2021 Evaluation and Management (E/M) Changes for Radiation Oncology

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CHAIR ASTRO CDVC & RUC ALTERNATE ADVISOR

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Agenda

E/M Revisions: Office and Other Outpatient Services
- New Patient (99201-99205)
- Established Patient (99211-99215)
- Medical Decision Making (MDM)
- Time

Sample Case Study

Radiation Oncology Case Scenarios

Discussion and Q&A
CAUTION

ONLY E/M OFFICE VISITS

ACTIVE 2021
Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

Eliminated history and examination as key components
- Continue to require a medically appropriate history and/or examination

Components for code selection. Use either:
- MDM level or
- Total time on the date of the encounter

Deleted code 99201 and revised codes 99202-99215
- Codes 99201 and 99202 both required straightforward MDM in 2020

Created guidelines specific to E/M office and other outpatient services
Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

Select the appropriate level of E/M services based on the following:
1. The level of the MDM as defined for each service, or
2. The total time for E/M services performed on the date of the encounter.

Extensive clarifications in the guidelines to define the elements of MDM

- Total time spent on the date of the encounter
  - Including non-face-to-face services
  - Clearer time ranges for each code

Addition of a shorter 15-minute prolonged service code (99417)
- To be reported only when the minimum time required for time-based coding has been exceeded by 15 minutes
### Overview of Major E/M Revisions: Office or Other Outpatient Services Compared to Other E/M Codes

<table>
<thead>
<tr>
<th>Component(s) for Code Selection</th>
<th>Office or Other Outpatient Services</th>
<th>Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History and Examination</strong></td>
<td>• As medically appropriate. Not used in code selection</td>
<td>• Use Key Components (History, Examination, MDM)</td>
</tr>
<tr>
<td><strong>Medical Decision Making (MDM)</strong></td>
<td>• May use MDM or total time on the date of the encounter</td>
<td>• Use Key Component (History, Examination, MDM)</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>• May use MDM or total time on the date of the encounter</td>
<td>• May use face-to-face or time at the bedside and on the patient’s floor or unit when counseling and/or coordination of care dominates.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Time is not a descriptive component for E/M levels of emergency department services</strong></td>
</tr>
<tr>
<td><strong>MDM Elements</strong></td>
<td>• Number and complexity of problems addressed at the encounter</td>
<td>• Number of diagnoses or management options</td>
</tr>
<tr>
<td></td>
<td>• Amount and/or complexity of data to be reviewed and analyzed</td>
<td>• Amount and/or complexity of data to be reviewed</td>
</tr>
<tr>
<td></td>
<td>• Risk of complications and/or morbidity or mortality of patient management</td>
<td>• Risk of complications and/or morbidity or mortality</td>
</tr>
</tbody>
</table>
MDM Table Changes (Only for Office and Other Outpatient; Effective January 1, 2021)

<table>
<thead>
<tr>
<th>MDM 2020</th>
<th>MDM Effective January 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Diagnoses or Management Options</td>
<td>Number and Complexity of Problems Addressed at the Encounter</td>
</tr>
<tr>
<td>Amount and/or Complexity of Data to be Reviewed</td>
<td>Amount and/or Complexity of Data to be Reviewed and Analyzed</td>
</tr>
<tr>
<td>Risk of Complications and/or Morbidity or Mortality</td>
<td>Risk of Complications and/or Morbidity or Mortality of Patient Management</td>
</tr>
</tbody>
</table>
Medical Decision Making (MDM)

Modifications to the criteria for MDM:

Create sufficient detail in CPT code set to reduce variation between contractors/payers

Attempt to align criteria with clinically intuitive concepts

Use existing CMS and contractor tools to reduce disruption in coding patterns

E/M Workgroup came back to real-life examples in their deliberations.
MDM: Number and Complexity of Problems Addressed at the Encounter

• Based on CMS Documentation Guidelines’ Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test</td>
<td>Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, eg, lump in breast</td>
<td>Deep needle or incisional biopsy</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, eg, head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, eg, lumbar puncture, thoracentesis, culdocentesis</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
</tbody>
</table>
MDM: Number and Complexity of Problems Addressed at the Encounter

• Added guidelines and definitions to clarify each type of problem addressed in the MDM table, for example:
  o Stable, chronic illness
  o Acute, uncomplicated illness or injury

