

CPT[®] Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes

This document includes the following CPT E/M changes,
effective January 1, 2021:

- E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215
- Revised Office or Other Outpatient E/M codes 99202-99215

For the complete version of E/M Introductory guideline changes, Office or Other Outpatient (99202-99215) code changes, Prolonged Services code (99354, 99355, 99356, 99XXX) and guideline changes, see *Complete E-M Guideline and Code Changes.doc*.

Note: this content will not be included in the CPT 2020 code set release

Category I

Evaluation and Management (E/M) Services Guidelines Guidelines Common to All E/M Services

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021 and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or

other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and ~~or~~ other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate add-on code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

- ***Total time on the date of the encounter (office or other outpatient services [99202-99205, 99212-99215]):*** For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, 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
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

Guidelines for Office or Other Outpatient E/M Services

History and/or Examination

Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services.

Number and Complexity of Problems Addressed at the Encounter

One element in the level of code selection for an office or other outpatient service is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Definitions for the elements of medical decision making for office or other outpatient services are (see Table 2 Levels of Medical Decision Making):

Problem: A problem is 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.

Problem addressed: 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. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Minimal problem: 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 (see 99211).

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). ‘Stable’ for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: 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. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Chronic illness with exacerbation, progression, or side effects of treatment: 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.

Undiagnosed new problem with uncertain prognosis: 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.

Acute illness with systemic symptoms: 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’ or ‘acute, uncomplicated.’ Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury: 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. An example may be a head injury with brief loss of consciousness.

Chronic illness with severe exacerbation, progression, or side effects of treatment: 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.

Acute or chronic illness or injury that poses a threat to life or bodily function: 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. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.

External physician or other qualified healthcare professional: 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 organizational provider such as a hospital, nursing facility, or home health care agency.

Independent historian(s): An individual (eg, 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 (eg, due to developmental 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(s) is needed, the independent historian(s) requirement is met.

Independent Interpretation: 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.

Appropriate source: For the purpose of the **Discussion of Management** data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as ‘high’, ‘medium’, ‘low’, or ‘minimal’ risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Morbidity: 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 despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Drug therapy requiring intensive monitoring for toxicity: 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. The 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 or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The 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 of monitoring that does 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.

Instructions for Selecting a Level of Office or Other Outpatient E/M Service

Select the appropriate level of E/M services based on the following:

1. The level of the medical decision making as defined for each service; **or**
2. The total time for E/M services performed on the date of the encounter.

Medical Decision Making

Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. Medical decision making in the office and other outpatient services code set is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data is divided into three categories:
 - Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
 - Independent interpretation of tests.
 - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source
- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Four types of medical decision making are recognized: straightforward, low, moderate, and high. The concept of the level of medical decision making does not apply to code 99211.

Shared medical decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Medical decision making may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service.

The Level of Medical Decision Making table (Table 2) is to be used as a guide to assist in selecting the level of medical decision making for reporting an office or other outpatient E/M service code. The table includes the four levels of medical decision making (ie, straightforward, low, moderate, high) and the three elements of medical decision making (ie, number and complexity of problems addressed, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded.

Table 2: Level of Medical Decision Making (MDM)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents • Any combination of 2 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* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment

<p>99204 99214</p>	<p>Moderate</p>	<p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; <p>or</p> <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; <p>or</p> <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; <p>or</p> <ul style="list-style-type: none"> • 1 acute complicated injury 	<p>Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) 	<p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
<p>99205 99215</p>	<p>High</p>	<p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	<p>Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	<p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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

Evaluation and Management

Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or initial nursing facility care.

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226. For observation or inpatient care services (including admission and discharge services), see 99234-99236.

-----Coding Tip-----

Determination of Patient Status as New or Established Patient Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the **exact** same specialty and exact same **subspecialties** as the physician.

*CPT Coding Guidelines, Evaluation and Management,
Definitions of Commonly Used Terms, New and Established
Patient*

New Patient

(99201 has been deleted. To report, use 99202)

★▲ **99202** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★▲ **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.

- ★ ▲ 99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

- ★ ▲ 99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

(For services 75 minutes or longer, see Prolonged Services 99XXX)

Established Patient

- ▲ 99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

- ★ ▲ 99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

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

- ★ ▲ 99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

- ★ ▲ 99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

- ★ ▲ 99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes or longer, see Prolonged Services 99XXX)

Prolonged Services

Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)

Codes 99354-99357 are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient, observation or outpatient setting, except with office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215). Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure. Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period.

Codes 99354-99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes 99356-99357 are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.

Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.

Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

The use of the time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99XXX.

For prolonged total time in the Office or Other Outpatient Services, use 99XXX.

The following table illustrates the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the inpatient or observation setting beyond the usual service time.

Total Duration of Prolonged Services	Code(s)
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99356 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99356 X 1 AND 99357 X 1
105 or more (1 hr. 45 min. or more)	99356 X 1 AND 99357 X 2 or more for each additional 30 minutes.

★+▲99354 Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient **Evaluation and Management** or psychotherapy service, except with office or other outpatient services [99202-99215])

(Use 99354 in conjunction with 90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483)

(Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99415, 99416, 99XXX)

★+▲99355 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99355 in conjunction with 99354)

(Do not report 99355 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99415, 99416, 99XXX)

+▲99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation **Evaluation and Management** service)

(Use 99356 in conjunction with 90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)

+99357 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99357 in conjunction with 99356)

Prolonged Service Without Direct Patient Contact

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215). For prolonged time without direct patient contact on the date of office or other outpatient services, use 99XXX. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to face encounter.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time without direct patient contact reported in other services such as care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other qualified health care professional (99491), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/internet/electronic health record consultations (99446-99452), or on-line digital evaluation and management services (9X0X1, 9X0X2, 9X0X3).

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

+99359 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99359 in conjunction with 99358)

(Do not report 99358, 99359 on the same date of service as 99XXX)

(Do not report 99358, 99359 during the same month with 99484, 99487-99489, 99490, 99491, 99492, 99493, 99494)

(Do not report 99358, 99359 when performed during the service time of codes 99495 or 99496, if reporting 99495 or 99496)

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	Code(s)
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99358 X 1 AND 99359 X 1
105 or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes.

