2021
E/M Guidelines

020WDLGSP34A-11

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020WDLGSP34A-11

Acknowledgments

Courtney Pruitt-Sanderson, M.Ed., RHIA, *Author*

Brenda Blomberg, B.A., CPC, *Author/Curriculum Project Manager*

Mary Siegrist, PhD, RHIA, *Subject Matter Expert*

Sa'mone Dixon, *Subject Matter Expert*

Editorial Staff

Leslie Ballentine, M.S., *Dean of Curriculum*

Heather Deibert, B.S., CPC, *Academic Content Editor*

Jamie Schenkel, *Editorial Assistant*

Jessica Babb-Raymundo, B.A., *Graphic Designer*

Fort Collins, CO 80525
www.westondistancelearning.com

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2021 E/M Guidelines

Introduction

Documentation establishes the level of service for an evaluation and management code. In 1995, CMS (known as the Health Care Financing Administration at that time) established guidelines for documentation, known as the 1995 Guidelines. To encourage more detailed documentation to better support the level of service billed, CMS created the 1997 Guidelines. The history and medical decision-making components remained the same, but the examination component went through quite a transformation. The 1995 Guidelines recognized organ systems and body areas for the purpose of obtaining an overall examination level. The 1997 Guidelines established a multisystem examination as well as various single-organ examination requirements. However, many professionals in the medical field felt that the 1995 Guidelines were less cumbersome, and the 1997 Guidelines were missing valid details. Therefore, CMS determined that carriers are to continue reviews using either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services (whichever is more advantageous to the physician) until further notice. Because the 1995 Guidelines are more widely used and straightforward to work with, those are the guidelines used in your course materials.

In 2021, the AMA has revised the guidelines and element scoring for new and established patients (99202-99215). The information provided in your course materials still applies to all codes using key components, except for codes 99202-99215. Please complete your course using the guidelines and processes provided in your course materials. If you are using a 2021 CPT coding manual, you'll note that codes 99201-99215 have been deleted from the Evaluation and Management section. However, you can still access the information you need as the deleted codes can be found in Appendix B. To assist you in learning the 2021 revised guidelines for 99202-99215, we created a supplement to walk you through the process of coding office visit for new and established patients.

Office or Other Outpatient Services

These codes are for office visits and are categorized by the patient status. You'll recall that a new patient is one who has not received any professional services from the physician or qualified healthcare professional or another physician or qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the last three years. When the documentation indicates "initial office visit," you will be coding for a new patient office visit.

Prior to 2021, medical coders typically used the *1995 Guidelines* with key components to determine the overall level of service for both new and established office visits. However, the American Medical Association (AMA) was committed to changing the coding and documentation requirements for office E/M visits to simplify the work of the healthcare provider and to improve patient care. To decrease the administrative burden of documentation, the AMA removed the counting process for history and examination. This also decreased the unnecessary documentation requirements that are not needed for patient care.

According to the *2021 Guidelines*, the provider should document a medically appropriate history and/or examination for office visits, and the overall level of services can be determined using either medical decision making or the total time spent on the date of the encounter. Note, the documented history and/or exam is not used in the code level selection. Furthermore, "medically appropriate" means what the provider feels is necessary for patient care should be documented.

Time Component

With the *1995 Guidelines*, time is used to assign an evaluation and management code only when the physician spends more than 50 percent of the time face-to-face with the patient and/or family. In 2021, the AMA changed the definition of time as it relates to office visits (*99202-99215*).

Prior to 2021	Begin in 2021
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: • A detailed focused history; • A detailed examination; • Medical decision making of low complexity Counseling and/or coordination with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs. Usually the presenting problem(s) are of low to moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	**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.
99213 Office or other outpatient visit for the evaluation and management of a new patient, which requires at least 2 of these 3 key components: • An expanded problem focused history; • An expanded problem focused examination; • Medical decision making of low complexity Counseling and/or coordination with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs. Usually the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	**99213** 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, 20-29 minutes of total time is spent on the date of the encounter.

When coding office visits for new or established patients (*99202-99215*), time is the total time spent with the patient on the date of the encounter. Time may be used to select a code level for office visits, whether or not counseling and/or coordination of care dominates the service. Note that a key shift for the office visit codes is that the time referenced is the total time, which includes both face-to-face and non-face-to-face time spent by the provider on that encounter day. When determining the cumulative time, you should not include time spent on services that are reported separately. For instance, if you report care coordination using a separate CPT code, you should not include that in the time for the E/M code. In addition, the total time also will not include time for activities the clinical staff normally performs.

