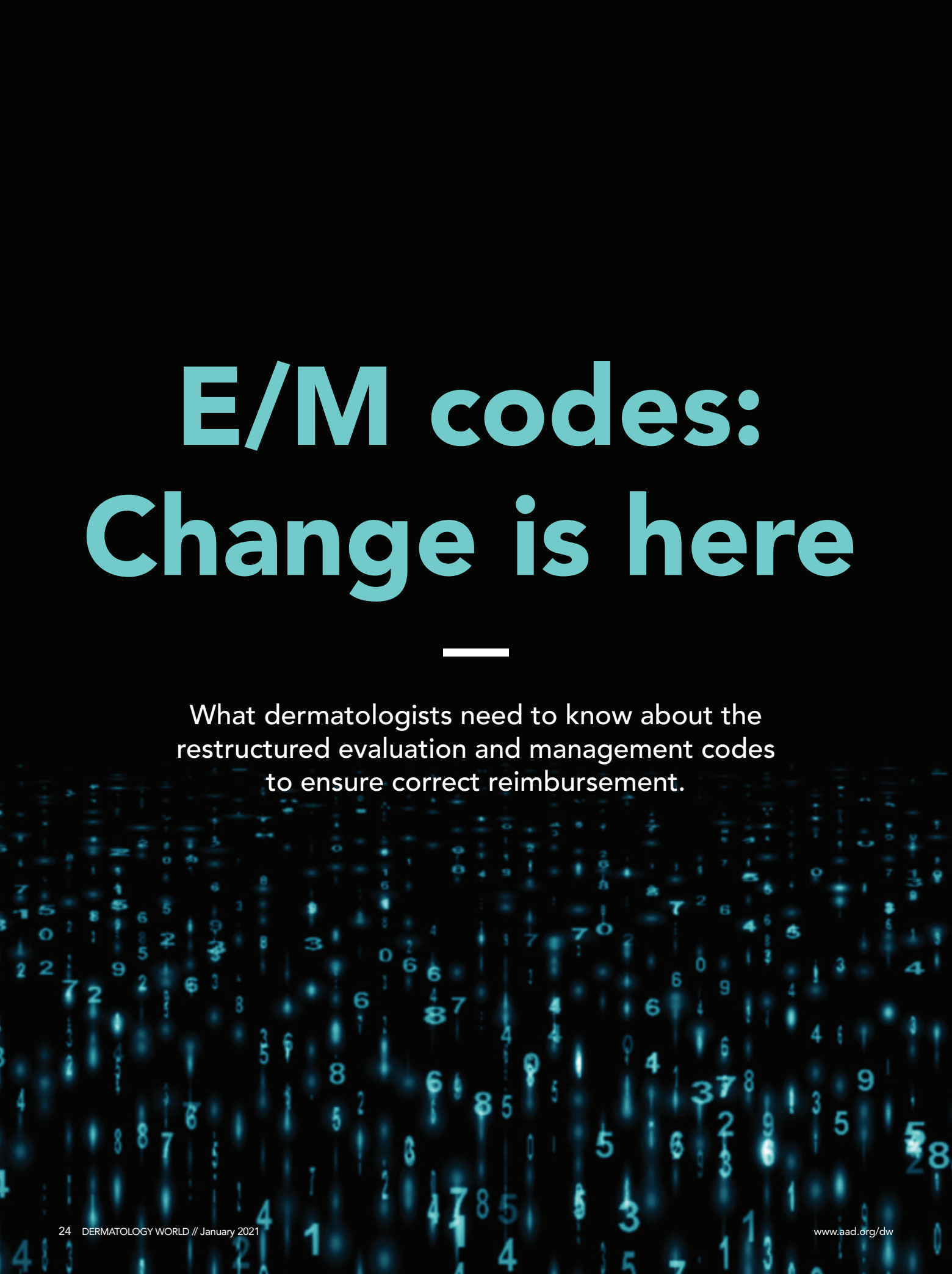
E/M codes: Change is here

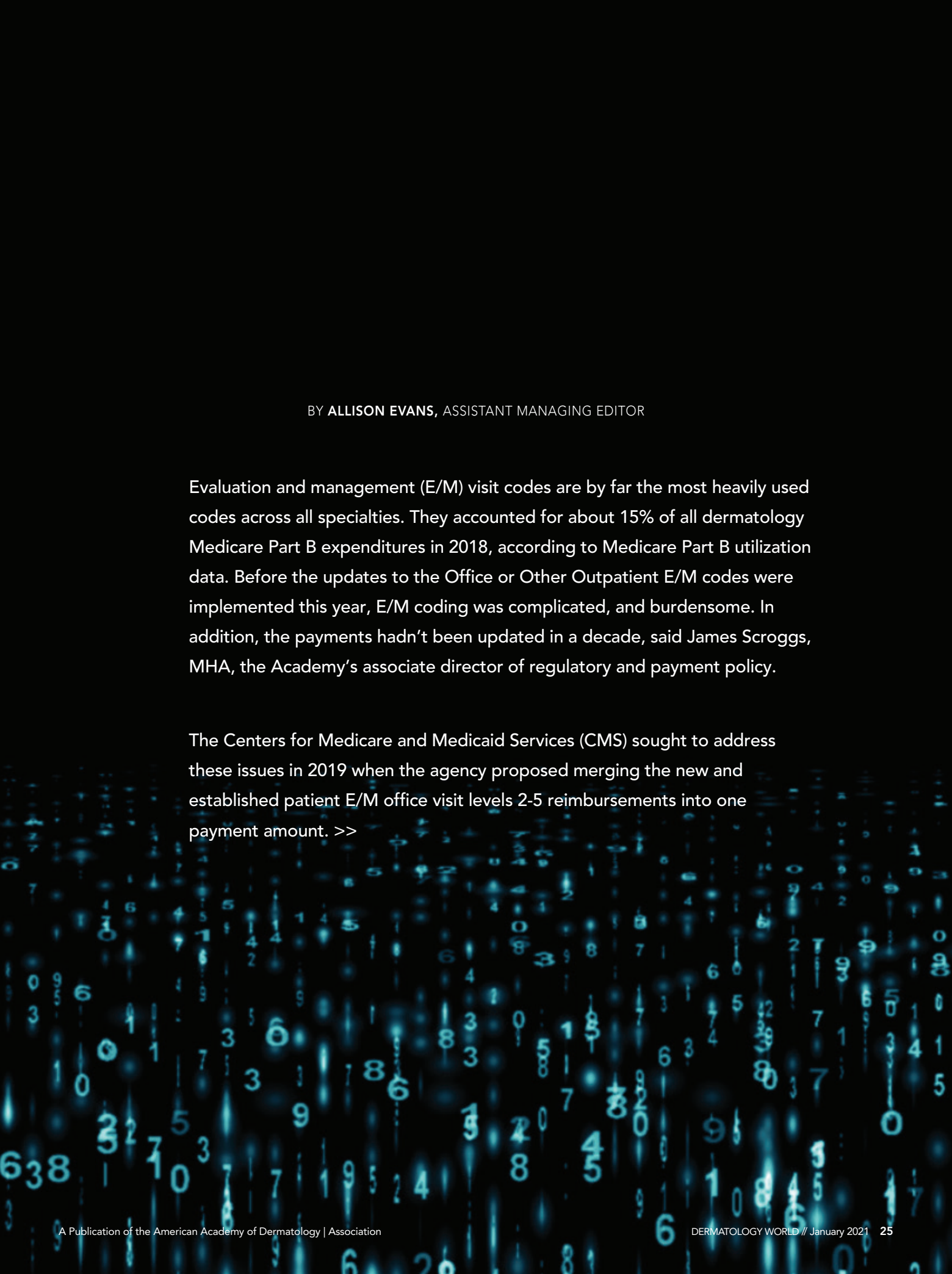
What dermatologists need to know about the restructured evaluation and management codes to ensure correct reimbursement.



BY **ALLISON EVANS,** ASSISTANT MANAGING EDITOR

Evaluation and management (E/M) visit codes are by far the most heavily used codes across all specialties. They accounted for about 15% of all dermatology Medicare Part B expenditures in 2018, according to Medicare Part B utilization data. Before the updates to the Office or Other Outpatient E/M codes were implemented this year, E/M coding was complicated, and burdensome. In addition, the payments hadn't been updated in a decade, said James Scroggs, MHA, the Academy's associate director of regulatory and payment policy.

