**Clinical Chats Official Podcast Transcript**

**Title:** Coding with Ann Episode 22: Updated Guidelines for E/M Codes

**Speaker:** Ann Finn

**Duration:** 00:18:27

**Katherine Atcheson (**[**00:05**](https://www.rev.com/transcript-editor/shared/vrfyJcnLPqY5aIeCFnhTZcPi2kCYVSPzvfUBC4uDvz8DcdYzQt0i7a--8jWbsUTZNhEa1Y2uYl8bpWrUhU2YBfbl7gA?loadFrom=DocumentDeeplink&ts=5.07)**):**

Hello and welcome to Clinical Chats, a podcast for sexual and reproductive healthcare professionals. Clinical chats, formerly known as the Family Planning Files, is a program of the Clinical Training Center for Sexual and Reproductive Health, or CTC-SRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff. Our guest speaker today is Ann Finn from our popular Coding with Ann series, and head Ann Finn Consulting LLC, where she's a healthcare reimbursement and billing and coding consultant. Ann has worked as a national trainer with many reproductive healthcare organizations since establishing Ann Finn Consulting in 2003. Welcome back to the podcast, Ann. We're so excited to have you today.

**Ann Finn (**[**00:58**](https://www.rev.com/transcript-editor/shared/5ImXFwAqTJwe35IEvFJGc0ihDp-OBtNJLKojSrnzeNq1faeJh2NleiVUvmBi8XVt0PbkuA32nYBVWPhHvV7NYuDFR8U?loadFrom=DocumentDeeplink&ts=58.83)**):**

Thank you, Katherine. And hello to everyone. Welcome back to our latest podcast in our Coding series. Today we are going to talk about some key changes to E&M outpatient and office visit coding that took place back in January 2021. The outpatient guidelines continue to be updated with clarifications, including being able to count point of care tests as data for E&M level calculations. You should all now be using these guidelines when determining the optimal E&M code to bill for a client's visit. E&M stands for evaluation and management. E&M services represent a category of current procedural terminology or CPT codes used by physicians and other qualified healthcare professionals such as nurse practitioners, physician assistants, or midwives for billing purposes. These codes are the core of most family planning visits and reflect the time and decision making the clinician spends on providing patient care, often including family planning, STI testing and treatment, and other risk reduction counseling.

**Ann Finn (**[**02:07**](https://www.rev.com/transcript-editor/shared/hmn-hyV2mKoGu8rTnfTtZh24h2jdQiXtYzEY7S4L85y6OTot-9u51DuIuLp4uLP19-9QxwGSRMF0l9R5tLbT9-G6p88?loadFrom=DocumentDeeplink&ts=127.89)**):**

There are two types of E&M codes, commonly youth and family planning visits. The first one is a preventive visit code such as 99385 or 99396, based on the patient's age, which we refer to as the well visits, annual exams, and checkups. We are not going to focus on these today since they are not part of the new guideline changes. The second type of E&M code is a problem-oriented visit code such as 99203 or 99214 depending on the level of services provided and if the patient is new or established to your practice. These codes are commonly used for healthy and sick patient visits and family planning for contraception, screening, counseling, and sick visits. Today, we'll be focusing on these problem-oriented codes and highlight the key changes that impact your coding for family planning visits. Let's take a moment and look back at what was. So up until the end of 2020, providers would select an E&M visit code based on either the combination of three key components of the documented history, physical exam and the medical decision making.

**Ann Finn (**[**03:23**](https://www.rev.com/transcript-editor/shared/Ogcs_hB-X_NJjKpQ2EcI7HbKLWhKdwdZ7ZuaSvSZw8V9kCMP81tKagY9l0756z4gyoD1Oy8iDWSQpucCcixyJnThD1g?loadFrom=DocumentDeeplink&ts=203.19)**):**

Or I would use a face-to-face time if more than half of the visit was spent on counseling and/or coordination of care. These guidelines were hard to apply, and they didn't often capture the work done in family planning visits. So, the American Medical Association or the AMA, worked with many healthcare professionals to revise the guidelines and modify the MDM criteria to make them more clinically intuitive and to increase coding consistency among clinicians, coders, and payers, and release new guidelines that went into effect January 1st, 2021. We now determine the E&M code using either updated medical decision making or MDM or total cumulative time on the date of the encounter. I think these guidelines are much more straightforward and easier to use. Make sure you are no longer using the old guidelines or tools that reference them. These are important changes and it's important that you ensure your templates, your EHR and your billing systems have been properly updated to reflect these changes to avoid billing denials and audit takebacks.