Physician and/or other qualified healthcare professional time for office visits includes the following activities:

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam and/or evaluation
- Counseling and educating the patient, family or caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other healthcare professionals (when not reported separately)
- Documenting clinical information within the medical record
- Independently interpreting results (when not reported separately) and communicating results to the patient, family or caregiver
- Care coordination (when not reported separately)

Time includes communicating with other healthcare professionals.

Currently, there is no guideline as to how the time must be documented in the medical record other than the total time is to be noted. The cumulative time must be from the calendar day of the encounter; it does not carry over from the previous or to the following day. Finally, clear time ranges are established for each code.

99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

2021 CPT Update

The AMA deleted code *99201* because codes *99201* and *99202* both required a straightforward MDM; only code *99202* remains. There are some situations in which you may still report *99201*, such as for workers' compensation or payers that have not adopted the 2021 CPT changes.

The time component for code *99211* was removed in 2021. Code *99211* is 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. This patient is usually assisted by the clinician and does not see the provider directly.

Prolonged Service Code

In addition to the clear time ranges for office visits, a prolonged service code was created to capture services for a patient that requires longer time on the date of the encounter. While the typical patient with a runny nose may require a 15-minute appointment, the patient with additional questions, prompted from online research or a worried family member, may require a longer visit to answer these questions.

Some family members may have more time.

Prolonged services (*99417*) are to be reported when the visit is based on time *and* after the total time of the highest-level service (*99205/99215*) has been exceeded. This code allows for face-to-face and non-face-to-face care on the date of the encounter. However, this code should not be used for any time unit less than 15 minutes.

99205 Total Time	Code(s)	99215 Total Time	Code(s)
< 75 minutes	Not reported separately	< 55 minutes	Not reported separately
75-89 minutes	*99205* × 1 + *99417* × 1	55-69 minutes	*99215* × 1 + *99417* × 1
90-104 minutes	*99205* × 1 + *99417* × 2	70-84 minutes	*99215* × 1 + *99417* × 2

Medical Decision Making Component

You've already studied medical decision making when you explored the key components for the *1995 Guidelines*. However, in 2021, the AMA removed ambiguous terms, provided terminology definitions and used the *1995 Guidelines Table of Risk* as a foundation to create the *2021 Guidelines Level of Medical Decision-Making Table*. The goal of the new table is to reduce variation, align with clinically intuitive concepts and reduce disruption in the current coding patterns. You will see similarities to the MDM component you studied previously. Remember, you will not use the *2021 Guidelines* for anything other than codes *99202-99215*.

Now, let's look at the *2021 Guidelines Level of Medical Decision-Making Table* that is used to determine the level of service for office visits. Similar to the *1995 Guidelines*, there are three parts to the MDM table:

- **Number and Complexity of Problems Addressed at the Encounter**
- **Amount and/or Complexity of Data to be Reviewed and Analyzed**
- **Risk of Complications and/or Morbidity or Mortality of Patient Management**

Although these elements may seem like the 1995 table, they are different and should not be confused. When coding for an office visit (*99202-99215*) you are to use the *2021 Guidelines Level of Medical Decision-Making Table*. Any other E/M codes that require the use of *1995 Guidelines* will use the MDM table.

Number and Complexity of Problems Addressed at the Encounter

First, you will consider the problem that is addressed or managed when it is evaluated or treated at the encounter by the provider. This includes consideration of further testing or treatment that may not be elected by the patient and/or family. However, noting a problem without documenting additional assessment or care coordination does not count. According to the guidelines, *comorbidities or 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 complication and/or morbidity or mortality of patient management.* For instance, if the PCP notes the patient's congestive heart failure is managed by the cardiologist, the PCP does not count that as a problem that was addressed during this encounter, unless how it affects the treatment plan is documented.

Definitions for the elements of MDM are included in the *E/M Guidelines*. Here are some highlights of those definitions:

- **Self-limiting 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.
  - **Stable**—Defined by the specific treatment goals for an individual patient. A patient who 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.
  - **Chronic**—Conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition).

