E/M changes take effect January 2021

October 5, 2020
Lisa Eramo, MA
Medical Economics Volume 97, Issue 14
Relevant Topics

Is your practice ready for the changes that are coming?

Good news for physicians tired of counting bullet points to assign an evaluation and management (E/M) level for an outpatient office visit: Per new AMA guidelines, it's going to be a whole lot simpler. As of January 1, 2021, physicians will select an E/M code based on total time spent on the date of the encounter *or* medical decision making (MDM)—whichever is most financially advantageous. An added bonus? Medicare payments for almost every E/M level will increase if proposed payment rates become final.

History and exam

Today, the three key components of an E/M level are history, exam, and MDM. In 2021, the history and exam must simply be medically appropriate. They aren't factored directly into the E/M level, nor must they adhere to a specific type (i.e., problem-focused, expanded problem-focused, detailed or comprehensive) says Cheryl Cyrus, RHIT, CPMA, quality assurance auditor at ComforceHealth, a health care business consulting company. This means streamlined documentation, fewer cumbersome requirements to remember and potentially more time spent on direct patient care, she adds.

"We're shifting back to the patient-provider relationship," says **James P. Fee, M.D., CCS,** CEO of Enjoin, a clinical documentation integrity company. These changes also reflect the AMA's desire to reduce physician burnout, a major component of which is documentation, he adds.

Still, physician documentation must accurately depict what occurred during the encounter, says Dreama Sloan-Kelly, M.D., CCS, president of Dr. Sloan-Kelly Consulting, a medical coding consulting company. "You still need to be covered in the event of a lawsuit or post-payment recoupment," she adds.

Although January 1 is several months away, experts say physicians must prepare now to ensure they understand precisely what is changing.

MDM

Current E/M guidelines require physicians to document one of the following four types of MDM: Straightforward, low complexity, moderate complexity, or high complexity. Each of these types is driven by a complicated point system derived from the number of diagnoses or treatment options, the amount and/or complexity of data reviewed, and the risk of complications and/or morbidity and mortality.

In 2021, these four types and drivers remain; however, physicians will use a "new and improved" MDM table that includes easy-to-understand requirements for each E/M level.

Other good news? Physicians get credit for the following:

Reviewing prior external notes from each unique source.

Reviewing the results of each unique test, including imaging, lab, psychometric or physiologic data.

Ordering each unique test.

Performing an assessment requiring an independent historian, defined by the AMA as an individual who supplements information provided by a patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia or psychosis) or because a confirmatory history is deemed necessary. Examples include a parent, guardian, surrogate, spouse or witness.

Independently interpreting a test performed by another physician or other qualified health care professional (QHP). Note that physicians and QHPs can only count this toward the MDM when they cannot report the service using another CPT code.

Discussing patient management or test interpretation with an external physician or other QHP (i.e., someone who is not in the same group or who is in a different specialty or subspecialty, a licensed professional practicing independently, a hospital, nursing facility or home health care agency), or another appropriate source (e.g., lawyer, parole officer, case manager or teacher). It does not include discussion with family or informal caregivers. Note that physicians and QHPs can only count this toward the MDM when they cannot report the service using another CPT code.

Fee provides this example of the new MDM table in action:

An established 69-year-old female patient presents to the office with her daughter. The patient has had stable depression for the last three years and a new onset of mild amnesia. She reports increased frustration in losing objects over the past few months. Her daughter confirms this and also says the patient frequently forgets names and isn't able to remember certain words during conversations. The patient denies any stressors, headaches, dizziness or problems with sleep or anger. The physician reviews recent TSH, CMP, and B12 labs; orders an MRI scan; and renews her anti-depression medication. The total duration of the visit is 25 minutes. This maps to a 99214 code based on the 2021 MDM table.

Physicians will be happy to hear that the new MDM table compensates them for complex MDM regardless of the time spent, as long as documentation supports medically necessary services, says Joe Rivet, Esq., CEMC**,** health care reimbursement attorney and coding compliance and audit expert. Currently, physicians are only compensated for a complex MDM when they also document a higher-level history or exam, he adds.

Time-based billing

Current E/M guidelines permit physicians to select an E/M level based on time only when they spend more than 50% of the visit counseling and/or coordinating care. In 2021, this requirement no longer applies. Instead, physicians can count the total time on the date of the encounter that may or may not include counseling and care coordination. Eligible time includes both the face-to-face and non-face-to-face time that the physician personally spends before, during and after the visit on that same day. Specific examples include:

Care coordination (when not separately reportable).

Counseling and educating the patient, family and/or caregiver.

Documenting clinical information in the electronic or other health record.

Independently interpreting results (when not separately reportable) and communicating results to the patient, family and/or caregiver.

Getting and/or reviewing separately obtained history.

Ordering medications, tests or procedures.

Performing a medically appropriate exam and/or evaluation.

Preparing to see the patient (e.g., reviewing tests).

Referring the patient to and communicating with other health care professionals (when not separately reportable).