**Katherine Atcheson (**[**04:30**](https://www.rev.com/transcript-editor/shared/EYA8guogaN8BOAjwSWpRVBYkpQc_iNrtnEqx_5Z8K0gRk44SHZU1da00Kr7Bvs--0OevR-426S7eDfKVoZTYsoCzVJA?loadFrom=DocumentDeeplink&ts=270.69)**):**

So, Ann, can you tell us a little bit more about using the medical decision making for the code selection?

**Ann Finn (**[**04:38**](https://www.rev.com/transcript-editor/shared/0k7jKUfKsuE1MKW65ieW-6yWnA-GvvGM4lenFxuPpvqh6BT-GmruG5-gmRuSU-ojJdV5V5-oTzbxMjPZw6Ue5DgwiWs?loadFrom=DocumentDeeplink&ts=278.46)**):**

Yes, let's start with that. Let's dive in and look at the specifics. So, when using MDM now, there is still a medically appropriate history taken and a physical exam performed and documented, but the nature and the extent of the history and/or physical exam are determined by the treating clinician reporting the service. These two components no longer factor into the code determination. Medical decision making now includes establishing the diagnosis, assessing the status of the condition and/or selecting a management option, and we use these three elements to determine the optimal code. The first element is the number and complexity of problem or problems the provider addresses at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis, and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases in and of themselves are not considered in selecting a level of E&M services since they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed for the risk of complications and/or morbidity or mortality for patient management.

**Katherine Atcheson (**[**05:55**](https://www.rev.com/transcript-editor/shared/dnPav-JqBQnHM95AaIDomOBbRnFBgF0ySEMEPFt3IiJ62nsH34Ri3nxZJ2OFeh3Tr6VLR0ydlQko0i1RiGBjzSQ6pfo?loadFrom=DocumentDeeplink&ts=355.38)**):**

So, what are some common problems and what would you consider them?

**Ann Finn (**[**05:59**](https://www.rev.com/transcript-editor/shared/C_91srB0tIdPV_gJWJq9gExaS0C6BcXB-I1TMD9QC-8d6bWcEhhrXCuLM1C-eJ_ifX5S3OCZrndpZmxLRodtR9vHekQ?loadFrom=DocumentDeeplink&ts=359.88)**):**

So, if your client was an asymptomatic patient presenting for STI counseling only, this typically would be considered a self-limited or a minimal problem. A healthy patient presenting for comprehensive family planning and birth control, we would typically consider that a low-level problem, and a sick patient presenting with pelvic pain or one undiagnosed new problem with uncertain prognoses may be considered a moderate level problem. The second element used in selecting the level of services is the amount and/or complexity of data to be reviewed and/or analyzed at the encounter. The new guidelines list three categories for the data element. One, tests, documents, orders or independent historians. Two, independent test interpretation. And three, the discussion of management or test interpretation with external providers or appropriate sources, which refers to non-healthcare or non-family sources involved in patient management such as a parole officer or a case manager.

**Ann Finn (**[**07:04**](https://www.rev.com/transcript-editor/shared/4LgV8inn81q3E866sWeWn64oyggLgQU_3wlaNIpkqvCfBrXa0BDES2zl8G4BfuFNz58tP9FYNfFbFu3_fQ93vEMVsl4?loadFrom=DocumentDeeplink&ts=424.2)**):**

Here's a few coding tips when ordering and reviewing lab tests. Each single test ordered is considered one point. This does include common point of care tests such as a urine pregnancy test or a rapid HIV test. The guidelines state, tests that do not require separate interpretation, for example, tests that are results only and are analyzed as part of MDM, do not count as an independent interpretation, and may be counted as ordered and reviewed for selecting an MDM level. The review of results is included with the order. So, it's one point in total for ordering and reviewing each unique test. Next, you can count the review of test result only for tests that you didn't order. So, if you are reviewing tests from an outside provider like a primary care physician, then you could count it. A panel such as a complete blood count or CBC is considered one unique test.

