

Coding Update Regarding Changes in 2021

ADAPTED FROM AAP CODING NEWS

Questions about Time Based Code Selection

1. Can I choose to code all office E/M services based on time?

Yes. There is no limitation on when time may be used to select office E/M codes for services provided in 2021. However, with the simplified method of determining MDM, it might be advantageous to determine the code supported by the documented elements of MDM. You can then choose the code that best reflects the service provided.

2. What activities can be included in the total time spent by the physician or other qualified health care professional (QHP) when selecting an office E/M code based on time?

Include all time spent by the reporting individual(s) in activities directly related to the care of the individual patient on the day of the E/M services. However, do not include time spent in activities performed or typically performed by clinical staff (eg, rooming the patient). Include time spent in the following activities, when performed:

- Preparation before the face-to-face service (eg, reviewing test results or other records)
- Obtaining and 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 (eg, time of a separately reported interprofessional consultation is not included in the time of the office E/M service)
- Documenting clinical information in an electronic or other health record
- Independently interpreting results and communicating results to the patient/family/caregiver (Do not count time interpreting and reporting on a separately reported test [eg, do not count time spent in interpretation and report of an electrocardiographic (ECG) tracing when also billing for the ECG interpretation and report].)
- Care coordination when not separately reported (eg, time used to support reporting care plan oversight is not counted toward the time of the office E/M service)

3. Must I document each episode of time when my time on the date of an office visit is not continuous?

No. The intent of the office E/M codes is that only the total time is required. Total time is that spent by a physician or other QHP in activities directed to the individual patient on the date of the visit. Do not include any time in activities not directed to a single patient or any time spent by clinical staff.

4. Can I count my time spent on the day before or day after the visit in the total time of the office E/M service?

No. Current Procedural Terminology (CPT®) states that the total time used in code selection is time spent on the date of the visit. All office and other outpatient E/M codes were valued to include some time spent within 3 days prior and within 7 days after the date of the visit. However, when 30 minutes or more is spent in prolonged service without the patient/caregiver present on dates other than the date of an office E/M service, prolonged service codes 99358 and 99359 may be reported. Payer policies regarding codes 99358 and 99359 may vary.

5. If an advanced practice professional (eg, nurse practitioner) provides a substantive portion in an office E/M service (ie, evaluates patient history, examines the patient, makes decisions about diagnosis and management) and a pediatrician of the same group practice also provides a substantive portion of the visit to the same patient on the same date, can a code be selected based on time?

Yes. The sum of the times spent independently by each individual is used for code selection

EXAMPLE

A nurse practitioner is seeing a patient to follow up on a problem that is not responding adequately to current management. The nurse practitioner asks the pediatrician to see the patient and recommend new management. The nurse practitioner's total time devoted to the patient on that date is 15 minutes, including time preparing for the visit and time spent in activities such as documentation and/or coordination of care after the visit. The pediatrician's time that is not overlapping of the nurse practitioner's time is 15 minutes total (patient visit and clinical documentation after the visit). The periods of time counted by each individual are not overlapping (ie, both do not bill for the same minutes of time). The 30-minute combined time of the nurse practitioner and pediatrician supports either 99203 (new patient, 30–44 minutes) or 99214 (established patient, 30–39 minutes).

Note that payer guidelines may determine whether the service is billed by the nurse practitioner or the pediatrician. Some payers follow Medicare policies that require reporting under the nurse practitioner's name and National Provider Identifier if incident-to requirements are not met (eg, incident-to requires that the pediatrician has previously seen the patient for the complaint and established a plan of care).

6. Can I report prolonged office E/M service code 99417 when I select an office E/M code based on the level of MDM?

No. Code 99417 is reported only when code selection is based on time and only in conjunction with code 99205 or 99215. See a time chart for use of code 99417 in your CPT reference.

NOTE: At the time of publication, it appeared that the currently published CPT instructions for code 99417 (ie, time begins when the minimum total time is exceeded by 15 minutes) may not be accepted by Medicare, Medicaid, and other payers that align their payment policies to Medicare. The Centers for Medicare & Medicaid Services (CMS) has proposed requiring 15 minutes beyond the maximum time of code 99205 (ie, the CMS may require 89 minutes of total time rather than the 55 minutes currently instructed by CPT) or 99215 (ie, the CMS may require 69 minutes in lieu of the 55 minutes currently instructed by CPT) as the minimum time for reporting 99417. Please check the AAP Pediatric Coding Newsletter™ website (<http://coding.aap.org>) for up-to-date information on use of code 99417.

Questions About Medical Decision-making

1. Is the same level of MDM required for codes 99204 and 99214?

Yes. For all levels of office E/M codes, the MDM is the same whether the patient is new or established. However, the relative value units used by most payers to calculate fee-for-service payment is higher for new patient codes than for established patient codes at each level of service due to the additional work of establishing the patient to the practice.

2. If we order tests and review the results of the tests in the same encounter, can we count both the order and the review of each test?

No. The instructions for MDM selection state, "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." Each unique test, as described by a single CPT code, is counted once toward the amount and/or complexity of data to be reviewed and analyzed. An order for a point-of-care laboratory test and review of the result on the same date counts only as review of 1 unique test (ie, the order is included in the review). However, count each review of a unique test result toward the required combination of data to meet Category 1 in the CPT level of MDM table.

3. Are tests that yield multiple results (eg, metabolic panel) counted as multiple tests ordered or reviewed?

No. CPT instructs that any tests that are reported with a single CPT or Healthcare Common Procedure Coding System code are counted only once. For instance, a basic metabolic panel (80047 or 80048) includes testing and results for 8 substances but is counted as 1 test.

4. If a pediatrician interprets and creates a report for findings of a diagnostic test during a visit, does this count toward the amount and/or complexity of data?

Not if the pediatrician also separately reports the service because the work of the interpretation and report cannot be counted twice. For instance, if reporting 94010 for interpretation and report of spirometry, the spirometry is not counted toward the amount and/or complexity of data. However, a review of a report of spirometry findings created by another physician is counted. If, however, you review the results of a test that you ordered that does not have interpretation or report built in (per code descriptor or CPT instruction), such as developmental screening (96110) or depression assessment (96127), that would count.

5. When an advanced practice professional (eg, nurse practitioner) is working under a physician's supervision, does discussion of the patient's diagnosis and/or management between the advanced practice professional and the supervising physician count as discussion with an external physician or other QHP when determining the amount and/or complexity of data reviewed and analyzed? What about when the advanced practice professional independently reports the service?

The answer is typically no for both circumstances. The definition of "external physician or other qualified health care professional" is "an external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently." CPT guidance instructs that 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. (Also, an advanced practice professional who provides a service that will be reported by a supervising physician does not seem to meet the "licensed professionals who are practicing independently" portion of the definition.) However, clinically indicated discussions between physicians and/or other QHPs in the same practice and same specialty do contribute to the total time of the E/M service, which may lead to more accurate code selection based on the total time of the reporting individual.

Count discussion of management or test interpretation only when the discussion is with a party that meets the definition of an external physician, other QHP, or appropriate source (eg, discussion with a physician in the same group practice who practices a different specialty or subspecialty). When a discussion between 2 physicians or other QHPs is billed as an inter-professional consultation, do not count the discussion in the selection of the level of MDM.