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Preparing your practice for 2021 E/M changes

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CODING & DOCUMENTATION

SAVE TO MY DASHBOARD ★

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The American Medical Association (AMA), in conjunction with the Centers for Medicare & Medicaid Services (CMS), announced guideline and code descriptor changes for E/M services to be enacted on Jan. 1, 2021. The changes only pertain to office or other outpatient E/M codes (99202-99215); all other E/M services will remain unchanged.¹

For these services, code selection will be based on medical decision making (MDM) or total time on the date of the encounter. Medically appropriate history and/or examination will not be part of the basis for code selection; however, history and exam findings that are pertinent to the visit should still be documented. In addition to this major change, the descriptions and guidelines surrounding MDM and time have been redefined.

Let's start by looking at the stated goals and resolutions for these changes (Table 1).

TABLE 1. GOALS AND RESOLUTIONS FOR E/M UPDATES

Goal	Resolution
Decrease administrative burden	Remove scoring for history and exam. Code the way providers think
Decrease need for audits	More details in CPT code to promote consistency in coding and auditing
Decrease unnecessary documentation not needed for patient care	Eliminate history and exam scoring. Promote higher-level activities of MDM
Ensure payment for E/M is resource-based; has no direct goal for payment redistribution between specialties	Use current MDM criteria as a basis for changes. Use CMS and educational/audit tools to reduce likelihood of change in patterns

Medical decision making

The current CMS table of risk and other Medicare Administrative Contractor (MAC) tools were used as a foundation to create the new guidelines for MDM. This allows for minimal disruption in coding

as a foundation to create the new guidelines for MDM. This allows for minimal disruption in coding patterns and reduces variation between MACs and other payers. In addition, these changes align criteria with clinically intuitive concepts.

The E/M guidelines for 2021 include various definitions for terms that appear in the new MDM table (**Available online at** bit.ly/3iqiQ0q). For example, an acute, complicated injury is defined as:

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.²

Before choosing a level of service, it is imperative to understand all terms defined.

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

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

However, each element is defined differently. The level of MDM required ranges upward with the levels of service for codes 99202 to 99205 for new patients, and 99211 to 99215 for established patients. This is unchanged from current levels of MDM, though code 99201 has been deleted, as it is no longer needed in the future framework. For code 99211, the concept of the level of MDM does not apply.

Total time

As stated, MDM or time can be used to choose a level of service for office and other outpatient E/M services beginning Jan. 1, 2021. For these services, time may be used to select a code level whether counseling and/or coordination of care dominates the services. Revisions for billing using time address ambiguity surrounding exact increments of time and allowing for the most accurate elements to be considered for code selection.

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

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

- independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

The appropriate time must be documented in the medical record when it is used as the basis for code selection. For shared or split visits, both providers' individual time is summed to define the total time. If the patient is seen jointly by both providers at the same time, only the time of one individual should be counted. Time requirements are defined in Table 2.

TABLE 2. TIME REQUIREMENTS FOR NEW PATIENT AND ESTABLISHED PATIENT CODES 99202-99205, 99211-99215

New patient code	Total time (2021)	Established patient code	Total time (2021)
99202	15-29 minutes	99211	N/A
99203	30-44 minutes	99212	10-19 minutes
99204	45-59 minutes	99213	20-29 minutes
99205	60-74 minutes	99214	30-39 minutes
		99215	40-54 minutes

Prolonged services

For office or other outpatient services, a new prolonged services code will be established to report with codes 99205 and 99215. The following guidelines will apply:

- Only to be used when the office or other outpatient service has been selected using time alone and only after the highest-level service has been exceeded (i.e., 99205, 99215)
- 15 minutes of additional time must have been attained; do not report prolonged services for an additional time of less than 15 minutes
- Time spent performing separately reported services is not counted in the E/M of prolonged services time
- Prolonged total time may include combined time with and without direct patient contact provided by the provider on the date of office or other outpatient services.

This code has not yet been released by the AMA.

KEY TAKEAWAYS

- Changes apply only to office and other outpatient E/M services (99202-99215)
- CPT code 99201 will be deleted due to low utilization
- Providers will select the E/M code based only on the level of medical decision making (MDM) or total time
- History and examination will no longer be significant in determining the level of service
- Total time is defined as “total time spent on the day of the encounter”
- Revisions to the MDM elements for codes 99202–99215:
- “Number of Diagnoses or Management Options” will change to “Number and Complexity of Problems Addressed”

– “A patient with a diagnosis of chronic obstructive pulmonary disease (COPD) who is being treated with a long-acting beta-agonist (LABA) and an inhaled corticosteroid (ICS) is being seen for a follow-up visit. The patient is stable on the current treatment and has no new symptoms. The provider will continue the current treatment and will discuss the importance of adherence to the treatment plan. The provider will also discuss the importance of avoiding triggers and will provide education on the use of the inhaler. The provider will also discuss the importance of avoiding triggers and will provide education on the use of the inhaler. The provider will also discuss the importance of avoiding triggers and will provide education on the use of the inhaler.”

- “Amount and/or Complexity of Data to be Reviewed” will change to “Amount and/or Complexity of Data to be Reviewed and Analyzed”
- “Risk of Complications and/or Morbidity or Mortality” will change to “Risk of Complications and/or Morbidity or Mortality of Patient Management”

Preparing for E/M changes

The new guidelines may appear simpler and more flexible but be sure to prepare for this transition. It's important to remember the new guidelines only apply to the office or other outpatient codes (99202 to 99215). For other services, such as inpatient, observation, emergency department and all other E/M services, the 1995 and 1997 guidelines will remain unchanged.

NOTES:

1. AMA. “CPT® Evaluation and Management.” Nov. 1, 2019. Available from: bit.ly/3fhyYyY.
2. AMA. “CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes.” Available from: bit.ly/30ci94a.
3. CMS. “Evaluation and Management Services Guide.” January 2020. Available from: go.cms.gov/3fc7RoS.

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