**Ann Finn (**[**08:01**](https://www.rev.com/transcript-editor/shared/nFItBpRlqDABuPCjD4ikEMRpixPP8KNDH4s99c3NWd384_IycmKGEUI6oxCG5XCejkOsEhoU7TbJNF6IzpSEJdxDToQ?loadFrom=DocumentDeeplink&ts=481.89)**):**

If you order both a chlamydia and a gonorrhea test, that's two unique tests, so that counts as two data points. An independent historian is considered an individual, for example, a 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. For example, due to a developmental stage or a mental health issue, or because a confirmatory history is judged to be necessary. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information. A combination of different data elements, for example, a combination of notes reviewed, test ordered, test reviewed, or an independent historian allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered plus a note reviewed and an independent historian would be combined into three elements.

**Ann Finn (**[**09:03**](https://www.rev.com/transcript-editor/shared/smbygFsJP6ZtGVk7V4S00Es7XP6mWkSdwcM_yQup2IXDplfRphF80ybRNwXvBvgcd8URaz-niaa8odQ_KRzc4w8QyBU?loadFrom=DocumentDeeplink&ts=543.75)**):**

An example of determining data using common labs ordered during a family planning visit include an in-house urine pregnancy test, an HIV rapid test, and a chlamydia and gonorrhea test that are ordered. These would be four unique tests or a moderate level of data. Our third element is the risk of complications and/or morbidity or mortality of patient management decisions made at the visit associated with the patient's problems, the diagnostic procedures, and treatments. A few examples of what might impact risk for common visits would be prescription drug and contraceptive management versus an over-the-counter drug or no treatment, decision regarding minor surgery or major surgery, diagnosis or treatments significantly limited by social determinants of health, such as a patient that is homeless. A prescription level drug ordered or dispensed during a visit such as oral contraceptive pills, Depo, or a LARC would be considered a moderate level of risk, whereas an over-the-counter drug is typically considered a low level of risk.

**Ann Finn (**[**10:10**](https://www.rev.com/transcript-editor/shared/F-h6smGB4dgQ4UMAAmnliE8lxaBrTdH32DVi7ICleJMZ5kRKXyf6_G0N032wJmvmQGEfzDwRGRhFsKtM2pTfGDpCcP0?loadFrom=DocumentDeeplink&ts=610.56)**):**

Remember, anytime you are prescribing a prescription level drug or contraceptive, you can count the risk as moderate. Let's look at Kiara who presents to initiate contraception. She is otherwise healthy but is screened for pregnancy, HIV and chlamydia and gonorrhea. Kiara is administered Depo-Provera at the end of the visit. The clinician spent 18 minutes total on the date of the encounter. Since Kiara is presenting with a single problem, the need for contraception to avoid pregnancy, this would fit to a low-level problem. Four unique lab tests ordered including the two point of care tests, are considered a moderate level of data. And last, we would assign a moderate level of risk based on Kiara being administered the Depo-Provera or prescription level drug.

**Katherine Atcheson (**[**10:57**](https://www.rev.com/transcript-editor/shared/w1s-YfNSOZRI3_MBfyORUQ_f-YsvuQ0teshnf4MebGAM_hOzfr7vb5Mi-0KMvxmYzS6p0hGYUpbzG6OIxjpKNCPIFHk?loadFrom=DocumentDeeplink&ts=657.72)**):**

That's a very helpful example. And once the provider has assessed the patient's problem, the amount of data and the risk, how do we put it all together and determine the overall code?

