COSMOS
Navigate the Compliance Universe

Compliance Today - September 2021
A review of the impact of the 2021 E/M coding changes in the office and outpatient setting

Sabrina Skeldon, JD, CIA, CHC, CCEP, CFE, CPC-A

Sabrina Skeldon (skeldonsabrina@gmail.com) is Attorney and Healthcare Consultant, Sabrina Skeldon Consulting PLLC, Carrollton, TX.

- linkedin.com/in/sabrinaskeldon/

The Centers for Medicare & Medicaid Services (CMS) changes to the final physician fee schedule,[1] which became effective January 1, have significant implications for office and outpatient healthcare professionals' operations, revenues, and compensation—and pose compliance issues.

Summary of changes to CPT E/M codes and guideline changes

CMS finalized office/outpatient evaluation and management (E/M) services visit codes 99201–99215 in the 2020 physician fee schedule rule, effective January 1, that update both the CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services and the 2019 Medicare physician fee schedule final rule. The 2021 changes include establishing a new documentation framework, where documentation of history and exam are no longer used to select the E/M code level for office/outpatient visits,[2] but rather total time or medical decision-making (MDM) are used. The history and exam components will only be performed when—and to the extent—reasonable, necessary, and medically appropriate. The term "medically appropriate" is defined in the new E/M guidelines as those E/M services that capture the nature and extent of any history or exam for a particular service.[3] This eliminates the need for the physician to perform a full review of systems for a minor medical problem and allows them to review and supplement prior histories taken of the patient, while relieving them of unnecessary paperwork.

Where time is used to select the correct E/M code, total time on the encounter date includes both face-to-face and non-face-to-face work (with the exception of 99211).

Three elements define MDM for office/outpatient visits in 2021: the number and complexity of the problem or problems addressed during the E/M encounter; the amount and/or complexity of data to be reviewed and analyzed; and the risk of complications and/or morbidities or mortality of patient management decisions made at the visit.[4] While the 2021 MDM guidelines may reflect a more precise clinical description of patient problems addressed, they create a maze of problems difficult for coders to navigate without clear documentation. The precise nature of each element listed under the three categories must be clearly detailed to ensure accurate coding of claims.

The 2021 guidelines redefine evaluation of patient risk, distinguishing risk associated with the condition addressed at the date of the encounter as different from risk of management. For example, 2021 E/M guidelines limit the scope of the problems addressed in a patient encounter to the conditions treated on a specific date. The 2020 guidelines, however, referred to problems addressed as including the "number of possible diagnoses and/or the number of management options that must be considered."[5] The 2020 guidelines also included the

evaluation of comorbidities as part of patient management options. The 2021 guidelines recognize that "comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management."[6]

In determining the level of MDM, the 2021 guidelines ask the question: What is the probability of an outcome, and if it occurs, what is the level of risk to the patient? A condition may have a low probability of death, but it may be a high-risk one. Multiple conditions of low severity may create a higher risk in the aggregate.[7] Even the recognition that a condition is characterized as chronic and stable can pose a significant risk of morbidity if the patient is not at their treatment goal—even though the condition has not changed and there is no short-term risk to life or function.[8] Conversely, the fact the final diagnosis does not represent a highly morbid condition, "does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion."[9]

The 2021 changes to office/outpatient coding, as with the 2020 and earlier E/M guidelines, create a table for scoring the presence or absence of elements in MDM. However, although the table appears to require a straightforward application of elements, the 2021 evaluation requires a grounding in 28 pages of new guidelines and key terms. Those guidelines are intended to redefine the complexity of the problem addressed, the risk associated with the problem, and the degree of testing required to diagnose it. Coders can accurately evaluate two columns of data involved on the scoring sheet, concerning the number of tests performed and the nature of the condition addressed, but where severity versus risk and complexity are not clearly defined in the medical records, and physician reporting of services lacks adequate documentation, the E/M services cannot be consistently or accurately coded.[10] Further, the discussion of risk in the guidelines is not consistent with the elements of decision-making table created by the American Medical Association to be used by coders.

The chief improvement brought by the 2021 E/M changes is that they have reduced overall physician documentation requirements. This has been accomplished by eliminating requirements, such as the requirement that physicians perform a full review of systems as part of the history and examination on both initial and subsequent visits.

Compliance issues

The 2021 E/M changes still raise compliance issues for providers and coders, and this article offers possible best practices providers can adopt to ensure compliance with the new CMS E/M changes. Clear documentation will be key to avoiding denial of claims or allegations of overbilling. CMS has stated that it will be watching trends in E/M coding to determine whether there is an overall increase in E/M coding levels and to assess the impact of the changes on particular specialty groups.[11] Recommended best practices for meeting the new E/M requirements for billing office/outpatient services include:

- In billing E/M services on an outpatient or office basis, physicians must remember to clearly identify whether they are reporting their time based on minutes of encounter and data review or by MDM. If the physician elects to report their services by time, the amount of time must be clearly documented to ensure correct payment. Both face-to-face time and non-face-to-face time personally spent by the physician or other qualified healthcare professional on the date of encounter is counted toward total time.[12]
- If the provider elects to be paid based on MDM, they must clearly document the information supporting the level of MDM. Where certain factors increase the amount of time required to arrive at a diagnosis, including the complexity of data reviewed, this should be documented. For example, where a physician in

their decision-making determines that a condition has a low probability of death, but represents a high risk, the need for adjusting the risk element should be clearly documented. The determination of risk vs. severity of condition should be discussed clearly in physician documentation.

