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2021 E/M Coding Changes

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This presentation will focus only on the changes in E/M coding for an office visit.

It does not include all the coding changes in the final rule.

Currently (August 2020) these coding changes only apply to Medicare

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Current Guidelines

The current iteration of CPT E/M codes was established in 1992. The CPT guidelines state that code selection is based on two primary tracks:

Key Components: History, Exam and Medical Decision Making.

Time: The time spent face-to-face in the office or other outpatient setting with the patient. Time is only to be used as a key component for code selection when counseling and/or coordination of care is more than 50% of the visit.

E&M Coder

Service Type: Office or Other Outpatient Services
Patient Type: ☐ New ☑ Established

HPI Questions Asked
☑ 1-3 Questions
☐ 4 or More Questions

ROS Addressed
☐ 1 System
☑ 2-9 Systems
☐ 10+ Systems

Medical, Family, and Social History
☑ Past Medical History
☐ Family Medical History
☐ Social History

History Summary
☐ Problem Focused
☑ Expanded Problem Focused
☐ Detailed
☐ Comprehensive

Describe abnormal findings in detail. Normal findings in unaffected organ systems may be noted as "normal", without elaboration. For purposes of tabulating the exam, E&M recognizes the following 12 organ systems: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular,

Examination Performed
☐ 1-5 Exam Items
☑ 6-11 Exam Items
☐ 12+ Exam Items
☐ 2+ Exam Items on 9 Systems

Exam Summary
☐ Problem Focused
☑ Expanded Problem Focused
☐ Detailed
☐ Comprehensive

Number of Diagnoses or Management Options
☐ Minimal
☐ Limited
☑ Multiple
☐ Extensive

Amount and/or Complexity of Data to be Reviewed
☐ None/Minimal
☑ Limited
☐ Moderate
☐ Extensive

Risk of Complications and/or Morbidity or Mortality
☐ Minimal
☐ Low
☑ Moderate
☐ High

Medical Decision Making Summary
☐ Straightforward
☐ Low Complexity
☑ Moderate Complexity
☐ High Complexity

Calculated Code: 99213

Modifier | Global Detail

Estimated time spent with patient: 00:00 (hrs:mins) ☐ Add to Note

Reset | Cancel | Accept

Level 1: TIME

ADULT
☑ Established Patient . . .
☐ New Patient . . .
☐ Consult . . .

PEDIATRIC
☐ Established Patient . . .
☐ New Patient . . .

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What is changing and why

For the CPT 2021 code set, the CPT Editorial Panel approved historic changes to the CPT E/M office visit codes. The primary objectives of these revisions were:

- To decrease administrative burden of documentation and coding
- To decrease the need for audits, through the addition and expansion of key definitions and guidelines
- To decrease unnecessary documentation in the medical record that may not be pertinent to the patient's care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

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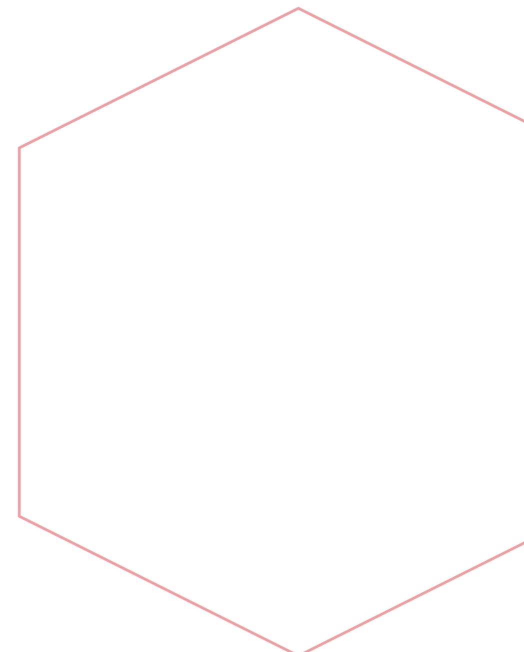
Summary of Revisions

Eliminate history and physical as elements for code selection: While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both time and medical decision making, these elements alone should not determine the appropriate code level.

