patient have to be “suicidal with a plan” to use the “acute or chronic illness that poses a threat to life or bodily function?”

Documentation must support the threat to life or bodily function. The AMA gives an example of psychiatric illness with potential threat to self or others. The AMA does not specify “suicidal with a plan.”

13. Seeing the patient to start or renew birth control, where would this fall under the level of problem addressed?

Base the level of problem addressed on the patient condition. An otherwise healthy patient would fall into the “self-limited or minor problem.” Documentation must support the patient condition.

Amount and Complexity of Data



1. Can we count an action in one of the three categories provided the day before the patient encounter?

Yes, verify the practitioner has not previously used the order of the test(s) in choosing a level of service for a previous encounter. Verify the practitioner has not previously billed for a professional service. The time used to determine the pricing for the E/M service is three days before or seven days after the patient encounter.

2. The column of amount and complexity of data indicates "not separately reported". What does this mean?

The practitioner cannot submit a separate charge for the professional service when using that as a data element. Look to other procedure codes that accurately reflect the service. Examples can include billing for:

Professional interpretation of test or studies

Charges for interprofessional consultations

Physiological testing and monitoring

3. The patient brings a log of their food intake, blood pressures, blood sugars, etc. Can the practitioner count this as "external notes"?

No. Reviewing notes from another unique source (data category 1) would be notes from another health care professional or organization. Look to other procedure codes. These could include physiological monitoring. Those codes may be more appropriate for that review. When choosing your level of service based on time, the practitioner can count the time spent reviewing the log.

4. When reviewing external notes, how does the practitioner indicate the review? Must the practitioner provide a summary of the notes?

When incorporating external notes into the patient medical record, a notation of reviewed is sufficient. This should include a signature and date of the review. The medical record will need to show the notes reviewed. If not incorporated, then document a summary of the external notes. Your medical record must indicate how the practitioner is using the information to treat the patient.

5. Notes reviewed from a previous ER visit and included lab test results. Would credit be given separately for the review of the note and the review of the tests separately?

No. The AMA document states, "Review of all material from any unique source counts as one element toward MDM." Reviewing the notes and tests results for the ER encounter counts once. Reviewing two previous ER encounters from the same ER would count only once.

6. The patient provides verbal results of tests ordered by another practitioner. Can this be counted as a review of unique tests?

No. A patient's verbal reporting of test results is not the same as reviewing test results.

7. Can we count the order and the review of the testing separately to meet category 1 requirements for a moderate level of service?

The order and review of the test is only counted once. The AMA states in the definition of Analyzed states in part “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.”

8. Can credit be given for the review of previous notes for the patient as part of category 1?

Category 1 includes the review of “external notes.” The AMA defines external as “External records, communications and test results are from an external physician, other qualified health care professional, facility, or health care organization.” The AMA definition of external physician or other health care professional is “An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organization provider such as a hospital, nursing facility, or home health care agency.” Your review of your previous notes are not “external” notes.

9. Can credit be given for the review of the PHQ-9, PHQ-2, and GAD-7 responses as psychometric tests?

Documentation of the reviewed results of the patient completed tests can count as a psychometric testing.

10. The practitioner reviewed the uploaded results of tests ordered by an external entity into the patient’s medical record. Can credit be given for the review of this unique test?

Since the practitioner or a member of your group with the same specialty did not order the service, credit could not be given for the review of a test. If the test was part of an external note, the practitioner would only count the review of the external note. Documentation should show the practitioner reviewed the results and used those results in the medical decision-making for the patient.

11. The practitioner checked the state’s automated prescription system to verify patient is taking opioids as prescribed. Would this fall into Category 3 – discussion of management or test interpretation?

This would fall into Category 1 under the “review of external notes from each unique source”.

12. Staff checked the state’s automated prescription system to verify the patient is taking opioids as prescribed. The staff provided the practitioner the results verbally. Can the practitioner include this under “review of external notes from each unique source”?

No. The staff performed the review.

13. The medical record contains the test results. Can credit be given for review of the tests?

Document the review or analysis of the test results. Documentation must show your review and use for your medical decision for that patient encounter. Credit cannot be given for a separate charge for the professional component of the test or use the independent interpretation as a data element

14. The practitioner ordered a lab test during the encounter. Based on the results, the test should be repeated in one month. Can credit be given for the analysis of the second test as a data element for the next encounter?