- **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 or mortality with treatment, and full recovery without functional impairment is expected. For example, 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.

When using the table, only one item needs to be selected to meet that level of service. For instance, one acute, uncomplicated illness meets the requirements for low complexity for problems addressed at the encounter.

Minimal	Low	Moderate	High
• 1 self-limited or minor problem	• 2 or more self-limited or minor problems • 1 stable, chronic illness • 1 acute, uncomplicated illness or injury	• 1 or more chronic illnesses with exacerbation, progression or side effects of treatment • 2 or more stable, chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 acute illness with systemic symptoms • 1 acute complicated injury	• 1 or more chronic illnesses with severe exacerbation, prognosis or side effects of treatment • 1 acute or chronic illness or injury that poses a threat to life or bodily function

Amount and/or Complexity of Data to be Reviewed and Analyzed

According to the *CPT*, the data here includes *medical records, tests and/or other information that must be obtained, ordered, reviewed and analyzed for the encounter*. However, if you are reporting the service with its own CPT code, you won't count it here. For instance, if your office does its own x-rays and you submit a code from the radiology section with the claim, you will not count that as data here. Essentially, the data is divided into three categories:

- Tests, documents, orders or independent historian(s). Each unique test, order or document is counted.
- Independent interpretation of tests not reported separately.
- Discussion of management or tests interpretation with external physician or other qualified healthcare provider or appropriate source (not reported separately).

For this element of the MDM, minimal or no data is straightforward, while two documents or independent historian are low. For moderate, you must have one category from count, interpret or confer.

- **Count** refers to documenting notes, tests, orders and independent historian(s). Notes refers to the documents reviewed are from external sources—not your last appointment with the patient. Tests apply when reviewing radiology, pathology and medicine tests. Finally, order indicates the provider requested a radiology, pathology or medicine test. An **independent historian** is 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.[1]

- **Interpret** refers to an independent interpretation of test(s) performed by another provider. In many healthcare centers, a number of specialists may be grouped together, allowing the specialist to work together in the patient care. For instance, your PCP suspects you have a fractured wrist and wants an x-ray to confirm this. Luckily, the diagnostic center is two floors up and you're able to get in right away. After the x-ray, you return to the PCP's office. The staff alerts the PCP that you've returned, so he logs into your electronic record and is able to view your x-ray right then. While the radiologist will read the x-ray and provide their results (and bill you for the professional service), your PCP has provided an independent interpretation of the test.
- **Confer** refers to the discussion of management or test interpretation with an external provider. For instance, the PCP determines his patient with the fractured wrist would benefit from seeing an orthopedic surgeon for the repair. The PCP contacts an orthopedic surgeon, discusses the situation and reviews the x-ray together. The surgeon agrees to take the case and the PCP refers the patient for further treatment.

Minimal or None	Limited (must meet 1 of 2)	Moderate (must meet 1 of 3)	Extensive (must meet 2 of 3)
• None	• Historian • Count (2) Notes x ___ Tests x __ Order x ___	• Count (3) Notes x ___ Tests x __ Order x ___ Historian • Interpret • Confer	• Count (3) Notes x ___ Tests x __ Order x ___ Historian • Interpret • Confer

Note, when a combination of two are required in the counting and the provider orders two unique tests, the requirements of this category have been met. Although each has its own CPT code, you are reviewing the results or ordering the test, not billing for doing the test.

Let's look at an example for clarification. Dr. Bates orders a CBC and a chest x-ray. Two tests are ordered for a count of two, and limited must meet one element; therefore, limited has been met. Now, say that Dr. Bates orders a CBC, a comprehensive metabolic panel and the chest x-ray, there's a count of three which meets the moderate level of service. If Dr. Bates orders the x-ray and interprets the results himself in addition to ordering the CBC and comprehensive metabolic panel, you have a count of three plus another category, which meets the extensive level of service.

Risk of Complications and/or Morbidity or Mortality of Patient Management

The final element of the MDM looks at *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) and treatment(s)*, according to the *E/M Guidelines.* This includes the possible management options selected and those considered but not selected after shared medical decision making with the patient and/or family. This may include the decision for palliative treatment rather than hospitalizing a patient with advanced dementia with an acute condition that generally warrants inpatient care. The provider may also address risks associated with social determinants of health. **Social determinants of health** are economic and social conditions that influence the health of people and communities.[2] Examples may include food or housing insecurity. For instance, the provider may document that Drug A would be beneficial to the patient, but because the patient doesn't have insurance, the less expensive Drug B will be prescribed.