• Removed some Table of Risk examples
  o Some were not office-oriented
  o Placed examples in guidelines (ie, in the definitions) to make MDM table less complex
Data are 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 health care professional or appropriate source...
MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Rely on clinical common sense, with some examples from CMS Risk Table
- Straightforward
  - No example for “Minimal risk”
- Low
  - No example for “Low risk”
- Moderate
  - Examples: elective major surgery without patient or procedure risk factors, consideration of social determinants limitations on diagnosis or treatment
- High
  - Examples: emergency major surgery, decision to de-escalate care due to a poor prognosis
To qualify for a particular level of MDM, two of the three elements for that level of decision making must be met or exceeded (concept unchanged from current guidelines).

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Elements of Medical Decision Making</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>1 self-limited or minor problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Limited</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>2 or more self-limited or minor problems; or 1 stable chronic illness; or 1 acute, uncomplicated illness or injury</td>
<td>Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ordering of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td></td>
</tr>
</tbody>
</table>
Time: Office and Other Outpatient E/M Services

Effective January 1, 2021

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...

There is no minimum time when using MDM for code selection
...Total time on the date of the encounter (office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 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)...

**Total Time** on the date of the encounter

- Includes physician/other qualified health care professional (QHP) face-to-face and non-face-to-face time
- Time spent by clinical staff is not included
- More than one clinician addressed (count only 1 person per minute)
Time: Office and Other Outpatient E/M Services—New Patient *(Total Time On the Date of the Encounter)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 minutes</td>
<td>Code deleted</td>
</tr>
<tr>
<td>99202</td>
<td>20 minutes</td>
<td>15-29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 minutes</td>
<td>30-44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 minutes</td>
<td>45-59 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 minutes</td>
<td>60-74 minutes</td>
</tr>
</tbody>
</table>

When selecting level based upon time
Time: Office and Other Outpatient E/M Services—Established Patient *(Total time on the Date of the Encounter)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5 minutes</td>
<td>Time component removed</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>10-19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>20-29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>30-39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>40-54 minutes</td>
</tr>
</tbody>
</table>

When selecting level based on time
Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

★★99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a medically appropriate history and/or examination and high level of medical decision making.

• A comprehensive history;
• A comprehensive examination;
• Medical decision making of high complexity.

Counseling and/or coordination with other physicians, other qualified health care 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, 40 minutes are spent face-to-face with the patient and/or family.

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 99417)➤
A Sample Case Study
A 64-year-old female established patient presents to the office complaining of pain and what she describes as a tingling/burning sensation in her extremities that has been occurring the past several weeks. She was otherwise stable being managed for diabetes mellitus type 2 and hypertension. The physician performs a relevant physical examination and orders a TSH, Vitamin B12, Basic Metabolic Panel and A1c. Idiopathic or diabetic peripheral neuropathy leads the differential. It is determined that the patient should be evaluated for peripheral neuropathy by neurology and the physician refers the patient. Total time spent on the date of the encounter is 21 minutes.
Case Study 1: Applying the Guidelines

Guidelines for Office or Other Outpatient E/M Services

History and/or Examination

…The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. …The extent of history and physical examination is not an element in selection of the level of office or other outpatient codes.

So, let’s move on to MDM selection
Case Study 1: Applying the Guidelines

▸ Number and Complexity of Problems Addressed at the Encounter ▸

▸ ...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. ...

Diabetes mellitus (DM) with new neuropathy?
Case Study 1: Applying the Guidelines

- Number and Complexity of Problems Addressed at the Encounter

- **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. …

Neuropathy symptoms is a new problem with risk of morbidity, with or without treatment.
Case Study 1: Applying the Guidelines

Number and Complexity of Problems Addressed at the Encounter

Two or more stable chronic illnesses: A problem with an expected duration of at least one 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 MDM is defined by the specific treatment goals for an individual patient.
Case Study 1: Applying the Guidelines

A patient who is **not at his or her 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, in 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, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia. …

Controlled DM and HTN
Case Study 1: Applying the Guidelines

Medical Decision Making

...MDM in the office or other outpatient services codes is defined by three elements:

- **The amount and/or complexity of data to be reviewed and analyzed.** These data include 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 reported separately and interpretation of tests that are not reported separately. 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.
Case Study 1: Applying the Guidelines

Data are 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 health care professional or appropriate source...
Case Study 1: Applying the Guidelines

- The risk of complications and/or morbidity 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 MDM with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care…

...Four types of MDM are recognized: straightforward, low, moderate, and high. …
Case Study 1: 
Code Selection

E/M Office Visit Code = 99214 (Established Patient)

Level of MDM = Moderate (2/3)

Number and Complexity of Problems Addressed = Moderate

1 or more chronic illnesses with exacerbation, progression, or side effects of treatment

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

Category 1: Tests, documents, or independent historian(s)

Review of prior external note(s) from each unique source (none);
Review of the result(s) of each unique test (none);
Ordering of each unique test (four).

