E/M Coding for 2021: Major Changes Ahead

Coding & Reimbursement Committee E/M Work Group
Speakers

Alexandra Flamm, MD, FAAD
AAD Alternate RUC Advisor

Alexander Miller, MD, FAAD
AAD CPT Advisor
Why the changes?

CMS 2019 Proposed Rule (PR)
- Administrative relief
- Simplify code selection

Compatibility to EHR
- Rise in physician use of EHR
- Led to “up-coding”

Aging codes
- CPT® E/M office visit codes were last updated 30 years ago

2019 PR included:
- consolidation to one fee for E/M 99212 through 99215 for new and established patient code;
- recommendation for new add-on G-code that would be used to increase payment for care of complex patients; and
- 50% payment reduction for E/M services when reported with modifier 25
AMA rationale for creating the E/M Workgroup

Needed CMS buy-in and participation for the changes to be successful and effective.

Used survey and conference calls to obtain input from specialty societies, including AAD/A.

Prolonged, thoughtful discussions. The process took over 12 months to complete.
2021 E/M Office and Other Outpatient Services: Selecting the level of service

Appropriate level of service will be based on:

- Level of MDM as defined for each service
- Total time for E/M performed on the date of the encounter
- Document a medically appropriate history and physical examination

OR
Modifications to the MDM criteria

CMS Table of Risk
Used as foundation to create the level of Medical Decision Table

CMS Audit Tool
Consulted to minimize disruption in MDM level criteria.
Sufficient details to reduce variations between payers and CMS contractors.

Ambiguity removed
Ambiguous terms have been removed for clarity and to allow consistency.
Aligns with clinically intuitive concepts.
Major 2021 office or other outpatient E/M revisions

Addition of extensive E/M guidelines

- Code descriptors have been restructured and revised
- The MDM for 99201 and 99202 is straightforward
  - 99201 was deleted – to report services that qualify for 99201, see 99202

Components for code selection specific to Medical Decision Making OR Time on the date of the encounter

- Medically appropriate history and/or examination no longer a component of the code selection
Summary of 2021 office and other outpatient E/M service changes

Office or other outpatient E/M levels of service will be reported based on:

Medical Decision Making (MDM)
- Extensive clarifications provided in the guidelines to define the MDM element

Total time spent with the patient on the date of the encounter
- Includes:
  - Non-face-to-face services
  - Clear time ranges for each code
Level of Medical Decision-Making Table:

Only used for office or other outpatient E/M services

Will be used as a guide to assist in the selection of the level of MDM

Includes four levels of MDM (unchanged from current levels of MDM):

*Straightforward; Low; Moderate; High*
Elements of Medical Decision Making

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

New guidelines and numerous definitions added to clarify each type of problem addressed in the MDM table, e.g.

- Stable, chronic illness
- Acute, uncomplicated illness or injury

Examples removed

- Some were not office oriented
- Added examples in the guidelines to make MDM less complex and clinically relevant
## Number and complexity of problems addressed; straightforward

<table>
<thead>
<tr>
<th>Level</th>
<th>Problems Addressed</th>
<th>Further defined as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>1 self-limited or minor problem</td>
<td>A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May include 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' or 'acute, uncomplicated.'</td>
</tr>
</tbody>
</table>
## Number and complexity of problems addressed; low

<table>
<thead>
<tr>
<th>Level</th>
<th>Problems Addressed</th>
<th>Further defined as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>2 or more self-limited or minor problems; <strong>OR</strong></td>
<td>Previously defined, see definition of straightforward complexity problems</td>
</tr>
<tr>
<td></td>
<td>1 stable chronic illness; <strong>OR</strong></td>
<td>A problem with an expected duration of at least a year or until the death of the patient. “Stable” is defined by treatment goals, a patient not at their treatment goal is not considered stable.</td>
</tr>
<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury</td>
<td>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 without functional impairment is expected.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A normally self-limited or minor problem that is not resolving consistent with a definite and prescribed course.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May include 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.</td>
</tr>
</tbody>
</table>
### Number and complexity of problems addressed; moderate

<table>
<thead>
<tr>
<th>Level</th>
<th>Problems Addressed</th>
<th>Further defined as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>1 or more chronic illnesses with exacerbation, progression or side effects of treatment; OR</td>
<td>A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.</td>
</tr>
<tr>
<td>Moderate</td>
<td>2 or more stable chronic illnesses; OR</td>
<td>Previously defined, see definition of low complexity problems</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 undiagnosed new problem with uncertain prognosis; OR</td>
<td>A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 acute illness with systemic symptoms OR</td>
<td>An illness that causes systemic symptoms and has a high risk of morbidity without treatment. Systemic symptoms may not be general but may be single system.</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 acute complicated injury</td>
<td>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/or associated with risk of morbidity.</td>
</tr>
</tbody>
</table>
Number and complexity of problems addressed; high

