CPT® Evaluation and Management (E/M) revisions FAQs

Current Procedural Terminology (CPT®) E/M office or other outpatient revisions went into effect Jan. 1, 2021. The landmark changes were developed by the AMA and adopted by the Centers for Medicare & Medicaid Services. The CPT Editorial Panel issued technical corrections in March to make the changes easier to implement.

Education on the changes has been produced through numerous channels, including educational modules on the AMA Ed Hub™, the publication, "E/M Office Visit Compendium 2021" and articles in CPT Assistant. An AMA webinar on the technical corrections provided additional clarification in key areas.

A subset of the questions generated during that webinar regarding Medical Decision Making (MDM), time and documentation not specifically covered in other CPT coding guidance, are provided to assist in applying the 2021 guidelines.

MDM element: Number and complexity of problems addressed

Q. The physician sees an established patient, who has uncontrolled type 2 diabetes mellitus (T2DM), with hyper- and hypoglycemic episodes. Depending on where this falls under the number of complexity and problems addressed in medical decision making (MDM), would it be appropriate to report a higher-level evaluation and management (E/M) code (e.g., 99214 or 99215)?

A. The Current Procedural Terminology (CPT®) E/M MDM table identifies "one or more chronic illnesses with severe exacerbation, progression or side effects of treatment" as qualifying for a high-level for number and complexity of problems addressed at the encounter. It is commonly known that patients with uncontrolled T2DM typically have such episodes periodically, and other related conditions or comorbidities as a result, which must be considered and managed as well.

Therefore, it is incumbent upon the clinician to properly evaluate a patient and to assign the appropriate level of E/M services code for that visit, based either on meeting MDM guidelines or documented time spent on the date of the encounter. Based on the scenario described in the
question, a higher-level E/M visit code may be appropriate according to the criteria of the MDM element identified.

Q. Should coders determine whether a patient's medical problem or illness is stable or worsening?

A. No, a coder should not determine whether a patient's medical problem or illness is stable or worsening. The patient's physician or other QHP is expected to determine whether the medical problem or illness is stable or worsening. A problem is addressed or managed when it is evaluated and/or treated at the encounter by the physician or other QHP reporting the service.

MDM element: Amount and complexity of data to be reviewed and analyzed

Q. Is it appropriate to count laboratory tests and other tests ordered during a preventive medicine service (99381-99397) visit in MDM selection?

A. No, because the 2021 revisions to the E/M office or other outpatient MDM do not apply to codes 99381-99397 (preventive services). These codes are used to report preventive services for infants, children, adolescents and adults, which were not affected by the CPT 2021 E/M changes.

However, if an abnormality is encountered or a preexisting problem is addressed, in the process of performing the preventive services, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then it would be appropriate to report the office or outpatient codes (99202- 99205, 99211- 99215) in which the number of laboratory tests and other tests ordered can be used to determine the appropriate level of E/M office or outpatient service code to report. Note that modifier 25 should be added to the office or outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive service. The appropriate preventive service is additionally reported.

Q. A family practice physician received records from a new patient's cardiologist, which includes electrocardiogram (EKG) and chest x ray (CXR). Would it be appropriate for the physician to receive credit for reviewing the cardiologist's notes (one unique source) and the EKG and CXR?

Yes. Based on the presented scenario, the records reviewed (cardiologist notes, EKG and CXR) may be reported as a unique source when selecting the Medical Decision Making (MDM) level. Review of
all materials from any unique source counts as one element toward MDM. Per the E/M 2021 Errata and Technical Corrections, CPT 2021, a "Unique" source is defined as follows:

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential and platelet count. A unique source is defined as a physician or qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

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

Q. If the decision for minor or major surgery is not dependent on the global period in the risk section of the updated MDM table, how would the determination of whether a procedure is low or moderate be made?

A. Per the E/M Technical Corrections (TC), CPT coding does not have recommendations for assessing the level of risk for particular procedures when the level of risk for the procedure is not noted in the record. However, it is recommended to discuss the documentation with the specific physician or other qualified health care professional (QHP) for clarification. Risk for any procedure depends on the specific patient-risk factors and circumstances as they are assessed by the physician or other QHP. For example, a procedure may be deemed as high risk for a patient because of his or her specific circumstances, while the same procedure may be assessed as moderate or low risk for a different patient.

Therefore, the physician or other QHP would make such determination based on his or her evaluation of the specific patient’s circumstances and risk factors. In addition, the E/M Technical Corrections describes risk as follows:

For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the
Q. Question: Do inherent risks (e.g., perforation) make all surgeries high risk to patients when selecting the level of risk for medical decision-making?

A. CPT coding does not define ordinary surgical risks (such as perforation) as high or low risk for patients. The physician or QHP who evaluates the patient is the best judge of the specific patient factors that make a procedure “high risk” for a patient. Every surgical procedure carries some element of risk; however, a relatively simple procedure for an otherwise healthy adult carries a different level of risk than the level of risk for an older patient with multiple comorbidities. Per the E/M 2021 Errata and Technical Corrections:

The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

As a result, the physician's documentation of his or her level-of-risk assessment based on the specific patient's risk factors is the determining component in how the MDM level of risk for the specific patient will be calculated. The MDM level has three components and level of risk is only one of three components required to determine the MDM level. The physician or QHP must also document and consider the number and complexity of the problems addressed at the encounter, as well as the amount and complexity of the data to be reviewed and analyzed. Two of the three components must be at a high level for the overall MDM level for that encounter to be considered as high. Therefore, not all surgeries will be assessed as "high risk" based simply on inherent or ordinary surgical risks.

Additional E/M questions

Q. If a physician documents time, but the encounter documentation reflects a higher level of service based on MDM, may code selection be based on MDM instead of time?

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A. The methodology that accounts for the most appropriate and relevant elements for a given patient encounter should be used to select the appropriate codes. For example, a high-intensity visit that lasts a short period of time may be more accurately reflected using MDM; whereas a time-intensive visit might be better captured using time as the criteria for code selection.

**Q. Does a physician or other QHP need to specifically document or use the terms "major surgery" or "minor surgery" to clearly differentiate the two classifications of surgery?**

A. Yes, it is recommended that a physician or other QHP should document whether it is considered a "major or minor" surgery. The classification of surgery into minor or major surgery is based solely on the common meaning of such terms when used by trained clinicians. These terms are not defined by the CPT coding’s surgical package classification.

Visit the Implementing CPT® Evaluation and Management (E/M) revisions page for additional information on the revisions and changes in E/M office visit documentation and coding.

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