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# Let's Talk About Time: A Deeper Dive into the 2021 Office Visit E/M Coding Changes

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# Agenda

- Brief Review of 2021 Changes
- Overview of the Time Definitions included into E/M Office Visit CPT codes
- Describe what counts vs what doesn’t count
- Explore note documentation to support time
- Discuss the use of “prolonged service” codes

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# Disclaimer

- I am not a certified coder
- I am have no legal credentials
- I do not work for AMA or the AAP
- The information that you are about to see is my personal interpretation of educational materials that are available in the public domain
- There are nuances about coding, documentation and audits that are yet unknown since we are entering uncharted territory
- I do not have a crystal ball
- ***It is the legal responsibility of each provider who sees patients to educate themselves to the fullest extent possible, and choose the most appropriate code that represents the work which they performed***

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# What's Changing?

- Effective 1/1/2021 Office Visit Coding and Documentation is changing to use only Medical Decision Making OR **Time** when choosing an E/M level
- There will be no more rounding of time
- The time is not just dependent on counseling or coordination of care
- There is no longer a difference between coding levels for new/established patients
- The RVUs for these office visit E/M services have been increased
- ~~99201~~ will be removed

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# Established Patients

- **99212: 10-19** minutes of total time is spent on the date of the encounter
- **99213: 20-29** minutes of total time is spent on the date of the encounter
- **99214: 30-39** minutes of total time is spent on the date of the encounter
- **99215: 40-54** minutes of total time is spent on the date of the encounter

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# NEW Patients

- ~~**99201**~~**: Has been deleted**
- **99202: 15-29** minutes of total time is spent on the date of the encounter
- **99203: 30-44** minutes of total time is spent on the date of the encounter
- **99204: 45-59** minutes of total time is spent on the date of the encounter
- **99205: 60-74** minutes of total time is spent on the date of the encounter

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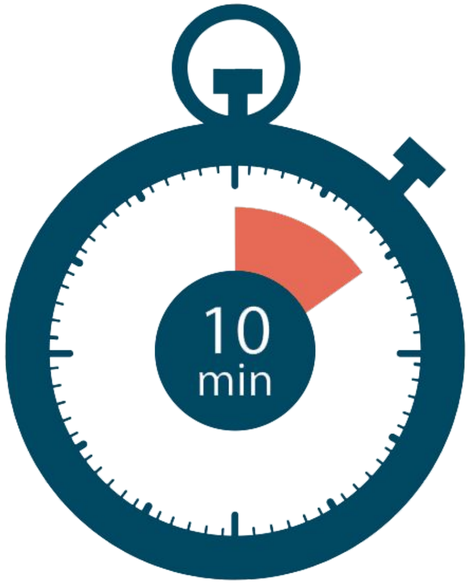
# Time: What Counts?

- Provider time
- Spent the same calendar day as the office visit (00:01am -12:59 pm)
- Clinical time

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# Time: What Counts?

PROVIDER doing work the **SAME DAY** as the encounter:

- 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*)

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# What is this “not separately reported?”

- If you are billing a separate CPT code that has its own inherent charges/payment, you cannot “double dip” and count that time
- Examples:
  - You see an infant for a weight check and also note that he has an umbilical granuloma that you cauterize. Since you will charge **17250 (***Chemical cauterization of granulation tissue)* if you are billing by time, then you must remove the time spent preparing for and performing the cauterization from your time.
  - You see a patient with ADHD in follow-up and review 3 Vanderbilts. Since you will charge **96160** x 3 units *(Patient-focused health risk assessment instrument)* then you must remove the time spent reviewing the Vanderbilts from your total time when choosing the E/M

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# What if I’m Speedy?

- If you spend <10 minutes for an established patient (the minimum time for a 99212)
  - You can either use a 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 healthcare professional. Usually, the presenting problem(s) are minimal.)*

    ***OR***
  - Use MDM
- If you spend <15 minutes for a new patient (the minimum time for a 99202)
  - I want the coffee you are drinking!
  - There is no 99201
  - Use MDM

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# What About Shared/Split Visits?

- 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 on the same day.
- When ***time*** is being used to choose E/M level:
  - Includes time personally spent by the physician
    **Summed with**
  - ***Distinct time spent*** by another physician or other qualified healthcare professional(s)
- When two or more individuals ***jointly*** meet with or discuss the patient, only the time of ***one individual*** should be counted for the period where they were together

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# What is an “other qualified professional?”

- Includes other professionals in your office that could bill the same E/M codes independently with their own credentialed NPI
- Does not including medical assistants or nursing staff
- Does not include scribes
- Does not include lactation consultants, mental health providers, dieticians who are not credentialed and per their license able to report/bill office visit E/M services
- ***Does*** include Nurse Practitioners, Physician Assistants or other APRNs (whether or not you bill incident to)

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# What Time is **NOT** Included?

- Clinical staff time
- Time spent the day previous or the next day *(only on the date of the face-to-face encounter or virtual face-to-face/Telehealth)*
- Time spent doing work that you are billing for separately with its own CPT codes
  - Time spent reviewing Vanderbilts
  - Time spent performing a procedure you bill for separately (cauterization of an umbilical granuloma, reduction of a subluxed radial head)
- Time of a “non-qualified” other healthcare professional that you supervise
- Time the provider spends doing non-clinical work
  - Scheduling an appointment
  - Processing payment

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# What About Physicians Co-signing APNs Notes?

- If the APNs is the rendering provider and billing under their own NPI, then likely doesn't count unless the physician can document "medical necessity appropriate for clinical care"
- Remember this is ***clinical care*** and has to be done the ***same day as the visit***
- Administrative work does not count
- If the APN is billed incident to under the supervising physician and the physician documents review of clinical information and any adjustments or additions to the plan of care as medically appropriate including appropriate discussion with the APN and/or family, then ***if documented***, likely justifiable.