Yes. Since the review was not included in the review of the second test as a data element for today's encounter.

15. Discuss the difference between analyzed, review, and independent interpretation.

The AMA defines:

Analyzed includes: "The process of using the data to make a medical decision for the patient. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment."

Review evaluates the test or results in determining the medical decision for that patient for that encounter.

Independent interpretation as "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 is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test."

16. During the last four encounters with the patient, the practitioner ordered a particular diagnostic test. The patient has yet to comply. Can these additional orders be used as a data element in subsequent encounters?

Yes. If a determination is needed for the test and order provided, one data point can be used for the individual encounter. Ordering a test includes those considered but not selected after shared decision-making. The patient may request a test, but the practitioner may decline to order. The physician may order, but the patient may decline. The practitioner may consider, but due to risk to the patient, may determine not to perform. Document the considerations and discussion.

17. The practitioner requested the patient get labs done two weeks from today. The analyzed results will be reviewed during the next encounter. Can credit be given for this data element?

Include the order of the test in today's encounter. The review of the test is part of the order and not counted separately.

18. The practitioner ordered a complete blood count, chemistry panel, and lipid test for the patient today. Can credit be given for the three unique tests under the amount and complexity of data?

The AMA defines unique in part as "A unique test is defined by the CPT code set. When multiple results of the same unique test (e.g., 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 identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count." The AMA does not require each unique test to be in a separate category of CPT codes.

19. Can multiple credits be given for ordering tests in different categories (e.g., labs and radiology)?

No. The practitioner must have separate tests, but they do not need to be in different categories of service.

20. Screening test were ordered (e.g., A1C, cholesterol, mammogram, screening colonoscopy, etc.) Will credit be given as a unique test data element?

Lab and radiology tests ordered, but perhaps not covered by Medicare, could still count as a unique test when part of the practitioner's medical decision for the patient.

21. The practitioner's documentation did not include a notation of a request for a test, but staff has a requisition. Can credit be given for this data element?

Documentation must show the need for the test in making medical decisions for the patient. Credit would not be given as one of the data elements.

22. Two tests were ordered with the same procedure code (right and left elbow x-ray). Would credit be given for one or two data elements?

The practitioner can use this as two. Credit would be given for two elements, even though the procedure code is the same.

23. During today's encounter, one lab test was ordered for patient to repeat quarterly. Can credit be given for the order today and the review of the subsequent tests in the next encounter?

In the case of recurring orders, credit can be given for each new result in the encounter in which the practitioner analyzed the result. For example, an encounter that includes an order for monthly prothrombin times could count for one test ordered and reviewed. Additional future results, if analyzed in subsequent encounters, can count as a single test in that encounter.

24. The practitioner ordered an electromyography (EMG) and a colonoscopy for the patient. Is credit given under the Data or Risk element?

Medicare would consider these services as procedures rather than tests. However, the determining factors would be the reason for the order. If ordering to determine results for further medical decision-making, the practitioner can count this as a test. If the practitioner ordered or perform the test, this could be part of the Risk element. the E/M is subject to the global surgery guidelines.

25. Under Amount and Complexity of Data, the practitioner doesn't have the independent historian or discussion of management. Would have to order testing the patient does not need to meet the requirements?

The practitioner would not order testing just to meet a certain level of service. All testing and activities as part of the E/M service must be medically necessary for the patient. To meet a level of service, the practitioner must meet two out of the three elements.

26. What documentation is required to support the independent historian?

The AMA defines independent historian as "An individual (e.g., 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 (e.g., due to development 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. The independent historian does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.” Documentation must support the reason the patient is unable to provide the complete or reliable history, and from whom the practitioner obtained the additional history.

27. Can credit be given for the use of an interpreter as an independent historian?

No. An interpreter is not the same as an independent historian. The patient is providing the information. The interpreter is translating the information from the patient to the practitioner.

28. A pulse oximetry (procedure code 94760) was performed to gather the vitals for the patient. Can credit be given for this as a data element?

This is not a data element. The AMA states “For purposes of data reviewed and analyzed, pulse oximetry is not a test.” This would be part of the clinically appropriate exam.