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

Codes 99415, 99416 are used when a prolonged evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.

Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than 45 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes. The typical face-to-face time of the primary service is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 25 minutes, and 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed. When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.

Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Codes 99415, 99416 may be reported for no more than two simultaneous patients. The use of the time-based add-on codes requires that the primary E/M service has a typical or specified time published in the CPT code set.

For prolonged services by the physician or other qualified health care professional, see 99354, 99355, 99XXX. Do not report 99415, 99416 with 99354, 99355, 99XXX.

Facilities may not report 99415, 99416.

#+99415 Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient **Evaluation and Management** service)

(Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)

(Do not report 99415 in conjunction with 99354, 99355, 99XXX)

#+99416 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99416 in conjunction with 99415)

(Do not report 99416 in conjunction with 99354, 99355, 99XXX)

The Total Duration of Prolonged Services Table illustrates the correct reporting of prolonged services provided by clinical staff with physician supervision in the office setting beyond the initial 45 minutes of clinical staff time:

Total Duration of Prolonged Services	Code(s)
less than 45 minutes	Not reported separately
45-74 minutes (45 minutes - 1 hr. 14 min.)	99415 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99415 X 1 AND 99416 X 1
105 or more (1 hr. 45 min. or more)	99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.

Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service

Code 99XXX is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services (ie, 99205, 99215). Code 99XXX is only used when the office or other outpatient service has been selected using time alone as the basis and only after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded. To report a unit of 99XXX, 15 minutes of additional time must have been attained. Do not report 99XXX for any additional time increment of less than 15 minutes.

Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.

For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, see 99415, 99416. Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416.

Prolonged services of less than 15 minutes total time on the date of the office or other outpatient service (ie, 99205, 99215) is not reported.

★+●99XXX Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

(Use 99XXX in conjunction with 99205, 99215)

(Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)

(Do not report 99XXX for any time unit less than 15 minutes)

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99XXX X 1
90-104 minutes	99205 X 1 and 99XXX X 2
105 or more	99205 X 1 and 99XXX X 3 or more for each additional 15 minutes.
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99XXX X 1
70-84 minutes	99215 X 1 and 99XXX X 2
85 or more	99215 X 1 and 99XXX X 3 or more for each additional 15 minutes.

Billing Scenarios – 2020

CAPC Webinar – 11/9/2020

Chris Jones, MD, MBA, HMDC, FAAHPM

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within this presentation, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. I am giving this series of talks without compensation to help the PalCare field. I make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.

This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

THIS PRESENTATION CONTAINS ABBREVIATED CODE DEFINITIONS, IS NOT A SUBSTITUTE FOR YOUR CODE BOOKS, AND DOES NOT INCLUDE ALL CHANGES YOU MAY NEED TO KNOW. TO CODE AND BILL ACCURATELY.



Review from Last Time

- Can bill on Time or Complexity
- If billing on time, note requires:
 - Number of Minutes
 - That >50% of the time was spent in counselling and/or care coordination (NB: if counseling/coordination doesn't dominate, can't bill on time)
 - The content of the counseling/care coordination (to “nodding head” standard)
- Time is counted unit/floor time (inpt/SNF) or in the room with the patient (office/home).

Review on Advance Care Planning

- Can only be billed on time
- Discussion face-to-face (video/phone OK during PHE) with patient or surrogate about goals/values/preferences. Any setting; can be combined with other codes; doesn't require completion of documents; can be as often as every day (should have change of goals or medical status to bill frequently)
- If billing with other codes, bill ACP code on time and bill the symptom management on complexity

- 99497 = 16-45min
- Add 99498 = 46-75min

Review on complexity

- **Chief complaint** (prove medical necessity)
- **History**
 - HPI – 4 boxes
 - ROS – Comprehensive (10 system)
 - Past Medical/Family/Social Hx – 1 item from each of the 3
- **Physical Exam** – 8 system exam (not body areas; we get a lot by looking)
- **Medical Decision Making** (2 of 3 high = high MDM)
 - Diagnoses managed (high = \geq 4 points)
 - Data Reviewed (high = \geq 4 points)
 - Risk (any 1 item in high risk)

M
D
M
↳ 2 of 3
High

Ding
≥ 4 pts

Selfilin / -ison - 1 - max 2
Est prob same better - 1
Est prob worse - 2
New prob \bar{x} w/o - 3 (max 1)
New prob \bar{z} u/o = 4
↳ same specialty = old
same group = old

Data
≥ 4 pts

lab - 1 - creat
Radiology (xray, MRI, magnet) - 1
med section (u/s / EKG / echo) - 1
decision old records - 1
review + sum old records
or hx from "not the pt" } 2
independ visit of image
imaging (EKG) } 2