The code descriptors are revised to state providers should perform a "**medically appropriate history and/or examination**"



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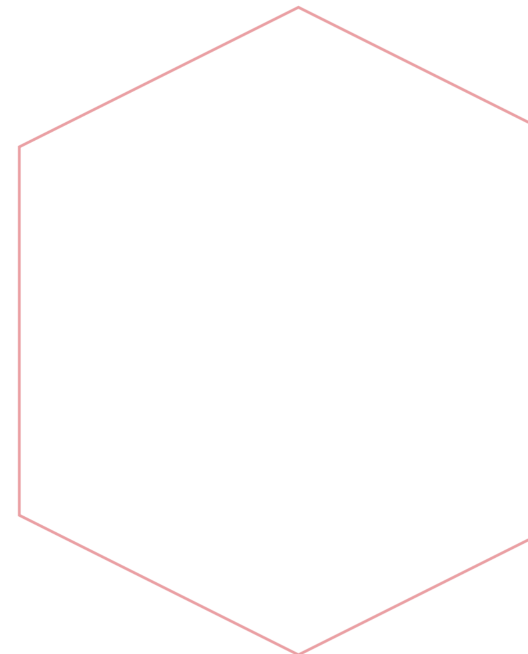
Summary of Revisions

Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time:

MDM: The three current MDM sub-components did not materially change but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines.

Time: The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and not MDM.



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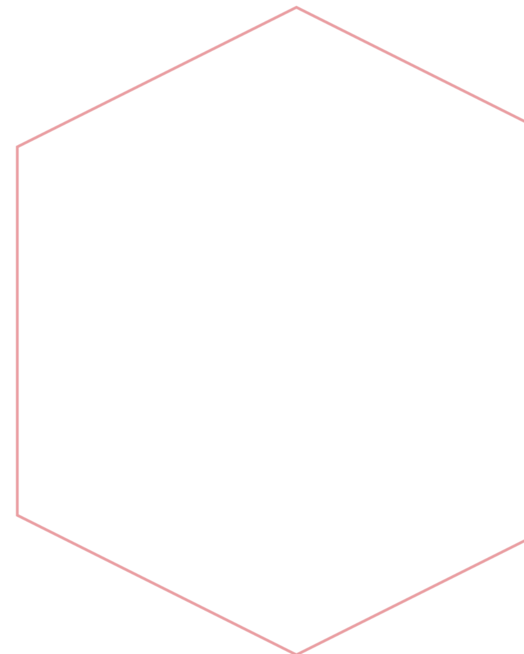
Summary of Revisions

Deletion of CPT code 99201: deleted CPT code 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.

Creatio**n of a shorter Prolonged Services code:** 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. (Code still to be determined)



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Let’s Dig Deeper

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Medical Decision Making

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Medical Decision Making (MDM)

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

MDM in the office code set is defined by three elements:

1. Number and complexity of problems that are addressed during the encounter.
2. Amount and/or complexity of data to be reviewed and analyzed. Data is divided into three categories:
   - Tests, documents, orders, or independent historian(s). Each unique test, order, or document is counted to meet a threshold number.
   - Independent interpretation of tests.
   - Discussion of management or test interpretation with: external physician, QHP, or other appropriate source.
3. Risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

There are four levels of MDM: straightforward, low, moderate, and high.

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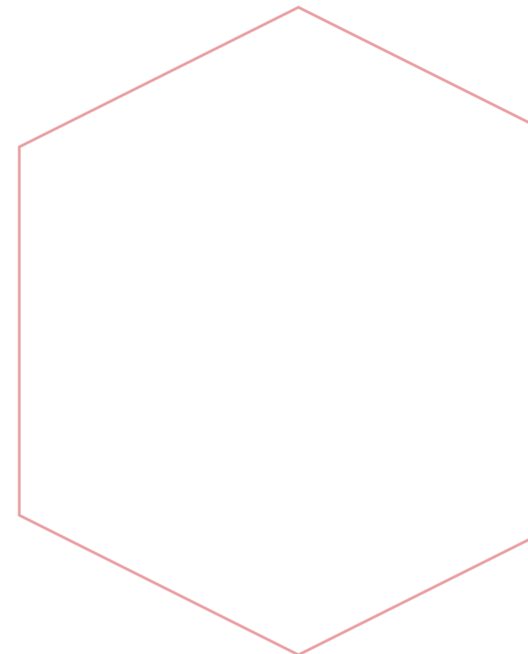
Medical Decision Making (MDM)

the three current elements were left fundamentally intact and maintained the current CMS Table of Risk as the primary guide to selecting the level of MDM for E/M office or other outpatient visits.

