Question	Answer
Note Templates	
Are the new templated notes available now?	Yes, notes are available in Playground now and will go into Production Jan 2021. It would be detrimental to be live in Production environment prior to the change in E&M requirement.
Can one still use Dragon w/the templated notes?	Yes
Should the general "APSO" note be available? I do not have Ambulatory Epic but followed your search instructions and there wasn't an APSO note available?	Yes, both SOAP and APSO are available in Playground. Please check the Playground tip sheet and contact EpicPartnerTopic@CentraCare.com if still having problems; make sure your search string in the SmartText Lookup is appropriately simple to avoid errors in the search – try "gen off vis"
Is the template set up to capture data to meet 99205 and 99215?	The template will assist you in capturing the MDM and time spent to support whatever level of service is appropriate; it is embedded with all possible problem/data/risk features that maximize opportunity of capturing level 5 when appropriate. The E/M calculator will assist you in determining which LOS is appropriate.
Correct me if I am wrong, MACROS do not follow the user to different job locations i.e. Primary Care at one site, to ASAP at another work site?	Notewriter macros stay with the user across Ambulatory sites or ED sites, however, ASAP has a unique Notewriter that is different from Notewriter used in clinics.
Can nursing still document ROS?	Yes, one can use 'Make Me the Author' (ambulatory tool) and nursing can document the ROS.
Can we use .ROS and .exam with the macro edit now?	The ROS and PE Notewriter blocks are embedded in the note, one may utilize macros at the top of the note. Use the system level macros or create your own on the fly and/or using the macro editor.
Not all providers will have access to the note "button", will Primary Care providers have it?	Primary care providers will have the note button right away, as will most specialists.
I have very specific HPI/ROS smart phrases embedded into a smartphrase template. It would be more efficient to not pull the smart phrases into various sections of this templated note. Can standard note templates be used as framework?	We realize we will need to make some modifications for certain specialties and will be working with specialties. Please request modifications, via email to EpicPartnerTopic@CentraCare.com. If you use this as a basic framework but make your own version, you will risk missing out on any updates designed to capture E&M features as the new rule evolves.
If we are in a department without Ambulatory Epic (i.e. Physiatry), how different will this look?	One can search for the note smart text and 'favorite' the note template. However, unfortunately, the level of service calculator is not present in that environment; please rely heavily on the handout.
What type of note would I used for a routine prenatal visit? The notes I create for these visits are generally very short. Do these changes apply to those notes?	It will depend on how your services are billed. Some payers allow E/M's and others want all services billed as global. If using E/M's one could edit this note, per your specialty, to help meet the new 2021 guidelines. If the services are billed as a global charge with the pregnancy, you should continue very brief notes. If a prenatal patient sees you for an issue not directly related to the pregnancy (ex UTI, rash, fall with injury) you would want to use the standard note as that would likely be billable as an E/M service.

How will this affect notes in the ER when we see a patient as a consult to the ER provider and then the patient goes home?	One should document as you do currently for outpatient consults. Coding can determine if the payer accepts consult codes or requires outpatient E/M (which will follow new 2021 guidelines).
Are there no specialty exams anymore?	Yes, but only for consultations (inpatient *or* ambulatory) and inpatient, observation, SNF or ED services (these still have very specific exam requirements). New and established patient visits, 99202-99215, are the only services changing in Jan 2021 and simply require whatever exam features you deem clinically relevant. If you feel the new/established visit needs a specific exam for your specialty, please contact us at EpicPartnerTopic@CentraCare.com as that may warrant a modified note specifically for your specialty.
Will parts of that note be available as smart phrases if we make our own templates?	This is strongly discouraged as if you use this as a basic framework but make your own version, you will risk missing out on any updates designed to capture E&M features as the new rule evolves. Please give the new note a try. If you absolutely feel it will not work for you, please reach out to an epic optimizer to be sure you keep the features that are necessary to capture E&M features.
Can we adjust the template note to be more like what we usually do rather than having to select them each time? Are we required to use the template, or can we get our notes approved?	The standard note is not required. However, it is strongly recommended you try your own. If you make your own version, you will risk missing out on any updates designed to capture E&M features as the new rule evolves. Epic will not approve/maintain a whole host of individual notes. Please give the new note a try. If you absolutely feel it will not work for you, please reach out to an epic optimizer to be sure you keep the features that are necessary to capture E&M features. You would then be responsible for being aware of rule updates and making commensurate changes to your note.
