Update 2021:

Outpatient E/M Documentation & Coding

Provider Documentation Education

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Brief Goals for Today

- **Basics** for Outpt E/M changes for 2021.
- Strategies for improving **MDM** documentation.
- **Time-based** outpt billing changes.
- Tools and **Resources** for further help.

Outpt CMS E/M Changes – Jan 1, 2021

- Outpatient E/M for New and Established Office Visits now emphasize:
  - **Medical Decision Making (MDM)**

  Or
  - **Time spent managing/coordinating on day of service**.

What type of E/M visits are affected?

Affected

- New Pt Office Visits (99202-99205)
- Est Pt Office Visits (99212 -99215)

Includes Urgent Care.

Not Affected

(Stays the same)

- Consultation
  (Outpt-Initial if not Medicare; Inpt)
- Emergency Department
- Inpatient visits

New Patient Office Visits
2021 E/M Codes 99202-99205

CODE*	(Level)	History/Exam	MDM	Total Minutes
99202	2	Medically appropriate history and/or examination	Straightforward	15-29
99203	3		Low	30-44
99204	4		Moderate	45-59
99205	5		High	60-74

* Note there will no longer be a 99201

https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx

Established Patient Office Visits
2021 E/M Codes 99212-99215

CODE*	(Level)	History/Exam	MDM	Total Minutes
99212	2	Medically appropriate history and/or examination	Straightforward	10-19
99213	3		Low	20-29
99214	4		Moderate	30-39
99215	5		High	40-54

*99211: Office or other outpatient visit for eval and management of Established Patient, that may not require presence of physician or qualified health professional. Problems are minimal.

https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx

Updates are Clinically Intuitive

MDM

- Always been part of coding outpt & inpt notes.
- New coding: emphasizes MDM for outpt notes.
- Documenting HPI, ROS, Past Hx and PE – just what's medically appropriate.

OR

Time-based

- Now: Can bill for time for face-to-face **and** non-face-to-face time.
  - *Previously: only counted if >50% face-to-face time spend counseling.*
- Time spent MUST be on same date of encounter.

Medical Decision Making

CODE*	Level of MDM	Number and Complexity of Problems	Amount and Complexity of Data Review	Risk of Complications Related to Pt Management
99202 99212	Straightforward	Minimal	Minimal/None	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

*For definitions see: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

MDM Coding Tip Sheet: To guide E/M level for New or Established Outpatient Encounters. Effective Jan 1, 2021

Code	Level of MDM (Based on 2/3 MDM Elements)	Elements of Medical Decision Making (MDM)		
		Number and Complexity of Problems	Amount and Complexity of Data Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3.	Risk of Complications and/or Morbidity/Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor	Minimal or None	**Minimal** risk of morbidity from additional diagnostic testing or treatment.

99203
99213
	Low	Low
		• ≥ 2 self-limited or minor;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited (1 of 2 categories required)
			Category 1: Tests & Documents
			• **Any combination of the following 2:**
			  • Review of prior external note(s) from each unique source*
			  • Review the results of each unique test*
			  • Ordering each unique test*
			Category 2: Historians
			• Assessment requires independent historian(s).
			  • Pt is a minor
			  • Pt is incapacitated/ incompetent adult.
				Low risk of morbidity from additional diagnostic testing or treatment.

99204
99214
	Moderate	Moderate
		• ≥ 1 chronic illness with exacerbation, progression, or side-effects of treatment;
		or
		• ≥ 2 stable chronic illnesses;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury.
			Moderate (1 of 3 categories required)
			Category 1: Tests, Documents, or Historians
			• **Any combination of the following 3:**
			  • Review of prior external note(s) from each unique source*
			  • Review the results of each unique test*
			  • Ordering each unique test*
			  • Requires independent historian.
			Category 2: Independent interpretation of tests
			  • Independent interpretation of test performed by another physician/qualified health professional (not separately reported).
			Category 3: Discussion w/external consultant
			  • Discussion w/external consultant regarding management or test interpretation
				Moderate risk of morbidity from additional diagnostic testing or treatment.
				