**Ann Finn (**[**11:10**](https://www.rev.com/transcript-editor/shared/PDk0PCRsctR59wCRzBiRJ74TsBbP9vY0mvW2yYFc9TWpDX5WwZgs4sBesA3DKgy9LtfDXG6RH2XxTXXntnTSmnyZ4wc?loadFrom=DocumentDeeplink&ts=670.95)**):**

I know it seems complicated, but the more you use the MDM method, the more comfortable you'll become by using MDM and you'll see how quickly you can determine the overall code for common visits. So, the overall medical decision making is chosen based on the highest level that code is met or exceeded using two of the three MDM elements. In Kiara's example above, we determine that three MDM elements to be a low-level problem, a moderate data, and a moderate risk. So, the overall MDM level is moderate or a 99204 if a new patient and a 99214 if she's an established patient.

**Katherine Atcheson (**[**11:51**](https://www.rev.com/transcript-editor/shared/X41qR8vXFeci7lSxoQn4iLukD_xChsX59ZaFfk9-nmmptZoP9cB68aLhezxk71QSUKraai0e6qpb_4SbNXFgR6XU8Fc?loadFrom=DocumentDeeplink&ts=711.42)**):**

And how do we use time or length of visit under the new guidelines?

**Ann Finn (**[**11:57**](https://www.rev.com/transcript-editor/shared/o8K8s5rtmy5t7PUk6hd50wtqqGqtm15HiEY4pDd481vNr7HBRefTkptdAp3gzkaHTrKdb3s9of51Jky-XVFra5x62Fc?loadFrom=DocumentDeeplink&ts=717.21)**):**

That's a great question, Katherine. Using time is really easy now. Time for problem-oriented E&M visit is now based on the clinician's total cumulative time on the date of the encounter rather than just the clinician's face-to-face time as in the past. This is a big shift and really important to go over with your clinical staff. Be careful to not include time and activities normally performed by other clinical staff such as nurses, medical assistants, and/or front desk staff, unless otherwise stated in your payer's policy. You also can't count the time spent on separately reported services such as a LARC procedure. So, documentation really matters. The new guidelines include examples of activities that occur that can be used when calculating the total time.

**Ann Finn (**[**12:47**](https://www.rev.com/transcript-editor/shared/_lg9zX990dkXAM8meM79PnrbZ_-5rtPQYi6iC4n_-aRauHjYdvCJPshQqKbBreJNzNAgy0sVDc9t5-wC2qmOkpKZ-TM?loadFrom=DocumentDeeplink&ts=767.01)**):**

Some examples include preparing to see the patient. Some example, reviewing the tests or connecting to a telehealth platform before the visit, obtaining and/or reviewing separately obtained history, performing a medically appropriate exam or evaluation, counseling, and educating the patient, family or caregiver, ordering medications or contraceptives tests or procedures, referring and communicating with other healthcare professionals, documenting clinical information in the electronic or other health record, independently interpreting results that are not separately reported and communicating the results to the family, the patient, the caregiver, and care coordination.

**Ann Finn (**[**13:29**](https://www.rev.com/transcript-editor/shared/cg7uOsWatGtEk-w3g9czPB9ko2H34aj9x3q-EuU12vVDq7ys62VwHOoYAvf3OUXZv_rnAemC2AiGQwQC83VO22_bZ9k?loadFrom=DocumentDeeplink&ts=809.04)**):**

So, remember to clearly document all the time you spent on the day of the encounter on different tasks to support the E&M code build. I just want to mention again, to not include time you spent on other separately reported procedures such as the LARC insertion or a lesion removal or a colposcopy. Be sure your documentation is clear. No double dipping here. Do check with your payers for their coding expectations. For example, a few family planning programs have opted to include nursing or staff time for contraceptive counseling when billing an E&M service. Let's look back at Kiara's visit to start contraception. The clinician documented total of 18 minutes on the visit on the documentation. Kiara was an established patient using the time method and updated tables, the appropriate code would be 99212.

**Katherine Atcheson (**[**14:19**](https://www.rev.com/transcript-editor/shared/jvvRFXOmY0zqCbbqj1UtR3_GomgTtQmlGk2GO4mytT-Xvxqkl07yRGxMw8KdGHwi3lz-7R48ImjufvGhLT8gSctcp2c?loadFrom=DocumentDeeplink&ts=859.41)**):**

So, we calculated different codes using time and MDM, so which one can we used here?