ONLINE LEARNING

Build on what you are learning by reading more about social determinants of health at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

Minimal	Low	Moderate	High
• Minimal risk of morbidity from additional diagnostic testing or treatment	• Low risk of morbidity from additional diagnostic testing or treatment	• Moderate risk of morbidity from additional diagnostic testing or treatment	• High risk of morbidity from additional diagnostic testing or treatment

Let's look at the details of these levels. For straightforward, there is minimal risk from the treatment or testing. You will select this level when there is no treatment required for the service. Low risk, on the other hand, has very low risk of severity problems and often minimal consent or discussion is required.

The *E/M Guidelines* offer examples for moderate and high risk, so be sure to reference it when coding from this section. With moderate risk, the provider typically discusses the risk with the patient and/or family or obtains consent and monitors the treatment. Examples for this level of risk include prescription drug management; decision regarding minor surgery with identified risk factors; decision regarding elective major surgery without identified risk factors; and diagnosis or treatment significantly limited by social determinants of health.

High level of risk are services in which the provider needs to discuss higher risk problems that could happen, and the provider will need to monitor the treatment. Examples for this level of risk include drug therapy requiring intensive monitoring for toxicity; decision regarding elective major surgery with identified risk factors; decision regarding emergency major surgery; decision regarding hospitalization; and decision not to resuscitate or to de-escalate care because of poor prognosis.

Overall MDM

To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded. For instance, you have the *Number and Complexity of Problems Addressed at the Encounter (Dx)* at **low**; the *Amount and/or Complexity of Data to be Reviewed and Analyzed (Data)* at **moderate**; and *Risk of Complications and/or Morbidity or Mortality of Patient Management (Risk)* at **high**. You'll drop the lowest and use the other two to determine the MDM level. At this point, you'll select the lower of the remaining two, which is the **moderate** for *Data*. Your overall MDM is *Moderate Complexity*.

	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Dx	minimal	~~low~~	moderate	high
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Let's walk through an example of an office visit for an established patient.

SUBJECTIVE
The patient is a 2-year-old male. The mother states she was called to pick her son up from the preschool, because he had a low-grade fever, sore throat with blisters in his mouth and refused to eat.

OBJECTIVE
A vesicular exanthema is distributed over the buccal mucosa and palate with similar lesions on the hands and feet and in the diaper area. Rectal temperature: 103 °F. A rectal swab specimen was ordered, and the results were positive for Coxsackie A virus.

ASSESSMENT
Hand, foot and mouth disease.

PLAN
Tylenol with codeine prescribed for pain and fever. Bed rest. Encourage increase in fluid intake, including milk, liquid gelatin, ice cream, custard or drinks made with syrup of wild cherry (available at pharmacy). Prevent exposure to other infants and young children and any persons with a respiratory illness. Symptoms should subside in 4-5 days, and then he can return to school.

To code this report, the provider must indicate a medically appropriate history and/or exam, which has been done. For this service, the provider has selected to code by MDM rather than time, so you'll refer to the medical decision-making table. Let's walk through the process.

First, consider the number and complexity of the problem addressed at the encounter. The patient has hand, foot and mouth disease. If you refer back to the definitions, this recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk or mortality with treatment, and full recovery without functional impairment is expected. Therefore, it is an acute, uncomplicated illness, which is **low** for the problem addressed.

Next, you'll look at the amount and/or complexity of the data to be reviewed and analyzed. The provider ordered and reviewed the results of the rectal swab. You see that under tests and documents, the provider can do a combination of any two. The provider ordered a test (1) and reviewed the results of that test (1). Because both are documented and not billed by the provider, you can count both for this element. The provider did not indicate interpreting the results so you'll stop there. This count results in a **limited** level for data.

Finally, you'll look at the risk of complications and/or morbidity or mortality of patient management. You see that the provider prescribed Tylenol with codeine, which is an example of prescription drug management found under the **moderate** level of risk.