The Centers for Medicare and Medicaid Services (CMS) sought to address these issues in 2019 when the agency proposed merging the new and established patient E/M office visit levels 2-5 reimbursements into one payment amount. >>



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"This would not have been helpful to dermatology as a whole because it would have reimbursed a simple, straightforward visit at the same level as some of the more complicated patients we see, like those with cutaneous t-cell lymphoma or lupus, which may require multiple medications, close monitoring, and lab work," said Alexandra Flamm, MD, an alternate advisor for the Academy with the American Medical Association (AMA) RVS Update Committee (RUC).

To offset the cost of the consolidation, CMS also proposed reducing payments for the E/M service or the procedure by 50% when the E/M service was reported with modifier 25. The modifier 25 cut would have resulted in a reduction in office E/M payments for dermatologists of about 25%, or about 7% of total dermatology payments. After vehement opposition from the medical community, CMS held off on its proposal, giving the house of medicine the opportunity to take the lead.

The house of medicine attempts to solve the problem

The AADA, the AMA, and other partner organizations and societies implored CMS to allow the AMA CPT Editorial Panel and the RVS Update Committee to find a more equitable solution that would not penalize dermatologists and other specialty physicians and would reflect the actual amount of work done by a physician or qualified health professional (QHP) while also satisfying CMS' financial concerns.

"We wanted to try to create something better, something that would decrease the administrative and documentation burden, but at the same time would appropriately reimburse physicians for the time spent with patients and the medical decision making that goes into it," Dr. Flamm explained.

The CPT panel made several code changes and the RUC made valuation recommendations to CMS. The agency accepted the recommended changes, and these changes, as well as a few add-ins from CMS, went into effect Jan. 1.

This month, *DermWorld* provides a comprehensive overview of the restructuring of E/M codes so that dermatologists can confidently code office-based E/M services to ensure appropriate reimbursement. The article will also explain why dermatologists may see changes in payment in 2021 because of the changes to E/M codes.

MDM elements

MDM elements	Description
Number and complexity of problems addressed during the encounter	**Determination of number and complexity of the patient condition as either:** • Self-limited or minor • Stable, chronic illness • Acute uncomplicated illness or injury • Undiagnosed new problem with uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury • Chronic illness with severe exacerbation, progression, or side effects of treatment • Acute or chronic illness or injury that poses a threat to life or bodily function
Amount and/or complexity of data to be reviewed and analyzed	**Includes reviewing:** • Medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter o Information obtained from multiple sources or interprofessional communications that are not separately reported o Interpretation of tests that are not separately reported ✓ Ordering a test is included in the category of test result(s). The review of the test result is part of the encounter and not a subsequent encounter. o Data to be reviewed 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 or other qualified health care professional or appropriate source
Risk of complications, morbidity and/or mortality of patient management	**Includes:** • Decisions made during the visit associated with the patient's problem(s), the diagnostic procedure(s), treatment(s) • Possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family (e.g., decision to perform surgery includes consideration of alternative options of treatment)

Choose one: MDM or time

Most notably, and what is likely a breath of fresh air for dermatologists, coding for office or outpatient E/M services is now based solely on either the level of medical decision making (MDM) OR total time spent by the physician (or QHP) on the date of the encounter. While a medically appropriate history and examination must be documented in the patient record, it will not impact the billing level, said Alexander Miller, MD, who represents the Academy on the AMA-CPT Advisory Committee.

"Coding guidance for the 2021 E/M service codes has a clear focus on patient care," said Scroggs. "By reducing the administrative burden of checking boxes for the history and examination, the new guidelines allow dermatologists to code for E/M services based on their medical decisions." These changes promote appropriate coding and payer consistency when audits are performed.

"It's just going to be easier," said Dr. Miller. "You don't have all of these different facets of history and physical exam and problem severity to deal with. We just have medical decision making or time."

Physicians will need to decide whether it is more appropriate to report a patient visit by MDM or total time. In the previous structure, total time could be reported as the sole determinant — but only when greater than 50% of the time spent with the patient was spent on coordination of care or counseling. Now time alone can qualify, regardless of whether it is for coordination or counseling.

Breaking it down

Medical decision making

MDM includes establishing a diagnosis, assessing the status of a condition, and/or selecting a management option. "Within the criteria of medical decision making, the levels are explained much more effectively and with much greater specificity per level so that we can choose more easily," explained Dr. Miller.

