Practice Learning Community

Thursday February 18th, 2021

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ENOS Medical Coding

Changes for E/M Office and Other Outpatient Coding January 1, 2021

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Enos Medical Coding

ENOS Medical Coding

Agenda

- Differences between office/outpatient and other locations
- Deletion of CPT code 99201
- Elimination of history and physical as elements for code selection
- Modifications to the Criteria for MDM
- Allowing physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Time
- Creation of a shorter Prolonged Services Code

Comparison to other E/M Codes

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use Key Components (History, Examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use Key Component (History, Examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates. *Time is **not** a descriptive component for E/M levels of emergency department services*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

Deletion of 99201

The AMA will delete 99201 from the E/M code set. That is an official code deletion, meaning it will no longer appear in the codebook after 2020.

There are some situations in which you may still need to report 99201, such as those entities that will not immediately adopt the 2021 CPT code changes

e.g., workers compensation payers	Other “HIPAA exempt payers such as auto insurance

History and Exam Are Required, but Not Scored

- The approved revisions to 99202-99215 require that a medically appropriate history and examination be performed: beyond this requirement, the history and exam do not affect coding.
- Instead, the E/M service level is chosen either by the level of medical decision making (MDM) performed, or by the total time spent performing the service on the day of the encounter
- Today, the level of scoring is based on:
  - Extent of the documentation
  - Medical necessity

Medical Decision Making Revisions (99202-99215)

"Number of Diagnoses or Management Options" is changed to "Number ***and Complexity of Problems Addressed***"

"Amount and/or Complexity of Data to be Reviewed" is changed to "Amount and/or Complexity of Data to be Reviewed ***and Analyzed***"

"Risk of Complications and/or Morbidity or Mortality" is changed to "Risk of Complications and/or Morbidity or Mortality ***of Patient Management"***

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: 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.	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
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 • 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 test*; • ordering of each unique test* or **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 illnesses 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 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)	**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
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 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 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

AMA's new Medical Decision Making Complexity Grid

Number and Complexity of Problems Addressed
N/A
Minimal • 1 self-limited or minor problem
Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury
Moderate • 1 or more chronic illnesses 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
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

Number and Complexity of Problems Addressed at the Encounter

- Based on CMS Documentation Guidelines' Table of Risk
- New guidelines and numerous definitions added to clarify each type of problem addressed in the MDM table
  - Stable, chronic illness
  - Acute, uncomplicated illness or injury
- Removed examples
  - Some were not office oriented
  - Examples in guidelines to make MDM table less complex

Definition Examples

- Number and Complexity of Problems Addressed:
  - Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Definition examples

- ***Stable, chronic illness:*** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic, whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition).
- "Stable" for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.
- For example, a patient with persistently, poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant.
  - Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

Definition Examples

- ***Acute, uncomplicated illness or injury:*** A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
- A problem that is normally self limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.
  - Examples may include cystitis, allergic rhinitis, or a simple sprain

Definition Examples

- ***Undiagnosed new problem with uncertain prognosis:*** A problem in the differential diagnosis that represents a condition likely to result in a high risk or morbidity without treatment.
  - An example may be a lump in the breast.

Number and Complexity of Problems Addressed at the Encounter/Clinically Relevant

- Straightforward
  - Self-limited
- Low
  - Stable, uncomplicated, single problem
- Moderate
  - Multiple problems or significantly ill
- High
  - Very ill

Amount and/or Complexity of Data to be Reviewed and Analyzed

- Data are divided into three categories:
  1. Tests, documents, orders, or independent historian(s) – each unique test, order or document is counted to meet a threshold number
  2. Independent interpretation of tests not reported separately
  3. Discussion of management or test interpretation with external physician/other QHP/appropriate source (service not reported separately)

Amount and/or Complexity of Data to be Reviewed and Analyzed

- Straightforward: minimal or none
- Low(one category only): two documents or independent historian
- Moderate (one category only): Count: Three items between documents and independent historian; or interpret; or confer
- High: (two categories): Same concepts as moderate

New Data Category Definitions

*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1

Elements of Medical Decision Making
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.*
N/A
Minimal or none

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)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

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 professional\appropriate source (not separately reported)

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 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)

Definition examples

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g. basic metabolic panel) is a single test.
- The differentiation between single or multiple unique tests is defined in accordance with CPT.

