2021 E/M Changes: Are You Ready?

The last big change for Evaluation and Management (E/M) coding was in 2010 when Medicare stopped accepting consultations. Not since 1997 have the guidelines gone through such a big adjustment. Due to the pandemic, though, many practices are not prepared for this upcoming change. This article will look at an overview of the changes and what you should do (or should have done already) to prepare for January 1, 2021.

CMS Has E/M on Their Radar

In 2018, CMS announced a new initiative called "Patients Over Paperwork" to address what it considered an undue financial burden on physicians and other providers to meet CMS-mandated compliance, among other things. So, in 2019, CMS proposed to collapse the E/M office visit services from 5 codes to 2 for each type (new and established). It was even officially in the Federal Register's proposed 2019 Physician Fee schedule Rule. After holding physician listening sessions and reviewing the comments made on the proposed fee schedule, CMS did not move forward. They revised the proposal the next year and discussed expanding the E/M levels to 2 for each type, instead of two. Again, it was met with resistance and comments that the three levels would still not be sufficient to indicate differentiation of complexity of the patients seen. The AMA met with CMS and showed them their proposal for new E/M guidelines, and CMS agreed to them. The AMA posted their new guidelines and CMS stated formal adoption to begin using January 1, 2021.

And Then..... COVID

Practices began to think about preparations for the change. When and how to perform education, how to educate the auditors, etc. Then the pandemic hit the United States in February and we went on lock down. Patients were not presenting for office visits, surgeries were cancelled, and offices were temporarily closed (some may still be). The 2021 E/M changes kind of took a back seat to what was going on and shelved while facilities and practices had to figure out how to navigate the new healthcare world. Many practices had to learn how to offer telehealth services to their patients, which took up a lot of time and attention away from the 2021 E/M changes. I heard from more than one of my clients when I brought the subject up that they thought it would undergo delay after delay as the ICD-10 implementation did when it was decided the U.S. would finally update to it. But in August 2020, CMS put out the proposed Final Rule for the 2021 Medicare Physician Fee Schedule and guess what? They confirmed the switch to the new guidelines for 2021. Now, panic is setting in at those practices that delayed as there is only four months left before this mega change. All that is needed is a good plan, starting with the new guidelines.

Beginning in 2021, there will be more than one set of guidelines

New CPT Guidelines

The AMA has published the new 2021 E/M guidelines for office visits on their website at https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.

Beginning in 2021, there will be more than one set of guidelines in the CPT book for E/M codes: one for office visits and one for everything else. The first major change that one needs to be aware of is the guidelines on History and Examination. Starting January 1, 2021, the only History and Examination documentation required is what the physician/other provider deems medically necessary for the patient encounter that day. No more will anyone have to count elements of the History of Present Illness (HPI), Review of Systems (ROS), Past Medical, Family, and Social History (PFSH), body areas or organ systems. No longer will physicians/other providers have to pull forward all the information from the last visit to justify their level of service. The new guidelines state, "The extent of history and physical examination is not an element in selection of office or other outpatient services."

The new guidelines also define some of the more ambiguous terms that are used in the Medical Decision Making portion of E/M coding.

Following are some clarifications made:

- **Problem addressed:** The guidelines state that CPT considers a problem addressed if it is evaluated or treated at the encounter, including any treatment or testing recommended that the patient does not elect to move forward with them due to patient/guardian/parent choice or risk/benefit analysis. There is a new distinction on what is not considered a problem addressed. "Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified healthcare professional reporting the service." The documentation must state that the physician/other provider of the service actually did something, not just stating that the patient has a chronic condition that another professional is managing.
- **Stable, chronic illness:** An important clarification is what constitutes a stable, chronic illness. A problem is chronic if it is expected to last at least a year, or until the patient dies. That part is how most people were using that distinction. But the guidelines further state that a condition is not considered "stable" if the patient is not at their treatment goal for the condition, even if there is no change in their condition and there is no threat to the patient's life or bodily function. A diabetic patient presenting with high blood sugar counts is not considered stable, even if it is improved from a prior visit (not at goal).
- **External physician or other qualified healthcare professional:** External has been added to definition, explaining that the physician/other provider must either be from a different specialty/subspecialty, or from a different group (if of the same specialty).
- **Social determinants of health:** This new definition indicates that the patient's economic and social conditions should be considered if they will influence the patient's health or community. Factors such as homelessness or a patient that cannot afford to eat every day are examples.