29. The practitioner ordered a radiology test. The radiologist in the group will provide and bill for the professional component. Can the performance be used as an independent interpretation data element?

The first consideration is whether a review or an independent interpretation of the test was performed. Documentation would determine what was performed. The AMA defines an independent interpretation as “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 is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.” The practitioner providing the E/M and the practitioner providing the formal interpretation must be different specialties.

30. Does “Discussion of Management or Test Interpretation” include other professionals in the office? An example could be a pharmacist or mental health practitioner. Does the patient’s previous Family Medicine doctor from outside practice count? Can we count the discussion between the resident and the teaching physician?

The “Discussion of Management or Test Interpretation” is part of Amount and Complexity of Data reviewed and analyzed. This is category 3 in the moderate and high level. This is a discussion of management or test interpretation with external physician, other health care professional or appropriate source (not separately reported). The discussion would be on the date of the encounter or within a day or two. This is an individual (doctor or non-physician practitioner) not in the same group or with a different specialty. This can also include other licensed professionals practicing independently. It may also be a facility such as hospital, nursing facility, or home health care agency. A pharmacist or mental health practitioner could be appropriate. A practitioner with a different specialty could be appropriate. A practitioner with the same specialty, but in a different group could also be appropriate. The definition of “appropriate source” includes professional sources who are not health care professionals, but are involved in patient management (e.g.,

Lawyer, parole officer, case manager, or teacher). This would not include a discussion between a resident and teaching physician. Document should show how the discussion played a part in the medical decision for the patient.

31. Another physician provided a letter explaining their previous care of the patient. The practitioner indicated they would request medical records from another practitioner. Can credit be given for this as a Category 3 – Discussion of management or test interpretation?

No. Category 3 is a discussion between practitioners. A letter or an indication of future activity would not satisfy this requirement. Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries. Sending chart notes or written exchanges within the progress notes do not qualify as interactive exchanges.

32. The practitioner texted or messaged another physician concerning the patient care. Would this text or message count as “discussion of management or test interpretation”?

Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries. Sending chart notes or written exchanges within the progress notes do not qualify. The discussion does not need to be on the date of the encounter. However, shall only be counted once and only when used in the decision making of the encounter. It may be asynchronous, and the practitioner must initiate and complete within a short period, within a day or two.

[Back to Categories](#)

## Risk and Complications of Patient Management

1. The practitioner discussed possible surgery, hospitalization, etc. as listed in the risk category. Can these discussions be considered when the final decision is no to those options?

Yes, credit can be given for the discussions and options.

2. How will Medicare determine “minor” or “major” surgery?

Base the determination of minor or major surgery on the clinical condition for that specific patient. We would also review any medical record data that is specific to that patient. The type of anesthesia is also a consideration, examples include local anesthesia, conscious sedation, or general anesthesia. The AMA document includes the following:

“Surgery – Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by surgical package classifications.”

“Surgery, Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.”

“Surgery – Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.”

3. The practitioner ordered a CT with contrast; can credit be given as an order in the data category and the same test under the risk category?

Credit can be given for the order of the test under the amount and complexity of data. Credit could be given for the associated risk and use the resulting level in choosing the level of service.

4. What documentation would Medicare require to meet the substantial duration as part of the definition of morbidity?

The AMA document defines morbidity as “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 in nature.”

5. The MDM table does not have examples of straightforward or low in the risk category. Can we use examples provided in the 1995 and 1997 DGs?

The 1995 and 1997 DGs do not apply to procedure codes 99202 – 99215 provided January 1, 2021, and after. Documentation would need to support the level of risk as listed in the new document. Do not mix the 1995 or 1997 DG with the AMA MDM table. The AMA MDM table is for office and other outpatient services provided January 1, 2021 and after.

6. The practitioner determines the patient needs surgery during one encounter, but the patient must meet certain qualifications such as levels in blood work or reducing weight. The patient met the qualification for a subsequent encounter. Can credit be given for the decision for surgery in both encounters?

Credit could only be given for the decision for surgery at one encounter. This would be when the decision for the surgery was made, and the patient met the established criteria.