<table>
<thead>
<tr>
<th>Level</th>
<th>Problems Addressed</th>
<th>Further defined as</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR</td>
<td>The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.</td>
</tr>
<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.</td>
</tr>
</tbody>
</table>
Amount and/or complexity of data to be reviewed and analyzed

Simplified and standardized contractor/payer scoring guidelines

Emphasized clinically important activities over number of tests or documents to be reviewed

Need to account for quantity of documents ordered and/or reviewed and create “counting rules”
# Amount and/or complexity of data to be reviewed and analyzed

<table>
<thead>
<tr>
<th>Level</th>
<th>Data reviewed and analyzed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>Encounter includes minimal or no data to be reviewed and analyzed</td>
</tr>
<tr>
<td></td>
<td>Categories do not apply</td>
</tr>
<tr>
<td>Low</td>
<td>Limited – Must meet requirements of 1 of the following 2 categories</td>
</tr>
<tr>
<td></td>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td></td>
<td>Any combination of 2 from the following:</td>
</tr>
<tr>
<td></td>
<td>• Review of prior external note(s) from each unique source*;</td>
</tr>
<tr>
<td></td>
<td>• review of the result(s) of each unique test*;</td>
</tr>
<tr>
<td></td>
<td>• ordering of each unique test*</td>
</tr>
<tr>
<td></td>
<td><strong>Category 2</strong></td>
</tr>
<tr>
<td></td>
<td>Assessment requiring an independent historian(s)</td>
</tr>
</tbody>
</table>

*Each unique test, order, or document contributes to the combination of 2 in category 1.*
# Amount and/or complexity of data to be reviewed and analyzed

<table>
<thead>
<tr>
<th>Level</th>
<th>Data reviewed and analyzed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limited – Must meet requirements of 1 of the following 3 categories</td>
</tr>
<tr>
<td><strong>Category 1</strong></td>
<td><strong>Category 2</strong></td>
</tr>
<tr>
<td>Tests, documents, or independent historian(s)</td>
<td>Independent interpretation of tests</td>
</tr>
</tbody>
</table>
| Any combination of 3 from the following:  
  • Review of prior external note(s) from each unique source*;  
  • Review of the result(s) of each unique test*;  
  • Ordering of each unique test*;  
  • Assessment requiring an independent historian(s) |  
  • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); |  
  • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) |

*Each unique test, order, or document contributes to the combination of 3 in category 1.
## Amount and/or complexity of data to be reviewed and analyzed

<table>
<thead>
<tr>
<th>Level</th>
<th>Data reviewed and analyzed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High</strong></td>
<td>Limited – Must meet requirements of 2 of the following 3 categories</td>
</tr>
<tr>
<td></td>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td></td>
<td>Tests, documents, or independent historian(s)</td>
</tr>
</tbody>
</table>
|   | Any combination of 3 from the following:  
  • Review of prior external note(s) from each unique source*;  
  • Review of the result(s) of each unique test*;  
  • Ordering of each unique test*;  
  • Assessment requiring an independent historian(s) |  
  • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); |  
  • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) |

* Each unique test, order, or document contributes to the combination of 3 in category 1.
Risk of complications and/or morbidity or mortality of patient management decisions;

- Made during visit;
- Associated with the patient’s problem(s), treatment(s)

Includes possible management options selected and those considered, but not selected

Addresses risks associated with social determinants of health
Levels of risk

<table>
<thead>
<tr>
<th>Level</th>
<th>Risk of patient management</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Straight Forward</strong></td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
<td>• No treatment recommended or patient to monitor at home</td>
</tr>
</tbody>
</table>
| **Low**             | Low risk of morbidity from additional diagnostic testing or treatment                       | • Recommendation of over the counter (OTC) hydrocortisone 1% cream for itchy, red, cracked skin on hands  
                     | • Over-the-counter medication or drug management                                            | • Decision to perform a biopsy on a patient otherwise in good health, not on anticoagulants |
|                     | • Decision for minor surgery without identified patient or procedure risk factors*        |                                                                                              |