- Without clear documentation of patient management by a particular provider, any E/M claim by that provider would not be allowable. Notation in the patient's medical record that another professional is managing the problem, without additional assessment or care coordination documented, does not qualify, and that documentation may not be considered as supporting a problem addressed. Likewise, a referral to another physician without documentation of a history, examination, or results of diagnostic tests also does not support an assessment that the physician addressed that problem.[13]

- In billing split or shared visits, total time only may be billed. When coding these visits based on time, sum the time spent by the physicians or other qualified healthcare professionals. For example, a 15-minute meeting between physicians to discuss a patient cannot be billed as a 30-minute meeting; it can only be billed once (i.e., when two or more individuals jointly meet with or discuss a patient, only the time of one individual can be counted).[14] Care must be taken in this area to avoid government claims of "double counting."

- Counseling and the sharing of information with the patient and the family need not make up 50% or greater of the office or outpatient visit in order to code for services based on time.[15]

- Services reported separately for specifically identifiable services performed on the date of the E/M services may be separately reported, in addition to the appropriate E/M code.[16] For example, if an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation (99381–99387, 99391–99397), and if the abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then codes 99202–99205 and 99211–99215 should be reported with the modifier -25.[17] Independent interpreting diagnostic test results can be separately billed; however, to the extent they are, they cannot be included in determining the E/M level for the patient visit without documentation that on the day the service or procedure identified by the CPT code was performed, the patient's condition required a significantly separate identifiable E/M service. The increased E/M service must be documented as having been prompted by the symptoms for which the test was ordered, with a modifier -25 attached.[18]

- Codes 99415 and 99416 are used to report prolonged E/M service face-to-face time provided by clinical staff. Documentation should clearly reflect that the clinical staff's prolonged E/M services involved direct patient contact, under physician supervision, and that such services were accurately calculated.[19]

- 2021 E/M code for prolonged services for physicians and other qualified healthcare providers is found in codes 99417 and G2212. Code 99417 applies to services performed "beyond the *minimum* required time of the primary procedure" (emphasis added) and includes both time with and without direct patient contact. These codes are used in conjunction with 99205 and 99215. Medicare created its own HCPCS Level II code, G2212, when billing Medicare for prolonged office/outpatient E/M services.[20] G2212 is to be coded for Medicare claims submitted for prolonged E/M services, but the positions of other payers should be ascertained to determine how they would like to see prolonged services coded.

- The Medicare guidelines allow for the consideration of "social determinants of health" as part of MDM.[21] These relate to ICD-10 codes Z.55–Z.65, involving persons with potential health hazards relating to socioeconomic conditions. Documentation of such factors must be included in the patient history so that they can be considered as part of the risks weighed in MDM.

Operational and revenue issues

Medicare payments are based on relative value units (RVUs) that include physician work, practice expense, and malpractice coverage work value units. Each of those components is multiplied by a geographic adjustment (GPCI) and conversion factor. Those units are applied to each service for physician work, practice expense, and malpractice coverage.[22]

The structure of resource-based relative value scale is based on the formula: Work RVU (wRVU) x Work GPCI + Practice Expense (PE) RVU x PE GPCI + Professional Liability Insurance (PLI) RVU x PLI GPCI x Conversion Factor = Adjusted fee schedule payment rate. The various components are assigned the following RVU weights:

- wRVU: 51% of total RVU
- PE: 45% of total RVU
- PLI: 4% of total RVU weight

The RVUs become a payment rate through the application of a conversion factor set annually by CMS. To align the increases for E/M payments largely attributable to increases in the work RVU, with budget neutrality principles, CMS initially reduced the conversion factor from $36.09 (the CY 2020 rate) to $32.41, a 10.2% drop. Industry criticism resulted in Congress mitigating these cuts to a payment reduction of 3.32%, with an updated conversion factor of $34.89. The increased funding in the conversion factor is a one-time funding, applicable only in 2021.[23]

HCPCS code[24]	2020 wRVU	2021 wRVU	Percentage increase
99202	.48	n/a (deleted)	n/a
99203	.93	.93	0%
99204	1.42	1.6	12.6%
99205	2.43	2.6	7%
99211	.18	.18	0%

99212	.48	.7	45.8%
99213	.97	1.3	34%
99214	1.5	1.92	28%
99215	2.1	2.8	32.7%
G2212	n/a	.97	n/a

Table 1: Calculation of volume-weighted average of increase to office outpatient E/M visits

The increases to the E/M wRVU for office-based and outpatient providers and facilities is expected to have dramatic impact on Medicare payments received by certain subspecialities, in particular family physicians who are expecting an increase of more than 10% in Medicare payments.