While the framework was maintained, the revisions primarily address several critical issues with the current understanding of MDM:

- Integrated current documentation standards into CPT guidelines
- Lack of key definitions & ambiguity within the current definitions
- Coding designed around counting and check boxes and not patient care



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Medical Decision Making (MDM)

Integrated current documentation standards into CPT guidelines

As there are two sets of CMS E/M Documentation Guidelines (1995 and 1997), and there is no single, unified source of documentation standards for CPT E/M office or other outpatient visits, the CPT E/M reporting guidelines have historically incorporated many, but not all, of the concepts outlined by CMS.

To ensure a consistent understanding across all payers and providers alike, the new CPT E/M office visit reporting guidelines have been written to align with CMS documentation guidelines and to refine the many different standards into a unified source for reporting E/M office visits.

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Medical Decision Making (MDM)

Lack of key definitions & ambiguity within the current definitions

Removed ambiguous terms (e.g., mild exacerbation) which were difficult to define and had multiple interpretations across not just payers, but ambiguity across all users alike.

Added key definitions to common concepts currently used in assigning MDM levels.

- Example: Acute illness with systemic symptoms > An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications.

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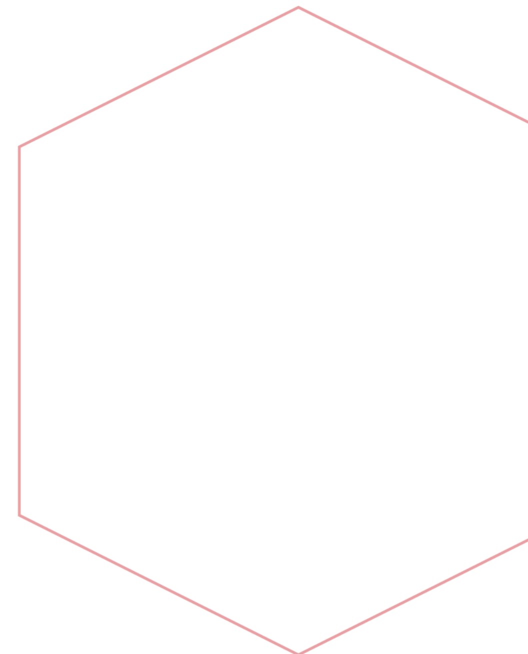
Medical Decision Making (MDM)

Lack of key definitions & ambiguity within the current definitions (cont.)

Added definitions to common concepts not currently used in assigning MDM levels

- Independent historian(s): An individual (i.e. 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 (i.e, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
- Social Determinants of Health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.



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Medical Decision Making (MDM)

Lack of key definitions & ambiguity within the current definitions (cont.)

Current coding is designed around counting and check boxes and not patient care

- Re-defined the Amount and/or Complexity of Data to be Reviewed element of MDM to move away from simply summing tasks to focusing on tasks that affect the management of the patient (e.g., adding tasks such as: independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP).

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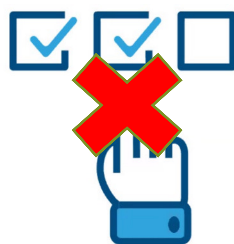
How will these revisions change the way I document MDM levels for E/M office visits?

You can now select your level of E/M office visit based on how you think through good patient care rather than focus on counting elements and check boxes that may or may not be relevant to your patients



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Requirements for each level of MDM

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Risk of Complications and/or Morbidity or Mortality of Patient Management
Definitions of risk are based upon the usual behavior and thought processes of a Physician/QHP in the same specialty. Trained clinicians apply Common language usage meanings to terms such as "high", "moderate", "low", or "minimal" risk and do not require quantifications for these definitions.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**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.*	**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**

99211: MDM does not apply, as the visit is not designed to be reported by a physician/QHP.

99202/99212: Straightforward is the lowest level of MDM and requires minimal elements throughout.

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Number/Type and Complexity of Problems Addressed at the Encounter

Adel information on next slide.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**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.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
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

Low risk

For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter.

Catefory1: Test and documents

Each test, order, or document can be counted towards the category (e.g., ordering two test fully qualifies under this category).

Number/Type and Complexity of Problems Addressed at the Encounter

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

Stable, chronic illness: a Problem with an expected duration of at least one year or until the death of the patient.

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 acute, uncomplicated illness.

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Number/Type and Complexity of Problems Addressed at the Encounter

Adel information on next slide.

	3 Elements of MDM)	Number and Complexity of Problems Addressed	*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or**	**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

Category 2: Independent Interpretation of Tests

Categories 2 and 3 were added to the data element of the MDM table to introduce greater weight to the cognitive skills the physician uses in caring for the patient and not on simply counting the number/type of test ordered/reviewed.