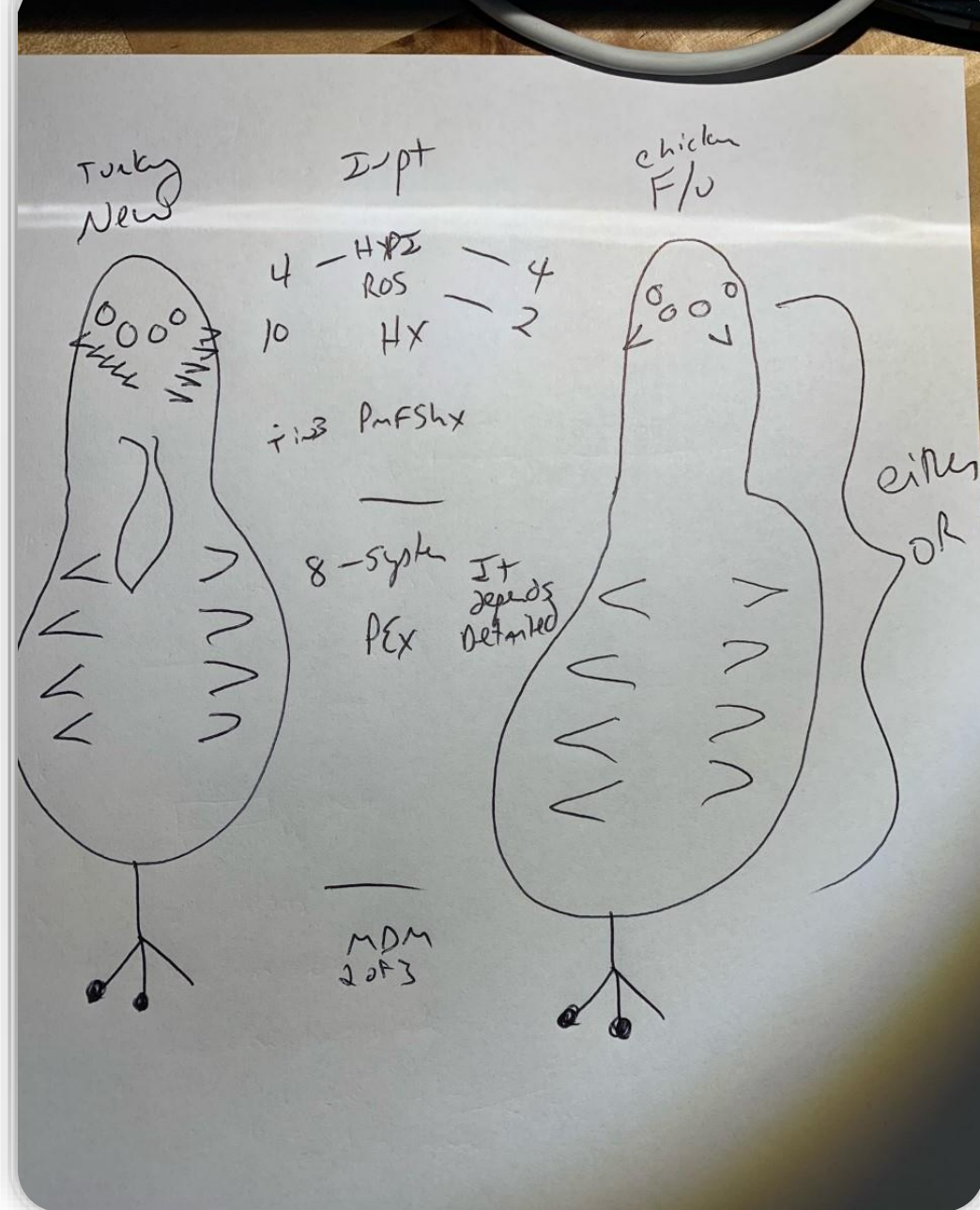
Risk
"High"
any
= high

- chronic illness
- severe exacerb
- IV opioids
- IV benzos
- decision SWR
- Decision deescalate

(+) Drug therapy intensive monitoring
↳ methadone 293mo

Billing fowl

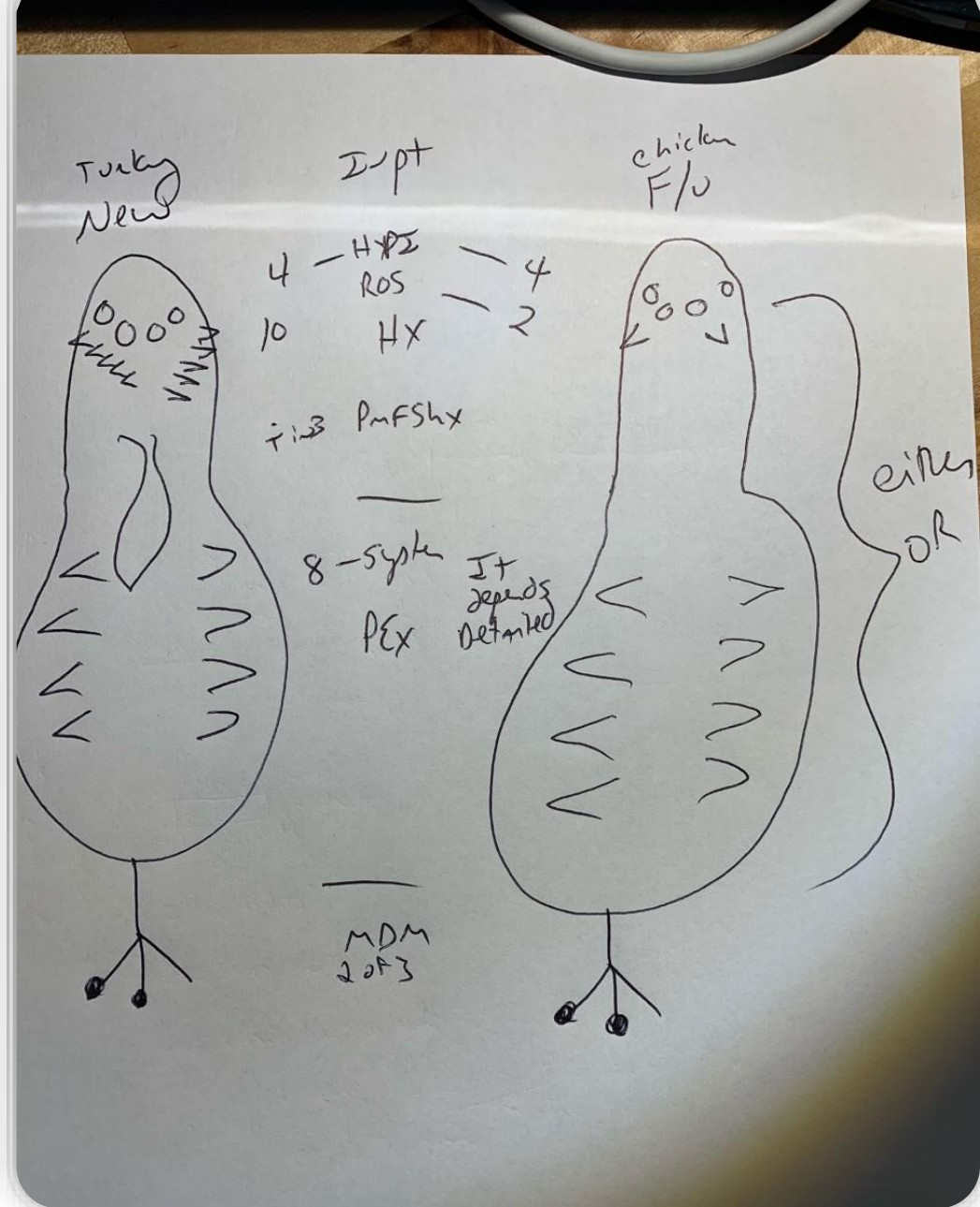
- Turkey (left) = documentation that supports high-level new inpatient visit
- Chicken (right) = documentation that supports high-level inpatient subsequent visit



Billing fowl

Stupid or genius?