				Examples:
				- Prescription drug management.
				- Decision on minor surgery
				- Decision on major elective surgery
				- Diagnosis or treatment significantly limited by social determinants of health.

99205 99215	High	• ≥ 1 chronic illness 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 (2 of 3 categories as noted above are required)	**High** risk of morbidity from additional diagnostic testing or treatment. Examples: -Drug therapy requiring intensive monitoring. -Decision on major elective surgery w/pt -Decision on emergency major surgery -Decision to hospitalize -Decision not to resuscitate

CODE*	Level of MDM	Number and Complexity of Problems*	
99202 99212	Straightforward	1 Self-limited or minor problem	(Self-limited)
99203 99213	Low	2 or more Self-limited minor problem Or 1 Stable Chronic illness (Htn); Or 1 acute; uncomplicated illness or injury.	(Stable, Uncomplicated, Single Problem)
99204 99214	Moderate	1 or more chronic illnesses with exacerbation, progression, or side effect of treatment; Or 2 or more stable chronic illnesses; Or 1 acute illness with systemic symptoms; Or 1 acute complicated injury.	(Multiple Problems or Significantly ill)
99205 99215	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.	(Very Ill)

*For definitions see: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Straightforward	Minimal • 1 self-limited or minor
Low	Low • ≥ 2 self-limited or minor; **or** • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness or injury
Moderate	Moderate • ≥ 1 chronic illness with exacerbation, progression, or side-effects of treatment; **or** • ≥ 2 stable chronic illnesses; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury.
High	• ≥ 1 chronic illness 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.

MDM: Number and Complexity of Problems- comments

- The provider must be actively addressing the problem(s) at time of visit.
  - Existing on “Problem List”- not counted.
- “Self-limited or minor” – would have gotten better on its own without visit.
- “Stable” – dependent on treatment goals of the pt. If med needs adjustment b/c goal not reached, not stable.

CODE*	Level of MDM	Amount and Complexity of Data Review
99202 99212	Strfwd	Minimal or None
99203 99213	Low	**(Must meet 1 of 2 categories)** **Category 1:** Tests and Documents • **Any combination of 2 from the following:** 1) Review of prior external notes from each unique source* (can't be own notes); **2)** Review of result(s) of each unique test*; **3)** Ordering of each unique test*. Or **Category 2**: Assessment Requiring an independent historian (pt is unable to provide own history)

*For definitions see: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

CODE*	Level of MDM	Amount and Complexity of Data Review
99204 99214	Moderate	**(Must meet 1 out of 3 categories)** **Category 1:** Tests and Documents--Any combination of 3 from the following: • Review of prior external notes from each unique source* (can't be own notes); • Review of result(s) of each unique test*; • Ordering of each unique test*. • Assessment requiring independent historian Or **Category 2**: Independent interpretations of tests. Example the treating provider independently reviews an imaging and provides their analysis. Or **Category 3:** Discussion of management or test interpretation • Discussion of management or interpretation with another physician or other qualified health personnel.
99205 99215	Extensive	(Must meet 2 out of 3 categories) Categories noted above

*For definitions see: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Amount and Complexity of Data Reviewed

- Minors &Incompetent/Incapacitated
  - Always document there was another historian.
- With data lab review - providers should make diagnoses, not simply have the lab values in the note.
  - For example, serum sodium is 153 (not a diagnosis); write hypernatremia.
- Discussion with a specialist regarding the case = complexity.
  - Document it.

Imaging

- Viewing images? Document:

  "I personally reviewed the imaging on the PACS…"

  Coders will give extra credit for MDM

- Reviewing report? Counts for MDM, not as much impact as viewing.

  "I reviewed the CT with the patient."

  Coders will presume only report reviewed and not the image.