Definition examples

- ***Independent historian(s):*** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
- A language interpreter is not an independent historian.

Definition examples

- ***Independent Interpretation:*** The interpretation of a test for which there is a CPT code, and an interpretation or report is customary.
  - This does not apply when the physician or other qualified health care professional is **reporting the service** or has previously **reported the service** for the patient.
- A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Definition Examples

- Each Unique Test or Order that is “not separately reported”
  - Tests ordered, performed, and interpreted on the same date cannot count for ordering or analyzing data (same billing provider with a CPT)
  - MDM 2021 guidelines indicate “on the date of the encounter”. Therefore, any tests performed in-house but not interpreted until different date would be considered as ordered only.

Documentation Tip

- Prior test results might be documented in the history section of your note, but will count towards MDM
- Ordering further tests (not billable by your practice) counts towards MDM
- Make changes to your templates to differentiate between “outside tests and data” and “separately billable tests and results” within your practice
  - Tests done in your office at an earlier encounter, cannot count as data points
- Did you get paid, or will you be billing for this test?

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Includes possible management options selected and those considered, but not selected
- Addresses risks associated with social determinants of health

Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A
Minimal risk of morbidity from additional diagnostic testing or treatment
Low risk of morbidity from additional diagnostic testing or treatment
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
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

Definition Examples

- ***Risk:*** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.
  - For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.

- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.

- For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Definition Examples

- ***Social determinants of health:*** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
  - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
- Low
  - Low risk (ie, very low risk of anything bad), minimal consent/discussion
- Moderate
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- High
  - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

Levels of Medical Decision Making

Time ranges do not have to be documented or met if code selection is based on MDM

- Straightforward- 99202, 99212
- Low- 99203, 99213
- Moderate- 99204, 99214
- High- 99205, 99215

When is MDM the optimal method of coding?

- When the note includes history and exam as required to meet clinical purposes, and the medical decision making supports the appropriate level based on the provider's work
- The number of diagnoses, amount of data, and level of risk are documented and can be coded
- “Risk based coding” is used when the problem matches the level of service provided
- Many of these visits do not meet the time (e.g. 99213 – 20 minutes) but do meet the MDM complexity
  - Examples are: Urgent Care visit for a sinus infection, a follow up visit to an Orthopedic Surgeon, minor illness treated by a Pediatrician

Time

- The CPT Editorial Panel also approved a revised definition of time, as associated with 99202-99215, from “typical face-to-face time” to “total time spent on the day of the encounter.”
- CPT will be adding guidelines for reporting time when more than one individual performs distinct parts of an E/M service
- **CMS:** Updated as of the Final PFS, CMS will now allow E/M level selection based on a simple statement of total time spent on the date of service by the billing provider.
- This applies ONLY to the office/outpatient subcategory.
- Clinicians who want to base their office E/M reporting on time spent on the day of the patient’s visit by physicians and other QHPSs*

What Counts for Time Based Reporting?

1. Prepare to see the patient
   a) For example, review tests to the patient's chart before the visit
2. Obtain and/or review a separately obtained history
   a) Count time spent by the treating practitioner or practitioners, Do not count clinical staff time.
3. Perform a medically appropriate examination and/or evaluation.
4. Counsel and educate the patient, family member or caregiver.
   a) Include discussions that take place before/after the face-to-face visit on the same date.
5. Order medication, tests, procedures
6. Document clinical information in the electronic Health Record (same date!)
7. Refer and communicate with other health professionals
8. Independently interpret results (for studies that are not separately billable, such as outside tests)
9. Care Coordination

Billing Provider and other Clinical Staff

- **Do not report "overlapping" time, e.g. QHP sees patient, MD comes in, there is time that the QHPS and MD are seeing the patient together. Do not count time twice.**

- *QHPSs (qualified health care professionals) "A 'physician or other qualified health care professional (QHP) ' is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service"

What doesn’t Count for Time?

- Morning “huddle”
  - Is there a note in each patient record of huddle conversations?
- Pre-visit Screening
  - MA calls the patient prior to the appointment date to update history, review labs being obtained, other orders from last visit
  - But, if physician reviews this data on the date of service, it does count
- Staff time with patient(nurse, medical assistant, non-QHP)
- Staff time on telephone (insurance company, pharmacy)
- Time spent performing separately billable services (EKG, injection)

Time Rules Effective January 1, 2021

AMA and CMS 2021 Office/Outpatient

CPT: Total time spent by the provider on the date of service

CMS 2021 adopted the same definition (Final PFS) allows G2212 after meeting time thresholds above level 5

CMS: Total time spent by the provider on the date of service includes 3 days before and 7 days after in the global period.