You decide!



New Content

Non-face-to-face prolonged service – 99358/99359

- 31 minutes or more spent on one calendar day caring for the patient – does not require face-to-face contact
- In preparation for or in response to a face-to-face encounter
- Reviewing records, coordinating care, long phone call, etc.
- "Nodding head" documentation (with number of minutes) including why the service went above normal time/effort
- Start/stop time(s) – don't need to be continuous minutes
- Read the next few slides for changes on 1/1/2021

New Content – The times they are a changin’

Inpatient/SNF/Home Changes in 2021

None. All current dysfunction continues unabated.

New Content – The times they are a changin’

Outpatient Changes in 2021 (53 days from now)

- Holy crap... (but mostly good crap)
- Time is no longer just ‘in the room time’ - now includes total provider time on date of encounter. Prep, review, history, counseling, exam, orders, coordination, etc. Any tasks that require provider-level expertise (damn prior auths...)
- If complexity-based, history and exam is just whatever’s medically necessary
- Medical Decision Making (or time) drive the level of service (straightforward, low, mod, high).
 - Number/complexity of problems addressed
 - Amount/complexity of data to be reviewed analyzed
 - Risk of complications/morbidity/mortality of decisions made at the visit

<https://bit.ly/36nfw1k>

Times are different than Now

New

- 99202 – straightforward – 15-29min
- 99203 – low – 30-44 min
- 99204 – moderate – 45-59 min
- 99205 – high – 60-74 min

Established

- 99211 – RN visit
- 99212 – straightforward – 10-19min
- 99213 – low – 20-29 min
- 99214 – mod – 30-39 min
- 99215 – high – 40-54 min

Level 1/2/3 visits are not palcare patients

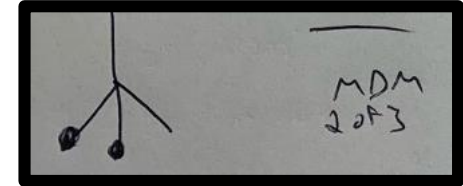
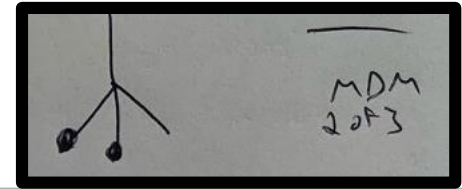


Table 2: Level of Medical Decision Making (MDM)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents • Any combination of 2 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* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment

Level 4/5 are PalCare patients



<p>99204 99214</p>	<p>Moderate</p>	<p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; <p>or</p> <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; <p>or</p> <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; <p>or</p> <ul style="list-style-type: none"> • 1 acute complicated injury 	<p>Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	<p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
<p>99205 99215</p>	<p>High</p>	<p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	<p>Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	<p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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

Prolonged Service With or without direct patient contact on the date of an office or other outpatient service

- **99417** (no, you have never heard of this before)– 0.61 wRVUs
- Report 15 minutes of additional time on the date of an office visit (so no 99358/9 on date of office visit) beyond max time in the code series

Total Duration of new Patient or Other Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 x 1
90-104 minutes	99205 X 1 and 99417 x 2
105 or more minutes	99205 X 1 and 99417 x 3 or more for each additional 15 minutes.
Total Duration of Established Patient Office or Other Outpatient Service (use with 99215)	Code(s)
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 x 1
70-84 minutes	99215 X 1 and 99417 x 2
85 or more	99215 X 1 and 99417 x 3 or more for each additional 15 minutes.

**OR MAYBE
NOT**

TABLE 22: Proposed Prolonged Office/Outpatient E/M Visit Reporting – New Patient

↓ **CPT** **CMS** -
 >

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99417 x 1	89-103 minutes
99205 x 1 and 99417 x 2	104-118 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes.	119 or more

Total Duration of new Patient or Other Office or Other Outpatient Services (use with 99205)

less than 75 minutes

Not reported separately

75-89 minutes

99205 X 1 and 99417 x 1

90-104 minutes

99205 X 1 and 99417 x 2

105 or more

99205 X 1 and 99417 x 3 or more for each additional 15 minutes.

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)

Code(s)

less than 55 minutes

Not reported separately

55-69 minutes

99215 X 1 and 99417 x 1

70-84 minutes

99215 X 1 and 99417 x 2

85 or more

99215 X 1 and 99417 x 3 or more for each additional 15 minutes.

**CPT AND
 CMS TIME
 CHARTS
 DON'T
 MATCH!!!!**

TABLE 23: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99417 x 1	69-83 minutes
99215 x 1 and 99417 x 2	84- 98 minutes
99215 x 1 and 99417 x 3 or more for each additional 15 minutes.	99 or more

to
 :e
 ve Care

Smoke 'em if you got 'em

JOURNAL OF PALLIATIVE MEDICINE
Volume XX, Number XX, 2019
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2018.0641

Palliative Care Specialists Series

Feature Editors: Christopher A. Jones and Arif H. Kamal

Top Ten Tips Palliative Care Clinicians Should Know About Medical Cannabis

Joshua Briscoe, MD,^{1,2} Arif H. Kamal, MD, MBA, MHS, FACP, FAAHPM,^{1,3,4}
and David J. Casarett, MD, MA, FAAHPM^{1,3}

Scenario 1

You come on to work on the inpatient PC consult service on Monday and take over for a colleague who was on last week. Your partner had been seeing a man for cancer pain and nausea. The patient is not taking IV opioids, benzos, or methadone, the patient did not decide to become a DNR or comfort care today, and the exacerbation of his chronic illness is no longer severe. Prognosis is months to years. What is the highest level of bill that you could potentially achieve today? Name 3 ways to get there.

Scenario 1

Initial or Subseq?

Is there any way to get to Level 3 (or maybe 3 ways – hint: think of the 2 ways to bill and the components of MDM)?