Diagnosis/treatment significantly limited by Social Determinants of Health.

For the first time, the CPT guidelines expressly define Social Determinants of Health and Include it as part of the consideration for the level of patients risk of complications.

Number/Type and Complexity of Problems Addressed at the Encounter

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side affects but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ. The injury is extensive or the treatment options are multiple and/or associated with risk of morbidity.

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Number/Type and Complexity of Problems Addressed at the Encoumter
Add'l information on next slide.

Code	(Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**...unt 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.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of 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

Number/Type and Complexity of Problems Addressed at the Encounter

Adel information on next slide.

Extensive:

To quality for the Extensive level, note that two of the listed categories mut be completed. In all other levels of MDM, only one category must be completed.

Number/Type and Complexity of Problems Addressed at the Encounter

Chronis illnesses with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Acute or Chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effect of treatment, that poses a threat to life bodily function in the near term without treatment.

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Requirements for Time Coding

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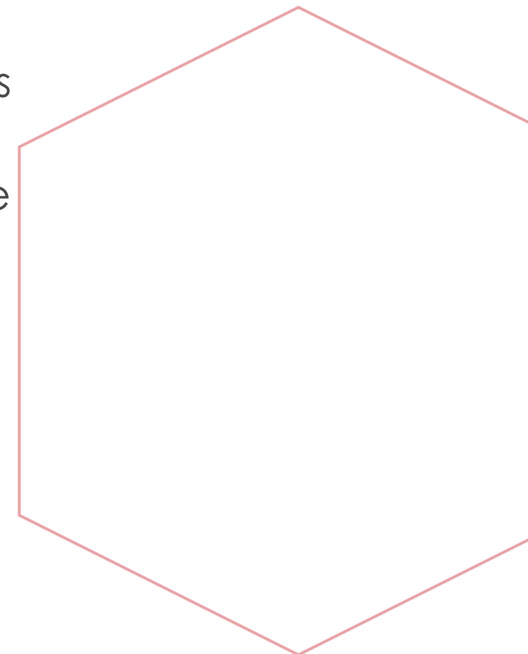
Current Time Coding

According to the current CPT guidelines and code descriptors, time can only be used as a controlling factor for selecting office visit levels when **counseling and/or coordination of care dominates (more than 50%) the encounter** with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility).

This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian).

The extent of counseling and/or coordination of care must be documented in the medical record.



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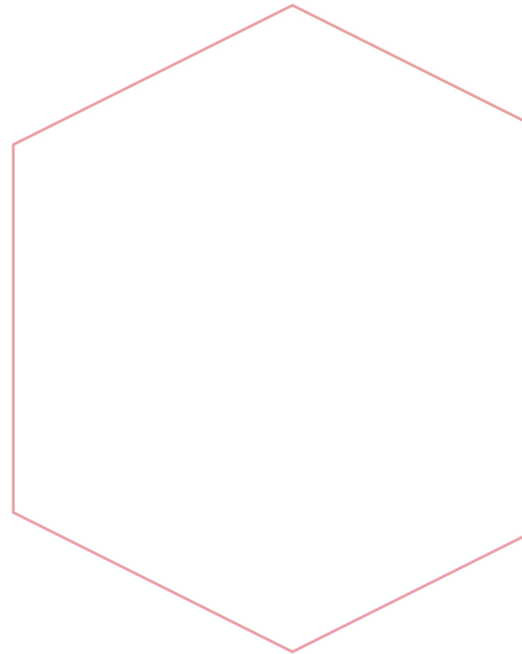
Current Time Coding

Also, each CPT code has a "typical" time associated.

CPT Code	Current Typical Face-to-Face Time (in minutes)
99201	10
99202	20
99203	30
99204	45
99205	60



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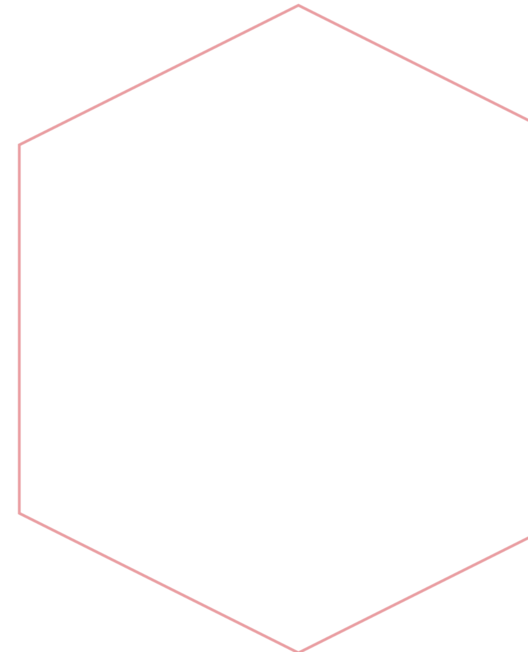
2021 Time Coding

In order to make time-based code selection accurate "typical" times were removed and specified time ranges for the total E/M service time spent on the date of the face-to-face encounter were added.

