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

Nancy M. Enos, CPC, CPMA, CEMC Emeritus

Enos Medical Coding

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# Agenda

- Differences between office/outpt 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.<br><br>*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<br>• Amount and/or complexity of data to be reviewed and analyzed<br>• Risk of complications and/or morbidity or mortality of patient management | • Number of diagnoses or management options<br>• Amount and/or complexity of data to be reviewed<br>• Risk of complications and/or morbidity or mortality |

# Deletion of 99201

The AMA is planning to 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 effect 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 (beware of cloned history)

# 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"***

# 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 wellcontrolled hypertension, noninsulin-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 |
| --- |
| N/A |
| **Minimal**<br>• 1 self-limited or minor problem |
| **Low**<br>• 2 or more self-limited or minor problems;<br>or<br>• 1 stable chronic illness;<br>or<br>• 1 acute, uncomplicated illness or injury |
| **Moderate**<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>or<br>• 2 or more stable chronic illnesses;<br>or<br>• 1 undiagnosed new problem with uncertain prognosis;<br>or<br>• 1 acute illness with systemic symptoms;<br>or<br>• 1 acute complicated injury |
| **High**<br>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>or<br>• 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

# 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 (not reported separately)

# New Data Category Definitions

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

| Amount and/or Complexity of Data to be Reviewed and Analyzed<br>*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**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* |
| **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) |
| **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• 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 differentiaton 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. In the case where there may be conflict or poor communication be-tween multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

# 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.

# 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

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**<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| **High risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• 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 deci-sion 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

# 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:** Crucially, CMS does not revise its definition of time for 2021. CMS will still count only face-to-face time to select an E/M level in 2021. However, CMS is eliminating its requirement that physicians must spend at least 50% of the face time on counseling and/or coordination of care, and document this explicitly. CMS will now allow E/M level selection based on a simple statement of total face time spent for the encounter.
- This applies ONLY to the office/outpatient subcategory.

# Effective January 1, 2021

**AMA 2021 Office/Outpatient**

- Total time spent by the provider on the date of service

**CMS 2021 Outpatient**

- Total time spent by the provider, face-to-face with the patient and/or family

- Watch for consensus on this!

**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

# What Counts for Time Based Reporting?

- 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 QHCSs*
- Day-of activities that can be used for time calculation will include:
  - Preparation for the visit, such as reviewing tests
  - Obtaining and/or reviewing separately obtained history
  - Performance of medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Orders for medications, tests or procedures

# Billing Provider and other Clinical Staff

- **Do not report “overlapping” time. E.g. QHCS sees patient, MD comes in, there is time that the QHCS and MD are seeing the patient together. Do not count time twice.**

- *QHCSs (qualified health care professionals) “A ‘physician or other qualified health care professional (QHC) ’ 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
    - AMA – total time on date of service
    - CMS- total time spent face to face (is this recap done in the room w/patient?)
- Staff time with patient(nurse, medical assistant, non-QHP)
- Staff time on telephone (insurance company, pharmacy, etc)
- Time spent performing separately billable services (EKG, injection)

# Typical times vs planned times for 2021

| E/M Code | Typical Time | 2021 Time Outpatient/Office |
|---|---|---|
| 99201 | 10 | N/A code deleted |
| 99202 | 20 | 15-29 |
| 99203 | 30 | 30-44 |
| 99204 | 45 | 45-59 |
| 99205 | 60 | 60-74 |
| 99211 | 5 | N/A no time listed |
| 99212 | 10 | 10-19 |
| 99213 | 15 | 20-29 |
| 99214 | 25 | 30-39 |
| 99215 | 40 | 40-54 |

- Total time on the date of the encounter
- Recognizes the important non-face-to-face activities
- Uses easy to remember
  - 15-minute increments New Patient
  - 10-minute increments Established Patient
- Removes "midpoint" vs "Threshold" by giving exact ranges
- Is for code selection when using "time" (not a required minimum when using "MDM)
- RUC valuation includes work before and after the date of the encounter (typical 3 days before and 7 days after)

# Prolonged Services Changes

The Editorial Panel also approved the revision of codes 99354, 99355 to exclude reporting of Office and other Outpatient Services codes, revision of 99356 to include observation, and the addition of a new code (not yet designated) to report prolonged office or other outpatient E/M services

99254 Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)

99354 each additional 30 minutes

**The CPT Panel Created a Shorter prolonged services code that would capture physician/QHP time in 15 minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection**

# New Prolonged Services Code

- 99XXX 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 Rule

- 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)

# TAKEAWAYS

# 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

# Collaboration with CMS

The Editorial Panel will share its approved E/M documentation changes with CMS for review, and possible 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 July 2020 CMS proposed 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.
- The AMA RUC-recommended values would increase payment for office/outpatient E/M visits.
- The 2018 proposal for blending E/M payments will be abandoned.
  - The new AMA changes to the office/outpatient EM codes simplify the code selection so much that the payment collapse is no longer necessary.

# Est. payments based on revised work RVUs

| Code | 2020 | 2021 | Diff | % Diff |
|---|---|---|---|---|
| 99202 | $76.51 | $106.46 | $29.95 | 39.2% |
| 99203 | $110.43 | $116.93 | $6.50 | 5.9% |
| 99204 | $166.37 | $172.51 | $6.14 | 3.7% |
| 99205 | $209.68 | $221.59 | $11.91 | 5.7% |
| 99211 | $23.46 | $23.46 | $0 | 0% |
| 99212 | $45.83 | $53.77 | $7.94 | 17.3% |
| 99213 | $75.43 | $87.34 | $11.91 | 15.8% |
| 99214 | $110.43 | $125.59 | $15.16 | 13.7% |
| 99215 | $148.69 | $173.59 | $24.90 | 16.7% |

This is an ongoing process, make no changes now

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)

# Summary

- 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?

- The CPT Editorial Committee met in May 2020and the results have been recorded on their website.
- We may see even more E/M changes following the summary from those meetings
  - September 2020

# 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