You come on to work on the inpatient PC consult service on Monday and take over for a colleague who was on last week. Your partner had been seeing a man for cancer pain and nausea. The patient is not taking IV opioids, benzos, or methadone, the patient did not decide to become a DNR or comfort care today, and the exacerbation of his chronic illness is no longer severe. Prognosis is months to years. What is the highest level of bill that you could potentially achieve today? Name 3 ways to get there.

Scenario 1

Level 3 follow-up (99233) on:

- Time
- Data/Diagnoses
- Data/Recommend an 'in case' IV opioid
given nausea

Scenario 2

Your partner saw a patient a month ago for complex medical decision making and pain. She signed off. The patient has been marooned on the Island of Chronic Critical Illness since then and has not left the hospital. You reconsult and spend 70 minutes face to face with the patient, managing pain and counseling about prognosis, pain medication options, and hospice. What is/are the right code(s) to use for this situation?

Scenario 2

Initial or subseq?
One code or multiple?

Your partner saw a patient a month ago for complex medical decision making and pain. She signed off. The patient has been marooned on the Island of Chronic Critical Illness since then and has not left the hospital. You reconsult and spend 70 minutes face to face with the patient, managing pain and counseling about prognosis, pain medication options, and hospice. What is/are the right code(s) to use for this situation?

Scenario 2

IT'S A TRAP! CANNOT USE NEW VISIT CODE.

Can do either of the following:

- 99233 + 99356 (billing all on time; 3.71 wRVUs) or
- 99233 on complexity and 99497+99498 (ACP) on time (4.9 wRVUs). Could bill over 46 minutes on ACP if that's what you did.

Scenario 3

You see a followup patient in the office who has decided on home hospice for her congestive heart failure. Your visit lasts 35 minutes, with 20 of those minutes counseling about home hospice and ensuring goals of care don't involve the term "just 1 chest compression". You recommend the timeless "HAM Sandwich" as comfort meds (Haldol/Ativan/ Morphine/ Something for secretions) along with continuing her cardiac meds. How should you bill your visit? What if your visit lasted 40 minutes? What if the visit was in 2021?

Scenario 3

**What level links with 35 minutes?
40 minutes? Just 1 code or 2 (compare wRVUs)? How do times change in 2021?**

You see a followup patient in the office who has decided on home hospice for her congestive heart failure. Your visit lasts 35 minutes, with 20 of those minutes counseling about home hospice and ensuring goals of care don't involve the term "just 1 chest compression". You prescribe the timeless "HAM Sandwich" as comfort meds (Haldol/Ativan/ Morphine/ Something for secretions) along with continuing her cardiac meds. How should you bill your visit? What if your visit lasted 40 minutes? What if the visit is in 2021?

SCENARIO 3

- Likely 99214 (level 4 followup) billed on complexity given multiple prescription medications and 99497, ACP.
- If the visit lasted 40 minutes, you'd bill it the same way since 99215 is only worth only 2.11 wRVUs (around 2/3 of the 3.0 wRVUs available from 99214 + 99497).
- In 2021, you'd STILL bill it the same way. Adding an ACP code is almost always better than the higher level single code.

Scenario 4

You are playing a fun game of “Billing and Coding: Name That Tune” with your team. They challenge you to write a ‘stupid billing sentence’ about pain in 10 notes (words) or less. Can you do it?

Scenario 4

A stupid billing sentence checks 4 boxes in the history section

You are playing a fun game of “Billing and Coding: Name That Tune” with your team. They challenge you to write a ‘stupid billing sentence’ about pain in 10 notes (words) or less. Can you do it?

SCENARIO 4

→ Pain was moderate,
back, constant, for 2 days

Scenario 5

You are called about a new hospital consult on a patient with GI bleeding from his gastric cancer. You talk with the team, read through the chart, and speak with the nursing staff about his pain and the family dynamics. That takes 40 minutes. You then find his wife in the waiting room and talk about her understanding of his goals for 20 minutes.

He is due back from EGD “any time now”. It is 230pm... 330pm...430pm...530pm. At some point, if you don’t go home, the dog will pee on the carpet or your spouse will start swiping left on Tinder (or swiping right... the one that means your time is short). Have you donated your time to the ethos today or can you get paid for something?

Scenario 5

**Can you bill a patient
consult if you don't
see the patient?
What did you do?
Who did you see?
What did you chat
about?**

You are called about a new hospital consult on a patient with GI bleeding from his gastric cancer. You talk with the team, read through the chart, and speak with the nursing staff about his pain and the family dynamics. That takes 40 minutes. You then find his wife in the waiting room and talk about her understanding of his goals for 20 minutes.

He is due back from EGD “any time now”. It is 230pm... 330pm...430pm...530pm. At some point, if you don't go home, the dog will pee on the carpet or your spouse will start swiping left on Tinder (or swiping right... the one that means your time is short). Have you donated your time to the ethos today or can you get paid for something?

SCENARIO 5

→99497 – ACP code for face-to-face conversation with the family (1.5 wRVUs) OR

→99358 -- prolonged non-face-to-face time given >30 minutes of work (2.1 wRVUs)

OR... wait for it... BOTH if >30 min on top of 20 min!

Scenario 6

You are planning to see a patient in the clinic. You receive and review her records/talk to the referrer on Thursday for 35 minutes to ready yourself for her Friday visit. On Friday, you see the patient and her family in the office for 80 minutes (since your 35% no-show rate left you some flex in the system) to manage pain and nausea with MS Contin and ondansetron. The decision, during a 20 minute conversation, was made for DNR status. You then communicated with her primary care and oncology physicians by phone for 15 and 20 minutes each while writing your note and imagining your nightly cocktail. How can this be billed? How about in 2021?

Scenario 6

**Carve up the time
day by day. Be
careful not to bill
time and acp in
same encounter**

You are planning to see a patient in the clinic. You receive and review her records/talk to the referrer on Thursday for 35 minutes to ready yourself for her Friday visit. On Friday, you see the patient and her family in the office for 80 minutes (since your 35% no-show rate left you some flex in the system) to manage pain and nausea with MS Contin and ondansetron. The decision, during a 20 minute conversation, was made for DNR status. You then communicated with her primary care and oncology physicians by phone for 15 and 20 minutes each while writing your note and imagining your nightly cocktail. How can this be billed? How about in 2021?