If I like the diagnoses in certain order, does the note refresh if I had already downloaded the note and then fix the order after?	Some of the diagnosis list options are refreshable, some are not. The note offers six different formatting options, please experiment to see which one works best for you. If none of them do, please provide that feedback at EpicPartnerTopic@CentraCare.com
Will virtual visits use the same new templates?	We are updating the Virtual note template to have the new Standard note with the Telehealth statement that is needed
If we currently have LOS buttons (E3,E4, etc.) saved, will they need to be redone to reflect the new criteria?	The LOS buttons do not need to be redone for new criteria as long as the provider fulfills and documents the needs within the new criteria to meet the level of service
What is an ACO dot phrase?	They are the smart phrases in the BPA's for ACO metrics; diabetes, HTN, etc.
What about ACO dot phrases? Do we need to use these for HTN, etc.?	The ACO dot phrases help you document to reflect information for the risk score and would help with E/M documentation too. It is not necessary to use them – one could use your own wording as well.
Split Billing Combination Visits	
For those of us who do a lot of split billing with wellness visits and E&M codes, how does that work for the requirements and for the note elements?	**One may still bill MAW or PE codes with additional E/M codes,** with the E/M level driven by either time or MDM, just as it would be for a standalone E/M visit. A goal is to build a note to support both the well visit and the add'l E/M in one note. **New patient E/M codes:** 99202-99205 **Established patient E/M codes:** 99212-99215

	New patient Physical codes: 99381-99387 (based upon age) **Established patient Physical codes:** 99391-99397 (based upon age) **MAW codes:** G0438-G0439 (initial and subsequent)
Are there any changes to requirements for MAWs, Welcome to Medicare or HCM visits?	No, MAW, Welcome to Medicare, and HCM visits are not changing.
For split billed visits (like MAW and an E/M chronic disease at the same time), how do we calculate that? It would be difficult to split out the time spent on the chronic diseases and the time spent on preventative care.	In theory, one could split the time, but it would require significant mental gymnastics and difficult to validate. The calculator gives the total time, one could then best estimate the time dedicated to the chronic disease (E/M) and the time dedicated to preventative care, but it is probably easiest and most valid to let MDM drive the E/M portion.
Currently using **modifier 25** for split billing, will that still work?	Yes, when split billing a 25 modifier will still be required; the process has not changed.
Is there a list of additional codes (advanced care planning, smoking cessation counseling, etc.) that might be added to our E&M codes?	You may add those codes in addition to your E/M services. There is not a list, one could reach out to your coding staff if there are questions about a particular service.
E/M codes can be submitted along with procedure codes, if the reason for the E/M code submission is different from the reason for the procedure code, correct?	Yes, though documentation must support a separately identified reason for the E/M.
If I do a procedure that is otherwise appropriately billed with an E&M code (i.e. an encounter to manage rheumatoid arthritis and the requisite medication therapy, during which the patient mentions pain in a joint, for which I perform a joint injection), I imagine I can still bill the procedure CPT code(s) in addition to E&M CPT code(s). My question is regarding time: If I end up billing the E&M code on time, do I need to subtract the time done performing the procedure?	Correct, the E&M time should exclude procedure time, as the procedure is billed separately.
We just keep using the same templates for all MAW's and physicals, correct? The majority of my visits are those visit types, and the majority of those need to be split billed. Will the coders be looking for the elements in the new system if we aren't using the new template? Or do we have to list time outside of the preventive measures?	The template and documentation requirements for MAWs and physicals has not changed. Therefore, one may continue using the same templates. Coders will be using the new 2021 E/M guidelines to support the split billing process, based on either medical decision making or time, within your documentation. When billing based on time, the time used to support the E/M must be carved out from the time spent on the preventive service.
If I spend 75 mins in the room for a Medicare Annual Wellness (MAW) visit, and the patient is new to me, but not the clinic, how would that be coded?	MAW has no time associated. If one provides care above and beyond the MAW visit, for chronic conditions, and documentation supports – one could split bill an established pt E/M based on MDM or time spent on those chronic conditions.
Can I just hit “modifier 25” and add the add’l code for split billing?	You can – otherwise, Coding will apply
Previously for split billing, I used mod 25 and the separate code. Now, having the secondary code first, and having to add back the actual code for the visit feels backwards?	If one uses the calculator to determine the add’l E/M level of service, it wipes out the preventative code if chosen first.
We can just pick our wellness code and add a 25 mod and we are done?	It is preferred that one choose the wellness code, along with the split bill E/M.

Split billed visits are hard to code, I get asked how much time was spent on the MAW (or AWV) and how much on the chronic conditions for the add'l E/M. How do you recommend determining the time split?	Time for split billing the E/M must be carved out of the time spent for the wellness visit. (It is the same concept as an E/M billed on time with a procedure.) One would look to your workflow process to help determine the time in which you addressed acute/chronic conditions. One also has the option to bill the add'l E/M on documented MDM.
Can split billing be based on number of diagnoses addressed or just on time?	Split billing for additional conditions which you are addressing may be supported by documentation of the diagnoses and medical decision making or total time carved out from the wellness visit. Non-Medicare payers look to split billing for acute or exacerbated conditions addressed.