CODE*	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management	
99202 99212	Strfwd	Minimal risk of morbidity from additional diagnostic testing or treatment	Including no treatment
99203 99213	Low	Low risk of morbidity from additional testing or treatment	minimal consent discussion
99204 99214	Mod	Moderate risk of morbidity Examples only: Prescription drug management; • Decision regarding minor surgery with pt or identified procedure risk factors; • Decision regarding major elective surgery without identified patient or procedure risk factors; • Diagnosis or treatment significantly limited by social determinants of health.	Would typically review with pt/surrogate, obtain consent and monitor; or there are complex social factors in management.
99205 99215	High	High risk of morbidity Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding major elective surgery with identified pt or procedure risk factors; • Decision regarding emergency major surgery; • Decision regarding hospitalization. Decision to not resuscitate or de-escalate b/c of poor prognosis. *For definitions see: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf	Need to discuss or manage therapy with significant complications, needing close monitoring.

New Patient Office Visits
2021 E/M Codes 99202-99205

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99202	2	Medically appropriate history and/or examination	Straightforward	15-29
99203	3		Low	30-44
99204	4		Moderate	45-59
99205	5		High	60-74

15

30

45

60

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Established Patient Office Visits
2021 E/M Codes 99212-99215

CODE*	(Level)	History/Exam	MDM	Total Minutes
99212	2	Medically appropriate history and/or examination	Straightforward	10-19
99213	3		Low	20-29
99214	4		Moderate	30-39
99215	5		High	40-54

10
20
30
40

*99211: Office or other outpatient visit for eval and management of Established Patient, that may not require presence of physician or qualified health professional. Problems are minimal.

https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx

Time-based Coding

- Total time **on date of encounter**
- Face-to-face and non-face-to-face time **you** spent
- Does not include time by other people
- Document the time spent

Time-based Coding

- Total time **on date of encounter**.
- Includes both face-to-face and non-face-to-face time personally spent by the billing provider.
- The time spent personally by the provider on the total care of the patient on day of service.
- The time billed does not include time in activities performed by clinical staff/residents/students (Provider did not invest time personally).
- The appropriate time should be documented when it is used as the basis for code selection.

Billing Provider time includes:

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

Example - MDM

Clinic Note × List

Tahoma | Size

Chief Complaint:
Hypertension

History of Present Illness:
Test Test is a 18 year old female who has Trisomy 21 is here for follow up of hypertension and right solitary kidney. The patient is accompanied by her mother, Kathy, who provides the interval history....

Review of Systems:
No complaints of dizziness, no cough, nose bleeds or headaches.

Physical Exam:

Vitals & Measurements
Temperature: 97.9
Systolic BP Sitting: 122
Diastolic BP Sitting: 76
Dosing Weight: 206.0 kg
Height: 64.0 cm
Body Mass Index: 502.93

The patient is in no distress, Lungs clear to auscultation bilaterally, Heart regular rate and rhythm, abdomen soft, no pretibial edema.

Assessment/Plan:
Test Test is a 18 year old female who present for her follow up of her hypertension due to obesity from excessive caloric intake.

Imaging review: I personally reviewed the patients kidney ultrasound on the PACS workstation. The solitary right kidney is compensatorily hypertrophied at 12 cm, renal parenchymal thickness and echotexture are normal. No hydronephrosis. Final ultrasound read is pending.

Laboratory review: The patient has clinically insignificant hypernatremia, no evidence of hyperkalemia. Creatinine is normal. Serum albumin and transaminases are normal. The patient is vitamin D deficient. Urinalysis is normal without proteinuria.

Medical Decision Making: The patient's blood pressure appears to be adequately controlled on her current dose of lisinopril. Laboratory studies obtained today demonstrate no evidence of medication side effects. Her solitary kidney is compensatorily hypertrophied. Screening CKD labs demonstrate no evidence of kidney impairment or proteinuria. Incidental finding of vitamin D deficiency.