SCENARIO 6

2020

→ Thursday warrants 99358 on time for record review.

→ During the visit, bill 99204-5 on complexity and 99497 on time.

→ 99358 bills again for Friday evening's communication with multiple providers. Total of 8.13 wRVUs.

2021

→ 99358 on Thurs + complexity 99204/5 plus ACP plus donate phone call time (6.77) // 99358 on Thurs + 121 min on Fri 99205 + 99417x3 (7.1)

Scenario 7

→ You are working on a busy inpatient PC consult service. You follow up in the morning on a patient you saw last week for pain, managing her patient controlled analgesia (PCA) pump for 15 minutes. Later in the day, you are called back for a planned family meeting with the patient and her daughter that lasts 22 minutes. The decision is made for comfort and the patient wants to go home ASAP. You then spend 35 minutes on the telephone in your office organizing a quick hospice discharge for the next morning. How would you have billed these encounters 5 years ago? How should you bill them today?

Scenario 7

**Inpatient setting –
remember times and
locations where time
is billable**

→ You are working on a busy inpatient PC consult service. You follow up in the morning on a patient you saw last week for pain, managing her patient controlled analgesia (PCA) pump for 15 minutes. Later in the day, you are called back for a planned family meeting with the patient and her daughter that lasts 22 minutes. The decision is made for comfort and the patient wants to go home ASAP. You then spend 35 minutes on the telephone in your office organizing a quick hospice discharge for the next morning. How would you have billed these encounters 5 years ago? How should you bill them today?

Scenario 7

- 5 years ago – 99233 for unit/floor time (2.0 wRVUs)
- Today – 99233 on complexity, 99497 for ACP conversation, and 99358 for work in the office (5.6 wRUV)

Scenario 8

You are a nurse practitioner scheduled for a followup visit with a patient in a SNF. Drama abounds. You talk with the facility social worker for 20 minutes on Monday, 15 minutes on Wednesday, and for 40 minutes on Thursday to prepare for the family meeting. You talk with her primary care physician on Wednesday for 18 minutes as well. You are in the SNF for 40 minutes managing pain and dyspnea though the family is a no-show for the meeting.

Relieved you made it out drama free, the SWer then brings her cell phone to you in your car so you can spend 25 minutes being yelled at by the patient's daughter, who ended up going to the casino instead, about advance care planning. How can all of this be billed? Where did you leave time on the table? What about dermatology as a career?

Scenario 8

**Carve up the time
day by day. What
about the parking lot?**

You are a nurse practitioner scheduled for a followup visit with a patient in a SNF. Drama abounds. You talk with the facility social worker for 20 minutes on Monday, 15 minutes on Wednesday, and for 40 minutes on Thursday to prepare for the family meeting. You talk with her primary care physician on Wednesday for 18 minutes as well. You are in the SNF for 40 minutes managing pain and dyspnea though the family is a no-show for the meeting.

Relieved you made it out drama free, the SWer then brings her cell phone to you in your car so you can spend 25 minutes being yelled at by the patient's daughter, who ended up going to the casino instead, about advance care planning. How can all of this be billed? Where did you leave time on the table? What about dermatology as a career?

Scenario 8

99306 by complexity for initial SNF visit.
99358 for Wednesday (both facility SWer AND
PCP sum to >30 min) and 99358 for
Thursday.

Parking lot time WAS nonbillable as was ACP
done on the phone but COVID offers flexibility
for now. So a 99497 ACP code can be billed
as well.

Dermatology is gross and all rashes look
alike.

Scenario 9

You see a patient who is unconscious, intubated, and sedated. There is no family around and the patient's name in Epic is "Unknown, Whiskey". She is on the trauma service so the notes are difficult to follow and mention something about a bus. You are consulted for complex medical decision making. What are the parts of the "History" section of the note? Which ones can you skip out on in this scenario? What should you document to get full credit?

Scenario 9

History has 3 parts
(Turkey head)

You see a patient who is unconscious, intubated, and sedated. There is no family around and the patient's name in Epic is "Unknown, Whiskey". She is on the trauma service so the notes are difficult to follow and mention something about a bus. You are consulted for complex medical decision making. What are the parts of the "History" section of the note? Which ones can you skip out on in this scenario? What should you document to get full credit?

Scenario 9

- HPI, PMH, SocHX, FHX, ROS
- Can skip out on PMH, SocHx, FamHx, ROS BUT NOT HPI
- Prove you tried with something like “Unable to obtain PMH, SocHx, FamHx, ROS as pt is intubated and sedated. No information in Epic as identity is unknown and no family at bedside to ask. RN unaware as well.”

Scenario 10

The inpatient team's intrepid NP, transfixed by the discussion you just had together about the Billing Turkey and Chicken™, wonders out loud how few words in the Assessment/Plan section could support a high level note. She gives you the below framework and dares you to add fewer than 8 words to support high level medical decision making. Can you?

Scenario 10

Assessment: 72yoM new consult with 10/10 hip pain likely from cancer.

Plan:

1) Pain -

Scenario 10

Assessment: 72yoM new consult with 10/10 hip pain likely from cancer.

Plan:

1) Pain (new) – check hip XR, IV dilaudid

Thank you!

Questions always welcome.

Now or by email at:

Christopher.jones@duke.edu

Scenario 1: You come on to work on the inpatient PC consult service on Monday and take over for a colleague who was on last week. Your partner had been seeing a man for cancer pain and nausea. The patient is not taking IV opioids, benzos, or methadone, the patient did not decide to become a DNR or comfort care today, and the exacerbation of his chronic illness is no longer severe. Prognosis is months to years. What is the highest level of bill that you could potentially achieve today? Name 3 ways to get there.

HINT: Initial or Subseq? Is there any way to get to Level 3 (or maybe 3 ways – think of the 2 ways to bill and the components of MDM)?

Scenario 2: Your partner saw a patient a month ago for complex medical decision making and pain. She signed off. The patient has been marooned on the Island of Chronic Critical Illness since then and has not left the hospital. You reconsult and spend 70 minutes face to face with the patient, managing pain and counseling about prognosis, pain medication options, and hospice. What is/are the right code(s) to use for this situation?

