2021 E/M Changes—Are You Ready?

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On Jan. 1, 2021 CPT E/M coding will undergo the largest change since the Centers for Medicare and Medicaid Services (CMS) introduced the 1997 documentation guidelines for E/M services.

These changes apply to face-to-face encounters with physicians or other qualified healthcare providers in the ambulatory office setting and include deletion of E/M code 99201 and changes to 99202-99215. The code-level decision will be based on MDM or total time spent on the encounter, with the physical exam and history being excluded as a factor determining the level of service.

A new prolonged service code has been created to be utilized in conjunction with total time, after the highest level has been met.

The Medicare Physician Fee Schedule references specific services and CPT codes related to telehealth that will be included on a permanent and temporary basis as well as codes that will not be included.

Minimizing Provider Burden

The guiding principles for the basis of these changes are to minimize provider burden as it relates to coding and documentation, ensure accuracy of E/M payments on a resource base perspective, addition and further expansion on definitions and guidelines and to reduce unnecessary documentation.

The previous guidelines did little to improve patient care and created extra work by physicians and other providers. In addition, many of the elements were populated by cut and paste which led to an unnecessary amount of errors.

This change works in harmony with the shift to the quadruple aim which in addition to improving the patient experience, population health and reducing costs, also improves the work experience of the providers. A perfect example of the expansion of definitions would be “time” or what is known as “total time” come 2021.

Currently, time is defined as “time spent in face-to-face with the patient and/or family.” Come 2021, time has been redefined to “total time”, which includes pre-, intra-, and post-time spent on an encounter. It is important to mention the time must occur on the same day as the encounter. Reviewing the chart the day prior to the visit will not count towards total time.

Breaking Down Medical Decision-Making

The medical decision-making has been broken down into four levels: straightforward, low, moderate, or high. The level is based upon the number and complexity of the problems addressed, the amount and complexity of the data to be reviewed and the risk of complication and /or morbidity or mortality associated with patient management.

Two out of the three elements must be met to fall into an MDM level. Something important to note is that these guidelines pertain to face-to-face encounters with physicians or other qualified healthcare providers in the ambulatory office setting except for code 99211, per E/M guidelines the level of MDM does not apply.

Impact on Revenue

These changes could potentially have a significant impact on revenue. Although there are proposed increases for RVUs, to keep budget neutral the conversion factor for 2021 will be decreasing.

Healthcare organizations committed to optimizing reimbursement through efficient and compliant coding/documentation practices must start preparing now by establishing a comprehensive approach to ongoing targeted education and improvement efforts related to their unique vulnerabilities.

The first step is to thoroughly review and understand the proposed changes and become familiar with the definitions. Another very important step is to review the guidelines outlined by the specific Medicare Administrative Contractor (MAC).

EHR templates should be updated to incorporate the changes, keeping in mind the changes apply for Medicare and not necessarily private payers. Also, periodic documentation reviews should be conducted for all practitioners within the practice to confirm each diagnosis submitted is supported by the documentation in the chart.

Preparing for Compliance

Now is the time to invest in audits and provider education programs to confirm practices are prepared for the upcoming financial impact and potential compliance risks.

The 2019 CERT report released by CMS revealed an overall 7.3 percent improper payment rate which exceeded $3 billion dollars in overall E/M coding. Over 60 percent of the errors were associated with insufficient or no documentation to support the billing, and almost 19 percent was medical necessity related.

It will be interesting to see if documentation will play as large a role with these 2021 changes. But we need to remember that these changes only apply to codes 99202-99215 ambulatory office visits. In addition, the OIG workplan referenced two phases of upcoming reviews with the goal of examining the use of telehealth services and the identification of program integrity risks to ensure appropriate use and reimbursement during the pandemic.

Beyond the initial assessment and education, Enjoin recommends clients to include a scalable system centered around efficient and compliant documentation and coding practices on their strategic roadmap. Including ongoing auditing, monitoring, education that is communicated peer-to-peer to promote rapid behavior change, tracking of KPIs and resource alignment to support these initiatives will ensure optimal readiness for the upcoming E/M changes and success into 2021 and beyond.

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