7. Please explain further “prescription drug management?”

Prescription drug management does not require a new drug, a new dosage, or a discontinuation of a current prescription. The medical record will show the physician work to determine the medical necessity of the prescription drugs. An encounter documented as only a prescription refill without documentation of a problem addressed would not suffice. The AMA defines a problem addressed in part as “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. Credit can be given for prescription medications considered but not given could be patient choice, possible drug interactions, etc. Prescription drug management does not include drugs injected during the current or subsequent encounter.

8. Can credit always be given as a moderate level of risk using the example of “prescription drug management” when we order an injection for the patient?

Ordering an injection for the patient is not prescription drug management. There can be many different reasons for ordering injections including, but not limited to, birth control, cancer



treatments, joint issues, allergies, and antibiotics. The column of risk is “Risk of Complications and Morbidity or Mortality of Patient Management.” The MDM table includes examples of situations that could fall under that category of risk. The AMA definition of morbidity reads “A state of illness or functional impairment that is expected to be a substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.”

The AMA definition of risk reads in part: “The probability and consequences of an event. The assessment of the level of risk is affected by the nature of event under consideration.” “Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified healthcare professional in the same specialty.” “For the purposes of MDM, level of risk is based on 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 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.” Choose the level of risk based on the physician or other qualified health care professional’s determination and documentation of the risk to that specific patient for that specific encounter for that specific treatment choice. Documentation in the medical record must support the decision for the treatment to bill for the administration of the injection and drug.

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

Yes, the primary care physician could decide surgery is a treatment option. Part of the medical decision-making is to determine whether to refer the patient for surgery.

10. The practitioner provided a sample prescription drug to the patient. Is this “prescription drug management”?

This would be counted as “prescription drug management.”

11. How would the practitioner document “social determinants to health”?

Document the social determinants and identify how these affect the MDM for that patient for that encounter. The AMA defines social determinants of health as “Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.”

12. Can “risks discussed with the patient” be documented and credit given?

Documentation should identify the specific risks associated with that patient and that procedure. Risk factors are those relevant to the patient and procedure. It is not required to use evidence-based risk calculators.

13. Instructing the patient to take an over-the-counter medication, the practitioner evaluates the possible interactions with the current prescription medications. Can credit be given as prescription drug management?

An order for an over the counter (OTC) drug does not count as prescription drug management. However, managing the patient’s prescription drugs in connection with adding an OTC or supplement would show prescription drug management. If the patient can purchase the drug OTC,



Medicare would not consider this a prescription drug. Documentation must show the additional risk or benefit to the patient taking this OTC drug. This can include the additional risk from off-label use, higher dosage, frequency changes, etc.

14. The practitioner ordered a lab with instructions to start a medication based on the result of the test. Can this be counted as prescription drug management?

Yes, this would count. Your documentation would describe the test and the actions to take depending on the result of the test.

15. The patient is refusing the advised treatment. Is this “social determinants of health?”

The AMA, “Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.” The patient’s non-compliance would not fall into this category. However, credit could be given for the medical decision made to determine the level of risk.

16. The practitioner advised the patient to start a prescription drug. The patient declined. Can this be used as a data element?

Yes. The medical decision for the patient is to start a medication therapy. Documentation would show the patient’s decline and any adjustments the physician made to the plan of care.

17. The practitioner is performing an encounter to provide a clearance for surgery at the request of the surgeon. Can this encounter be used as a “decision for surgery” in the risk column?

No. A determination of the patient risks for the surgical intervention is not being performed. The surgeon already made the decision for surgery. Utilize the problem the practitioner is addressing, amount or complexity of data and the risk to the patient from your decision to determine your level of care.

18. The practitioner ordered compression stockings and oxygen for the patient. Is this “prescription drug management”?

Ordering oxygen can be considered as prescription drug management, but not ordering of compression stockings.

19. Please further explain “drug therapy requiring intensive monitoring?”

The AMA definition states in part “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.” Monitoring is not less than quarterly. The monitoring is by lab test, a physiologic test, or imaging. Monitoring by history or exam does not qualify. 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.

20. Can we count Warfarin monitoring as Drug Therapy Monitoring?

Warfarin testing could meet the AMA definition when monitoring for toxicity. Examples:

Example 1: A patient with A-Fib who is chronically anticoagulated with routine laboratory testing and intermittent slight adjustments to their medication dosing would not be considered intensive monitoring or high risk.