HINT: Initial or subsequent? One code or multiple?

Scenario 3: You see a followup patient in the office who has decided on home hospice for her congestive heart failure. Your visit lasts 35 minutes, with 20 of those minutes counseling about home hospice and ensuring goals of care don't involve the term "just 1 chest compression". You recommend the timeless "HAM Sandwich" as comfort meds (Haldol/Ativan/ Morphine/ Something for secretions) along with continuing her cardiac meds. How should you bill your visit? What if your visit lasted 40 minutes? What if the visit was in 2021?

HINT: What level links with 35 minutes? 40 minutes? Just 1 code or 2 (compare wRVUs)? How do times change in 2021?

Scenario 4: You are playing a fun game of "Billing and Coding: Name That Tune" with your team. They challenge you to write a 'stupid billing sentence' about pain in 10 notes (words) or less. Can you do it?

HINT: A stupid billing sentence checks 4 boxes in the history section

Scenario 5: You are called about a new hospital consult on a patient with GI bleeding from his gastric cancer. You talk with the team, read through the chart, and speak with the nursing staff about his pain and the family dynamics. That takes 40 minutes. You then find his wife in the waiting room and talk about her understanding of his goals for 20 minutes. He is due back from EGD “any time now”. It is 230pm... 330pm...430pm...530pm. At some point, if you don’t go home, the dog will pee on the carpet or your spouse will start swiping left on Tinder (or swiping right... the one that means your time is short). Have you donated your time to the proverbial ether today or can you get paid for something?

HINT: Can you bill a patient consult if you don’t see the patient? What did you do? Who did you see? What did you chat about?

Scenario 6: You are planning to see a patient in the clinic. You receive and review her records/talk to the referrer on Thursday for 35 minutes to ready yourself for her Friday visit. On Friday, you see the patient and her family in the office for 80 minutes (since your 35% no-show rate left you some flex in the system) to manage pain and nausea with MS Contin and ondansetron. The decision, during a 20 minute conversation, was made for DNR status. You then communicated with her primary care and oncology physicians by phone for 15 and 20 minutes each while writing your note and imagining your nightly cocktail. How can this be billed? How about in 2021?

HINT: Carve up the time day by day. Be careful not to bill time and acp in same encounter

Scenario 7: You are working on a busy inpatient PC consult service. You follow up in the morning on a patient you saw last week for pain, managing her patient controlled analgesia (PCA) pump for 15 minutes. Later in the day, you are called back for a planned family meeting with the patient and her daughter that lasts 22 minutes. The decision is made for comfort and the patient wants to go home ASAP. You then spend 35 minutes on the telephone in your office organizing a quick hospice discharge (writing prescriptions and coordinating care with the admit nurse) for the next morning. How would you have billed these encounters 5 years ago? How should you bill them today?

HINT: Inpatient setting – remember times and locations where time is billable

Scenario 8: You are a nurse practitioner scheduled for a followup visit with a patient in a SNF. Drama abounds. You talk with the facility social worker for 20 minutes on Monday, 15 minutes on Wednesday, and for 40 minutes on Thursday to prepare for the family meeting. You talk with her primary care physician on Wednesday for 18 minutes as well. You are in the SNF for 40 minutes managing pain and dyspnea though the family is a no-show for the meeting.

Relieved you made it out drama free, the SWer then brings her cell phone to you in your car so you can spend 25 minutes being yelled at by the patient's daughter, who ended up going to the casino instead, about advance care planning. How can all of this be billed? Where did you leave time on the table? What about dermatology as a career?

HINT: Carve up the time day by day. What about the parking lot?

Scenario 9: You see a patient who is unconscious, intubated, and sedated. There is no family around and the patient's name in Epic is "Unknown, Whiskey". She is on the trauma service so the notes are difficult to follow and mention something about a bus. You are consulted for complex medical decision making. What are the parts of the "History" section of the note? Which ones can you skip out on in this scenario? What should you document to get full credit?

HINT: History has 3 parts (Turkey head)

Scenario 10: The inpatient team's intrepid NP, transfixed by the discussion you just had together about the Billing Turkey and Chicken™, wonders out loud how few words in the Assessment/Plan section could support a high level note. She gives you the below framework and dares you to add fewer than 8 words to support high level medical decision making. Can you?

Assessment: 72yoM new consult with 10/10 hip pain likely from cancer.

Plan

1) Pain

Scenario 1: You come on to work on the inpatient PC consult service on Monday and take over for a colleague who was on last week. Your partner had been seeing a man for cancer pain and nausea. The patient is not taking IV opioids, benzos, or methadone, the patient did not decide to become a DNR or comfort care today, and the exacerbation of his chronic illness is no longer severe. Prognosis is months to years. What is the highest level of bill that you could potentially achieve today? Name 3 ways to get there.

HINT: Initial or Subseq? Is there any way to get to Level 3 (or maybe 3 ways – think of the 2 ways to bill and the components of MDM)?

ANSWERS: Level 3 follow-up (99233). Time, Data/Diagnoses, recommend an ‘in case’ IV opioid given nausea.

Scenario 2: Your partner saw a patient a month ago for complex medical decision making and pain. She signed off. The patient has been marooned on the Island of Chronic Critical Illness since then and has not left the hospital. You reconsult and spend 70 minutes face to face with the patient, managing pain and counseling about prognosis, pain medication options, and hospice. What is/are the right code(s) to use for this situation?

HINT: Initial or subsequent? One code or multiple?

ANSWER: CANNOT USE NEW VISIT CODE. Can do either of the following:

- 1) 99233 + 99356 (billing all on time; 3.71 wRVUs) or
- 2) 99233 on complexity and 99497+99498 (ACP) on time (4.9 wRVUs). Could bill over 46 minutes on ACP if that’s what you did.

Scenario 3: You see a followup patient in the office who has decided on home hospice for her congestive heart failure. Your visit lasts 35 minutes, with 20 of those minutes counseling about home hospice and ensuring goals of care don’t involve the term “just 1 chest compression”. You recommend the timeless “HAM Sandwich” as comfort meds (Haldol/Ativan/ Morphine/ Something for secretions) along with continuing her cardiac meds. How should you bill your visit? What if your visit lasted 40 minutes? What if the visit was in 2021?

