

2021 E&M Changes: Avoiding pitfalls with the right technology-enabled strategy

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Extensive revisions aim to prioritize patient care information, resource-based reimbursement, and lessening the need for audits.

As part of its goal to reduce administrative burdens on physicians, the Centers for Medicare and Medicaid Services (CMS) has introduced a final rule for Evaluation and Management (E&M) coding changes that go into effect in January 2021. Extensive revisions to the guidelines aim to minimize the amount of time physicians spend on documenting visits—prioritizing the documentation of information pertinent to patient care, creating resource-based reimbursement, and achieving less need for audits.

The move reflects a positive step forward in terms of patient care and administrative burden, yet documentation readiness hinges on a clear understanding of how the changes impact current practices. Rather than focusing on a checklist of conditions for reimbursement, documentation must prioritize a holistic view of patient care to align with the framework supporting E&M codes going forward.

The best strategies for ensuring compliance make use of ongoing monitoring and use of prospective and retrospective auditing. Coupled with the right technology-enabled workflow, these tactics can go along way toward helping the average resource-strapped provider organization avoid pitfalls and maximize reimbursement.

E&M Changes: A Bird's Eye View

While the American Medical Association (AMA) provides a [comprehensive view of the changes](#), key highlights that coding teams need to be aware of include:

- **Eliminating history & physical (H&P) exam as element for code selection**
 - While H&Ps can still be calculated as part of the total time of a visit, they no longer serve as the basis for what level of service a clinician should choose for that visit.
- **Medical decision making (MDM) or total time as basis for documentation and code selection**
 - With the changes, MDM or “total time” is now the basis for coding, with the goal of better recognizing the work involved in services that are not performed

face-to-face, such as care coordination. “Total time” is now defined as the time spent with a patient that is greater than 15 minutes and includes such activities as reviewing tests, obtaining and reviewing histories, performing exams, ordering medications, tests or procedures, and counseling patients and caregivers. MDM is now based on the number and complexity of the problems addressed in an encounter, the amount of complexity associated with patient data that are analyzed, and the risk of complications.

- **Changing MDM criteria to focus on tasks that affect the management of a patient’s condition**
 - As part of the changes to MDM criteria, ambiguous terms such as “mild” were removed, and terms such as “acute” or “chronic illness with systemic symptoms” are now more clearly defined.
- **Eliminating CPT code 99201**
 - CPT code 99201 is being eliminated since 99201 and 99202 are both straightforward and differentiated by only history and exam elements.
- **Creation of shorter prolonged service codes**
 - Since time is the primary basis for code selection, when the visit exceeds 75 minutes there is an additional code to capture time in 15-minute increments when time exceeds the levels in 99205 and 99215. It can only be used with those codes and when time is the basis for code selection.

A New Perspective for Coders and Auditors

The 2021 E&M coding changes will usher in a new way of thinking in terms of auditing practices. The focus now shifts to a holistic view of the patient, the problem, and the risks.

For example, consider how age may have impacted care planning in the past. Going forward, no two patients should have the same treatment plan based on age. Providers will need to document a clear understanding of the problem— for example what kind of acuity exists and/or whether there any chronic conditions or a differential diagnosis. In terms of risk, documentation should answer questions such as: “What are the risks of having a treatment plan versus not having one?” and “What social conditions exist that impact outcomes?”

With these shifts in focus, providers face revenue integrity challenges and should prepare for these in a proactive manner. Morbidity and mortality levels will still drive MDM, and accurate diagnosis coding and level compatibility are critical. Consequently, providers should avoid non-specific codes and include comorbidities.

Documentation must support the time spent with a patient to maximize reimbursement. Insights into the patient risks, complex conditions and acuity will be paramount to support optimal revenue capture. In addition, complexity and “leveling” driven by MDM will help providers support the “why” for poor outcomes when they occur.

The financial impact of over/under coding cannot be overstated. E&M codes 99211-99205 represent 40% of total revenue on average. Thus, auditing and denial monitoring will be critical to ensure no revenue is being left behind.

The [AMA offers 10 tips](#) (see image at right) to help practices prepare. Working in tandem with these tactics, the best strategies draw on the power of advanced analytics, automation, and artificial intelligence tools to improve collaboration between coding, billing, and compliance teams. Solutions exist now that can extract insights from claims in near real-time and detect anomalies, fueling new and expanded insights to advance process improvement initiatives around E&M changes. And, not surprisingly, the value proposition of these tools is growing rapidly as healthcare organizations try to maximize reimbursements against current revenue shortfalls associated with the COVID-19 pandemic and rapidly changing regulations.

Healthcare stakeholders stand to benefit in significant ways with current movements aimed at achieving patient-centered care. Changes to E&M coding reflect this progress by reducing administrative burden for providers and helping them focus on their primary priority: care delivery. Providers who embrace this shift and prepare for it with the right technology-enabled workflows will be best positioned for success.