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MGMA Stat

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47%<sup>25</sup> of medical practices audit charts internally. An April 19, 2022, MGMA Stat poll asked medical group leaders how their organizations audit charts/coding. The majority (47%) reported “internal,” followed by “both” (34%) and “external” (13%). Another 6% reported they do not audit charts internally or externally. The poll had 524 applicable responses.

Among those conducting audits, respondents said the frequency of their audits were:

Quarterly (34%)

Annually (32%)

At least monthly (26%)

Biannually (9%).\*

\*Figures do not add up to 100 due to rounding.

Several medical practice leaders told MGMA that they work to have flexibility in the frequency of chart audits, opting to do them more frequently for certain providers and specialties based on performance. Many respondents also noted that they will perform some chart audits at irregular intervals as a “spot check” of performance.

There are different types of audits medical practices can perform to assist providers in understanding documentation requirements and revenue cycle deficits. There are changes to medical code sets, such as CPT® and ICD-10-CM, each year, and HCPCS codes change quarterly.

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Audits help to identify areas of strengths and weaknesses and can help the practice set up a quality assurance (QA) process. The QA process can also help onboard new coding staff and providers. Lastly, an audit can help ensure medical practices are compliant.

Read more about the value and purpose of medical coding audits in this 2020 insight article.

E/M updates to watch

The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) aligned in 2019 to transform outpatient E/M coding to enrich physician or qualified healthcare professional (QHCP) documentation requirements, which were finalized Jan. 1, 2021. The enhancements were made to reduce administrative burden, improve accuracy of payer reimbursement and update the E/M code set to produce well-defined medical decision making (MDM). Changes include time-based coding capture, definitions of acute and chronic illnesses, deletion of code 99201 and, most significantly, modifications to MDM guidelines.

The 2021 MDM guidelines in CPT® is now specified as establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

Many medical practices have not made the appropriate modifications or are not aware of how they affect documentation requirements. This is evident in the volume of audit requests MGMA has received to ensure accuracy of outpatient E/M coding capture. Audits have revealed:

Improper use of time-based statements

Inaccurate MDM data reviewed

Misunderstanding of risk of complications and/or morbidity or mortality of patient management

Lack of timely EHR updates and documentation templates

Deficiency in educating physicians and QHCPs in coding guideline changes.

Medical coding auditors highly recommend thoroughly reviewing medical records to guarantee 2021 E/M outpatient coding guideline adherence. For this reason, an audit can help educate providers.

FAQs — Answers to common audit inquiries:

What is a unique test?

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, it should be counted as a unique

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test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT® codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified healthcare professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Examples of a unique test:

73110 and 73000 is a unique test (radiology)

84520 and 85004 is a unique test (pathology)

93000 and 95907 is a unique test (medicine)

What is prescription drug management?

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of a service. This may be a prescription being written or discontinued or the decision to maintain a current medication/dosage.

Simply listing current medications is not considered prescription drug management.

Prescription drug management differs from "drug therapy requiring intensive monitoring for toxicity."

Per CPT® definitions, "drug therapy requiring intensive monitoring for toxicity" is for a drug requiring intensive monitoring which is a therapeutic agent with the potential to cause serious morbidity or death. Monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. Monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long term (not less than quarterly) or short term. Monitoring may be by lab test, physiologic test or imaging. Monitoring by history or examination does not qualify. Monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.

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

Is an in-office injection considered prescription drug management?

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Injections administered in the office are not prescribed via pharmacy; they are billed as DME using HCPCS J code. The patient is then observed for adverse effects by physician or ancillary staff as considered in the CPT® administration code; therefore, it is not considered part of the risk in medical decision making of an E/M code under prescription drug management.

CMS states: The term “administered” refers only to the physical process by which the drug enters the patient’s body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the “incident to” benefit. With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are considered to be usually self-administered by the patient.

What is the definition of "external" for purposes of reviewing data as part of MDM?

"External" is defined as records, communications and/or test results from an external physician or QHP, or external facility or healthcare organization. An external physician or QHP is an individual who is not in your group practice or is in a different specialty or subspecialty.