*When minor procedure is performed on a subsequent day.*
## Levels of risk

<table>
<thead>
<tr>
<th>Level</th>
<th>Risk of patient management</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Moderate | Moderate risk of morbidity from additional diagnostic testing or treatment  
• Prescription drug management  
• Decision regarding minor surgery with identified patient or procedure risk factors*  
• Elective major surgery with no identified risk factors  
• Diagnosis or treatment significantly limited by social determinants of health | • Isotretinoin prescribed for patient with severe acne  
• Decision to perform a lesion excision for a patient on systemic anticoagulants  
• Mohs surgery followed with reconstruction with flap or skin graft in otherwise healthy patient |

*When minor procedure is performed on a subsequent day.*
# Levels of risk

<table>
<thead>
<tr>
<th>Level</th>
<th>Risk of patient management</th>
<th>Examples</th>
</tr>
</thead>
</table>
| High  | High risk of morbidity from additional diagnostic testing or treatment | • Drug therapy requiring intensive monitoring for toxicity  
• Decision regarding elective major surgery with identified patient or procedure risk factors  
• Decision regarding emergency major surgery  
• Decision regarding hospitalization  
• Decision not to resuscitate or to de-escalate care because of poor prognosis | • Patient with newly diagnosed immune thrombocytopenic purpura requiring a wide excision and sentinel lymph node biopsy of an aggressive melanoma  
• Mohs surgery followed with reconstruction with flap or skin graft in patient on multiple systemic anticoagulant therapy and history of thromboembolic stroke |
## Selecting the level of MDM

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity of Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99213</td>
<td>Low</td>
<td>Low</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents: Any combination of 2 from:</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
<td>Moderate</td>
<td>• Review of prior external notes from each unique source;</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of the result(s) of each unique test;</td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ordering of each unique test;</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Case management requiring an independent historian(s)</td>
<td>• Decision regarding minor surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Category 2: Independent interpretation of tests:</td>
<td>• Decision regarding elective major surgery without identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (separately reported);</td>
<td>• Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Category 3: Discussion of management or test interpretation:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discussion of management of test interpretation with external physician/other qualified health care professional/appropriate source (separately reported);</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>High</td>
<td>High</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Any combination of 3 from the following:</td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of prior external note(s) from each unique source;</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of the result(s) of each unique test;</td>
<td>• Decision regarding elective major surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ordering of each unique test;</td>
<td>• Decision regarding emergency major surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Case management requiring an independent historian(s)</td>
<td>• Decision regarding hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Category 2: Independent interpretation of tests:</td>
<td>• Decision not to resuscitate or to discontinue care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (separately reported);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Category 3: Discussion of management or test interpretation:</td>
<td></td>
</tr>
</tbody>
</table>
Time

- Time by itself may be used to select a code level for office or other outpatient services.
- Regardless of whether counseling and/or coordination of care dominates the service.
- Time is based on ‘Total time spent by the physician/other QHP dealing with the patient’s problem(s)’
  - Includes non-face-to-face services: pre-service and post-service
    - Time spent by clinical staff is not included
- Clear time ranges have been included the code descriptors
- Can only be used when coding based on time – Not MDM
Time: Pre- or intra- encounter

Physician/QHP time includes the following activities (when performed):

- Preparing to see the patient (e.g. review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
Time: Post Encounter

- Ordering medications, tests, or procedures
- Documenting clinical information in the health record
- Referring and communicating with other health care professionals (when not reported separately)
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)
# 2021 office E/M services: Time

<table>
<thead>
<tr>
<th>New patient E/M code</th>
<th>2021 total time</th>
<th>Established patient E/M code</th>
<th>2021 total time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Code deleted</td>
<td>99211</td>
<td>Time component removed</td>
</tr>
<tr>
<td>99202</td>
<td>15 – 29 minutes</td>
<td>99212</td>
<td>10 – 19 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 – 44 minutes</td>
<td>99213</td>
<td>20 – 29 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 – 59 minutes</td>
<td>99214</td>
<td>30 – 39 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 – 74 minutes</td>
<td>99215</td>
<td>40 – 54 minutes</td>
</tr>
</tbody>
</table>

Time = Total time on the date of the encounter

(Before, during, and after face-to-face)
New prolonged service code 99417

New 15-minute prolonged service code 99417 to be reported only when the visit is based on time and the minimum required time of the highest-level of service (99205 or 99215) has been exceeded by 15-minutes.