AMA and CMS 2021 other subcategories

- Time rules:
  - When counseling and/or coordination of care dominates (more than 50%) of the encounter with the patient and/or family.
  - No time element in the Emergency Department

AMA-New Prolonged Services Code

- **99417** Prolonged office or other 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 or 99215
- Only used when coding by time
- Prolonged services of less than 15 minutes should not be reported
- Either face-to-face or non-face-to-face care of the date of the encounter
  - Therefore, do not report 99354 or 99358 for time of the date of the encounter
- 99358 may be reported on a date **other than the date** of the encounter (example, large volume of records received to review after a visit)
- Additional units may be added as needed

CMS –New HCPCS Code, New Rule

- G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
- To report G2212, - 15 minutes must have passed beyond the maximum time for 99205/99215

CMS Final Physician Fee Schedule

- 99358 and 99359 are not reportable with office or other outpatient E/M codes after 1/1/2021
  - This is due to the fact that there is a global period associated with E/M codes (3 days before and 7 days afterwards)
  - 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour
  - 99359 each additional hour
- Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416
- Do not report G2212 for any time unit less than 15 minutes

When to Report Prolonged Services

Base Code - CPT	Prolonged Services	Prolonged Services	Prolonged Services
99205 60 minutes	99417 x1 75 minutes	99417 x2 90 minutes	99417 x3 105 minutes
99215 40 minutes	99417 x1 55 minutes	99417 x2 70 minutes	99417 x 3 85 minutes
CMS issued G2212 on 12/1/2020			
99205 60-74 minutes	G2212 X 1 89-103 minutes	G2212 X 2 104-118 minutes	G2212 X 3 119 minutes
99215 40-54 minutes	G2212 X1 69-83 minutes	G2212 X 2 84-98 minutes	G2212 X 3 99 minutes

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)

Time Based Reference Guide-Prolonged Services

New Patients

Total Time	AMA Billing
60 – 74 minutes	99205
75 – 89 minutes	99205 and 99417
90 – 104 minutes	99205 and 99417 x 2
105 or more	99205 and 99417 x 3+

Total Time	CMS Billing
60 – 74 minutes	99205
75 – 88 minutes	99205
89 – 103 minutes	99205 and G2212
104 or more	99205 and G2212 x2+

Established Patients

Total Time	AMA Billing
40 – 54 minutes	99215
55 – 69 minutes	99215 and 99417
70 – 84 minutes	99215 and 99417 x 2
85 or more	99215 and 99417 x 3+

Total Time	CMS Billing
40 – 54 minutes	99215
55 – 68 minutes	99215
69 – 83 minutes	99215 and G2212
84 or more	99215 and G2212 x2+

CMS HCPCS Code for Complexity

- G2211 Visit complexity inherent to evaluation and management associated with medical care services that serve as the *continuing focal point* for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.
- Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established

Visit Complexity G2211

- CMS notes that in the 2020 Final Rule, they replaced the placeholder GPC1X add-on code for 2021 with G2211.

  – Although they are not limiting the specialties that can use the code, they believe it will be used by primary care clinicians and other clinicians who engage "the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinicians with specialized clinical knowledge skill and experience." It may be used by physicians and non-physician practitioners, as an add-on to an E/M service.

  – Following the passage of year-end legislation which added $3 billion to the Physician Fee Schedule and delayed implementation of G2211 (add-on complexity code), CMS has confirmed that the new 2021 conversion factor will be **$34.8931** instead of $32.4085.

Collaboration with CMS

The Editorial Panel shared its approved E/M documentation changes with CMS for review, and implementation in the Medicare Physician Fee Schedule for 2021.

This means that the elimination of history and exam as key components when selecting an E/M service level for 99202-99215 will become a reality, no later than January 1, 2021.

This should reduce the overall documentation burden for providers, but the sole emphasis on MDM means that this element (or time) will need to be documented scrupulously to support the chosen level of service.