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

Low risk of morbidity from additional diagnostic testing or treatment
### Case Study 1: Applying the MDM Table

<table>
<thead>
<tr>
<th>99204</th>
<th>Moderate to Moderate</th>
<th>Moderate</th>
<th>Moderate risk of morbidity from additional diagnostic testing or treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury</td>
<td>(Must meet the requirements of at least 1 out of 3 categories) <strong>Category 1: Tests, documents, or independent historian(s)</strong> • Any combination of 3 from the following: ■ Review of prior external note(s) from each unique source*; ■ Review of the result(s) of each unique test*; ■ Ordering of each unique test*; ■ Assessment requiring an independent historian(s) or <strong>Category 2: Independent interpretation of tests</strong> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or <strong>Category 3: Discussion of management or test interpretation</strong> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td>Examples only: • 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</td>
</tr>
</tbody>
</table>
Case Study 1: Lessons and Questions

You seem to have made a case for 3 different Moderate MDM level problems. Doesn’t that add up to a high level of MDM?

- No, other than what is specifically stated in the tables there is no summing up of problems
I understand giving credit for 2 or more stable chronic illnesses, but the physician did not manage the neuropathy

- It was “addressed”

...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, examination, 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. ...
Case Study 1: Lessons and Questions

The risk level of low seems wrong. Wouldn’t someone with DM and HTN be on medications? Don’t these count as prescription drug management?

- Good point. You may be correct. The CPT code set does not define prescription drug management in detail. There is no rule that medication must be started, changed, or stopped. Most importantly, however, in this case, it seems the MDM revolves around the new symptom. The key is to always tie it back to the clinical care, ie, the clinical MDM that is addressed at the encounter. One might have to read the whole note, but it seems the DM and HTN were not really addressed. But it also does not matter for code selection in this specific case. Only 2 of the 3 MDM elements must be met to qualify for the moderate level.
Case Study 1: Lessons and Questions

That’s nice, but you only spent 21 minutes. The correct code is 99213.

- Code selection can be by time or MDM. The times in the descriptors are not minimums UNLESS the basis of code selection is by time.
How to apply the new E/M changes to radiation oncology coding scenarios
New Patient - Clinical Scenario #1

55 year old male new patient with Stage III right tonsil cancer
- Reviewed ENT note, pathology report from biopsy, CT neck report
- Opened PET scan and interpreted images
- Discussed case with medical oncologist and ENT
- Decided to treat with concurrent chemoradiation
- Extensive time spent discussing treatment options and referring to dentist, nutrition, speech and swallow rehab, social work
- Total time 90 minutes

What level with MDM?
What level with Time?
Clinical Scenario 1: Applying the Guidelines

Number and Complexity of Problems Addressed at the Encounter

...Acute or chronic illness or injury that poses a threat to life or bodily function:
An acute illness with systemic symptoms, 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. ...

New oropharyngeal cancer that is life-threatening
Clinical Scenario 1: Applying the MDM Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Elements of Medical Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
</table>
| 99205  | High                                             | 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function | Extensive (Must meet the requirements of at least 2 out of 3 categories) | High risk of morbidity from additional diagnostic testing or treatment Examples only:  
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 |
| 99215  |                                                  |                                                              |                                   |                                                                        |

Category 1: Tests, documents, or independent historian(s)
- Any combination of 3 from the following:
  - Review of prior external note(s) from each unique source*;
  - Review of the result(s) of each unique test*;
  - Ordering of each unique test*;
  - Assessment requiring an independent historian(s)
  or

Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
  or

Category 3: Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Clinical Scenario

# 1: Code Selection

E/M Office Visit Code = 99205 (New Patient)

Level of MDM = High (3/3)

Number and Complexity of Problems Addressed = High
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 = High

Category 1:
Review of prior external note(s) from each unique source (one);
  • ENT note

  Review of the result(s) of each unique test (two);
  • Biopsy and CT neck results

Category 2: Independent interpretation of tests (PET images)

Category 3: Discussion of Management or test interpretation (ENT and Medical Oncologist)

Risk of morbidity from additional diagnostic testing or treatment = High

Decided to treat with definitive concurrent chemotherapy and radiation therapy
But what about if we looked at time?

