Evaluation and Management Changes **Starting January 1, 2021**

What and why is changing?

- Eliminate history and exam scoring, which will promote higher level activities for medical decision making. The extent history and physical exam will be determined by the provider. These will not be a determining factor, but will still need to be documented.
- The goal is to decrease administrative burden and unnecessary documentation not needed for patient care.
- Promote more consistency in coding and billing across all specialties.

When selecting a level of office or other out-patient E/M service:

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

- The total time of the E/M serviced performed on the date of the encounter personally by the physician
- The level of the medical decision making (MDM) as defined by each service

Time:

Time for these services is the total time on the date of the encounter, including both face-to-face and non-face-to-face time **personally** spent by the provider. Activities may include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other healthcare professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

The appropriate time must be documented in the medical record when it is used as the basis for code selection**.**

Medical Decision Making:

MDM is still based on meeting the requirements for the level of service for two of the three elements of:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed; and
- Risk of complications and/or morbidity or mortality of patient management

Medically appropriate history and/or examination will not be part of the basis for code selection; however, history and exam findings that are pertinent to the visit will still need to be documented.

Four types of medical decision making are recognized: straightforward, low, moderate, and high.

DOCUMENTATION WILL BE KEY!!!

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Number and complexity of problems addressed at the encounter:

Multiple new or established conditions may be addressed at the same time and may affect medical decision making.

Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

Amount and/or complexity of data to be reviewed and analyzed:

The amount and/or complexity of data to be reviewed and analyzed. Data is divided into three categories:

- Tests, documents, orders, or independent historian(s).
- Each unique test, order or document is counted to meet a threshold number
- 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.

Independent interpretation of tests

Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

Risk of complications and/or morbidity or mortality of patient management:

The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

This must be documented to be counted. Document thought process!

New Patient:	Time minutes of total time is spent on the date of the encounter:	MDM:
99202	15-29 minutes	Straightforward
99203	30-44 minutes	Low
99204	45-59 minutes	Moderate
99205	60-74 minutes	High

Established Patient:	Time minutes of total time is spent on the date of the encounter:	MDM:
99212	10-19 minutes	Straightforward
99213	20-29 minutes	Low
99214	30-39 minutes	Moderate
99215	60-74 minutes	High