“My fear is that physicians would forget to count some of this, so they need to make sure they review this list,” says **Kim Huey, MJ, CPC,** independent coding and reimbursement consultant. For example, physicians will be able to count the time they spend reviewing their state’s prescription drug monitoring program database when prescribing opioids.

7 E/M tips for 2021

Experts provide these seven tips to maintain compliance:

Avoid generic documentation

For example, if a physician obtains and reviews medical records, they should document what specific records, from whom, and for which treatment dates, says Jessica Miller, CPC, CPC-P, manager of professional coding at Ciox Health, a coding outsource company.

Describe diagnosis management

Simply selecting a diagnosis from a drop-down menu won’t be sufficient, says Huey. To get credit for diagnosis management in the new MDM table, physicians need to link each diagnosis with some type of action—a prescription, test, counseling or some other type of workup. Stating that the diagnosis is managed by another provider doesn’t count.

Tell the truth

Physicians aren’t required to itemize their time; however, their documentation must be an accurate depiction of services rendered, says Rivet. “I think itemizing starts to dilute the benefit of these new guidelines.” It could also open physicians up to scrutiny, he adds. For example, an auditor may question why it took 12 minutes to review a complete blood count.

However, be mindful of total time spent, says Rivet. For example, a physician sees 20 patients a day and documents that they spend 35 minutes per patient, totaling approximately 12 hours. This exceeds a typical eight-hour workday and could be a red flag for a payer, says Rivet.

Pay attention to when services are rendered

For example, a physician reviews lab results two days after an encounter. They can’t count this time toward the E/M level for the previous visit to which the labs pertain, says Rivet.

However, they may be able to report CPT codes 99358 and 99359 for prolonged services on a date other than the date of a face-to-face encounter, says Huey. The code description for 99358 states that it requires at least 60 minutes of services; however, per CPT rules, physicians may bill it once they have reached the midpoint (30 minutes). The code description for 99359 is for each additional 30 minutes, but physicians may bill it once they have reached 15 minutes. These codes must pertain to a face-to-face encounter that has occurred or will occur related to ongoing patient treatment, she adds.

There is also a new code that physicians may be able to report when they personally render prolonged services when billing 99205 and 99215 based on time: 99XXX. Physicians can report this code only when they spend at least 15 minutes of additional time on the date of the encounter with or without direct patient contact, says Huey. For 99205, this means more than 75 minutes. For 99215, it means more than 55 minutes.

Don't count services that are separately reportable

For example, if a physician performs an ECG interpretation and report, they can't apply that toward the E/M level because separate CPT codes exist (93000, 93005 and 93010), says Rivet.

Focus on social determinants of health (SDOH)

Capturing SDOH via ICD-10-CM diagnosis codes (e.g., Z59.0 for homelessness or Z59.5 for extreme poverty) may help support a more complex MDM and thus a higher-level E/M code, says Huey.

Always remember medical necessity

"You're not going to be able to justify 50 minutes on a patient with strep throat," says Sloan-Kelly.

Coding based on time or MDM—that is the question

Although optimal code assignment depends on the clinical circumstances of each scenario, Fee provides three important questions to consider when determining whether it is more advantageous to bill based on time or MDM:

Did the physician spend a considerable amount of time collecting the history or performing the exam? If so, it may be more advantageous to bill based on time.

Did the physician order several tests, speak with other physicians, or review complex data? If so, it may be more advantageous to bill based on MDM.

Is the patient medically complex (and do they support a level five E/M) but the physician went beyond the time threshold associated with the code? If so, it may be more advantageous to bill based on time because then the physician can also bill for prolonged services.

Five tips to prepare now

Do you want to prepare for the upcoming E/M changes, but are not sure how? Experts provide the following five tips:

Find a coding champion

Identify someone within the practice (e.g., a coder or practice manager) to champion the education effort, says Courtney Davenport, CCS, CCS-P, lead educator at Aquity Solutions, a coding outsource company. This person can attend webinars or take online courses and provide staff members with need-to-know education.

Contact payers

Ask whether they will adopt Medicare's changes. Some payers may continue to require code selection based on history, exam and MDM—or they may have specific requirements for individual codes, says Davenport.

Contact your EHR vendor

Ask what the vendor is doing to incorporate Medicare's changes. In particular, how will the EHR's code calculator incorporate time and MDM? How will the algorithm distinguish between outpatient office visits and other types of E/M services to which the 2021 changes don't apply?

Create an edit in your practice management system for 99XXX

Flag this code for manual review to ensure documentation supports services lasting 75 minutes or longer for new patients and 55 minutes or longer for established patients, says Miller.

Look at your current documentation

Does it support total time spent with patients as well as complex MDM? How does your current documentation map to various E/M levels using the new AMA guidelines? Now is the time to start documentation improvement efforts, if needed, says Huey.

"Remember that if it's not documented, it didn't happen," says Sloan-Kelly. "We went to school for a long time to get paid for what goes on in our minds."