We spent so much face-to-face time with the patient going over risks, benefits of concurrent chemoradiation.

We also spent so much non face-to-face time on the day of the encounter reviewing records, PET images, making phone calls to discuss management with other providers, as well as scheduling referrals with support services.

All totaling 90 minutes!
Prolonged Services (99417)

Effective January 1, 2021

• Shorter prolonged services code to capture each 15 minutes of total time of physician/other QHP work beyond the minimum time captured by the E/M office or other outpatient service code.
  
  o Used only when the office/other outpatient code is selected using time

  o **For use only with 99205, 99215**

  o Prolonged services of less than 15 minutes are not reported
Prolonged Services (99417)

- Allows for face-to-face and non-face-to-face care on the date of the encounter

- Therefore, do not report 99354 or 99358 for time on the date of the encounter

- 99358 (non-face-to-face prolonged services of 30 minutes in a single day) may be reported on a date other than the date of the encounter, just as it may be reported in 2020

  *(Per CPT code set, but note CMS comments in 2020 PFS Final Rule)*
<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>NEW</th>
<th>1-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-59</th>
<th>60-74</th>
<th>75-89</th>
<th>90-104</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do not use time (99202 by MDM)</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td>99205+99417</td>
<td>99205+2 units</td>
<td>99417</td>
</tr>
<tr>
<td>ESTABLISHED</td>
<td>1-9</td>
<td>10-19</td>
<td>20-29</td>
<td>30-39</td>
<td>40-54</td>
<td>55-69</td>
<td>70-84</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not use time (99212 by MDM)</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td>99215+99417</td>
<td>99215+2 units</td>
<td>99417</td>
</tr>
</tbody>
</table>
New Patient - Clinical Scenario #2

• 60 year old new patient presented to multi-disciplinary breast clinic for early-stage, luminal type A breast cancer
  • Viewed mammogram and pathology images at the multi-D conference
  • Discussed case at the multi-d conference with medical oncologist, breast surgeon, radiologist, and pathologist
  • Decided to treat with radiation therapy with tangents only
  • Total face to face 50 minutes

What level with MDM?
What level with Time?
Clinical Scenario #2: Applying the MDM Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Elements of Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205 99215</td>
<td>High 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Number and Complexity of Problems Addressed at the Encounter</td>
</tr>
<tr>
<td></td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
<td>Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</td>
</tr>
<tr>
<td></td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td>Risk of Complications and/or Morbidity or Mortality of Patient Management</td>
</tr>
<tr>
<td></td>
<td>Any combination of 3 from the following: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment Examples only: 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</td>
</tr>
<tr>
<td></td>
<td>Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Category 3: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Scenario #2: Code Selection

E/M Office Visit Code = 99204? (New Patient)

Level of MDM = Moderate (2/3)

Number and Complexity of Problems Addressed = High
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 = Moderate

Category 1:
- Review of the result(s) of each unique test (two);
  - mammogram and pathology results

Category 2: Independent interpretation of tests (none)

Category 3: Discussion of Management or test interpretation (Breast surgeon, med onc, pathologist, radiologist)

Risk of morbidity from additional diagnostic testing or treatment = Moderate?

Decided to treat with adjuvant breast tangent radiation therapy
We discussed management and interpretation of tests with several different physicians so don’t we meet high MDM for amount and complexity of data to be reviewed?

No, we can’t sum across categories.
   ◦ We met two of three needed criteria for category 1 by reviewing tests
   ◦ We did not review any external notes
   ◦ Did not meet category 2.
   ◦ For category 3, it doesn’t matter if we spoke to one or 10 providers, it still only counts as one.
What if we coded by Time?