99417 is reported in 15-minute increments starting after the highest time for level 5 visits.
Prolonged services (99417)

Use 99417 in conjunction with 99205, 99215 ONLY

Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416

Do not report 99417 for any time unit less than 15 minutes

Prolonged Office or Other Outpatient Evaluation and Management Service, With or Without direct patient contact beyond total time of primary procedure on the date of the primary service
# Prolonged service code 99417

## Time needed to qualify for use of prolonged service code use

<table>
<thead>
<tr>
<th>Minutes</th>
<th>1-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-59</th>
<th>60-74</th>
<th>75-89</th>
<th>90-104</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not use time (Code 99202 by MDM)</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td></td>
<td><strong>99205 + 99417</strong></td>
<td><strong>99205 + 2 Units 99417</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes</th>
<th>1-9</th>
<th>10-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40-54</th>
<th>55-69</th>
<th>70-84</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not use time (Code 99212 by MDM)</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td></td>
<td><strong>99215 + 99417</strong></td>
<td><strong>99215 + 2 Units 99417</strong></td>
</tr>
</tbody>
</table>
Caution

These changes only apply to E/M Office and other Outpatient Services.

These changes go into effect January 1, 2021.

Code changes applicable to ALL Payers.

Other E/M services will continue using the 2020 coding guidelines (Consultation Services, Emergency Department (ED), Hospital in- and out-patient services, nursing facilities, home health services, Domiciliary/Rest home or Custodial care services).
All changes made with the physicians in mind

In summary, these changes support clear focus on patient care and documentation burden reduction

- No more scoring (checking boxes) for history and examination
- Coding will be based on the way physicians think
- Intent is to provide higher-level activities in MDM
- There is more detail in the CPT® E/M office codes to promote coding consistency in the event payer audits are performed
Office or Other Outpatient Services/New Patient

99203 *Office or other outpatient* visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter

**2021 E/M Service Code**
Coding example 1: Coding by time

Established patient presents for follow-up of a clearing patch of localized contact dermatitis.

Time spent: 15 minutes was spent discussing the problem with the patient, ordering medications and documenting in patient medical record.

CPT code: When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99212
Coding example 2: Coding by MDM

Established patient

56-year-old man whose wife noticed a new dark spot on his back and would like it checked. Patient has no history of atypical nevi or skin cancer.

Medical Decision Making

The spot is not symptomatic.

Physical examination reveals a dark brown, flat, stippled-surfaced 1 cm “stuck on” papule on the back typical of a seborrheic keratosis

No treatment is recommended.

CPT Code Selection

Complexity and number of problems addressed:

1 (one) self–limited or minor problem

(Straightforward)

Amount and complexity of data to be reviewed:

None (Straightforward)

Risk of complications and morbidity: Minimal to none (Straightforward)

99212
An 18 y.o. patient presents for evaluation of a wound on his right forearm and an acute onset of malaise. Patient states that he was attempting to pet his girlfriend’s cat which became agitated and bit him.

He was previously seen in the practice for management of atopic dermatitis within the last 2 years.

The atopic dermatitis is currently well-controlled with use of topical steroids as needed for flares.

The physical exam is notable for a 3mm ulceration consistent with puncture wound with surrounding ill-defined erythema, edema and warmth. There is mild tenderness but no fluctuance. He denies fever or chills.

Complexity and number of problems addressed:
3 mm puncture wound with defined erythema, edema warmth and new onset of malaise - acute illness with systemic symptoms (malaise) (Moderate)

Amount and complexity of data to be reviewed:
None (Straightforward)

Risk of complications and morbidity: Prescription drug management - systemic antibiotic (Moderate)

CPT code selection:
99214
Introducing 2021 E/M coding tool

Welcome

We are pleased to share the AAD/A’s 2021 Evaluation and Management (E/M) coding tool based on the revised tenets of E/M coding for office and other outpatient encounters fulfilling the selection of either time or the elements of medical decision making to determine the complexity of care provided during the encounter.

I have read and agree to the terms of use.

The E/M Tool is designed to assist the user through the steps needed to determine the appropriate E/M code for a single office and other outpatient encounter. Determination of an E/M code is dependent on essential factors associated with each encounter. These factors are the building blocks for office and other outpatient E/M services.

- The E/M tool was created with user-friendly tips throughout to assist you when making selections.
- Click the information icon next to each option for additional tips and content.
- The process involved in determining an E/M code begins with:
  1. Identification of the patient’s status as new or established.
  2. Input based on the chief complaint or reason for the patient-provider encounter based on the total time of the encounter or the elements of medical decision making.
- Once you have completed the selection process, a synopsis of the encounter with its associated CPT code will be provided for review.

Continue
Patient Status

Is this patient new or established?

- New
- Established

Did you document the Chief Complaint?

- Yes
- No

Did you document a medically appropriate history and examination?

- Yes
- No

Was the encounter based on time?