Face-to-face counselling/Coordination of care: Discussion with the patient's mother regarding need discuss transition of care to an adult provider. Recommended that the family contact social work to help coordinate the need for guardianship. Reminded family the need for NSAID avoidance, and to have the patient stay well-hydrated.

Recommendations:
1. Continue Lisinopril as prescribed, sent refills electronically.
2. Vitamin D deficiency- rx'd cholecalciferol 4000 int units q Day.
3. Family to work on transition planning, and continue to work on health life style goals.
4. Follow up in 6 months to reassess weight/BP and transition planning.

Allergies:
sulfADIAZINE (rash)

Medications:
Lisinopril 10mg po qDay

Problem List:
No qualifying data available.

Past Medical History:

Past Surgical History:

Social History:
Smoking Status - 08/13/2020
Declines to answer (current status unknown)

Family History:

Health Maintenance:
Health Maintenance
Pending (in the next year)
OverDue
Depression Screening due 07/25/20 and every 1 yr(s)
Influenza Vaccine due 07/31/20 and every 1 yr(s)
Due
Advance Directives due 10/21/20 and every 1 yr(s)
Alcohol Screening due 10/21/20 and every 1 yr(s)
Family History Required due 10/21/20 and every 1 yr(s)
HIV Infection Screening due 10/21/20 One-time only

ALTERNATIVE MDM EXAMPLE:

A/P: 18y/o female w/trisomy 21 w/hypertension and right solitary kidney here for f/u with history from mother

#Hypertension, chronic, controlled
#w/solitary right kidney
#CKD stage 1
- BP in good range on Lisinopril, tolerating med
- Reviewed renal US report w/pt today – without hydronephrosis or acute concerns

(*or independently reviewed the renal US on PACS and found …include 3 elements interpretation)
- reviewed labs w/pt today, with hypernatremia without hyperkalemia, normal Cr. u/a normal without proteinuria. +vit D def.
- Continue Lisinopril at same dose, rx refilled
- Counseled avoid NSAIDs and hydration

#vitamin D deficiency
- Reviewed lab result w/pt, counseled risks/benefits of rx, plan start vit D3 at 4,000iu daily

#obesity – counseled diet/lifestyle modifications and goals w/parents (*could specify goals)
- f/u 6mo for weight/BP recheck

Example – Using Time

Chief Complaint:
New Pt Transfer from Oregon

History of Present Illness:
Test 1 Test is a 3 year old male who present to establish care at UNM with a prior history of chronic HSP previously followed by pediatric nephrology at OHSU. Both parents are present at today's visit who provide the interval history since moving to New Mexico 6 months ago. The parents have copies of the last clinic notes, laboratory studies, and kidney biopsy reports. Records have also been scanned into powerchart and were reviewed prior to clinic.

The parents state that the patient was initial dx as UTI one year ago. The "infections" at that time were not associated with fevers, dysuria, or other symptoms. Patient had developed rash on his lower legs and swelling. Parents sought a second opinion and was referred to a pediatric nephrologist where he had eventually undergone kidney bx. Pt was treated with a course of corticosteroids and recently weaned off prednisone and enalapril prior to moving to NM. Pt currently well and family inquiring about the safety of the flu shot in light of his kidney condition.

Outside record review: Pt kidney biopsy from 10/10/2019 demonstrated a mesangiopriliferative glomerulonephritis affecting 5 of 15 glomeruli, no acute crescents, minimal tubulointerstitial fibrosis. Predominant IgA staining. Pt last labs from 3/19/2020 demonstrated normal serum creatinine of 0.35, serum albumin of 3.5; and urinalysis with neg protein, 2+ blood and urine protein/creatinine ratio of 0.4

Review of Systems:
Pt with no recent fever, No cough or recent URI symptoms, No complaints of abdominal pain, normal stools, no gross hematuria.