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>NEW</th>
<th>1-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-59</th>
<th>60-74</th>
<th>75-89</th>
<th>90-104</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do not use time (99202 by MDM)</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td>99205+99417</td>
<td>99205+2 units 99417</td>
<td></td>
</tr>
<tr>
<td>ESTABLISHED</td>
<td>1-9</td>
<td>10-19</td>
<td>20-29</td>
<td>30-39</td>
<td>40-54</td>
<td>55-69</td>
<td>70-84</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not use time (99212 by MDM)</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td>99215+99417</td>
<td>99215+2 units 99417</td>
<td></td>
</tr>
</tbody>
</table>
But can we use review of test results and discussion of management at multi-d conf?

IT DEPENDS . . .

◦ If the conference is on the same day as the encounter and the purpose is just to discuss the case and not also have a separate education/teaching component we can use that part for either time or MDM

◦ If we spent 10 minutes discussing that case we could also add those 10 minutes to total time to give us 99205 by time
What if patient was 70 years old and we decided to not treat with radiation but hormonal therapy instead?

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (or Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>High</td>
<td>High</td>
<td>Extensive</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99215</td>
<td>High</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>(Must meet the requirements of at least 2 out of 3 categories)</td>
<td>Examples only:</td>
</tr>
</tbody>
</table>

**Category 1: Tests, documents, or independent historian(s)**
- Any combination of 3 from the following:
  - Review of prior external note(s) from each unique source*;
  - Review of the result(s) of each unique test*;
  - Ordering of each unique test*;
  - Assessment requiring an independent historian(s)

**Category 2: Independent interpretation of tests**
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

**Category 3: Discussion of management or test interpretation**
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
### Revised Clinical scenario #2:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99214</td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td>- Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding minor surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding elective major surgery without identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>- Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
</tbody>
</table>

**Category 1: Tests, documents, or independent historian(s)**
- Any combination of 3 from the following:
  - Review of prior external note(s) from each unique source*;
  - Review of the result(s) of each unique test*;
  - Ordering of each unique test*;
  - Assessment requiring an independent historian(s)

**Category 2: Independent interpretation of tests**
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

**Category 3: Discussion of management or test interpretation**
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Revised Clinical Scenario #2: Code Selection

E/M Office Visit Code = 99204 (New Patient)

Level of MDM = Moderate (2/3)

Number and Complexity of Problems Addressed = High
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 = Moderate
Category 1:
  Review of the result(s) of each unique test (two);
    • mammogram and pathology results

Category 2: Independent interpretation of tests (none)

Category 3: Discussion of Management or test interpretation (Breast surgeon, med onc, pathologist, radiologist)

Risk of morbidity from additional diagnostic testing or treatment = Moderate
Decision to treat with adjuvant hormonal therapy (not moderate risk breast tangent radiation therapy)
New Patient - Clinical Scenario #3

- 85 year old male with newly diagnosed early-stage prostate cancer
  - Reviewed PSA labs and pathology reports
  - Reviewed notes from urologist
  - Discussed management with urologist
  - Decided to treat with watchful waiting
  - Total time 60 minutes

What level with MDM?
What level with Time?
Clinical scenario #3: Applying the MDM Table

<table>
<thead>
<tr>
<th>Category 1: Tests, documents, or independent historian(s)</th>
<th>Category 2: Independent interpretation of tests</th>
<th>Category 3: Discussion of management or test interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples only:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescription drug management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Decision regarding minor surgery with identified patient or procedure risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Decision regarding elective major surgery without identified patient or procedure risk factors</td>
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<td></td>
</tr>
<tr>
<td>• Diagnosis or treatment significantly limited by social determinants of health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Moderate (Must meet the requirements of at least 1 out of 3 categories)
  - 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or
  - 2 or more stable, chronic illnesses; or
  - 1 undiagnosed new problem with uncertain prognosis; or
  - 1 acute illness with systemic symptoms; or
  - 1 acute, complicated injury

- Any combination of 3 from the following:
  - Review of prior external note(s) from each unique source*;
  - Review of the result(s) of each unique test*;
  - Ordering of each unique test*;
  - Assessment requiring an independent historian(s)

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Clinical Scenario
#3: Code Selection

**E/M Office Visit Code = 99204 (New Patient)**

**Level of MDM = Moderate (3/3)**

**Number and Complexity of Problems Addressed = Moderate**
1 acute, complicated injury, *(low risk prostate cancer in an 85-year-old not life threatening)*

**Amount and/or Complexity of Data to be Reviewed and Analyzed = Moderate**

**Category 1:**
- Review of the result(s) of each unique test *(two)*;
  - PSA and pathology results
- Review of the prior of each external notes from each unique source *(one)*;
  - Urologist

**Category 2:** Independent interpretation of tests *(none)*

**Category 3:** Discussion of Management or test interpretation *(Urologist)*

**Risk of morbidity from additional diagnostic testing or treatment = Moderate?**

Decided to treat with active surveillance *(not treat with moderate risk prostate only radiation therapy)*
## What if we coded by Time?

