# BILLING & CODING

## In the Outpatient Clinical Setting

## A Quick Reference

Kathy Baldridge, DNP, FNP-BC, FAANP

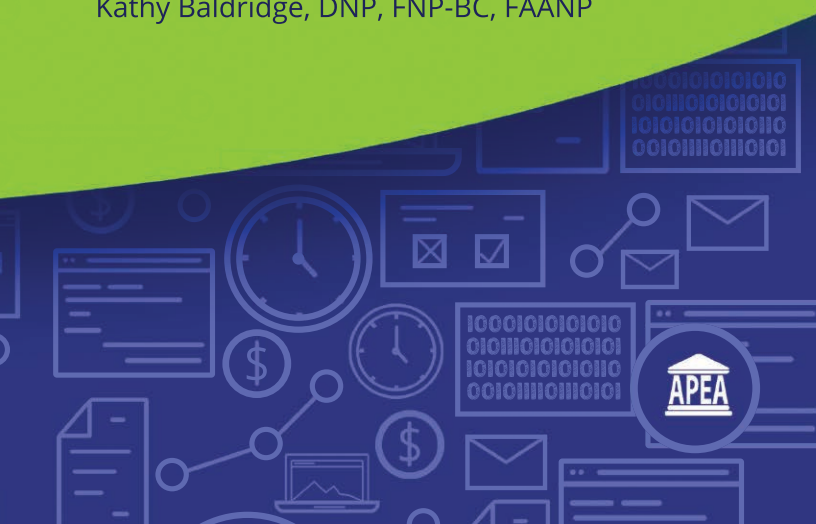

**Table of Contents**

## Introduction

Effective 1/1/2021, the American Medical Association revised the evaluation and management (E/M) codes for outpatient office visits. These codes have been adopted, and fee schedules have been revised by the Centers for Medicare & Medicaid Services (CMS; www.cms.gov).

The goal of these changes is to:

- **Decrease the administrative burden of documentation and coding**
- **Decrease the need for audits, through the addition and expansion of key definitions and guidelines**
- **Decrease unnecessary documentation that is not needed for patient care**
- **Ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties**

Changes include:

- The elimination of underutilized codes
- Elimination of the requirement to document a specific number of elements for the history and physical exam to determine code selection
- Allowing Qualified Healthcare Providers (QHPs) to choose whether their E/M code selection is based on medical decision making (MDM) or total time spent on the date of service.

## Determining the Appropriate Level of E/M Service

**Step 1:** Determine the appropriate category or subcategory:

- Site of service: outpatient setting
- Type of patient:
    - New
    - Established

**Step 2:** Choose whether to base CPT documentation on:

- Medical decision making (MDM)

  OR

- Total time spent on provision of services

**Step 3:** Document a medically appropriate history and/or examination to support MDM or time spent.

## Step 1: Determine if this outpatient visit is for a New or Established Patient

### A NEW PATIENT is defined as:

- A patient who has never received professional face-to-face services from you and/or anyone in your group practice in the exact same specialty
- A patient who has not received professional services from you and/or anyone in your group practice in the previous 3 years

**Examples:**

1. You transfer from one practice to another and assume the care of patients within the practice. Although the patients are new to you, they are not new to the practice and are considered established patients.
2. You transfer from one practice to another. A patient you have seen within the last 3 years establishes care with you at the new site. Although the patient is not new to you, this is a new site, with a new tax identification number. Therefore, this person would be treated as a new patient.
3. A patient presents to you to establish primary care. This is your first encounter with the patient; however, the patient was previously seen by cardiology within the same group practice. Because they were seen by cardiology and you are primary care, the patient will be a new patient.

## Step 2: Determine if E/M Code Will be Based on Medical Decision Making or Time

**Medical Decision Making** refers to the complexity of establishing a diagnosis and/or selecting a management option. ***See pg 12***

There are four levels of medical decision making:

- Straightforward
- Low
- Moderate
- High

The three elements to help determine the level of medical decision making are:

1. Number and complexity of problems addressed
2. Amount and/or complexity of data reviewed and analyzed
3. Risk of complications and/or morbidity or mortality of patient management

**Time-Based E/M coding** denotes the *total amount* of time spent on non-face-to-face and face-to-face activities provided by the QHP on the calendar date of the patient encounter. ***See pg 27***

To determine which method to use:

- **Consider Time-Based if:** considerable time is spent collecting the history or performing the exam, or considerable time is spent on patient education
- **Consider MDM if:** several tests are ordered, other providers are consulted, complex data are reviewed
- **Consider Time-Based if:** the patient is medically complex (e.g., a level 5 E/M), but time spent is excessive

| Summary of E/M Codes Comparing Time and MDM Levels | | | | | |
|---|---|---|---|---|---|
| **New Patient** | **Medical Decision Making** | **Time** | **Established Patient** | **Medical Decision Making** | **Time** |
| 99201 | Deleted Code | | 99211 | Service provided by ancillary office personnel | |
| 99202 | Straightforward | 15-29 min | 99212 | Straightforward | 10-19 min |
| 99203 | Low | 30-44 min | 99213 | Low | 20-29 min |
| 99204 | Moderate | 45-59 min | 99214 | Moderate | 30-39 min |
| 99205 | High | 60-74 min | 99215 | High | 40-54 min |