**Ann Finn (**[**14:26**](https://www.rev.com/transcript-editor/shared/o1wdnGDZViZFO2X2gMbfMV-L9OiqUK7gHXzqvvrBBerritpbyeZ9UYbney29vjm-0LVivgcX-tZX6yDyZ8Ii1u6uM0g?loadFrom=DocumentDeeplink&ts=866.43)**):**

That's a great point. Remember, it's appropriate to use either method to determine the highest-level E&M code for each visit. One method does not fit all visits and it can be interchanged. We determine the E&M code for Kiara's visit was 99214 using MDM and 99212 using the time method. So, we would choose a 99214 for billing. For visits that require extended time with the patient, there are prolonged service add-on codes that can be used, for example, visits over 74 minutes for a new client or 55 minutes for an established client. We're not going to go over these prolonged codes today, but if it applies, you can reference guidance on these codes through the AMA or ACOG. Finally, documentation matters and it supports the code you built for services when reviewed by payers. Total time should be clearly documented in the visit note.

**Ann Finn (**[**15:20**](https://www.rev.com/transcript-editor/shared/S1w2ajaAnNlHPDI3-1tXSwHA8Oy6-FYDGZU7Jrt-7jEl_IVv2KWtdUJwfr99XJiDvjuqlCtvUjgjU7KlpeJ3VKVumtc?loadFrom=DocumentDeeplink&ts=920.28)**):**

To ensure quality coding, I always recommend updating templates to reflect these changes and offer spaces for total time to be easily captured in the note. Sharing and posting updated E&M coding tools, including the updated time and MDM tables for easy reference. Reviewing AMA and other E&M coding guidance to fully understand the criteria involved in determining the MDM level and time and what's included. Ensuring your staff is trained on these key changes, including not only clinical staff, but billing and administrative staff as billing and coding is a team effort. Doing some chart reviews within your practice on regular intervals with internal trained staff or an outside coder to ensure your team is accurately applying the new guidelines. And finally, offer feedback and time for discussion with your staff. Thanks for joining us today,

**Katherine Atcheson (**[**16:15**](https://www.rev.com/transcript-editor/shared/U3D8oQ6Bzux2XzXTdM277MrCOx9FYmtjRDLEsbXkMMJmEMeSnaZXCCX5_4YnF0sdzoSyw1qoj-WxP6o6nuf4ooM6rAY?loadFrom=DocumentDeeplink&ts=975.39)**):**

And thank you, Ann for joining us today and for sharing your time and expertise. For more content, including previous podcast episodes, search for clinical chats or subscribe to our show on iTunes, Google Podcasts, Spotify, Stitcher, or wherever you listen to podcast. For a transcript of this podcast as well as other online learning activities and continuing education opportunities, please visit our website at www.ctcsrh.org. While you are there, you can sign up to receive our newsletter, Clinical Connections at the top of the page. You can also follow the Clinical Training Center for Sexual and Reproductive Health on Twitter at ctcsrh. all lower case and on LinkedIn. The CTCSRH is funded by the Office of Population Affairs to provide continuing education, training and technical assistance to Title X grantees, sub-recipients, and service sites, and is supported by DHHS grant number 5 FPTPA 006031-02-00.

**Katherine Atcheson (**[**17:25**](https://www.rev.com/transcript-editor/shared/Z9NqqkdVTXke5BPNBVjPItzLr_Q4LpPTxQ3stiN805gZGoe9c-k4K6u1wS6AHydu2EqYHTPBX539AtY9cktxSClLqjY?loadFrom=DocumentDeeplink&ts=1045.29)**):**

This podcast is intended for informational purposes only and does not constitute legal or medical advice or endorsement of specific products. Opinions expressed herein are the views of the contributors and do not necessarily reflect the official positions of the Department of Health and Human Services or DHHS, Office of the Assistant Secretary of Health, or OASH or the Office of Population Affairs or OPA. No official support or endorsement by DHHS, OASH, and/or OPA is intended or should be inferred. Theme music written by Dan Jones and performed by Dan Jones and The Squids. Other production support provided by the Collaborative to Advance Health Services at the University of Missouri, Kansas City School of Nursing and Health Studies. And finally, thank you to our listeners for tuning in today. We hope that you'll join us next time for another episode of Clinical Chats.