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# What About Scribes?

- Practices who use scribes cannot count the scribe time
- Only the provider time spent doing clinical work on the same day as the visit can be counted
- Providers can count time they spend “reviewing, editing and attesting to” the scribe’s documentation
- Any preparation time ***the provider*** spends on the same day as the visit, prior to the encounter itself counts
- If the scribe is the person reviewing the ER report for the provider, or the lab results, or the report from the specialist: only the time they spend clinically discussing the information together counts for provider time

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# Common Scenario

*A 6 year old girl, followed by the practice, who was seen in the ER for cellulitis, is scheduled for an office follow-up visit. The Nurse Practitioner who is scheduled to see her is prepping the night before, and reviews the ER report and the culture status (7 minutes).*

*The day of the appointment, having a good idea about what is going on, the NP opens the note as part of entering the room to see the patient. She spends 10 minutes with the family, examines the patient and is uncomfortable that the patient has developed an abscess that might need to be drained.*

*She grabs her supervising physician, they see the patient together, spend 5 minutes together discussing treatment plans with the family.*

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# Common Scenario

*They collectively decide to perform an I&D on the patient and change the antibiotic course.*

*The physician spends an additional 20 minutes prepping and performing the I&D (child frightened and won't cooperate) and getting a repeat culture; writing for a new antibiotic (2 minutes) and documenting the note (6 minutes)*

**What code, based on time is most appropriate?**

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# Common Scenario

- Pre-visit prep ~~7 minutes~~: can't count, was the day before
- NP patient visit time 10 minutes ✔️
- Combined NP/Physician time, 5 minutes each: ~~10~~ 5 minutes ✔️
- Performing I&D: ~~20 minutes~~ can't count because should bill CPT10060 *(incision and drainage of abscess; simple or single)* and that time is included in that code
- Writing a new antibiotic Rx: 2 minutes ✔️
- Writing a note (NP/physician combined): 6 minutes ✔️

**Total time: 23 minutes = 99213 (**20-29 minutes)

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# Common Scenario

- If that same NP came in 30 minutes early to prep for the day and did the chart prep then, those 7 minutes would have gotten the visit to 30 minutes = 99214

- What would happen if later that evening the physician on call (not involved during the day) took a call from the mom about the patient having low grade fever and complaining about pain?
  - That time spent could be added to the ‘total clinical time’ of the visit as long as the call was prior to midnight, the length of the call is documented, and an addendum to the note refers to the follow-up conversation if documented separately.

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# Prolonged Service Code: 99417

**Definition:**

*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***

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# Prolonged Service Code: 99417

- Can never be billed alone
- Can only be used ***in addition to*** level 5 visits that were based on time to begin with (99205, 99215)
- Bill units of this in 15 minute increments
- No rounding
- Can only be used when you exceed the low end of the timeframe threshold of level 5 visits by at least 15 minutes

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# Prolonged Service Code: 99417

- 99205 (60-74 minutes defined)
  - 60 minutes (low end of the timeframe) *
  - PLUS 15 minutes
  - = 75 minutes to bill ***1 unit of 99417***

- 99215 (40-54 minutes defined)
  - 4994170 minutes (low end of the timeframe) *
  - PLUS 15 minutes
  - = 55 minutes to bill ***1 unit of 99417*** and 70 minutes to bill 2 units

*** As of 11/6/20 there is a disagreement about this between AMA and CMS**

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# How Will Payers Know How Much Time I Spent?

- Remember the ever present payer mantra: *“If it’s not documented, it’s not done”*
- When you submit a CPT code for E/M office visit services, the payer doesn’t know if you chose the code by MDM or time
- It’s if/when you get audited that you will need to show documentation that supports the code you chose
- Best practice is to document “which way” you chose your CPT for reference in the future (will you remember next year if you are audited?)
- Your note documentation should make it fairly obvious

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# How will a Payer Know if I Did the Work a Different Day?

- In an audit, the onus is ***on you*** to prove you did do it the same day
- EHR audit trails know what day/time you were logged in, ***when*** you did the work you did even of the time stamp isn't in the note
- EHR audit trails know ***who*** was logged in and did the work
- It is now standard for legal teams to request audit trails as well as medical records when doing malpractice or other forensic investigations

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# What is “Best Practice” Documentation for Time?

- There is no “clear” CPT guidance on this
- We have never been in this situation before and so do not know what payers will be looking for
- Likely a good idea to document “I attest the total time spent by the provider doing clinical work including previsit, intravisit and postvisit work was x minutes.”

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# Payers and Audits Reminders

- This is new to **everyone**: we do not know how payers are going to react and what they will require regarding documentation
- When you send the CPT code you are not telling them which you chose, MDM or time
- It is likely on the audit that there will be any challenges: so make sure your note reflects your work (whichever path you choose)
- Some payers are now requiring “pre-adjudication” audits for “outliers”: where they require notes ***before*** they will pay the claim
- Code appropriately, document thoroughly
- ***It is the provider that did the work who is responsible for choosing the appropriate code and for making sure the documentation reflects what they chose***

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# Where Can I Learn More?

- AMA Guidance
- AAP Guidance including
  - Summary of Time Changes
  - New Prolonged Service Code
  - FAQs (updated frequently)
  - Coding Newsletter (subscription required but well worth it!)
  - Coding for Pediatrics 2021 Edition (purchase but a must have!)
  - Pediatric Evaluation and Management: Coding Quick Reference Card 2021 ($21.95 for non members, $16.95 for AAP Members)

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For your time & attention

Look for more info to come on Medical Decision Making!