	Straightforward 99202/99212	Low 99203/99213	Moderate 99204/99214	High 99205/99215
Dx	minimal	low	moderate	high
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

To determine the overall level, you only need to consider two of the three elements. In this case, two of the three are low, so your overall level will be low as well. You'll code *99213* for this established office visit.

As long as the provider performs a medically appropriate history and/or physical examination; indicates the level of medical decision making performed or the total time spent performing the service; and documents them as if she were there—and meets the basic conditions of a telemedicine visit—then you have a billable evaluation and management visit. Keep in mind that Medicare and most large commercial payers will accept the code with modifier 95. The place of service might be where the services normally take place, such as the physician's office, or the insurance carrier may require the telehealth code for the place of service.

Practice Exercise 1

Determine if each statement is true or false.

1. **Telehealth services can be provided using just audio.**

2. **The provider should document the history and examination information he feels is necessary for patient care.**

3. **To determine the overall level of service for an office visit, you will consider both the MDM and total time on the date of the encounter.**

4. **Time spent the day before and day after the service are considered when coding with time.**

5. **Activities usually performed by the clinical staff is included in the total time.**

6. **Care coordination is included in the total time when not reported separately.**

7. **Number and complexity of problems addressed at the encounter includes consideration of further testing or treatment that may not be elected by the patient and/or family.**

8. **An acute, uncomplicated illness is a problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status.**

9. **For the data element of the MDM, each unique test, order or document is counted.**

10. **Those treatment options considered but not selected after shared medical decision making with the patient and/or family help determine the risk.**

Answer as directed.

11. **Marj is coding a medical record for an established office visit based on the level of medical decision making, as directed by the practice guidelines. She determines the service is *99213* based on the documentation. However, the provider notes that the service was 45 minutes long. The time rage for code *99213* is 20-29 minutes; therefore, Marj add the prolonged service code (*99417*) to indicate the service exceeded the time for code *99213*. She submits codes *99213* and *99417* for this service. Was this correct?**

Read the following scenarios and use the forms found in your *E/M Audit for Practices Exercises* to answer as directed.

12. Initial Office Visit

SUBJECTIVE
Two weeks ago, the mother of this 7-year-old female noted a low-grade fever, headache and stuffy nose lasting 3 days. A couple of days after symptoms subsided, patient noticed a bright red rash on her face. Patient now presents with similar rash on trunk, arms and legs x 1 week.

OBJECTIVE
Temperature 100.7 °F. Physical examination reveals net-like rash on face, trunk, arms and legs.

ASSESSMENT
Patient has fifth disease.

PLAN
Plenty of bed rest. Drink lots of clear fluids and take acetaminophen as needed to reduce fever. Call office if rash does not begin to clear within 10 days.

E/M: _____

13. Office Visit Established Patient

HISTORY OF PRESENT ILLNESS
This is a middle-aged African American male who comes today for routine follow-up. He has no acute complaints. No neurological deficits or other specific problems. The patient denies any symptoms associated with opportunistic infection.

PAST MEDICAL HISTORY
Immunizations: Up to date.
Current medications: (1) He is on Trizivir 1 tab p.o. b.i.d. (2) Ibuprofen over the counter p.r.n.
Medication compliance: The patient is 100% compliant with his meds. He reports he does not miss any doses. Drug intolerance: There is no known drug intolerance in the past.
Illnesses: (1) Significant for HIV. (2) Chronic hepatitis. (3) PPD status was negative in the past. PPD will be placed again today. Treatment adherence counseling was performed by both nursing staff and myself. Again, the patient is 100% compliant with his meds. Last dental exam was 2 years ago, where he had 2 teeth extracted.
ALLERGIES: HE HAS NO KNOWN DRUG ALLERGIES.
Nutritional status: The patient eats regular diet and eats 3 meals a day.
Sexual history: He has had no recent STIs, and he is not currently sexually active.
Mental health and substance abuse: No history of substance abuse.

REVIEW OF SYSTEMS
Noncontributory except as mentioned in the HPI.