Total Time	
Can you now choose your level totally by time?	Yes, one may use total time for office outpatient codes 99202-99215; level will be driven by *either* time *or* MDM – whichever is higher. Time now includes provider "total time" spent for a patient (I.e., reviewing records, seeing pt, discussion w/other providers, documenting), on the day of the visit.
How does time get into the documentation?	Providers will need to document their total time within the note when selecting the level of service based on time. (I.e., xx total time, 1300-1340, etc.)
When does the timer start? Does Epic know which day it is to count it?	The calculator will start counting whenever you open encounters for office visits, but *only* on the date of service (as the calculator is aware that time only counts on that date). It does not matter where you are in the encounter for the time to calculate. The time clock in Epic has a stopwatch character, which is both an asset and liability. If you, as the provider, are doing anything to care for the patient on the date of the visit and have the encounter open, it is an asset in tracking all that time for you. One could even use it somewhat artificially: you call the Cardiologist to discuss patient X; the call does not involve the EMR but having patient X's encounter open will help you keep track of the time without you needing to find another methodology to stay organized on tracking your time. It is a liability if your workflow has you in the encounter when you are not doing something to care for that patient, then the calculator will not offer you a valid time.
The time requirement is per calendar day, correct?	Yes, any services rendered for that patient, on that "date of service", i.e., calendar day
If multiple chart encounter tabs are open in Epic, does it calculate times in all charts, or only the chart "on top"?	It will calculate time for *all* open encounters on the day of the visit. For a more accurate time we would recommend closing the encounters you are not working on. We acknowledge this is likely a change in workflow that will take awareness, but it is an asset that will allow the calculator to be your timekeeper if you are fastidious about opening/closing an encounter you may be billing on time.
What if we do not always open the EPIC encounter right away when getting in the room - will this create problems with billing based on time?	Total time includes all Epic time, along with any additional time spent on the day of the encounter. The calculator time tool is designed to help as a timekeeper, but it does not have the final say on the time you report for the day. Whether you utilize the calculator tool or not, one can bill based on whatever you document as total time.
Do we need to have the encounter open during the visit then?	Only if you want the calculator to count that time for you.

Do we still need to document time in our note?	Yes, time must be documented within your note when billing based on time.
Does the calculator track time if we are documenting after the DOS?	Only time spent on the date of the encounter will be tracked by the calculator (the calculator is aware that time only counts on that date).
Does the stopwatch flow into your note to document time?	No, as the stopwatch is just a suggestion on which to start – you must validate that time (if you inadvertently keep the encounter open, the stopwatch will be incorrect) and you should also consider if you applied any time outside of the having the encounter open.
I do a lot of "pre-charting". Can I do this function prior to the visit starting?	Yes, one may use pre-charting. Unfortunately, however, the only time that will count towards the level of service is the time on the date of the visit.
Documentation time counts toward time too, not just chart review?	Yes, time spent documenting within the EMR is counted towards your total time.
Do we document time spent before the encounter, on the day of the encounter, in addition to using MDM? I often look at pts charts multiple times prior to the day of visit or even after. I am wondering how to best capture that work. Time does not count when done the day before the encounter or week before, etc.?	Correct. Total time counts for time spent on the day of the visit only. If one is performing pre-chart review on the date of the service, one may count that time. If using the Epic tool, your time will be tracked once you open the chart on the date of service. The cognitive work/data review could give you MDM points (depending on if the nature of the work meets one of the points) even if not done on date of service. We acknowledge that the discordance is frustrating
If a pt has a 9am appointment, I may not see them until 11am (or at some other time), thus the time I am in their chart may not correspond with their appointment time. Does this matter?	Time to support the visit "is the total time you spent for the patient on the day of the encounter/visit". That determination is no way dependent on time the visit was scheduled.
To clarify, if you close out of the chart, it stops the "stopwatch" each time? And restarts when you open the chart again?	Correct. It counts time only when the encounter is open and only on the *date* of the visit. The calculator will stop counting when you close the encounter and would restart if you reopen the encounter on the day of the visit.
What about the computers in the exam rooms that quickly self-log-off? Often, I am explaining things to the patient and family and must log back in. Does that affect the calculator keeping track of time?	The screen saver comes on, but you are still logged into Epic. When you click on the computer, you do not have to log back into Epic - the encounter is still open, and it will be counting.
What happens with the time feature if a scribe is in the chart as well as the provider?	The time only counts for the provider, not for support staff or a scribe.
If I am going to call someone to discuss a patient, would it make sense to open the visit encounter during that phone call to help me keep track of it? Does it work that way?	Yes, if one opened the patient encounter during a call, it would track the time you are in the patient's chart. Adjusting your workflow this way would be a great way to make use of the time calculator as a stopwatch to track your time for you, so long as you are diligent about opening and closing the encounter as appropriate.
