Already Looking Forward to 2021—and (Hopefully) Smoother Sailing with E/M Coding

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On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) confirmed with the final rule for 2020 that they have accepted all of the American Medical Associations (AMA) recommendations for coding of office and outpatient evaluation and management (E/M) services starting in 2021.

This will offer some documentation relief for providers who have been held to dated 1995 and 1997 guidelines that were written before the use of electronic medical records. However, these guidelines should still be used for any code sets that require them outside of CPTs 99202-99215 (eg, hospital and home visits).

Since these changes are part of the CPT code set, they will apply to all private payers required by HIPAA to use the standard code set. Workers' compensation can be an exception. The AMA will be working with stakeholders across the industry on implementing the new E/M coding login.

The new coding guidelines can be found in the CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes published by the AMA.

Effective January 1, 2021, CPT codes for office visits will be selected by either medical decision making (MDM) or the total time spent on the visit. The AMA revised all descriptions for CPTs 99202-99215 for 2021. CPT 99201 will be deleted, as the MDM is the same as 99202. All code descriptors state a "medically appropriate" history and/or examination and MDM (meaning, the level of history and exam performed and documented will be up to the provider. It will not be a consideration in code selection).

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The requirements for the level of MDM for each code remains the same (ie, *straightforward*, *low*, *moderate*, or *high*). The definition of these levels is different, however. All codes state a total time spent on the date of encounter. The times are similar to the current code descriptors, with the addition of a specific range to remove any ambiguity.

No guidelines have been set for CPT 99211. This is still a valid code to be used for minimal services if the requirements for a higher level of visit are not met.

MDM

The AMA removed vague terms, such as *mild*, and defined other concepts like the type of problem addressed (eg, self-limited or minor problem, stable, chronic illness, and acute, uncomplicated illness or injury).

All of this has been consolidated into one table that will be used when audits are performed after January 1, 2021. (See **Table 1**.)

Guidelines are the same whether the patient is new or established. The level will continue to be based on two out of three elements, though the requirements have changed.

- *Number and complexity of problems addressed:* The term "problems addressed" is defined in the new guidelines, and must be comprised of those conditions that are clinically relevant.
- *Amount and/or complexity of data to be reviewed and analyzed:* Emphasis was given to clinically important activities over the number of documents, and accounted for clinically important activities over the number of documents.
- *Risk of complications and/or morbidity or mortality of patient management:* Includes possible management options selected and those considered but not selected, and addresses risks associated with social determinants of health. Those examples not office-oriented were removed.

Table 1. CPT E/M Office Revisions: Level of Medical Decision-Making (MDM)

		Elements of Medical Decision-Making		
Code	*Level of MDM (based on 2 out of 3 elements of MDM)*	*Number and complexity of problems addressed*	*Amount and/or complexity of data to be reviewed and analyzed (each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below)*	*Risk of complications and/or morbidity or mortality of patient management*
99211	n/a	n/a	n/a	n/a
99202 99212	Straight-forward	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems, *or* • 1 stable chronic illness, *or* • 1 acute, uncomplicated illness or injury	Limited (must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: – Review of prior external note(s) from each unique source – Review of the result(s) of each unique source – Ordering of each unique test Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see *moderate* or *high*)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illness with exacerbation, progression, or side effects of treatment, *or* • 2 or more stable chronic illnesses, *or* • 1 undiagnosed new problem with uncertain prognosis, *or* • 1 acute illness with systemic symptoms, *or* • 1 acute complicated injury	Moderate (must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: – Review of prior external note(s) from each unique source – Review of the results(s) of each unique test – Ordering of each unique test – Assessment requiring an independent historian(s) • Category 2: Independent interpretation of tests – Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported) • Category 3: Discussion of management or test interpretation – Discussion of management or test performed by another physician/other qualified healthcare professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment, or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: – Review of prior external note(s) from each unique source – Review of the results of each unique test – Ordering each unique test – Assessment requiring an independent historian(s) • Category 2: Independent interpretation of tests – Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported) • Category 3: Discussion of management or test interpretation – Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported	High risk of morbidity from additional diagnostic testing or treatment

Adapted from: CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed December 5, 2019.

Time

Time is defined as the total time spent by the "reporting" practitioner on the day of the visit (including face-to-face and non–face-to-face time). This is not limited to the time the patient is physically in the office. Examples of non-face-to-face time include reviewing of tests to prepare to see the patient; ordering medications, tests, and procedures; and documenting the service in the EMR.

Spending 50% of the visit in counseling and coordination of care is no longer a concept for this category of codes.

Per the AMA, when both a physician and a nonphysician provider see the patient, the total time for both providers should be combined to determine the correct code. Time spent by clinical staff (eg, nurses) and time spent on a procedure should be excluded from the total time calculation.

If the visit goes 15 minutes more than the time stated for 99205 and 99215, the add-on code 99XXX can be reported for each additional 15 minutes. It must be a *complete* 15 minutes to report this code–no rounding up. For your reference:

99XXX Prolonged outpatient evaluation and management service(s) (beyond the total time of the primary procedure which 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 Evaluation and Management services)

CMS has stated they would only expect to see billing by time on higher-level visits where extra time is spent on history and exam or coordination of care. Payers may monitor for higher-level visits with diagnoses for minor conditions and excessive time spent on a given day (eg, total time billed for a date is 25 hours). Time is expected to be a target area across the payer market due to risk of abuse.

Additionally, providers were warned that total revenue will ultimately be less when billing by time, as either levels will be lower or fewer patients will be seen.

Whether coding by MDM or time, stress was given to documentation being sufficient for a subsequent provider treating the patient and a proper legal defense. ■