The rise in compensation, coupled with general overall drop in outpatient and office-based revenue during the pandemic, creates a serious problem: How do you pay out more in physician compensation when the practice/facility is struggling with the reality of declining revenues? Under those circumstances, how can a practice/facility cover its operational costs? Traditional models of compensation involving payments based on wRVUs or fixed compensation are being adjusted to include, in some instances, an allocation of distributable revenue (net of costs), based on a percentage of billings or collections, which represents a sharing of financial risk (a pure productivity model).

This mirrors the reimbursement methods of private payers, who hold down costs by paying only a negotiated percentage of the Medicare physician fee schedule or using a prior year's fee schedule. Pure productivity–based reimbursement may likely lead to disparities in income, based on the payer mix.

Alternatively, practices could seek to tie compensation to the prior year's physician fee schedule. Another alternative could be benchmarking compensation against clinical work historical averages to cap compensation at reasonable levels. Along with those options, the physician productivity target component in the bonus structure of employment arrangements could be used to control increasing pressure on practice income.

Conclusion

The CMS changes to office/outpatient E/M codes signify a substantial change, assisting in the streamlining of coding and documentation requirements and positively affecting wRVUs for many medical specialties. The impact of these changes will greatly affect Medicare E/M reimbursements in the office and outpatient setting but will likely affect overall physician compensation as future employment agreements are negotiated, due to declining practice revenues caused by the pandemic and other factors.

Takeaways

- Under the 2021 evaluation and management (E/M) coding guidelines for services rendered in an outpatient/office setting base, physician reimbursement can be based either on total time (both face-to-face and non-face-to-face) and/or medical decision-making (MDM).
- Three elements define MDM for office/outpatient visits in 2021: the number and complexity of the problem addressed during the encounter, the amount and/or complexity of data considered, and the risk of complications and/or morbidities or mortality concerning the problem addressed at the encounter.
- Under the 2021 guidelines, the scope of problems addressed at a patient encounter is limited to the problems addressed on the date of the patient visit and does not automatically require consideration of comorbidities.
- The 2021 MDM guidelines expand the amount and complexity of data that may be considered in evaluating the appropriate level of E/M coding.
- Evaluation of the risk of complications and potential morbidities/mortality of the patient's condition has been redefined to classify risk in a way that cannot be consistently identified and scored by a coder without adequate documentation.

1 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/ Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 85 Fed. Reg. 84,472 (December 29, 2020) , https://bit.ly/398n6hu.
2 American Medical Association, *CPT 2021, Professional Edition* (Chicago: American Medical Association, 2020), 12.
3 American Medical Association, "CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes," accessed July 2, 2021, 4, http://bit.ly/36FLiVU.
4 American Medical Association, *CPT 2021, Professional Edition*, 12–15.
5 Centers for Medicare & Medicaid Services, *Evaluation and Management Services Guide*, MLN906764, February 2021, https://go.cms.gov/3dVY0Wz.
6 American Medical Association, "CPT® Evaluation and Management (E/M)," 4.
7 American Medical Association, "CPT® Evaluation and Management (E/M), 4–7.
8 American Medical Association, *CPT 2021, Professional Edition*, 12–14.
9 American Medical Association, "CPT® Evaluation and Management (E/M)," 4.
10 American Medical Association, "CPT® Evaluation and Management (E/M)," 11–14.
11 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 85 Fed. Reg. 84,549–84,551 .
12 American Medical Association, *CPT 2021, Professional Edition*, 8.
13 American Medical Association, "CPT® Evaluation and Management (E/M)," 4–5.
14 American Medical Association, *CPT 2021, Professional Edition*, 7.

15 American Medical Association, "CPT® Evaluation and Management (E/M)," 2.
16 American Medical Association, *CPT 2021, Professional Edition*, 8–9.
17 American Medical Association, *CPT 2021, Professional Edition*, 47.
18 American Medical Association, *CPT 2021, Professional Edition*, 8–9.
19 American Medical Association, "CPT® Evaluation and Management (E/M)," 20–22.
20 American Medical Association, *HCPCS 2021 Level II, Professional Edition 2021*, (Chicago: American Medical Association, 2021).
21 American Medical Association, "CPT® Evaluation and Management (E/M)," 13.
22 Anne B. Castro, *Principles of Healthcare Reimbursement, Sixth Edition* (Chicago: American Health Information Management Association, 2018).
23 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 85 Fed. Reg. 84,475–84,480, 85,000–85,003 .
24 "CMS-1734-F," U.S. Centers for Medicare & Medicaid Services, December 28, 2020, https://go.cms.gov/3BiCeq1.