Test your knowledge

Question: Using MDM, what is the appropriate E/M level service code for an established patient encounter for a 16-year old male with previously stable acne who today presents with an exacerbation of severe nodulocystic acne requiring care coordination and initiation of isotretinoin therapy? The dermatologist provided patient education, informed consent was obtained, and laboratory testing was ordered prior to initiating treatment. Turn to page 29 to view the correct answer.

In 2021 there are four levels of MDM: straightforward, low, moderate, and high. The four levels of MDM include the following three elements:

- Number and complexity of problems addressed during the encounter
- Amount and/or complexity of data reviewed/analyzed
- Risk of complications, morbidity, and/or mortality of patient management

Two of the three elements listed above must be met or exceeded to qualify for each level of service. The combination of these elements determines the E/M level of service reported. None of the MDM concepts apply to code 99211 (keep reading to find out why).

Derm Coding Consult

Get the latest information about accurate diagnostic and procedural coding as well as Medicare reimbursement issues in dermatology at **www.aad.org/member/publications/dcc**.

2021 office visit E/M service codes: Time

New patient E/M code	2021 total time	Established patient E/M code	2021 total time
99201	Code deleted	99211	Time component removed
99202	15 – 29 minutes	99212	10 – 19 minutes
99203	30 – 44 minutes	99213	20 – 29 minutes
99204	45 – 59 minutes	99214	30 – 39 minutes
99205	60 – 74 minutes	99215	40 – 54 minutes

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Time

The AMA has changed the definition of the time element associated with codes 99202-99215 from typical face-to-face time to total time spent on the day of the encounter and the amount of time associated with each code. Total time includes non-face-to-face services and reflects clear time ranges for each code.

Total time includes time in activities that require the physician/QHP and does not include time in activities normally performed by clinical staff. Time includes the following activities, when performed:

- Pre-service work, such as obtaining and/or reviewing separately obtained history/laboratory data prior to a face-to-face interaction with the patient
- Intra-service work, such as face-to-face patient work including performing a medically appropriate examination and/or evaluation and counseling the patient/family/caregiver, and educating, charting
- Post-service work, such as coordination of care, ordering medications, laboratory tests or procedures, referral letter writing, and documenting clinical information in the electronic or other health record by the physician/QHP

Each CPT code, 99202-99205 and 99212-99215 has defined time ranges listed within the code descriptors. See the time ranges for each code selection on page 27.

Test your knowledge

Question: Based on time, what is the correct coding for a new patient office visit where the total face-to-face time with the patient plus the time spent reviewing records prior to the encounter and then coordinating care post encounter total 23 minutes? Turn the page to view the correct answer.

So long, 99201

As most dermatologists may be aware, the new patient code 99201 no longer exists. "In 2020, the CPT-defined difference between codes 99201 and 99202 hinged upon distinctions in history and examination (problem focused versus expanded problem focused) areas, whereas the medical decision making is 'straightforward' for both," Dr. Miller explained. Since code selection is now based solely on MDM or total time, and the MDM for both 99201 and 99202 is "straightforward," the two codes would have had an identical MDM definition.

Instead, physicians can use the new MDM qualifying criteria, a straightforward MDM visit, which would be reported with CPT 99202. Another option would be to report the visit based on the total time spent dealing with the patient's problems on the day of the visit.

What about CPT code 99211? Is it deleted? "No. It is preserved, but somewhat modified," said Dr. Miller. "Since 99211 describes attention given to minimal problems for which the presence of a physician/QHP may not be required, MDM is not factored into this code selection. Neither is time relevant, as a physician/QHP is not required, and time is only summed for services delivered by a physician/QHP."

A dichotomy of E/M coding

The 2021 E/M changes only apply to the Office and Other Outpatient Services: 99202 – 99215. There are no changes to Hospital Observation, Hospital Inpatient, Consultation, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, and Home care services. E/M services provided by dermatologists in these settings must continue to be reported using the E/M key components (history, physical examination, and MDM). According to Dr. Miller, it is likely that these codes will be evaluated in the future. Currently, however, "a dichotomy of E/M parameters will exist, with the updated construct used to report office, outpatient care, and the older system for specifying E/M care provided in all other settings."