CMS Payments

- On December 1, 2020 CMS finalized adopting the AMA RUC recommendations for E/M outpatient visit codes for CY 2021 and the new add –on CPT code for prolonged service time, to be reported with G2211.
- The AMA RUC-recommended values would increase payment for office/outpatient E/M visits.
- In order to achieve budget neutrality, the increases to E/M, and Visit Complexity, will be offset by negative adjustments to other services, such as surgery

CMS Payments based on revised work RVUs

Code	2020	2021	*Diff based on 2020	% Diff
99202	$76.51	$73.97	$-2.52	-3%
99203	$110.43	$113.75	$3.32	3%
99204	$166.37	$169.93	$2.56	2%
99205	$209.68	$224.36	$14.68	7%
99211	$23.46	$23.03	$-.43	-2%
99212	$45.83	$56.88	$11.05	19%
99213	$75.43	$92.47	$17.04	18%
99214	$110.43	$131.22	$20.77	16%
99215	$148.69	$183.19	$34.50	19%

*With the budget neutrality adjustment to account for changes in RVUs, as required by law, the CY 2021 PFS conversion factor is $ **$34.8931**, a decrease of $1.20 from the CY 2020 PFS conversion factor of $36.09. **(figures updated 1/21/2021)**

SUMMARY

Does this affect all E/M levels of Service?

The proposed changes (CMS) and Published changes (AMA) specify codes for Office or Other Outpatient visits

- 99202-99205
- 99211-99215

Do not apply these changes to all other Evaluation and Management subsections, and remind providers that their documentation must meet the requirements for each CPT code, based on

- Location
- Type of Service
- Patient Status

The change went into effect on 1/1/2021

Understand the differences between guidelines from

- AMA (editors of the CPT)
- CMS
- Other Payers

When providers sign a contract with a payer, they must follow the current guidelines and policies specific to the contract

- Whether or not it agrees with the CPT or CMS Guidelines

Medicare may produce HCPCS code(s) with specific guidance for Medicare-contracted providers to follow (watch for G codes)

Key Takeaways

- Eliminate history and physical as elements for code selection
- Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Time
- Modifications to the Criteria for MDM
- Deletion of CPT code 99201
- Creation of a shorter Prolonged Services Code

Where do we go from Here?

- Start to note time today, and compare E/M levels based on MDM or Time.
- Verify policies with contracted payers, CPT vs CMS
- Work with Template gurus in your practice to make necessary changes

Resources

- https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions
- https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf
- https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Home › Products › Coding Books › Procedural Coding/CPT › 2021 E/M Office Visit Reference Guide

2021 E/M Office Visit Reference Guide

Product Code: EMOVRG

The 2021 E/M Office Visit Reference Guide delivers a comprehensive overview of the new E/M documentation guidelines and a clear, in-depth analysis of the 2021 changes, including the confusing new medical decision-making (MDM) guidelines so that you can ensure a seamless shift to the new guidelines.

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2021 E/M Office Visit Reference Guide

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The new 2021 E/M documentation guidelines are set to take effect Jan. 1, 2021, and are expected to create a sea change in how medical practices select a level of E/M service. The revised reporting requirements mark the first significant update in more than 20 years since the release of the 1995 and 1997 documentation guidelines.

The ***2021 E/M Office Visit Reference Guide*** delivers a comprehensive overview of the new E/M documentation guidelines and a clear, in-depth analysis of the 2021 changes, including the confusing new medical decision-making (MDM) guidelines so that you can ensure a seamless shift to the new guidelines.

Use the ***2021 E/M Office Visit Reference Guide*** to train staff, reduce the risk of miscoding and the denials and audits that may result, and lessen the disruption to a key revenue stream. E/M office visits account for 20% of total physician fee schedule charge. In 2018, practices gained $15.6 billion in payments from Medicare for the suite of E/M office visit codes 99201-99215.