The time ranges remove the ambiguity of determining what is considered as "typical" time. When the total time of the visit is between the listed ranges, the appropriate code is easy to identify



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2021 Time Coding

CPT Code	Revised Minimum Total Time Ranges
99202	15–29
99203	30–44
99204	45–59
99205	60–74

Note, CPT code 99201 was deleted to standardize the number of codes reportable by physician/QHPs.

CPT Code	Revised Minimum Total Time Ranges
99211	N/A (Non-physician/QHP code)
99212	10–19
99213	20–29
99214	30–39
99215	40–54

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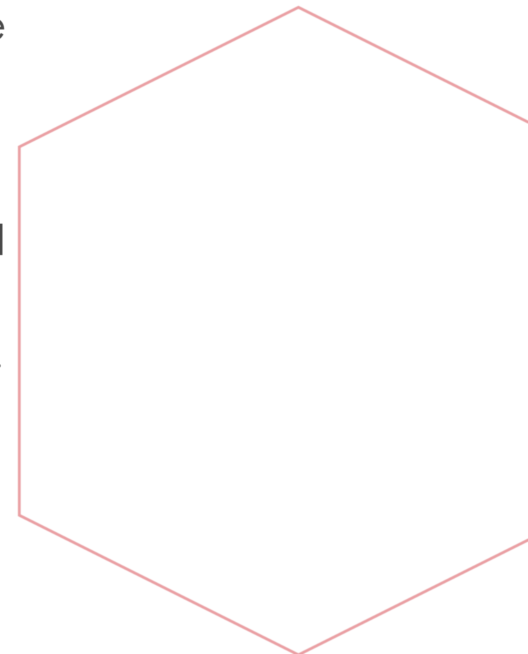
What is included when considering time?

Only the total time on the date of encounter should be counted. The time that is counted is all the time on the calendar date of the encounter only.

The revisions also added clarity to the activities that may be counted in the time the physician or/QHP spends with the patient. The time should only include that of the physician or/QHP that reports the visit. It should not include time spent by clinical staff.



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What is included when considering time?

1. Preparing to see the patient
2. Obtaining and/or reviewing outside history
3. Providing a medically appropriate exam and history
4. Counseling and educating the patient/family/caregiver
5. Ordering medications, test, or procedures
6. Referring and communicating with other health care professionals (when not reported separately)
7. Documenting clinical information in EHR or other health record
8. Independently interpreting results and communicating results to the patient/family/caregiver (when not reported separately)
9. Care coordination (when not reported separately)

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Prolonged Services

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2021 Time Coding: Prolonged Services

Prolonged services code

The new prolonged services code has a shorter time increment (15-minute increments) that would capture physician/QHP time beyond the time of the highest-level E/M office or other outpatient visit (i.e., 99205, 99215. This is a change from the current coding structure, which doesn't capture time until the first 30 minutes have been reached.

This new prolonged services code can only be reported in conjunction with 99205 and 99215 and is used when time is the primary basis for code selection.

The new code has not been set as of the date of this presentation. It is only referred to as 99XXX. It will be billed with the units (in 15-minute increments) above the set time for 99205 and 99215.