Example 2: A patient with A-Fib has discontinued their chronic anticoagulation medication in preparation for a surgical procedure. After the procedure, the physician has restarted the patient's anticoagulation medication and performs multiple dosing titrations with laboratory testing to reach the desired effect. Significant medication adjustments with testing, or other interventions such as Vitamin K administration, would be considered intensive and high risk.

21. Can credit be given for a decision to send the patient to the emergency room as a “decision regarding hospitalization?”

Documentation must show your MDM. Medicare would look at the documentation to determine if the practitioner is sending the patient for evaluation by the ER physician or sending the patient to the ER to accomplish admission.

22. The patient’s chronic illness can cause extreme flare-ups that could lead to functional limitations or death. Can this always count as high risk?

The diagnosis, by itself, does not determine the risk level. Risk is the probability and consequences of an event. Base the level of risk on consequences of the problem(s) addressed at the encounter when treated appropriately as well as the content of the medical documentation.

[Back to Categories](#)

#### Miscellaneous

1. Does the organization have to choose whether to document using time or MDM as an organization?

No. Credit can be given using time or using MDM for each patient encounter. Choose the method most. Any Medicare review of documentation will look at both methods to support the level of service billed. If the medical record does not contain time, Medicare will review based on the MDM.

2. Patient encounter is for yearly physical exam and treatment of ongoing condition. How do we subtract the two services?

When using time, document time spent in services to treat the medical condition. Subtract time spent performing the services related to the yearly exam. Choose the level of service based on the remaining time. When using MDM, choose based on number and complexity of problems addressed for the ongoing condition. Use the documentation to support the preventive service first and then use the remaining documentation to support the covered service. Information in the documentation cannot be used twice.

3. Can we apply the information in the new MDM table to other categories of services? This will assist my hospitalist in coding the inpatient visits.

The AMA MDM table is for procedure codes 99202 – 99215. This applies for services January 1, 2021, and after. These are office or other outpatient services. This does not apply to any other category of service. Additional categories of E/M services are subject to the 1995 or 1997 DG.

4. Would the new rules apply for observation consultations?

The practitioner ordering the patient's observation care submits the observation category of services. Any other practitioners seeing the patient while in observation submits the 99201 – 99215 currently. The changes described apply when you use procedure codes 99201 – 99215.

5. What additional information can you provide concerning the add-on G-code, G2211?

This code is for additional intensity of services. Starting January 1, 2024, this code is paid separately.

Medicare doesn't pay in the following situations:

When reporting an associated office/outpatient E/M visit with modifier 25.

Method II critical access hospitals on the same encounter for type of bill 85X.

Reference: MM13272 Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25

6. Can you provide further information on the procedure codes 99415 and 99416?

Use procedure codes 99415 and 99416 when the practitioner supervises prolonged clinical staff time. The 99415 is the first hour of additional time and the 99416 is each additional 30 minutes. This could be appropriate when the practitioner is submitting a 99211 for ancillary staff incident to services. This could be appropriate when submitting for a higher level of service provided by the physicians. The ancillary staff are completing additional services with that patient.

7. How does the practitioner submit for the 99358? Can it be connected to the office or other outpatient codes in 2021?

The practitioner cannot use the 99358 and 99359 in connection with office or outpatient E/M codes starting in 2021. The code will still be available and will need to connect to another professional service.

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

If other procedure codes require a moderate or high MDM, use the new 1995 or 1997 DG.

9. When the Public Health Emergency (PHE) began, CMS issued directives that, for E/M services (99202-99215) conducted via telehealth through audio and video, the E/M level could be selected based on medical decision making or time through the end of the PHE. The times for these codes have changed with the implementation of the new 2021 guidelines. Since the PHE is still in effect, the question has arisen as to which times to use now for telehealth E/M services. For example,

under 2020 times, a 99213 is met at 15 minutes. Under 2021 the time is 20-29 minutes. So which time should be used?

For dates of service on or after January 1, 2021, CMS aligned with the AMA and practitioners should use the new guidelines for office or other outpatient services.

[Back to Categories](#)

Was this page helpful?

Last modified: 03/14/2024