CMS' add-on code and valuation changes

In addition to the coding changes proposed by the CPT-RUC workgroup, CMS included an add-on code, G2211, for complex E/M visits, which costs an additional $3 billion. "The Academy does not support this code and it is something we have actively opposed," Scroggs said.

Furthermore, CMS has increased the value of several cognitive services to be paid more consistently with the office and outpatient E/M visits, including but not limited to: Transitional Care Management (TCM) Services; Cognitive Impairment Assessment and Care Planning, and Initial Preventive Physical Examination (IPPE); and Initial and Subsequent Annual Wellness (AWV) Visits. The

AADA is advocating that the E/M reimbursement changes are reflected/flow through into those codes that have incorporated an E/M value into them, including procedures with global periods.

Updated E/M coding tool
Answer a few key questions to help determine the appropriate levels of service. Try out the Academy's E/M tool at **www.aad.org/member/practice/coding/em/coding-tool**.

Budget neutrality and reimbursement

The work relative value units (RVUs) increased for nearly all E/M services, resulting in higher payment rates for the services that account for about 40% of all Medicare Physician Fee Schedule spending in a given year. CMS asserts it is required to apply the budget neutrality adjustment, which reduces the conversion factor by 10%.

Budget neutrality was passed on the congressional level, noted Dr. Flamm. "This means that we only have one pot for every single CPT code. If E/M codes are going to be valued higher, the conversion factor for all other codes has to be changed and decreased in order to account for this increase on the other side."

The money spent in providing higher reimbursement for office-based E/M visits must be paid for from elsewhere — and procedural codes have taken a substantial hit.

"If revisions to the RVUs cause expenditures for the year to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million," CMS stated in the proposed rule.

The final rule for the 2021 fee schedule will cut payments to dermatology by 1%, with proceduralists facing larger cuts. Pathologists face an overall 9% reduction and general surgeons face an estimated 6% reduction. This reduction doesn't consider the financial strain on dermatology practices as they recover from the unprecedented effects of the COVID-19 public health emergency (PHE).

The AADA worked tirelessly, both independently and in coalitions, to stop the pending Medicare cuts and will continue to advocate with CMS and Congress to ensure a viable physician workforce now and beyond the PHE, said Scroggs. The "AADA will continue to push for this change with CMS and through Congress, which would balance the impact on dermatology."

"Waiving the budget neutrality requirements is especially important in the setting of the public health crisis," noted Dr. Flamm. "This will be a hit to many dermatologists — and other physicians — and we want to make sure that CMS and Congress are aware of this tremendous burden during a precarious time."

"Throughout the pandemic, many practices already have seen drops in patient volume and reimbursement and have received loans to maintain the viability of their practices," said Dr. Miller. "Now, many dermatologists will be faced with an added penalty that can only be changed through congressional action."

What does it mean for dermatologists?

Overall, the news is mixed because while dermatologists frequently use E/M codes, they also perform a lot of procedures, Dr. Miller said. Even non-surgical dermatologists are still likely to commonly destroy lesions with liquid nitrogen (17000-17004), and those procedures are still subject to the 10% reduction in valuation.

Change is often unwelcome, said Dr. Miller. It can be hard to see the benefit of any new system, even if not for very logical reasons, he explained. While the new system is not perfect, compared to what CMS was prepared to implement, the new E/M coding structure that was implemented at the start of this year was a much better option for dermatologists.

"We, as physicians, had the choice of accepting something predetermined for us by CMS, or we could offer our own revision of outpatient E/M coding and reimbursement via the CPT-RUC system, which facilitates input from the house of medicine," Dr. Miller said. **DW**

Answer Key

Pg. 27 - **Answer:** Based on the new E/M coding guidelines, one must meet or exceed two out of the three elements for the selected E/M code. In this encounter, the patient presents with one chronic illness with exacerbation for which the dermatologist prescribes medication, orders, and will review laboratory testing. The chronic illness with exacerbation meets the moderate level for number of problems addressed, the laboratory test is ordered and will be reviewed by the dermatologist which supports the requirement for low complexity of data to be reviewed and analyzed, while the treatment course has a moderate risk of morbidity due to prescription drug management. Therefore, the correct code is 99214.

Pg. 28 - **Answer:** The encounter is appropriately reported with 99202 — total time spent 15-29 minutes.