Can you show how to add the extra time?	If your visit exceeds the maximum time for level 5, you should apply the additional CPT code 99417 per each 15 minutes. The 4th tab the calculator allows for additional E/M codes. Otherwise you can add it in the E/M tab just as you previously would without the calculator. CMS and commercial payers will apply 99417 with different criteria (CMS uses a similar code called G2212 with a higher threshold). **The provider should apply 99417 with the**

	same criteria of all patients regardless of payer and allow the coder to adjust if the payer requires it.
Do we have any updates on 99417 time-thresholds?	**99417 - Commercial Payers** – each add'l 15 mins beyond the minimum time for 99205/99215: New Pt: 75-89 mins = 99205, 99417; 90-104 mins = 99205, 99417x2, etc. Est Pt: 55-69 mins = 99215, 99417; 70-84 mins = 99215, 99417x2, etc. **G2212 – Medicare** – each add'l 15 mins beyond the maximum time for 99205/99215: New Pt: 89-103 mins = 99205, G2212; 104-118 mins = 99205, G2212x2, etc. Est Pt: 69-83 mins = 99215, G2212; 84-98 mins = 99215, G2212x2, etc. Provider should apply 99417 regardless of payer and allow the coder to adjust as req.
If I use the face-to-face prolonged service code, 99354, do I need to document counselling time (>50%), or is total face-to-face time sufficient?	99354 cannot be used in new/est patient visits 99202-99215; it is replaced by 99417/G2212. 99354 does apply to consults (99241-99245) thus the >50% counseling is necessary. One can only bill a consult on time if >50% of the face-to-face time is spent in counseling/coordination of care.
If all visits are level 4 based on time, even if correct, will this be brought up as a negative thing?	If the entire time billed for a provider's day does not add up, it will raise concerns. Nonetheless, being an outlier is not intrinsically bad - if the documentation supports what is billed. However, one needs to take care when patterns are outside the norm as our compliance department monitors these billing trends as do payers. Being an outlier can make one a target for an audit.
Is there a scenario, in which I could/would code both 99417 and 99354?	No, they are explicitly regulated as mutually exclusive. **See grid attached at end of this FAQ**
Out of curiosity, does the time calculator in EPIC also track prolonged care time when on a different day of the visit?	No, by design, the calculator only counts time on the date of the visit. Unfortunately, it is not smart enough to suggest the prolonged time code (99417) when it applies on the date of the visit.
With the new E&M rules, does documentation of a time statement still "trump" the MDM? For example, if I include a time statement in my documentation (i.e. "total encounter time on DOS was 24 min"), but my MDM for that encounter would legitimately qualify for a 99215, would I be stuck with a 99214 because I included that time statement? (This was a rule/interpretation in the "old" rules that I always found frustrating.)	Level of service should always be directed by whichever is higher, time or MDM. (This is not a change) One should not interpret the fact that you document time to mean one *must* bill on time – especially if the MDM documented supports a higher level.
How does this work for virtual visits that are time based?	If one is providing an E/M service (99202-99215) virtually, the same time or MDM billing requirements need to be met. If one is providing a non-E/M service virtually, follow specific time required per code.
Medical Decision Making (MDM)	

What is the severity if there are 3 or more stable chronic problems without an exacerbation?	2 or more stable chronic conditions are moderate severity (99204 and 99214); however, *2 of the 3* MDM components are needed to determine a level of service. One would also need Data or Risk to hit moderate to meet level 4 (99204 and 99214).
Regarding "undiagnosed" problem, for consultants, if you are the one to diagnose, though they were sent to you by PCP with that as suspected, does that still count as new diagnosis?	If you would still best describe the problem with a clinical symptom (ex. shortness of breath, joint pain/swelling, breast lump) with a workup planned for a broad differential, it would still be an undiagnosed new problem. At the time you make a diagnosis with your consult, it likely better meets the definition of one of the acute or chronic problems. There are nine separate definitions for various conditions under "Number and Complexity of Problems Addressed;" definitions for these different "types" of problems can be found on the backside of the E/M guide.
Will time that I spend reviewing CentraCare records count towards time even though it does not count towards complexity? Are points given for reviewing the referring providers notes (within CentraCare) as it pertains to the reason for referral to specialist?	**When using towards time:** The total time one spends for services provided to your patient on the date of the encounter visit should be counted and this would be part of the time of performing a complex visit. However, for outpatient consults, one should be reminded that might be billed as a new patient or a consult depending on the payer; consults can only be billed on time if >50% of total time is spent in face-to-face counseling . **When using towards MDM:** One may receive points for reviewing the notes of someone in a different specialty, department, or sub-specialty (external provider) – even if within CentraCare. (see AMA definition for "external provider" – E/M guide). Give reference and brief summarization.