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>NEW</th>
<th>1-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-59</th>
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<tbody>
<tr>
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<td>99205+2 units</td>
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<td>(99202 by</td>
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<td>ESTABLISHED</td>
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<td>10-19</td>
<td>20-29</td>
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<td>40-54</td>
<td>55-69</td>
<td>70-84</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not</td>
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<td>99213</td>
<td>99214</td>
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<td>99215+</td>
<td>99215+2 units</td>
<td>99215+2 units</td>
</tr>
<tr>
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<td>use time</td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>(99212 by</td>
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<tr>
<td></td>
<td>MDM)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
What if patient was 50 years old?

This is tricky . . . if we coded by MDM would this now rise to the level of acute life-threatening illness given patient’s life expectancy?

<table>
<thead>
<tr>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 99205 99215</td>
<td>High</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
</tr>
<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to or bodily function</td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any combination of 3 from the following:</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Review of prior external note(s) from each unique source*;</td>
<td>• Decision regarding elective major surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Review of the result(s) of each unique test*;</td>
<td>• Decision regarding emergency major surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Ordering of each unique test*;</td>
<td>• Decision regarding hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Assessment requiring an independent historian(s)</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Category 2: Independent interpretation of tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Category 3: Discussion of management or test interpretation</td>
<td></td>
</tr>
</tbody>
</table>
Established Patient - Clinical Scenario #4

65 year old female follow up visit for new radiation pneumonitis
- Reviewed pulmonologist notes
- Reviewed CT chest report
- Opened CT chest to view and interpret images
- Discuss management with pulmonologist
- Start on steroids
- Total time 30 minutes

What level with MDM?
What level with Time?
Clinical Scenario #4: Applying the MDM Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>High</td>
</tr>
<tr>
<td>99215</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or</td>
<td>• Any combination of 3 from the following:</td>
<td>Examples only:</td>
</tr>
<tr>
<td>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>• Review of the result(s) of each unique test*;</td>
<td>• Decision regarding elective major surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>• Ordering of each unique test*;</td>
<td>• Decision regarding emergency major surgery</td>
</tr>
<tr>
<td></td>
<td>• Assessment requiring an independent historian(s)</td>
<td>• Decision regarding hospitalization</td>
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<tr>
<td></td>
<td>or</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td>Category 2: Independent interpretation of tests</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>
Clinical Scenario #4: Code Selection

E/M Office Visit Code = 99215 (Established Patient)

Level of MDM = High (2/3)

Number and Complexity of Problems Addressed = High
1 or more chronic illness or injury with severe exacerbation

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

Category 1:
Review of prior external note(s) from each unique source (one);
  - Pulmonologist note

Review of the result(s) of each unique test (one);
  - CT chest results

Category 2: Independent interpretation of tests (CT chest images)

Category 3: Discussion of Management or test interpretation (Pulmonologist)

Risk of morbidity from additional diagnostic testing or treatment = Moderate
Decided to treat with steroids (prescription drug therapy)
What if we coded by Time?

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>NEW</th>
<th>1-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-59</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do not use time (99202 by MDM)</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td>99205+99417</td>
<td>99205+2 units 99417</td>
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<tr>
<td>ESTABLISHED</td>
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<td>10-19</td>
<td>20-29</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Do not use time (99212 by MDM)</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td>99215+99417</td>
<td>99215+2 units 99417</td>
<td></td>
</tr>
</tbody>
</table>
Established Patient - Clinical Scenario #5

60 year old female here for routine breast follow up
- Reviewed mammogram
- Reviewed medical oncologist and breast surgeon notes
- Follow up in 6 months
- Total time 15 minutes