HINT: What level links with 35 minutes? 40 minutes? Just 1 code or 2 (compare wRVUs)? How do times change in 2021?

ANSWER: Likely 99214 (level 4 follow-up) billed on complexity given multiple prescription medications and 99497, ACP. If the visit lasted 40 minutes, you’d bill it the same way since 99215 is only worth only 2.11 wRVUs (around 2/3 of the 3.0 wRVUs available from 99214 + 99497).

In 2021, you’d STILL bill it the same way. Adding an ACP code is almost always better than the higher level single code.

Scenario 4: You are playing a fun game of “Billing and Coding: Name That Tune” with your team. They challenge you to write a ‘stupid billing sentence’ about pain in 10 notes (words) or less. Can you do it?

HINT: A stupid billing sentence checks 4 boxes in the history section

ANSWER: Pain was moderate, back, constant, for 2 days.

Scenario 5: You are called about a new hospital consult on a patient with GI bleeding from his gastric cancer. You talk with the team, read through the chart, and speak with the nursing staff about his pain and the family dynamics. That takes 40 minutes. You then find his wife in the waiting room and talk about her understanding of his goals for 20 minutes. He is due back from EGD “any time now”. It is 230pm... 330pm...430pm...530pm. At some point, if you don’t go home, the dog will pee on the carpet or your spouse will start swiping left on Tinder (or swiping right... the one that means your time is short). Have you donated your time to the proverbial ether today or can you get paid for something?

HINT: Can you bill a patient consult if you don’t see the patient? What did you do? Who did you see? What did you chat about?

ANSWER: 99497 – ACP code for face to face conversation with the family (1.5 wRVUs) or prolonged non-face-to-face time given >30 minutes of work (2.1 wRVUs) or... wait for it... BOTH if >30 min on top of 20 minutes!

Scenario 6: You are planning to see a patient in the clinic. You receive and review her records/talk to the referrer on Thursday for 35 minutes to ready yourself for her Friday visit. On Friday, you see the patient and her family in the office for 80 minutes (since your 35% no-show rate left you some flex in the system) to manage pain and nausea with MS Contin and ondansetron. The decision, during a 20 minute conversation, was made for DNR status. You then communicated with her primary care and oncology physicians by phone for 15 and 20 minutes each while writing your note and imagining your nightly cocktail. How can this be billed? How about in 2021?

HINT: Carve up the time day by day. Be careful not to bill time and acp in same encounter

ANSWER: In 2020: Thursday warrants 99358 on time for record review. During the visit, bill 99204-5 on complexity and 99497 on time, and 99358 again for Friday evening’s communication with multiple providers. Total of 8.13 wRVUs!

In 2021: 99358 on Thurs. Friday one of the following:

- Bill complexity 99204/5 plus ACP plus donate phone call time (6.77)
- Bill 121 min on Friday on time 99205 + 99417x3 (7.1 via conservative CMS chart billing)

Scenario 7: You are working on a busy inpatient PC consult service. You follow up in the morning on a patient you saw last week for pain, managing her patient controlled analgesia (PCA) pump for 15 minutes. Later in the day, you are called back for a planned family meeting with the patient and her daughter that lasts 22 minutes. The decision is made for comfort and the patient wants to go home ASAP. You then spend 35 minutes on the telephone in your office organizing a quick hospice discharge (writing prescriptions and coordinating care with the admit nurse) for the next morning. How would you have billed these encounters 5 years ago? How should you bill them today?

HINT: Inpatient setting – remember times and locations where time is billable

ANSWERS: 5 years ago – 99233 for unit/floor time (2.0 wRVUs)

Today – 99233 on complexity, 99497 for ACP conversation, and 99358 for work in the office (5.6 wRVU)

Scenario 8: You are a nurse practitioner scheduled for a followup visit with a patient in a SNF. Drama abounds. You talk with the facility social worker for 20 minutes on Monday, 15 minutes on Wednesday, and for 40 minutes on Thursday to prepare for the family meeting. You talk with her primary care physician on Wednesday for 18 minutes as well. You are in the SNF for 40 minutes managing pain and dyspnea though the family is a no-show for the meeting.

Relieved you made it out drama free, the SWer then brings her cell phone to you in your car so you can spend 25 minutes being yelled at by the patient's daughter, who ended up going to the casino instead, about advance care planning. How can all of this be billed? Where did you leave time on the table? What about dermatology as a career?

HINT: Carve up the time day by day. What about the parking lot?

ANSWER: 99306 by complexity for initial SNF visit. 99358 for Wednesday (both facility SWer AND PCP sum to >30 min) and 99358 for Thursday. Parking lot time had been nonbillable as was ACP done on the phone. COVID has led to ACP done over the phone to be billable during the Public Health Emergency.

Scenario 9: You see a patient who is unconscious, intubated, and sedated. There is no family around and the patient's name in Epic is "Unknown, Whiskey". She is on the trauma service so the notes are difficult to follow and mention something about a bus. You are consulted for complex medical decision making. What are the parts of the "History" section of the note? Which ones can you skip out on in this scenario? What should you document to get full credit?

HINT: History has 3 parts (Turkey head)

ANSWERS:

- 1) HPI, PMH, SocHX, FHx, ROS
- 2) Can skip out on PMH, SocHx, FamHx, ROS BUT NOT HPI
- 3) Prove you tried with something like "Unable to obtain PMH, SocHx, FamHx, ROS as pt is intubated and sedated. No information in Epic as identity is unknown and no family at bedside to ask. RN unaware as well."

Scenario 10: The inpatient team's intrepid NP, transfixed by the discussion you just had together about the Billing Turkey and Chicken™, wonders out loud how few words in the Assessment/Plan section could support a high level note. She gives you the below framework and dares you to add fewer than 8 words to support high level medical decision making. Can you?

Assessment: 72yoM new consult with 10/10 hip pain likely from cancer.

Plan

- 1) Pain

ANSWER: - (new): check hip XR, IV dilaudid

MDM 2 of 3 sections: new diagnosis with workup = high level diagnoses; IV opioid = high risk