Familiarizing the coders and physicians on these definitions should be performed to ensure they understand how to assess the E/M levels for office visits starting in January of 2021.

New Ways to Level E/M Services

Beginning January 1, 2021 there will be two ways to level an office visit: by time or Medical Decision Making. The guidelines give no preference to one or the other.

Coding by Time

Choosing a level based on time will be different for office visits in 2021 than it is for other E/M services. Time can be considered the key and controlling factor for code selection currently if more than 50% of the visit time is spent on counseling and/or coordination of care with only physician/other provider face-to-face time with the patient being counted. In 2021, all the time a physician/other provider spends on the day of the patient encounter may be counted toward the level of service. For example, a physician can spend 17 minutes reviewing labs and reports from other physicians the morning of an established patient's visit. The physician sees the patient in the afternoon for a 15 minute visit; the 17 minutes spent in the morning is added to the 15 minutes spent at the face-to-face visit (32 minutes). CPT code 99214 would be reported for an established patient visit between 30 and 39 minutes cumulative time on a date of service.

The guidelines also indicate what time counts toward leveling the E/M service.

According to CPT, time spent on the following activities by the physician/other provider can be counted toward the level of E/M service chosen:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically 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 separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination

The times for the E/M office visit codes next year will also be time ranges instead of thresholds, but they are basically the same, except for a few codes where the time will increase. Below are two tables that show the new time ranges for the codes.

OFFICE VISIT – NEW PATIENT

E & M CODE	AVERAGE TIME	CURRENT TIME
99202	15-29 min	20 MINUTES
99203	30-44 min	30 MINUTES
99204	45-59 min	45 MINUTES
99205	60-74 min	60 MINUTES

OFFICE VISIT – ESTABLISHED PATIENT

E & M CODE	AVERAGE TIME	CURRENT TIME
99212	10-19 min	10 MINUTES
99213	20-29 min	15 MINUTES
99214	30-39 min	25 MINUTES
99215	40-54 min	40 MINUTES

Coding by Medical Decision Making (MDM)

The other way that a visit level can be chosen next year for office visits is by Medical Decision Making (MDM). Since there are 4 types of MDM (Straightforward, Low, Moderate, High) but 5 levels of codes, an adjustment was necessary. Since the MDM for 99201 and 99202 are both Straightforward, the decision was made to delete 99201. Because 99211 has traditionally been used for "Nurse visits," there is no MDM attached to it, so it will remain active next year. Below are two tables that show how the MDM will match to the code level.

OFFICE VISIT – NEW PATIENT

E & M CODE	HISTORY & EXAMINATION	MEDICAL DECISION MAKING
99202	Medically Appropriate	STFWD
99203		LOW
99204		MODERATE
99205		HIGH

OFFICE VISIT – ESTABLISHED PATIENT

E & M CODE	HISTORY & EXAMINATION	MEDICAL DECISION MAKING
99212	Medically Appropriate	STFWD
99213		LOW
99214		MODERATE
99215		HIGH

There will still be three elements to MDM, but their names have been altered slightly for 2021.

1. The number and complexity of the problem(s) that are addressed during the encounter.
2. The amount and/or complexity of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

NOTE: CPT defines Shared medical decision making as involving eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

New MDM Table

The MDM table for office visits contains all three elements on it. In order to select a level of MDM, 2 of the 3 elements for that level must be met or exceeded. The new table is shown below. The new definitions from the guidelines will be used in this section.