Do we have to say where we got records reviewed? Care Everywhere vs scanned in, etc.?	Yes, indicate where the records were from - i.e. records reviewed from TCHC. This matters as each independent source offers a separate point. It is also necessary to include a brief summarization of information reviewed.
If I review an MRI and MRA is that 2 points for each?	One point is given per each unique test reviewed. A test is considered unique if it has its own CPT (billing) code – i.e. if you ordered it separately.
If one orders, interprets, and charges for the interpretation of an ECG or x-ray, does it count for independent interpretation for E&M?	If one is billing for a test/interpretation, one receives credit within the interp billing, and cannot "double dip" to count it towards MDM. One could receive the interpretation credit if the test were ordered/performed/billed by another provider in a different department, specialty, or sub-specialty, per AMA
With my diabetes patients, I do lots of CGM interpretations. Would that be in the procedure spot? (There is a separate interpretation code also).	CGM codes are separately billed. Credit is already built within the interpretation for the CGM. As with EKGs/x rays as above, one could not "double dip" to also be counted as interpretation in the MDM table.
Is this calculator allowing credit simply by the checkmarks?	The calculator only knows what you tell it by applying the checkmarks; see the two questions above – if you checked these tests even though you cannot "double dip" for the test and the MDM of the visit, the calculator has no way to know this
Is the MDM magic link in ASAP & Inpatient or just Ambulatory care?	The changes are only for Ambulatory care (99202-99215) currently. Not for ED, Inpatient, or Ambulatory Consults (99241-99245).

Is there any change in the medical decision making for doing an office-based procedure and submitting an E&M code along with the procedural code?	Rules will still apply for a separate identifiable reason to support your E/M visit from a procedure.
Does discussing with another provider include staff message or MI secure message?	Yes, if the provider is from another specialty, sub-specialty, or department; the mode of communication does not matter. See definition of 'external provider' on E/M guide.
Does discussing the case with a peer in my clinic count like discussing with a specialist?	No - per AMA definitions, the discussion must happen with an external provider (a.k.a. provider of a different specialty, sub-specialty, or department)
Do we need to pull in labs/EKG/imaging results to the note for credit?	In fact, we recommend *not* pulling all results into the note, to prevent note bloat. However, one does need to discuss the results and how you are using them in your medical decision making for that patient; this does not have to be extensive.
In re: to "spoke with a specialist" does this have to be same day as visit? Often, for efficiency sake, we do not speak w/ the specialist. We send off a staff message to a particular Dr. with the MRN/chart linked so they can answer it. Does that count if documented?	Based on our initial interpretation, the hope was that cognitive work could count even if completed after the fact. However, this is becoming a very controversial area of interpreting the new rule and it may not turn out that way. We are vetting it with coding consultants, payers, and other organizations. We will update information on this area as soon as able; this topic will be covered in follow up education in January. On a side note, consider using an E-consult for the specialist. Then both you and the specialist can capture a charge for the work (via split charge 99451 or 99452). E-Consults are also better documentation of the conversation. Staff messages are purged and not part of the record.
Are refills of prescription meds moderate? Or only new meds?	Refills, new medications, and a decision to maintain current meds = moderate risk (level 4). However, *2 of the 3* MDM components are needed to determine a level of service. One would also need Data or Number of problems to hit moderate to meet level 4 (99204 and 99214).
Does the MDM 'magic wand' information get added to the visit note?	No, there is not a link to pull in the calculator, however the smart lists within the note mimic the calculator and document what is needed for the level of service.
Does the drug therapy requiring intensive monitoring include Coumadin/INR monitoring?	AMA does not define or name specific medications. One looks to the documentation to call out the need for monitoring of the medications if the patient is at risk, etc. Relatively routine monitoring probably would not count but if there is monitoring outside the norm (ex. due to labile INR or history of bleeding requiring tight INR goal), this could be justified as intensive monitoring with appropriate documentation.
What if you deem and recommend hospitalization and the patient ultimately does not pursue hospitalization?	Medical decision making is based upon your documented thought processes and assessment - not if the patient follows up on your recommendations; it is the nature of the situation not the outcome the patient chooses that matters.
What do you need for personal review of a surgical or endoscopic procedure?	If you or a peer within your department, specialty, sub-specialty is billing for a diagnostic procedure – one would not receive credit for review w/in the MDM – credit is given within the procedure code billed. Personal review of a diagnostic procedure would be relatively uncommon, but examples might include personally reviewing and independently interpreting images or

	photographs not already billed by your group. For example, patient has an angiogram done by IR and you personally review and interpret the images as a vascular surgeon; patient has a TEE done at an outside facility and you personally review and interpret the images; patient has a colonoscopy done at an outside facility and you personally review and interpret procedure photographs of findings. Reviewing procedure *notes* for a procedure not billed by your department, specialty, or sub-specialty would count as review of external notes (carrying the same weight as review of a test without personal interpretation).
