2021 E/M Guidelines: Your Questions Answered

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It's been 14 months since the new evaluation and management guidelines took effect. Many providers struggled to modify their documentation after 25 years with the 1995 guidelines. Urgent care practices stepped up with training programs to get through the learning curve with some new concepts. This month, I'll address some of the common questions that we receive.

Q. *Do I have to meet the level in all the elements to bill a code?*

A. No, the level is based on two out of three of these elements: problems addressed, risk of management options, and data reviewed. If the problem and the risk are moderate yet no data were reviewed, this would still be a level 4 visit based on the two highest levels.

Q. *Do I need to document a history and exam?*

A. Yes and no. A history *or* an exam is required for the visit to be billable. However, what you document is up to the provider and what they feel is appropriate for that patient. The volume of documentation has no impact on the level of the final code.

Q. *What if the visit level based on medical decision-making (MDM) is lower than the level based on time?*

A. You can base your code on either MDM or time. So, if the MDM for an established patient is a 99212 yet you spent 35 minutes on their visit on that date, you would report 99214.

Q. *What can't be counted towards time?*

A. When leveling based on time, do not count clinical staff time or time spent performing procedures or any other service that is reported separately. Do not count general teaching not related to the presenting problem or subsequent work on another date.

Q. *What is the difference between a complicated and uncomplicated problem?*

A. An uncomplicated illness or injury is a short-term problem with a low risk of morbidity. A complicated illness has a high risk of morbidity without treatment while a complicated injury includes "evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity."[1]

Q. *What tests count in data?*

A. All tests that do not have a professional component count toward your level of visit. If you are not billing the professional component of a test, that also counts. So, mainly in the urgent care setting, you are counting your labs whether they are performed in-house or sent out. Count these labs only once per unique CPT code. Don't count them again on subsequent visits.

Q. *Why can't I count x-rays performed in-house?*

A. If you are billing for the professional component of an x-ray, you are getting paid for the interpretation. Counting the tests toward your level of visit would constitute "double-dipping."

Q. *Can I count my independent interpretation?*

A. No. Independent interpretation is for tests performed elsewhere that have a professional component. This is rare in most urgent care settings.

Q. *Is prescription drug management always a moderate risk?*

A. No. There are no "always" for the risk of complications and/or morbidity or mortality of patient management option. Management options listed in the Level of MDM table are simply examples. The level of risk is a clinical decision by the provider.

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Q. *Should I always use a differential diagnosis?*
A. No. Use a differential diagnosis when you are considering multiple diagnoses. This supports your level of problem addressed and what tests were ordered.

Q. *When is an illness considered chronic?*
A. Chronic problems have an "expected duration of at least 1 year or until the death of the patient."[1]

Q. *When is a chronic illness considered stable?*
A. A chronic condition is stable when the patient has met their specific treatment goals. Treatment goals are unique to the patient.

Q. *When can I count chronic illnesses if they are not the presenting problem?*
A. Chronic conditions are considered in your level of problem addressed when "their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications."[1] Include the diagnoses of these chronic illnesses in your treatment plan.

Q. *What is the difference between an exacerbation or a severe exacerbation?*
A. An exacerbation does not require consideration of a hospital level of care while a severe exacerbation usually does.

Now that you've completed a year of training, my suggestion is to consider an external audit. You will learn whether your clinical opinion of the level is supported by the documentation and find problem areas on which to focus your training. For internal audits, I would focus on outliers by either overall acuity or diagnosis groups.

The 2021 E/M guidelines are a major shift, and it is not black-and-white. The more you understand the guidelines, the more confident you will be. Remember, providers must "show their work" and thought process for medical decision-making under the new guidelines. ■

References

1. American Medical Association. CPT Evaluation and Management (E/M). Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guidelines Changes. Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed March 18, 2022.