What is time-based coding?

Time may be utilized to select an appropriate level of E/M code when it dominates the visit. Be aware that time has been altered in 2021 for each level of E/M. Total time must be documented and can be a combination of face-to-face and non-face-to-face activities.

Activities that a provider can count toward total time include:

Prepare for the visit; for example, review test results.

Obtain or review “separately” obtained patient history.

Perform a medically necessary examination and/or evaluation.

Counsel and educate the patient, a family member or a caregiver.

Order tests, medicine additional services.

Refer or communicate with other healthcare professionals.

Enter clinical information in the patient’s medical record.

Interpret and share test results with the patient.

Coordinate patient care.

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Appropriate time statement examples include:

I spent 32 minutes today (include activities substantiating reasons time-based would be appropriate) caring for Patient A.

I spent 40 minutes obtaining the HPI, examining the patient, and counseling the patient on diagnosis “xxxxx.” I scheduled a follow-up with patient in three months.

I spent 25 minutes reviewing the patient’s records including previous charts and labs; 20 minutes talking with her about her history and in face-to-face counseling; and 25 minutes in charting due to labs, X-ray and setting up MRI after she leaves for a total of 70 minutes.

Inappropriate time statement examples include:

I had a lengthy discussion with the patient.

I spent 20 minutes in supportive counseling.

I spent 15 minutes talking about treatment options.

I spent 30 minutes with the patient.

Did not use range of time

Did not use previous statement of 50% of time spent counseling and/or coordination of care.

Documentation tips:

Complete charting and follow up on the day of the encounter. Only time spent on the day of the encounter can be counted for time-based.

On the day of the visit, keep track of and document time spent on getting ready for the patient encounter and follow-up work afterwards, such as care coordination.

Only provider time counts — not nurse or MA time. But provider time spent reviewing nurse, MA or scribe documentation does count.

Do not be vague on documenting assessment/plan as it establishes medical decision making and necessity for visit. For example, lab work should point out reason and type. (Document—Thyroid panel ordered due to patient’s fatigue. Do not document — will order labs).

Capture all illnesses and problems, including chronic conditions that affect treatment. For example, a diabetic patient sees an orthopedist for a joint steroidal injection and needs monitoring of blood glucose as steroid will affect level of blood glucose. The orthopedist should capture the condition for the joint injection and diabetes.

Medical coding and revenue cycle audits should be routine. When changes occur, you need to ensure accuracy of documentation, billing and compliance. The major changes in 2021 to E/M coding guidelines should prompt medical practices to review via an audit to improve tools,

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resources and education medical coders can provide their clinical staff. External audits are beneficial at least once a year as codes change or when significant changes to coding guidelines occur. This will help in many aspects of the practice including but not limited to coding compliance, denials, revenue gaps, benchmarking and many more elements of the revenue cycle.

## JOIN MGMA STAT

Our ability at MGMA to provide great resources, education and advocacy depends on a strong feedback loop with healthcare leaders. To be part of this effort, sign up for MGMA Stat and make your voice heard in our weekly polls. Sign up by texting “STAT” to 33550 or visit [mgma.com/stat](https://mgma.com/stat). Polls will be sent to your phone via text message.

Do you have any best practices or success stories to share on this topic? Please let us know by emailing us at [connection@mgma.com](mailto:connection@mgma.com).

## Additional resources

MGMA Chart Auditing and Coding Education Services

E/M Services Guide from CMS (PDF)

CPT® E/M Office and Other Outpatient and Prolonged Services Code and Guideline Changes, effective Jan. 1, 2021 (PDF)

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Veronica Bradley, CPC, CPMA, has more than 20 years’ experience in medical coding and auditing in various specialties. She is also well-versed hierarchical condition category and risk adjustment coding. Other areas of expertise include E/M, procedural coding, Medicare reimbursement and other critical factors in coding and auditing. Veronica has worked in private practice, group practices, academic school of medicine and hospitals. Veronica received a bachelor’s degree in

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