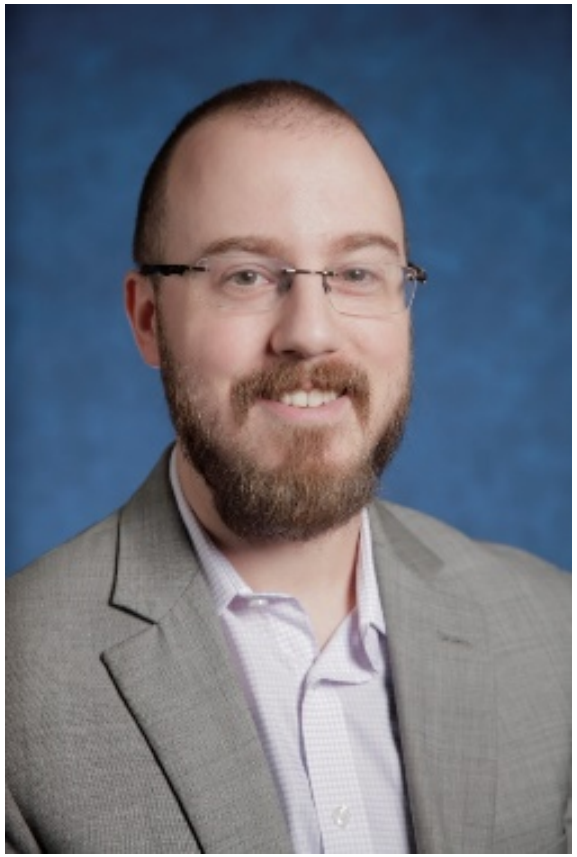
Additionally, the ***2021 E/M Office Visit Reference Guide*** will help you:

- **Guarantee a successful and smooth transition to the new system** with best practices on how to revise superbills and templates; what to know about working with third-party vendors such as electronic health record (EHR) providers; and how to manage two different E/M systems simultaneously.
- **Ensure your coders are accurately selecting the correct level of service** for E/M office visits with office and staff training tips, including separate breakout sections for coders and clinicians; audit safeguards; and more.
- **Train clinicians** on the 2021 documentation changes with several dozen documentation scenarios that clearly illustrate how a coder/clinician should accurately select a Level 1, 2, 3, 4 or 5 E/M code. The book will present scenarios tailored to specific specialties.
- **Understand the level of medical decision-making** or time for code selection with comprehensive coverage of MDM and time elements.

Resources

- Nancy Enos is the technical editor of this 2021 E/M Office Visit Reference Guide, with over 50 scenarios that illustrate how a coder or clinician should select an office E/M code using the new guidelines. For more information visit Decision Health here

About the Speakers



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Mike Enos, CPC,CPMA,CEMC has over 15 years of experience in medical coding, billing compliance and revenue cycle management and has developed a suite of online training courses on Evaluation and Management, ICD-10 and CPC preparation.

After earning a B.A. from Rhode Island College, Mike pursued three professional medical coding certifications, including Certified Professional Coder (**CPC**), Certified Professional Medical Auditor (**CPMA**) and Certified Evaluation and Management Coder (**CEMC**). Mike's experience with public speaking and education adds a unique perspective to the CPC training courses offered by Nancy Enos, FACMPE, CPC-I, CPMA, CEMC.

Mike has contributed articles to *Medical Economics* and *MGMA Connection* Magazine, and *AAPC Coder's Edge* magazine, and collaborated with *Physicians Practice*, *Contemporary OB/GYN*, and *Contemporary Pediatrics* magazines. He has presented at Regional and National MGMA Conferences, AAPC Chapter Meetings, the Rhode Island Medical Society, and the New England Quality Care Alliance (**NEQCA**) Fall Forum. He has joined the MGMA Health Care Consultant Group, and is a partner in Enos Medical Coding. He has joined several nationally accredited professional organizations, including the American Academy of Professional Coders (**AAPC**), National Alliance of Medical Auditing Specialists (**NAMAS**), Medical Group Management Association (**MGMA**), and American College of Medical Practice Executives (**ACMPE**.)

About the Speaker

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Nancy M Enos, FACMPE, CPMA, CPC-I, CEMC is an independent consultant with the MGMA Health Care Consulting Group and a principal of Enos Medical Coding. Mrs. Enos has 40 years of experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice, Nancy Enos Medical Coding (www.nancyenoscoding.com)

As an Approved PMCC and ICD-10 Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-10 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including National, State and Sectional MGMA conferences, and at hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She served as a College Forum Representative for the American College of Medical Practice Executives.

Disclosures

Enos Medical Coding does not provide legal advice. The information in this presentation is based on the coding guidelines in the Current Procedural Terminology (CPT) Manual published by the American Medical Association (AMA) and Evaluation and Management Coding Guidelines from the Centers for Medicare and Medicaid (CMS)

No fee schedules, basic units, relative values or related listings are included in CPT.

The AMA assumes no liability for the data contained herein.