- Yes
- No

**Patient Status**

New: Patient who has not received any professional services from the physician/qualified health care professional of the exact same who belongs to the same group for three years.

Established: Patient who has received services from the physician/qualified health care professional for the same practice and provider for more than three years.

**Chief Complaint**

A concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter.

**Medically appropriate history and examination**

Through not required, medically appropriate history and documented.

**Timed Encounter**

Total time spent by the dermatologist or non-physician clinician on the day of the encounter may be used when determining the level of service. Total time is considered both face-to-face and non-face-to-face time and includes time spent performing activities that require the dermatologist or non-physician clinician.

Time does not include activities normally performed by clinical staff.

Total time may include counseling and/or coordination, but these activities are no longer the determining factor for selection of a time-based level of service.
Time

Please select the total time spent by the dermatologist and/or non-physician clinician on the day of the encounter.

- 15-29 min
- 30-44 min
- 45-59 min
- 60-74 min

Total Time

Total time may be used when determining the level of service. Total time is considered both face-to-face and non-face-to-face time spent by the dermatologist or non-physician clinician on the day of the encounter. Total time includes time spent performing pre-, intra-, and post-encounter activities by the dermatologist or non-physician clinician. Time does not include activities normally performed by clinical staff. Total time may include counseling and/or coordination, but these activities are no longer the determining factor for selection of time-based level of service.
47 y.o. male patient presents with mild, itchy, red and cracking hands. Patient states the problem started six months ago when he started working in construction as a concrete mixer. He states that sometimes, his hands blister and bleed but not today. They improved and were better when he went on vacation.

You determine patient has irritant contact dermatitis.

Patient is educated on advantages of using personal protective clothing (PPE) i.e., liquid or chemical resistant safety gloves. A topical corticosteroid is prescribed. Over the counter (OTC) emollients are recommended. Patient is advised to return to the office if there is no improvement in 10 days.

Using MDM, what is the appropriate level of E/M service?

- Complexity and number of problems addressed: 1 acute, uncomplicated illness or injury (Low)
- Amount and complexity of data to be reviewed: None (Straightforward)
- Risk of complications and morbidity: prescription drug management (Moderate)

99213
Level of Service Code

99213

Level three established patient office or other outpatient visit

This code most accurately reflects the level of service for the encounter based on the criteria selected. The complexity of each key component is listed below for your review.

Patient Status: Established
Medical Decision Making: Low
A 35-year-old female patient presents with persistent inflammatory acne, predominately on her lower cheeks and jawline.

She has previously taken courses of oral antibiotics without long-term improvement and is on a combined oral contraceptive pill and has no plans for future pregnancies.

She is otherwise healthy and only takes a daily multivitamin.

After taking a relevant history and performing an appropriate physical exam, decision is made to initiate treatment with spironolactone.

Using MDM, what is the appropriate level of E/M service?

MDM level of service encounter must meet or exceed two of the three elements for the selected E/M code.

Complexity and number of problems addressed:
Acne vulgaris (Moderate) - 1 chronic illness poorly controlled

Amount and complexity of data to be reviewed:
None (Straightforward)

Risk of complications and morbidity: Prescription drug management (Moderate)

99204
Level of Service Code

99204

Level four new patient office or other outpatient visit

This code most accurately reflects the level of service for the encounter based on the criteria selected. The complexity of each key component is listed below for your review.

Patient Status: New
Medical Decision Making: Moderate

Disclaimer
You are called to see and evaluate an established patient of yours currently admitted to the local hospital. Now that you understand the revised 2021 Office and other Outpatient E/M coding guidelines, you document a medically appropriate history and physical examination.

Your documentation indicates a moderate level medical decision making.

You report 99222

The 2021 office and other outpatient E/M coding guideline changes only affect the office and other outpatient encounters e.g. 99202 - 99215.

Inpatient, domiciliary, rest home or custodial E/M services will continue to be reported using either 1995 or 1997 E/M coding guidelines which include documentation of history, examination and medical decision making or typical time ranges as described in the code descriptor.
E/M telehealth coding

2021 E/M codes 99202 – 99215 can be reported for services performed using telehealth

- Append the appropriate telehealth modifier and place of service (POS)
- Check with payer for specific coding guidance
Questions/Resources

coding@aad.org
AAD Practice Management Resource Center
The AADA Practice Management Center

For more information related to the topics discussed today:

- Table for MDM Elements
- Breakdown of Three Elements of Medical Decision Making
- Complete Definition on How to Calculate Time
- Derm Coding Consult Articles and Case Examples

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