What level with MDM?
What level with Time?
Clinical Scenario #5: Applying the MDM Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Scenario</th>
<th>Risk of morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal or none</td>
</tr>
<tr>
<td>99212</td>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Limited</td>
</tr>
<tr>
<td>99213</td>
<td>Low</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>

**Limited**

(Must meet the requirements of at least 1 of the 2 categories)

- 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*;
  - Category 2: Assessment requiring an independent historian(s)
    (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
E/M Office Visit Code = 99213 (Established Patient)

Level of MDM = Low (2/3)

Number and Complexity of Problems Addressed = Low
   One stable chronic illness

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

Category 1: Tests, documents, or independent historian (2 of 3 categories met)
   Review of prior external note(s) from each unique source (two – breast surgeon, med onc);
   Review of the result(s) of each unique test (one – mammogram);
   Order unique tests (none)

Assessment requiring an independent historian(s) (not present)
What if we coded by Time?

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>NEW</th>
<th>1-14</th>
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<td>99215</td>
<td>99215+99417</td>
<td>99215+2 units 99417</td>
<td></td>
</tr>
</tbody>
</table>
What if the patient called back later in the day to ask further questions for 10 min?

It would change total time since it is within the same 24 hours and includes non face-to-face time

This would add 10 minutes and bring total time to 25 minutes or 99213
Established Patient - Clinical Scenario #6

70 year old male with prostate cancer with very high PSA at follow up
- Reviewed PSA labs
- Reviewed urology note
- Discuss management with urologist
- Urologist and you recommend prostate biopsy
- Total time 25 minutes

What level with MDM?
What level with Time?
Clinical scenario #6: Applying the MDM Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

- 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or
- 2 or more stable, chronic illnesses; or
- 1 undiagnosed new problem with uncertain prognosis; or
- 1 acute illness with systemic symptoms; or
- 1 acute, complicated injury

<table>
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<tbody>
<tr>
<td>(Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following</td>
<td>Moderate</td>
</tr>
<tr>
<td>Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td>Review of the result(s) of each unique test**;</td>
<td></td>
</tr>
<tr>
<td>Ordering of each unique test***;</td>
<td></td>
</tr>
<tr>
<td>Assessment requiring an independent historian(s) or</td>
<td></td>
</tr>
<tr>
<td>Category 2: Independent interpretation of tests</td>
<td></td>
</tr>
<tr>
<td>Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or</td>
<td></td>
</tr>
<tr>
<td>Category 3: Discussion of management or test interpretation</td>
<td></td>
</tr>
<tr>
<td>Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td></td>
</tr>
</tbody>
</table>

Moderate risk of morbidity from additional diagnostic testing or treatment

Examples only:
- 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
Clinical Scenario
#6: Code Selection

E/M Office Visit Code = 99214 (Established Patient)

Level of MDM = Moderate (3/3)

Number and Complexity of Problems Addressed = Moderate
1 chronic illness with exacerbation or progression (prostate cancer with progression)

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

Category 1:
- Review of the result(s) of each unique test (one);
  - PSA results
- Review of the prior of each external notes from each unique source (one);
  - Urologist

Category 2: Independent interpretation of tests (none)

Category 3: Discussion of Management or test interpretation (Urologist)

Risk of morbidity from additional diagnostic testing or treatment = Moderate

Decided to treat with biopsy
## What if we coded by Time?

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

<table>
<thead>
<tr>
<th>ESTABLISHED</th>
<th>1-9</th>
<th>10-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40-54</th>
<th>55-69</th>
<th>70-84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not use time (99212 by MDM)</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td>99215+99417</td>
<td>99215+2 units 99417</td>
<td></td>
</tr>
</tbody>
</table>
What if rising PSA was borderline and you just wanted to repeat PSA?
Revised Clinical Scenario #6: Code Selection

E/M Office Visit Code = 99214 (Established Patient)

Level of MDM = Moderate (2/3)

Number and Complexity of Problems Addressed = Moderate
1 chronic illness with exacerbation or progression (prostate cancer with progression)

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

Category 1:
- Review of the result(s) of each unique test (one);
  - PSA results
- Review of the prior of each external notes from each unique source (one);
  - Urologist
- Ordering of each unique test (one);
  - Repeat PSA

Category 2: Independent interpretation of tests (none)

Category 3: Discussion of Management or test interpretation (none)
Thank you

Discussion and Questions?