Do labs performed the week before the visit, count towards your MDM on the date of service?	Based on our initial interpretation, the hope was that cognitive work could count even if completed after the fact. However, this is becoming a very controversial area of interpreting the new rule and it may not turn out that way. We are vetting it with coding consultants, payers, and other organizations. We will update information on this area as soon as able; this topic will be covered in follow up education in January.
If one orders an MRI, then requires another x-ray to further evaluate the findings, do we get credit the following day?	Based on our initial interpretation, the hope was that cognitive work could count even if completed after the fact. However, this is becoming a very controversial area of interpreting the new rule and it may not turn out that way. We are vetting it with coding consultants, payers, and other organizations. We will update information on this area as soon as able; this topic will be covered in follow up education in January. On a side note, if an additional test is ordered, it is possible one might call the patient to discuss this new recommendation; a telephone visit could be billed separately.
Does reconciling outside problems, etc. count as a data point [reviewing and summarizing outside records]?	If one noted in the "outside records summarized" section a statement along the lines that you "reviewed records from source X within Care Everywhere and incorporated that information into the EMR as summarized in the history below" that would count as a data point. This data point should only be captured if the provider was personally reviewing this information.
Do we get MDM data points for reviewing developmental and/or behavioral screening results?	Yes. The review should be reflected within your documentation. The AMA defines tests as imaging, laboratory, psychometric, or physiologic data.
Do data points apply to post ER follow-ups, when you discuss the entire visit and ER labs?	If one is reviewing labs from the ER encounter, you would receive credit for each unique test reviewed. If you also work in the ER, you would not receive this credit – as the order is inclusive of the review.
We usually order tests for the next visit, which could be 6 months away. Does this count towards data?	If the tests are ordered and documented within your note, one will receive credit upon ordering of each unique test. Review is inclusive of the order.
Does managing prescription medications count as level 4 if you are not making any changes at that visit?	If the condition has been evaluated and decided not to change meds (i.e., HTN stable, continue current meds), moderate risk is supported. Remember, problems addressed or data would also need to support 'moderate' to meet a level 4.
What is defined as a test? Ex: is BMP a single test? Or if I order a creatinine and potassium, are those individual tests?	A test is defined as a service which has its own unique billable CPT code. A panel is considered one unique test.

Does a spouse count as an independent historian if they are adding to the history?	Yes
Does an interpreter count as an independent historian?	No. Per AMA definition: an independent historian is on who provides history in addition to the history provided by the patient, who is unable to provide a complete or reliable history due to developmental stage, mental conditions, or because confirmatory history is determined to be necessary.
Does this statement 'the patient was accompanied by mother' automatically assume the mother contributed to the history and no other verbiage is necessary?	No. One will need to document that additional history was obtained from a source other than the patient. I.e., per mother or mother relayed, etc.
How would you define the complexity of the problem for supervision of a high-risk pregnancy or of gestational DM?	Complexity would be determined by you indicating the severity of the risk to the mother/baby in your documentation.
If I write a prescription for a medication that is available OTC, does it count as prescription drug management?	Per our Medicare carrier: 'Prescriptions given for an OTC medication, in any setting, cannot count as prescription drug management on the table of Risk. If there is additional documentation present to demonstrate that , for example, an Rx was given for OTC meds due to concerns about potential interactions with other medications the patient is on if the OTC med was not taken correctly, we may count that.'
Are OTC medications automatically considered low risk, as they were under previous guidelines?	Per our Medicare carrier: 'OTC drugs are not necessarily without risk and therefore, are not necessarily considered low risk for purposes of MDM. For example, recommending an OTC med to a patient with several co-morbidities may still result in a detailed discussion of risk. Therefore, each instance should be evaluated individually and not automatically characterized as low risk.'
Workflows	
Are we to wait to sign our notes until after all test results come back, or are we adding addendums?	This would be a personal workflow. One could add an addendum if the encounter has already been closed.