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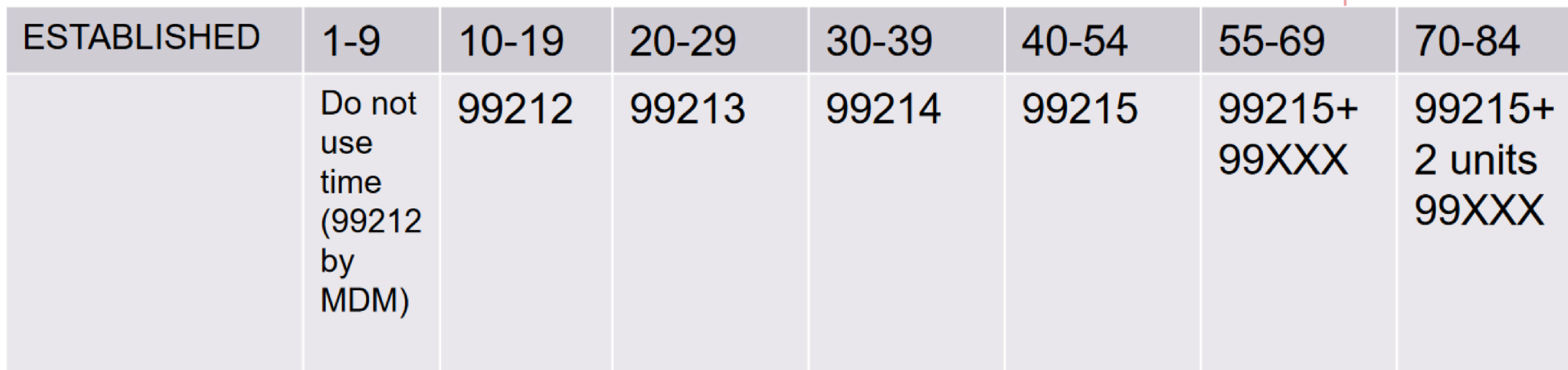
2021 Time Coding: Prolonged Services

Use 99XXX in conjunction with 99205, 99215

Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416

Do not report 99XXX for any time unit less than 15 minutes



ESTABLISHED	1-9	10-19	20-29	30-39	40-54	55-69	70-84
	Do not use time (99212 by MDM)	99212	99213	99214	99215	99215+ 99XXX	99215+ 2 units 99XXX

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Shared or Split Service

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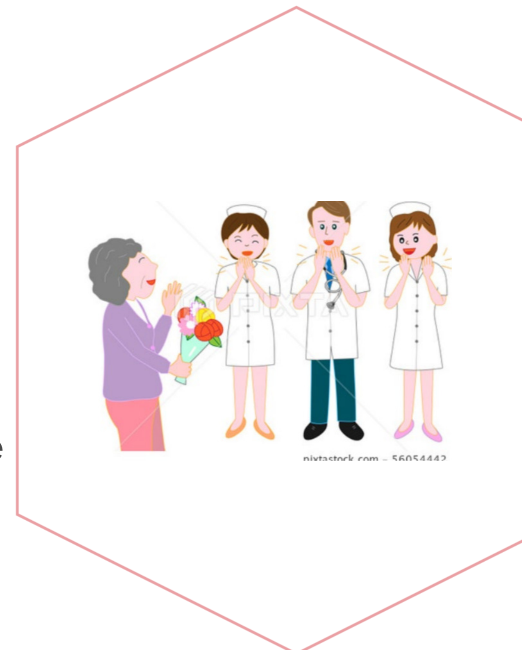
2021 Time Coding: Shared or Split visit

A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.

When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and/or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.

Only distinct time should be summed for shared or split visits. Only one provider/QHP can include the shared time when calculating their E/M code for the encounter.



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SERVICES REPORTED SEPARERATELY
(for both MDM and Time coding)

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SERVICES REPORTED SEPARATELY

Specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services maybe reported separately.

Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making and time coding.

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2021 Coding changes: Summary/Resources

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Summary

- Changes go into effect on January 1, 2020. Currently (Aug 2021) this only applies to Medicare.
- The patient history and physical exam elements will no longer be components of E/M level code selection.
- CPT code 99201 will be deleted and will no longer be available as a CPT code selection.
- Physicians will have the option to select the level of visit using either total time or medical decision making (MDM).
    - Total time may be used alone to select the appropriate code level for the office or other outpatient E/M services codes (99202-99205, 99212-99215). Total time is the cumulative amount of time spent in care of the patient on the date of the encounter, inclusive of face-to-face and non-face-to-face time spent by the physician and/QHP. It includes activities such as review of tests; obtaining and/or reviewing separately obtained history; ordering medications, tests or procedures; documentation of clinical information in the electronic health record (EHR) or other records; and communication with the patient, family, and/or caregiver(s).
    - MDM is the reflection of complexity in establishing a diagnosis, assessing the status of a condition and/or selecting a management option.

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Resources

AMA: Implementing CPT Evaluation and Management (E/M) Revisions: https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions

AMA Code and Guideline Changes: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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Expert Solutions
Stronger Partners
Healthier Patients

— Name, Title

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