Physical Exam:

Vitals & Measurements
T- 36.7, HR 101, BP 103/57 Wt: 17 kg

In general no apparent distress, HEENT: Eyes without periorbital edema, Nares clear, OP clear, Lungs: CTA bilaterally, Cor: reg rate and rhythm, Abdomen soft, NT, ND; + BS; Extremities: Pt with evidence of painless swelling in the right ankle; no peripheral rash, no edema.

Assessment/Plan:
Test 1 Test is a 3 year old male with a prior history of IgA nephropathy s/p treatment with corticosteroids and ACE inhibition. Pt now off therapy. No evidence of recent relapse. Pt remains in remission.

Face-to-face counselling: Discussed natural history of IgA nephropathy. Also discussed the risks and benefits of the flu vaccine. provided counselling on good handwashing, avoidince of touching the face. Indicated that prevention of active flui infection with vaccine would likely prevent relapse of IgA vasculitis. Other questions answered about diet and "long-term" side effects of his prior treatment with steroids. Discussed concerns of swollen right ankle.

Plan:
1. Follow up labs: Chem 10, Albumin, CBCwidff, CRP, ESR, UA and urine protein/creatinine.
2. Flu shot today.
3. Obtain biopsy slides from OHSU, and send to Arakana for review.
5. Referral to pediatric Rheumatology.

Post clinic called on-call pediatric rheumatology, made arrangement for clinic appointment at next available. Ordered right ankle films for tomorrow. Labs reviewed and demonstrated normal electrolyts, CBCwdiff, Albumin 3.8. no proteinuria and urine protein/createinin = 0.13 (normal).
Called parents to discuss lab results, need for Xray and referral to pediatric rheumatology clinic.

Time spent review outside records prior to clinic 10 min, time in clinic 35 min, post clinic coordination of care review of labs and call to parents 25 min, documentation in EMR 12 min.

Allergies:
aspirin

Medications:
No Discharge Medications

Problem List:
Hypertension
Psychosis
Psychosocial problem

Past Medical History:
RSV bronchiolitis

Past Surgical History:
Kidney biopsy 10/10/2019- OHSU

Social History:
Lives with parents in Belen, NM

Family History:
No family history of renal disease, dialysis or

Health Maintenance:
Health Maintenance
Pending (in the next year)
OverDue
Influenza Vaccine due 07/31/20 and
Due
Influenza Vaccine due 08/28/20 and
Satisfied (in the past 1 year)
There are no satisfied recommendations wi

Immunizations:

Time statements:

- Ideal - Narrative on what was discussed; and specific activities performed on behalf of patient care. Break down of how time was spent.
- Also acceptable: "Total time spent on review of records, face-to-face visit, and review of results: 82 minutes" Supporting narrative in HPI and A/P makes the summary of minutes work.
- Currently working on smart phrase in Cerner.

Prolonged Services

New Patient Total Outpatient Office Time (use with 99205)	Code(s)
less than 89 minutes	Not reported separately
89-103 minutes	99205 x 1 and G2212 x 1
104-118 minutes	99205 x 1 and G2212 x 2
119 minutes or more	99205 x 1 and G2212 x 3+ for each add'l 15 minutes
Est Patient Total Outpatient Office Time (use with 99215)	**Code(s)**
than 69 minutes	Not reported separately
69-83 minutes	99215 x 1 and G2212 x 1
84-98 minutes	99215 x 1 and G2212 x 2
99 minutes or more	99215 x 1 and G2212 x 3+ for each add'l 15 minutes

New Code G2212 - Prolonged Services

- Prolonged office or other outpatient E/M service(s):
  - Only use with time-based coding
  - For each total 15 minutes beyond the total time of level 5 codes
  - On the date of the primary service;
- ONLY with 99205, 99215
  - *NOT* with 99354, 99355, 99358, 99359, 99415, 99416
- Only when visit time exceeds 15 minutes beyond level 5 visit:
  - **89+ minutes** for new patients
  - **69+ minutes** for established patients

New Patient Office Visits
Work RVU Comparisons 99202-99205

CODE*	(Level)	2020 wRVU	2021 wRVU
99202	2	0.93	0.93
99203	3	1.42	1.6
99204	4	2.43	2.60
99205	5	3.17	3.50