If we wait to close the encounter waiting for results - are we subject to chart deficiency rules? Or should we close and come back and addend?	Chart deficiency standards are not changing. Whether to wait to close the encounter is likely a judgment call depending upon how long you expect the result to take. For furtherance of care across the continuum (ex. having your visit documentation available in the event the patient has an ER visit) closing the encounter and subsequently planning an addendum may be preferred
I am not clear on addendums; if one saw the pt one day, ordered a test, then got the results the next day & contacted the pt w/the results - I thought there was something mentioned that one could claim your time for things done w/in 24 hours of the visit, but I wasn't sure adding an addendum to a prior note for something you reviewed the next day made sense?	If one receives results the same day as the visit the order was placed, called the patient with the results: you could then add an addendum to reflect this or simply not finalize your note to your note until this work was reflected. All of this time would count toward the total time in the visit that day. Based on our initial interpretation, the hope was that cognitive work could count even if completed the following day. However, this is becoming a very controversial area of interpreting the new rule and it may not turn out that way. We are vetting it with

	coding consultants, payers, and other organizations. We will update information on this area as soon as able; this topic will be covered in follow up education in January. (It is possible that you are thinking of the rules in relation to telephone visits (slide 51). Pre-COVID, telephone codes could not apply if the call leads to an E&M service within the next 24 hours (or soonest available appointment) or if the phone call happened within the 7 days following an E&M visit. These rules will likely be reinstated post COVID).
Billing	
If I call to go over results after a visit or answer a question that is outside the visit, I can bill for that?	As above, per CMS: Telephone codes cannot apply if the call leads to an E&M service within the next 24 hours (or soonest available appointment) or if the phone call happened within the 7 days following an E&M visit
Do patients know they can be charged for telephone calls? Does insurance pay for that?	Patients should be made aware certain telephone encounters may be billable. During the public health emergency, most payers reimburse for telephone calls. We continue to watch to see how they will process once the pandemic is over.
Any updates to charging for telephone visits (not related to recent OV, but rather as an e-visit)? When I search LOS options for telephone for physician it is just 1-10 min or 11-20. Anything for 21+ min?	There have been no updates to telephone visits For providers who bill **E/M** codes: **Medicare & Medicaid** - bill 99441-99443 for audio only telephone visits (99441 = 5-10 mins, 99442 = 11-20 mins, 99443 = 21-30 mins; prolonged service codes may be added as appropriate) **Commercial payers** - bill E/M codes based on time for audio only telephone visits
Can you use the Advanced Care planning code in the nursing home, rehab, or assisted living when you do a visit?	Yes, if your documentation reflects the 30+ minutes required to bill the ACP, over and above your NH, Rehab or AL visit.
How is it recommended to bill a pre-op?	With an E/M code based on medical decision making or total time for the visit.
In the example of an outpatient visit resulting in recommendation for admission, can the outpatient E&M code be billed on the same day as admission (by someone else) for same problem?	If the outpatient visit and the admission are rendered by *different specialties*, both can be billed. Reimbursement will be dependent upon payer rules.
Can you clarify new vs established patient? If the patient has seen another provider in the same specialty, but you have not personally seen them before, does that count as a new patient?	A new patient is one who has NOT been seen by a specific specialty group in the past 3 years. (per this example, the pt would be established). Please note these rules have not changed
If a Family Physician sees a patient in the ED, that does not count for FM clinic right?	If asking from a new vs. established patient perspective – the patient would be considered established to the FM clinic if seen by a FM physician in the ER. The 3-year rule applies and follows the provider, not the site of service. If asking from a new E/M rules perspective – the new documentation guidelines only affect outpatient codes 99202-99215. ED codes 99281-99285 will still follow the 1995/1997 coding guidelines.
If an outpatient Internist and a Family Med provider working inpatient both see a pt on the same day, that would be ok for billing. But if an outpatient Internist and an IM Hospitalist working inpatient see the	It would be dependent upon the payer, but it is believed we could bill for both services, in either situation (i.e. outpatient Internist and IM Hospitalist are separate).

patient on the same day, that would not? Are Hospitalists counted as separate specialty?	
Is there a limit as to how high one can split bill? It was my understanding that 99213 was the max for non-Medicare visits?	Some payers will not reimburse higher than a level 3 – however – one should document what was provided and bill appropriately regardless.
Do we know who in Family Medicine bills EKG interpretation?	A grid will be created to assist in deciphering which departments bill their EKGs globally or if Cardiology bills the read.
Coding	
Are the coders going to be looking at all ambulatory notes?	Yes, Coding will be reviewing and giving provider feedback based on the new guidelines.
Instead of going to MDM elements, can we go with total time with full documentation?	2021 outpatient E/M (99202-99215) rules have changed to allow one to choose the level of service based on either MDM or Total Time – whichever gives you the highest level. While a medically relevant HPI and exam are still needed, a comprehensive HPI or exam is no longer required.
Will coders have access to the MDM calculator within the note? To clarify - could coders use the tool to figure out the MDM for the provider, if requested by provider?	Yes, coders will have access, but cannot change a providers MDM or time. Coders should be assessing documentation and will use an audit tool that is a more intensive version of the calculator. However, if there is a difference in opinion, one could look to the tool to help understand the "why" a provider chose a level.