Code	Level of MDM (2 out of 3 Elements)	Number and Complexity of Problems Addressed	AMT AND/OR Complexity of Data to Be Reviewed and Analyzed	Risk of Complications AND/OR Morbidity OR Mortality of Patient Management
99202 99212	**Straightforward**	**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** • 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 test*; - Ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)**	**Low risk of morbidity from additional diagnostic testing or treatment**

**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 under the Amount and/or Complexity of Data to be Reviewed and Analyzed element in the above table.*

Code	Level of MDM (2 out of 3 Elements)	Number and Complexity of Problems Addressed	AMT AND/OR Complexity of Data to Be Reviewed and Analyzed	Risk of Complications AND/OR Morbidity OR Mortality of Patient Management
99204 **99214**	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **OR** • 2 or more stable chronic illnesses; **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 result(s) of each unique test*; - Ordering of each unique test*; • Assessment requiring an independent historian(s) **OR** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professions/appropriate **source (not separately reported)**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 under the Amount and/or Complexity of Data to be Reviewed and Analyzed element in the above table.*

Code	Level of MDM (2 out of 3 Elements)	Number and Complexity of Problems Addressed	AMT AND/OR Complexity of Data to Be Reviewed and Analyzed	Risk of Complications AND/OR Morbidity OR Mortality of Patient Management
99205 **99215**	**High**	**High** **• 1 or more chronic illnesses with severe exacerbation, progression, or side effects 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 result(s) of each unique test*; - Ordering of each unique test*; • Assessment requiring an independent historian(s) **OR** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** **• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)**	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 under the Amount and/or Complexity of Data to be Reviewed and Analyzed element in the above table.*

So, if you had a patient with High number and complexity of problems, but Moderate complexity of data and Moderate risk of complication, the encounter should be coded as 99214 or 99204, depending on if they are new or established to the practice/specialty.

Preparation for January 1, 2021

What should a practice do to prepare? I suggest a multi-step approach.
First, read through the new CPT E/M Office Visit Guidelines to make sure everyone understands the new guidelines on coding by time. Get familiar with the definitions given in the new MDM section and study the revised MDM table. Next, in order to get an estimate of the financial impact of the changes, obtain a financial impact & documentation readiness assessment. This can be done by comparing the RVUs for the current levels to the 2021 RVUs for what the documentation would support using the new guidelines.

Communication will also be key. Decide the best way that the practice disseminates information (e-blast, intranet, newsletter, etc.) and decide on a schedule for communication. Multiple levels of communication may be warranted, so it can be split into groups, such as physicians/other providers, administration, auditors/coders, etc. Then, it is time to set up educational sessions.

There may need to be different types of sessions as there may be different groups (the education for the coders and auditors will be different from that of administration). Depending on the size, time commitment, and skill set of employees, it may be necessary to look to an outside consultant to provide some of the services.

Of course, don't forget about your IT needs. New templates may need to be made or requested from your vendor, along with software updates.

Conclusion

There is a lot to accomplish with preparing to switch on January 1, 2021, but it is not impossible. Remember these things:

- Make sure everyone that needs it gets scheduled and attends training
- Assess the financial/documentation impact the change will have on the practice to avoid big surprises with the budget
- Contact vendors to ensure they are updating all necessary software and templates with enough time for the practice to update everything on their end
- Use outside help, when necessary, to stay on track (and stay sane!)

The AMA has published a checklist for transition. It can be found at https://www.ama-assn.org/practice-management/cpt/10-tips-prepare-your-practice-em-office-visit-changes

As with all other changes that have come before, this is one that can be successful if the practice has a good game plan and keeps their eye on the prize.

Good Luck!

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Betty brings over thirty years of healthcare experience. She has worked for practices both large and small with the same intensity and attention. She has spent years on the "front lines" for practices handling medical billing, coding, claims, and denials. She has also managed practices and directed healthcare system departments. Her areas of expertise include Evaluation and Management, Primary Care, Dermatology, Plastic Surgery, Cardiology, Cardiothoracic Surgery, General Surgery, GI, E/M and procedural auditing, and ICD-10-CM.

As a speaker and trainer, Betty brings a welcoming mannerism that her attendees relate to and enjoy. She brings humor and real life experience to her educational sessions that allow her to ensure that everyone understands the training and has a good time. Betty has educated medical coders, managers, health plans, administrators, physicians and non-physician practitioners all across the country. She has co-written manuals on ICD-10-CM, ICD-10-PCS, and CPT specialty areas. She most recently authored a chapter for the soon to be released book, Telemedicine in Orthopedics and Sports Medicine: Development and Implementation in Practice.

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