

compliance

Preparing for E/M Changes to Outpatient Visits in 2021

BY TERI BEDARD BA, RT(R)(T), CPC

There is no argument that the Evaluation and Management (E/M) coding guidelines are in need of an update. The Centers for Medicare & Medicaid Services (CMS) has not updated E/M guidelines since 1997, with many providers and coders still following the 1995 guidelines. The use of electronic health records (EHRs) has prompted requests for updates. The ability to copy and paste documentation from another provider's visit notes and templates, which incorporate full documentation of the Review of Systems and Physical Exam, can result in documentation that is more complex than what took place during the encounter, creating issues not foreseen in 1995 or 1997.

It is not uncommon to see E/M visit notes run pages long and with no clear documentation of what is actually new and part of the patient encounter. Additionally, the ability to pull in statements from elsewhere in the EHR creates an issue with continuity, because these statements may be old or outdated and no longer pertain to the patient's current situation, resulting in contradictory documentation.

To solve this, CMS issued sweeping changes to the outpatient visit codes (99201-99215) in the CY 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS-1715-F, which go into effect Jan. 1, 2021, including collapsing visit levels from three individual reimbursed rates to one. Based on stakeholder feedback that showed that many disagreed with these reimbursement changes, the agency convened additional stakeholder meetings.

At the same time, the American Medical Association (AMA) convened a taskforce dedicated to updating the E/M CPT® codes. The AMA came up with guidelines based solely on medical decision-making (MDM) and time, as well as a dedicated prolonged services code specific to outpatient E/M visits. This meant that history and/or physical exam would no longer be used to determine the billable level. In an about-face, CMS did away with most, but not all, of the changes finalized in the CY2019 PFS rule and instead aligned with those established by the AMA. The agency's decision allows for consistency and continuity of coding and billing for all patients across all payers. Because most commercial and private payers follow AMA guidelines when using CPT codes, it made sense for CMS to do the same and not create more work and confusion for providers.

At the Resource-Based Relative Value Scale Symposium in Nov. 2019, the AMA provided updated definitions, time ranges, and MDM criteria for the outpatient E/M codes (99202-99215) that go into effect Jan. 1, 2021. The following is a summary of the changes for CY 2021 as we know them now, with the expectation that more updates and information may come during the CY 2021 CMS rulemaking cycle, as well as AMA coding updates for the CY 2021 CPT Manual. Beginning Jan. 1, 2021, practitioners will select either MDM or time on which to base their documentation and coding.

MDM Criteria

Providers who select MDM for documentation and coding can select from four levels, using these updated AMA parameters:

Straightforward

- Self-limited.
- Minimal or no data review and/or analyzed.
- Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk.)

Low

- Stable, uncomplicated, single problem.
- Two documents or independent historian.
- Low risk (i.e., very low risk of anything bad), minimal consent/discussion.

Moderate

- Multiple problems or significantly ill.
- Count: Three items between documents and independent historian, or interpret or confer.
- Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management.

High

- Very ill.
- Same concepts as Moderate.
- Discussion includes difficult topics or decisions for the very ill patient that could happen for which physician or other qualified healthcare professional will watch or monitor.

When counting the number and/or complexity of data reviewed and analyzed, three different categories are part of the MDM:

- Tests, documents, orders, or independent historian(s)—each unique test, order, or document is counted to meet a threshold number.

- Independent interpretation of tests is not reported separately.
- Discussion of management or test interpretation with external physician/ other qualified healthcare professional/ appropriate source (not reported separately).

Time-Based Criteria

Providers who use the time-based parameter must understand that more is required than just the mention of the total time spent on the date of the encounter. Documentation must include and support all of the work provided to which time was attributed on that date of service by the billing practitioner and may not include ancillary staff time. The AMA stresses that the following items are to be accounted for and/or included when using the time-based option:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate 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 patient/family/caregiver
- Care coordination (not reported separately).

The AMA also notes that practitioners should make every effort to improve their ability to document electronically in the EHR to avoid penalizing the patient and payer by charging a higher level of code billed.

Tables 1 and 2, page 10, list the updated definitions and time-based ranges for these new patient visits, **99202-99205**, and established patient visits, **99211-99215**. These will replace the current definitions and time ranges used in CY 2020.



CPT 99201 will be deleted effective Jan. 1, 2021.


Prolonged Services Code

A new prolonged services code will be available Jan. 1, 2021, that is only for use with level 5 outpatient visit codes, **99205** and **99215**. Updates will be made to codes **99358** and **99359** and providers will no longer be allowed to bill them in addition to the new and established outpatient visits. This new code has not been assigned a full CPT number, but the definition for the new **99xxx** code will be prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure that has been selected using total time), requiring total time with or without direct patient contact beyond the usual service on the date of the primary service; each 15 minutes (list separately in addition to codes 99205, 99215 for office or other outpatient E/M services).

Complexity Code

In 2021 CMS is adding a complexity code as an add-on to the E/M outpatient codes. This new code is a revision of language finalized in the CY 2019 MPFS final rule. At present not much is known about this code beyond the

definition, but more is expected at the time of the 2021 MPFS rulemaking cycle. Code **GPC1X** (the full Healthcare Common Procedure Coding System code will be released by CMS) is defined as visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established.)

As CY 2021 comes closer, more education and information from both the AMA and CMS is needed to help providers adjust to these new E/M guidelines. Both organizations understand the need for the change and are developing resources to assist providers and coders in understanding these big changes so that everyone starts off with their best foot forward in this new E/M landscape. 

Teri Bedard, BA, RT(R)(T), CPC, is director, Client Services at Coding Strategies, Inc., Powder Springs, Ga., and Revenue Cycle, Inc., Cedar Park, Tex.

Table 1. New Patient Visit Code Updates for 2021

CPT CODE	DEFINITION	TOTAL TIME IN MINUTES ON DATE OF ENCOUNTER
99201	Deleted for 2021	N/A
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making.	15-29
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision-making.	30-44
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making.	45-59
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision-making.	60-74

Table 2. Established Patient Visit Code Updates for 2021

CPT CODE	DEFINITION	TOTAL TIME IN MINUTES ON DATE OF ENCOUNTER
99211	Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal.	No time is part of this code in 2021
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making.	10-19
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision-making.	20-29
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making.	30-39
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision-making.	40-54