Do you anticipate different questions or processes from our coders regarding the questions they have and the queries they send us?	This will be addressed with Coding Leadership. Compliance has developed E/M audit tools/guides to support these changes and communicating them with the Coding team. We meet monthly, in addition to our teams auditing cases and asking questions on how compliance views guidelines. Good discussions are exceptional learning tools!
Do we need to determine if consults visits need to change to new patient codes?	The process for determining a consult has not changed; if the service rendered was a consult, document and bill a consult. Coding will assist with changing consults codes to E/M new patient codes, as payer rules dictate.
I notice that the template for Exam has Orientation x 3 under Neuro. Coders are taught to put orientation under Psychiatric. Has there been much discussion on this discrepancy?	The new ambulatory template note has Alert & Orientatedx3 in the appropriate organ systems.
What about for consults/99214/99215, etc.?	Consultation codes (99241-99255) will remain under the 1995/97 rules and require (3 of 3) HPI, Exam & MDM. 99214/99215 will change for 2021 to be determined by either MDM or Total time.
The codes that this new program has for billing are not the same as the NH/Rehab/AL codes, thus do the new guidelines apply to them?	No, NH, AL, Rehab and Inpatient service codes have not changed for 2021. 1995/1997 coding rules will still apply. The *only* visits changing for 2021 are new/established clinic visits (99202-99215)
Do you anticipate that changes will be coming for nursing home & assisted living facilities?	CMS will assess the changes - we do anticipate the Inpatient, ED and SNF/Assisted Living services changing in likely similar ways in the years to come.
Can the new notes be copied forward and edited with new info for that visit?	One may copy forward. As per preexisting copy forward policy, documentation should reflect edits/updates to reason for visit and Assessment/Plan.
If we note that our time has exceeded the limit for the code, but we forget to add the 99417, will coders add it for us?	Yes, Coding will be reviewing your notes and if applicable, will assign the additional code.

If I do not “done” a coding deficiency, will it be marked as an incomplete charge?	It is preferred that the provider ‘done’ or ‘decline’ a deficiency – otherwise, the coder needs to wait 5 business days. If the provider has not done/decline – the coder should close it and submit the charge supported by documentation.
I’ve been told in the past that one cannot take “full value” of an additional E/M code with a well child or non-Medicare annual physical because some of the work that gets you the E/M codes is included in preventative care. Is that still true?	The rules are complex. Expected components of a physical cannot be used towards an additional E/M. Coding will assist in extracting the prev med visit and the E/M components.
Have video/phone visit length requirements/coding changed from last year?	Currently, payers look to the E/M (99202-99215) total time requirements for video/phone visits, which did change as of 2021. If the payer requires a telephone code (99441-43) time requirements have not changed.
In WCC/split bill, which diagnosis is selected as primary?	The WCC code will have a preventative dx attached as primary. The additional E/M will have the primary diagnosis of the conditions evaluated to support the E/M. Coding will assist to align appropriately.
Have transitional care management (TCM) codes 99495-96 changed?	**UPDATE:** TCM codes are based on MDM, which are based on the 1995/1997 guidelines.
Miscellaneous	
What is the difference in H&P and Physicals?	H&P: reference history and physical visits – i.e., patient needing clearance for surgery or inpatient admission Physicals: reference preventative medicine visits – i.e., Well Child Check, Annual Physical, Annual Wellness Visit, etc.
We are wondering if this is effective for behavioral health patients as well?	Yes, if you are currently billing E/M services 99202-99215. The changes do not affect psychotherapy codes.
Have/will Scribes get any education on appropriate documentation?	Scribes have been invited to all educational sessions. We will reach out to the CC and Carris Scribe areas to ensure they have this information.
Are telephone wRVUs increasing with the 2021 changes?	Not to our knowledge.

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use in conjunction with	*Do NOT Report with
+99354	*F2F only	30 minutes (Beyond listed typical time)	90837, 90847,99241-99245, 99324-99337,99341-99350, 99483	99202-99205, 99212-99215, 99415, 99416, 99417
+99355	*F2F only	Each Addt'l 15 min (Beyond 99354)	99354	99202-99205, 99212-99215, 99415, 99416, 99417
99358 (not an add on code)	Non F2F only Must relate to an Inpatient and other outpatient services other than 99202-99215	30 minutes	Must relate to a service where F2F care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99205-99205, 99212-99215, 99417 on same date of service
+99359	Non F2F only	Each Addt'l 15 min (Beyond 99358)	99358	99205-99205, 99212-99215, 99417 on same date of service
+99417	F2F and/or Non-F2F	**Reported with 99205** (75 min or more) **Reported with 99215** (55 min or more) ***(Total time on the date of encounter)***	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416
F2F=Face to Face				
One cannot bill a telephone call (99441-99443) code the following day as the rules for telephone calls specifically state:				
Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to a patient, not originating from a related E/M service provided within the **previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment**				