PHYSICAL EXAMINATION
GENERAL: This is a thinly built male, not in acute distress.
VITAL SIGNS: Blood pressure 132/89 and pulse of 82.
HEAD AND NECK: Reveals bilaterally reactive pupils. Supple neck. No thrush. No adenopathy.
HEART: Heart sounds S1 and S2 regular. No murmur.
LUNGS: Clear bilaterally to auscultation.
ABDOMEN: Soft and nontender with good bowel sounds.
NEUROLOGIC: He is alert and oriented x 3 with no focal neurological deficit.
EXTREMITIES: Peripheral pulses are felt bilaterally. He has no pitting pedal edema, clubbing or cyanosis.
GENITALIA: Examination of external genitalia is unremarkable. There are no lesions.

DATABASE
Most recent labs show hemoglobin and hematocrit of 16 and 46. Creatinine of 0.6. LFTs within normal limits. Viral load of less than 48 and CD4 count of 918.

ASSESSMENT
1. Human immunodeficiency virus, stable on Trizivir.
2. Chronic hepatitis C, stable.

PLAN
Continue his current meds. I have discussed with him in the past about possibility of having to change off of his Trizivir in the future, if he develops resistance, since triple NRTI therapy is not the preferred, but he is not amenable to that at this time. He has excellent viremic control and good CD4 count. We will readdress this with him in the future if his status changes. The patient is to have PPD placed today. He has received his annual influenza vaccination for this season. He will be seen again by the dental clinic for routine evaluation and have labs today including CD4, viral load, RPR and urinalysis. He will return to our clinic in 6 months. The patient does not want to be seen more often since he has a job that he reports to and cannot miss more days off work. Again, this is acceptable since he has excellent viremic control. The patient has been educated regarding his meds and plan. His prognosis is excellent, and he will follow up with us in 6 months.

E/M: _____

Review Practice Exercise 1

1. Telehealth services can be provided using just audio. **False**

2. The provider should document the history and examination information he feels is necessary for patient care. **True**

3. To determine the overall level of service for an office visit, you will consider both the MDM and total time on the date of the encounter. **False**

4. Time spent the day before and day after the service are considered when coding with time. **False**

5. Activities usually performed by the clinical staff is included in the total time. **False**

6. Care coordination is included in the total time when not reported separately. **True**

7. Number and complexity of problems addressed at the encounter includes consideration of further testing or treatment that may not be elected by the patient and/or family. **True**

8. An acute, uncomplicated illness is a problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status. **False**

9. For the data element of the MDM, each unique test, order or document is counted. **True**

10. Those treatment options considered but not selected after shared medical decision making with the patient and/or family help determine the risk. **True**

11. Marj is coding a medical record for an established office visit based on the level of medical decision making, as directed by the practice guidelines. She determines the service is *99213* based on the documentation. However, the provider notes that the service was 45 minutes long. The time rage for code *99213* is 20-29 minutes; therefore, Marj add the prolonged service code (*99417*) to indicate the service exceeded the time for code *99213*. She submits codes *99213* and *99417* for this service. Was this correct? **No, the coding is not correct. Coding must be based on time or medical decision making, not a combination of both. Since office guidelines indicate she should only base the service on the level of medical decision making, Marj should follow the guidelines and apply code *99213*. However, she can discuss the option of coding based on time with the provider. In this case, if the time is documented appropriately, the provider could submit code *99215*. Either way, the prolonged service code (*99417*) only applies when the visit is based solely on time and after the total time of the highest level has been exceeded, which it has not.**

12. **99202** Office and/or Other Outpatient Services, Office Visit, New Patient 99202-99205; Dx: 1 self-limited or minor problem; Data: minimal or none; Risk: minimal risk from the treatment or testing

MDM	Straightforward 99202/99212	Low 99203/99213	Moderate 99204/99214	High 99205/99215
Dx	minimal	low	moderate	high
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

13. **99213** Office and/or Other Outpatient Services, Office Visit, Established Patient 99211-99215; Dx: 1 stable, chronic illness; Data: ordered PPD test today (1) and reviewed most recent labs (1); Risk: prescription drug management

MDM	Straightforward 99202/99212	Low 99203/99213	Moderate 99204/99214	High 99205/99215
Dx	minimal	low	moderate	high
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Endnotes

[1] "Revisions to the CPT E/M Office Visits: New Ways to Report Using Medical Decision Making (MDM)." *American Medical Association*. Accessed 20 October 2020. Web.

[2] "Revisions to the CPT E/M Office Visits: New Ways to Report Using Medical Decision Making (MDM)." *American Medical Association*. Accessed 20 October 2020. Web.