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New E/M Documentation Guidelines, Table Take Effect Soon; 'There Is a Different Mindset'

By Nina Youngstrom

A switch will soon be flipped on coding and documentation for office and other outpatient visits, with new guidelines[1] that take effect Jan. 1 for Medicare and private payers. Physicians and other clinicians will base their evaluation and management (E/M) levels of service on the documentation of time or medical decision-making only, with new definitions of both, so they don't have to factor in the history and exam, although they still must be medically appropriate. With the clock ticking, it's a good time to prepare, especially if providers are not swamped with COVID-19 patients, experts say.

CMS in the 2020 Medicare Physician Fee Schedule regulation "aligned" E/M coding with changes adopted by the American Medical Association (AMA) CPT Editorial Panel for office/outpatient visits, with a 2021 effective date. "Instead of the 1995 and 1997 Medicare documentation guidelines, we are going to be using a new set of guidelines for office and outpatient codes," said Valerie Rock, a principal with PYA in Atlanta, Georgia. The AMA documentation guidelines are baked into the CPT codes, which implies they apply to all payers, and CMS has embraced them. The E/M guidelines were created by the AMA and incorporated into the CPT manual, which is a departure from the past, when payers adopted the 1995 and 1997 guidelines.

The changes affect nine CPT codes: four for new patients (CPT 99202-99205)—99201 has been deleted—and five CPT codes for established patients (99211-99215).

"Technically, providers are going to be documenting as was always intended by the guidelines—documenting what's pertinent in the medical record, that communicates to you when you see the patient again and to your colleague who may see the patient later," and, in theory, for malpractice protections in the event of a lawsuit, Rock said. "Now there will not be this feeling that 'I have to do four HPI and 10 reviews of systems and three past, family, and social histories; eight organ systems; and medical decision-making.' Now it's less structured."

The AMA guidelines and its new medical decision-making table[2] (also known as a grid) represent the most sweeping changes to documentation requirements since CMS published its 1997 Medicare documentation guidelines, added Ronda Ash, president of RKAsh Consulting Associates, at a May 12 Health Care Compliance Association webinar.

She recommends compliance officers help physicians and advanced practice providers (APPs) consider how the new AMA guidelines will affect their coding and documentation practices. "It's important to start the conversation now," Ash said. Physicians will have to decide whether to base E/M levels of service predominantly on medical decision-making or time, which may depend on their specialty, she said. "How will we do this and support it in an audit trail?"

Providers have already gotten a taste of this with the expansion of telehealth during the COVID-19 public health emergency. CMS allows them to code their Medicare E/M telehealth services only by medical decision-making or time during the pandemic.[3]

Time May Take Backseat to Medical Decision-Making

Rock and Ash agree that medical decision-making will generally be preferable to time for CPT code selection when 2021 rolls around, partly because of the new definition of time. Currently, the 1995 and 1997 Medicare documentation guidelines only allow physicians to assign E/M codes when they spend at least 50% of the time on counseling and coordination of care—in other words, in face time with patients (e.g., discussing medication interactions). The new definition of time in the AMA guidelines is more expansive, Rock said. It includes face-to-face and non-face-to-face activities personally performed by physicians and APPs:

- "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 health care 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 (not separately reported)"

The guidelines label the time physicians must spend with patients the "minimum" amount of time, instead of the "typical" amount of time.

"Now that counseling and coordination of care have been removed and the entirety of the physician's work related to that patient is incorporated into that time, you can bill for that time," Rock said. But generally, there isn't much upside to billing E/M services based on time in terms of revenue. For example, physicians (and APPs) probably could support more 99213 or 99214 visits based on their documentation of medical decision-making than time-based 99213 or 99214. The 2021 definition of a 99213 (office or other outpatient visit for the evaluation and management of an established patient) is "a medically appropriate history and/or examination and low level of medical decision-making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

When physicians spend five minutes face to face with the patient and two minutes documenting the encounter, they probably don't want to bill the CPT code based on time, Rock said. The patient may have a minor condition that's stable or a chronic illness that may be better captured in terms of documentation and revenue with medical decision-making.

But physicians have to understand the new medical decision-making definitions "because there is a different mindset," Rock said. She recommends specialists devise examples suited to their own practices.

"The goal is to be clearer on the definitions, such as self-limited or minor problem and stable or chronic illness, as well as provide specificity to the data elements supporting different levels of complexity of service," Rock said. They were included in a table that's similar to the risk table used now to determine all three elements of medical decision-making.

The CPT panel revised the elements of medical decision-making. For example, instead of only counting the number of diagnoses, physicians will evaluate the complexity of problems addressed, and instead of counting the amount of data ordered or reviewed by category of service, they will count each order and review the discussion with an external provider.

The CPT panel also used the CMS table of risk "as a foundation for designing the revised required elements for medical decision-making," Ash said. Some ambiguous terms, such as "mild," were removed from the table of risk. The medical decision-making table also defines important terms, including "independent historian," she said.

"By clarifying the terms within the medical decision-making table, these new guidelines should be easy to apply, as the new table explains what's needed for each CPT code grouping," Ash said. But there are definitions in the guidelines that physicians must understand, Rock added. "If people use the table alone, they may make inferences that are not the same as the definitions."

Ash agreed that "clinicians will have to use medical decision-making predominantly." For example, infectious disease specialists probably want to base code selections on medical decision-making, although oncologists who are putting together a treatment plan for a new patient might want to use time. "It probably depends on the type of practice and its documentation patterns," she said.

What Do Definitions Mean for Your Practice?

There's a good chance that physicians will code to more level three E/M services vs. level four E/M than they did in the past based on the new guidelines, Rock said. With the new medical decision-making table, the concept of new vs. established problem is removed and the count of diagnoses is applied to an abbreviated version of the Presenting Problem column in the predecessor guideline's table of risk. This means that one acute, uncomplicated illness or injury will be in line with low complexity instead of what may have met the definition of a new problem and considered moderate before. There's a 30% increase in the relative value units of 99213 and a 25% increase in the relative value units of 99214, however, so it shouldn't be too worrisome to providers, she said.

The guidelines include examples with their definitions, and Rock suggests practices tailor the examples to help the physicians' training and understanding. For example, the guidelines describe acute, uncomplicated illness or injury as "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."

That's where the "rubber meets the road," Rock said. "What do the definitions mean for your practice? They need to be applied to your specialty."

There will be winners and losers with respect to the codes and the guidelines, she noted. "All the codes are going up in value. It will be a matter of how physicians use the codes and how the guidelines change the code selection," she said. "So it's a matter of learning the guidelines and starting to audit your own services and getting a sense of how your services might change so you can see what potential revenue impact it might have."

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1 American Medical Association, "CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes," last accessed May 15, 2020, http://bit.ly/36FLiVU.
2 American Medical Association, "Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)," last accessed May 15, 2020, https://bit.ly/2T3azEH.
3 Nina Youngstrom, "CMS Covers Telehealth Like In-Person Visits During COVID; Back-End Logic Frees M.D.s," *Report on Medicare Compliance* 29, no. 14 (April 13, 2020), https://bit.ly/35myHqR.