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Established Patient Office Visits Work RVU Comparisons 99212-99215

CODE*	(Level)	2020 wRVU	2021 wRVU
99211	1	0.18	0.18
99212	2	0.48	0.70
99213	3	0.97	1.30
99214	4	1.50	1.92
99215	5	2.11	2.80

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Strategies for Adopting New Approach

1. Continue usual workflow when seeing patients.
2. Document your work in review of information, and how info ties together for your decisions.
3. If time-based, document your coordination of care and/or counseling of the pts.
4. Identify illness categories of Low, Moderate, and High
5. Develop EMR templates for common conditions being seen in your practice.

MDM Coding Tip Sheet: To guide E/M level for New or Established Outpatient Encounters. Effective Jan 1, 2021

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		Number and Complexity of Problems	Amount and Complexity of Data Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3.	Risk of Complications and/or Morbidity/Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor	Minimal or None	**Minimal** risk of morbidity from additional diagnostic testing or treatment.

99203
99213
	Low	Low
		• ≥ 2 self-limited or minor;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited (1 of 2 categories required)
			Category 1: Tests & Documents
			• **Any combination of the following 2:**
			  • Review of prior external note(s) from each unique source*
			  • Review the results of each unique test*
			  • Ordering each unique test*
			Category 2: Historians
			• Assessment requires independent historian(s).
			  • Pt is a minor
			  • Pt is incapacitated/ incompetent adult.
				Low risk of morbidity from additional diagnostic testing or treatment.

99204
99214
	Moderate	Moderate
		• ≥ 1 chronic illness with exacerbation, progression, or side-effects of treatment;
		or
		• ≥ 2 stable chronic illnesses;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury.
			Moderate (1 of 3 categories required)
			Category 1: Tests, Documents, or Historians
			• **Any combination of the following 3:**
			  • Review of prior external note(s) from each unique source*
			  • Review the results of each unique test*
			  • Ordering each unique test*
			  • Requires independent historian.
			Category 2: Independent interpretation of tests
			  • Independent interpretation of test performed by another physician/qualified health professional (not separately reported).
			Category 3: Discussion w/external consultant
			  • Discussion w/external consultant regarding management or test interpretation
				Moderate risk of morbidity from additional diagnostic testing or treatment.
				
				Examples:
				- Prescription drug management.
				- Decision on minor surgery
				- Decision on major elective surgery
				- Diagnosis or treatment significantly limited by social determinants of health.

99205 99215	High	• ≥ 1 chronic illness 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 (2 of 3 categories as noted above are required)	**High** risk of morbidity from additional diagnostic testing or treatment. Examples: -Drug therapy requiring intensive monitoring. -Decision on major elective surgery w/pt -Decision on emergency major surgery -Decision to hospitalize -Decision not to resuscitate

Summary

- Documentation standards for Outpatient New and Est Visits change on January 2021.
- Does not effect documentation requirements continue for other E/M services (those will be the same).
- Return to thinking “S.O.A.P note” approach that emphasizes medical decision making.
- Outpatient visits can be coded based on time spent by the billing provider including face-to-face and non-face-to-face time, including time spent for documentation (must be on date of encounter).
- Please use the MDM tipsheet to help with leveling the outpt visit.
- For questions, contact: **Ask_ClinicalDocumentation@salud.unm.edu**

Other Resources

Videos re: the E/M changes for 2021 are from the Chair and the Co-chair of the AMA committee responsible for developing the changes adopted by CMS. The videos are around 30 minutes each.

- **Coding for MDM:** Peter Hollman, MD works through MDM for a level of service. https://www.youtube.com/watch?v=4WIGCVLK-u0
- **Coding based on Time:** Barbara Levy, MD works through using time as a basis for the level of service: https://www.youtube.com/watch?v=FdyqEAvxt1k
- More extensive content from the AMA:

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf