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2021 E/M Office and Outpatient Coding and Documentation:

3 Critical Concerns to Address in Your Update Plan

On Jan. 1, 2021, CPT® evaluation and management (E/M) coding will undergo its largest change since the Centers for Medicare & Medicaid Services (CMS) introduced the 1997 Documentation Guidelines for Evaluation and Management Services.

Healthcare organizations committed to optimizing reimbursement through efficient, compliant coding and documentation practices must start preparing now for a substantial overhaul of CPT® code descriptors and guidelines for office and other outpatient E/M services.

The American Medical Association (AMA), which holds copyright in CPT®, and CMS intend for the upcoming changes to better align E/M documentation and coding with how medicine is practiced today, but implementation will still bring challenges. Provider groups, health systems, hospitals, and others in the healthcare industry can streamline the transition through careful analysis of their current resources and documentation practices, and through focused training for their providers and coders. This groundwork will help healthcare organizations address three top areas of concern for 2021 and beyond:

1. Using the updated E/M codes properly
2. Applying different sets of guidelines to different E/M service types
3. Evaluating the organization-specific financial impact of these changes

Why Are E/M Changes Coming? A Brief History

In short, the upcoming changes affect only office and other outpatient E/M services currently reported using CPT® codes 99201-99215. Selection of office/outpatient codes will be based on either medical decision making (MDM) or time for dates of services on and after Jan. 1, 2021. The levels of history and exam provided will no longer be factors for office/outpatient E/M coding, and the time counted for these visits will change from intraservice (face-to-face) time to total E/M time on the service date. New, detailed CPT® E/M guidelines will apply to the revised codes, and Medicare payment for many of these codes will change, as well.

The plan for this dramatic shift in office/outpatient E/M coding did not appear without warning. Clinicians and medical coders have raised concerns about the complexity of E/M coding for many years. For instance, CMS' 1997 Documentation Guidelines include nearly 50 pages of rules, tables, and documentation requirements that apply to E/M services. And those rules do not exist in isolation. Coders and providers also must be aware of CPT®, private payer, and even other CMS guidelines that pertain to reporting and documenting E/M services.

The consequences of E/M reporting mistakes are costly for both providers and insurers, with these services often being the targets of audits. The "2019 Medicare Fee-for-Service (FFS) Improper Payments Report and Appendices," which contains reports produced by the Comprehensive Error Rate Testing (CERT) program, estimates that upcoding resulted in hundreds of millions of dollars in overpayments for office visits from July 1, 2017, through June 30, 2018. Upcoding is billing a higher level service or a service with a higher payment than is supported by the medical record documentation.

Medicare Services With Upcoding Errors, July 1 2017, to June 30, 2018

Part B Services	Projected Improper Payments	Improper Payment Rate
Office visits, established	$396,739,245	2.6%
Office visits, new	$321,432,147	10.6%

Source: "2019 Medicare Fee-for-Service (FFS) Improper Payments Report and Appendices," Table K3: Type of Services with Upcoding Errors: Part B

The current momentum for revising E/M coding and guidelines can be traced to the 2019 Medicare Physician Fee Schedule (MPFS) rule. The 2019 MPFS final rule included substantial revisions for E/M office/outpatient coding with a stated goal of reducing administrative burden, improving payment accuracy, and updating the code set to reflect current medical practice.

One policy change in the 2019 MPFS final rule that got significant pushback from stakeholders was a plan to pay a single rate, called a blended rate, for E/M visit levels two to four starting in 2021. In other words, Medicare intended to pay the same rate for new patient codes 99202, 99203, and 99204, regardless of which code was submitted on the claim. Medicare was going to pay another single rate for established patient codes 99212, 99213, and 99214. The plan included separate payment rates for level five visits (99205, 99215) to reflect the increased complexity those codes represent.

Although this plan for blended rates was in the 2019 final rule, Medicare has since stated this fee-structure change will not go through. The MPFS will continue to have distinct payment rates for each office/outpatient E/M code in 2021. Medicare eliminated the blended rates because of E/M code revisions and new valuation data AMA produced in response to the MPFS plan. The next section offers more insight into those code updates.

Focus Area 1: Using the Updated E/M Codes Properly

One major area of concern for healthcare organizations is proper use of the 2021 new office/outpatient E/M codes. This concern should not be underestimated given the volume of E/M codes that providers report and the resulting reimbursement. For example, "In total, E/M visits comprise approximately 40 percent of allowed charges for PFS [Physician Fee Schedule] services, and office/outpatient E/M visits comprise approximately 20 percent of allowed charges for PFS services," according to the 2020 MPFS final rule.

Because E/M services are so common, simple mistakes on claims for office/outpatient E/M visits may add up quickly in terms of audit risk and improper payments. Education on how to use the new office/outpatient E/M code structure is an essential step toward avoiding errors and the issues they cause.

Fortunately, organizations can begin training now. The AMA has already posted the revised 2021 office and outpatient E/M guidelines and code descriptors for review. (Note: The AMA could make additional changes before the complete 2021 code set is released. Organizations need to ensure they are using the official, final code set when reporting 2021 services.) The major changes anticipated for the E/M office/outpatient codes and descriptors fall into the categories below.

Elimination of 99201

In 2020, the office/outpatient E/M codes include 99201-99205 for new patient visits and 99211-99215 for established patient visits. In 2021, the CPT® code set will delete 99201, the lowest-level office/outpatient code for new patients. The reason is that in 2020, both 99201 and 99202 require a straightforward level of MDM, and, as shown below, you will have the option to select 2021 E/M office/outpatient codes based solely on MDM level. Having two codes with the same MDM level for new patients would be redundant, so 99201 will be eliminated.

Removal of history and exam as key components

Office/outpatient E/M codes 99201-99205 and 99212-99215 currently include history, examination, and MDM as the three key components for code selection. In contrast, the 2021 descriptors for 99202-99205 and 99212-99215 will require a specific level of MDM, but they will require only "a medically appropriate history and/or examination." The new wording leaves the level of history and exam, if performed, at the clinician's discretion.

Caution: Healthcare providers should not interpret this change to mean that documentation of history and exam is not necessary. A complete medical record of services rendered is important for many reasons, such as providing information for quality initiatives, continuity of care, and supporting medical decisions under scrutiny in legal cases. Additionally, the time spent on the history and exam portions of the visit will be relevant when coding the encounter based on time. So, although the specific level of history and exam will not be a factor in 2021 E/M code selection for office/outpatient services, accurate documentation of the visit, including a clear

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statement of any history and examination work involved, will remain an essential part of the medical record.

Code selection based on MDM and total time

As noted above, code selection for 99202-99205 and 99212-99215 will be based on either MDM or time beginning in 2021. Coders and providers both will need to be aware of the new CPT® guidelines for MDM level selection and time calculation for office/outpatient E/M codes.

Guidelines for Coding Based on MDM

For MDM, CPT® will clarify and expand the E/M section guidelines, including the addition of a new Level of Medical Decision Making (MDM) table. The new table will be similar, but not identical, to the Table of Risk in the CMS 1995 and 1997 Documentation Guidelines. Mastering these new CPT® guidelines will require careful study, but some elements coders and providers should note are described below.

Complexity of risk: One key point the 2021 guidelines include is that the final diagnosis is not the only factor when determining the complexity of risk. For example, a patient may have several lower severity problems that combine to cause higher risk, or the provider may have to perform an extensive evaluation in certain cases to determine the problem is one of lower severity. Education should cover this point so providers understand that documenting the factors involved in risk assessment gives a more complete picture of their work, allowing coders and auditors to identify the proper level of E/M service.

Comorbidities: The 2021 guidelines take a 2020 rule and expand it, clarifying that comorbidities and underlying diseases should not be part of E/M level selection "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." As with complexity of risk, this rule underscores the importance of documentation training. If additional diagnoses play a role in the provider's decision making, but the provider does not document that role, the final code selection may not capture all the work the provider performed. The coder may have to report a lower paying E/M code because that is what the documentation supports.

Definitions: One additional area of note is that the 2021 CPT® E/M guidelines will include definitions for nearly two dozen terms. The few examples below demonstrate that understanding the definitions will be crucial for proper coding using the 2021 MDM table:

- Problem addressed: The new MDM table includes a column titled "Number and Complexity of Problems Addressed." According to the 2021 CPT® definition, a problem addressed (or managed) is one the provider evaluates or treats. Consideration of further testing that is decided against because of risks involved or patient choice will count as addressed. This is an important point that recognizes the provider work involved in evaluating options for patient care and making recommendations, even if the patient decides to follow a different course.

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- Acute/chronic illnesses: The "Number and Complexity of Problems Addressed" column also will refer to acute and chronic illnesses when categorizing the low, moderate, and high levels in this column. The 2021 CPT® guidelines will define these terms for acute and chronic illnesses. For instance, the low level in this column may involve "1 stable, chronic illness." The guidelines provide additional information on this term, including the following:
    - A stable, chronic illness is expected to last at least a year or until the patient's death.
    - The patient's treatment goals determine whether the illness is stable. A patient who hasn't achieved their treatment goal is not stable, even if the condition hasn't changed and there's no short-term threat to life or function.
    - The risk of morbidity is significant without treatment.
- Independent historian: The MDM table's column for "Amount and/or Complexity of Data to be Reviewed and Analyzed" refers to assessment requiring an independent historian, defined in part as 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)." AAPC has received the following question many times in relation to this 2021 guideline: In cases where a young child is the patient and a parent must provide the history, does the encounter meet the requirement for assessment requiring an independent historian? AAPC has confirmed with a member of the AMA CPT® Editorial Panel and Relative Value Scale Update Committee (RUC) workgroup that the answer is yes.
- Drug therapy requiring intensive monitoring for toxicity: The 2021 CPT® MDM table's column for "Risk of Complications and/or Morbidity or Mortality of Patient Management" includes drug therapy requiring intensive monitoring for toxicity as an example of high risk. The guidelines add specifics for this type of monitoring:
    - The drug can cause serious morbidity or death.
    - Monitoring assesses adverse effects, not therapeutic efficacy.
    - The type of monitoring used should be the generally accepted kind for that agent, although patient-specific monitoring may be appropriate, too.
    - Monitoring may be long term or short term.
    - Long-term monitoring occurs at least quarterly.
    - Lab, imaging, and physiologic tests are possible monitoring methods. History and exam are not.
    - Monitoring affects MDM level when the provider considers the monitoring as part of patient management.

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Guidelines for Coding Based on Time

For coding based on time, the 2021 E/M guidelines will include new information particular to the revised office/outpatient codes. Below are the major points from the 2021 office/outpatient guidelines for time:

- You will be able to use time alone to select the correct code from 99202-99205 and 99212-99215 in 2021.
- Counseling and/or coordination of care will not need to dominate an office/outpatient E/M service for you to code the service based on time in 2021. But for other E/M services coded based on time, you will still need to meet the threshold of counseling and/or coordination of care making up more than 50 percent of the visit.
- A key shift for the office and other outpatient E/M codes is that the time referenced in the 2021 code descriptors is total time. The 2020 descriptors for these codes use intraservice (face-to-face) time.
    - The 2021 guidelines explain that for 99202-99205 and 99212-99215, total time on the encounter date includes both face-to-face and non-face-to-face time spent by the provider.
    - The guidelines offer the examples of preparing for the visit (such as reviewing tests); getting or reviewing a history that was separately obtained; performing the exam; counseling and providing education to the patient, family, or caregiver; ordering medicines, tests, or procedures; communicating with other healthcare professionals; documenting information in the medical record; interpreting results and sharing that information with the patient, family, or caregiver; and care coordination.
    - When you start counting time for the 2021 codes, you should not include time spent on services you report separately. For instance, if you report care coordination using a separate CPT® code, you should not include that in the time for the E/M code.
    - The total time also will not include time for activities the clinical staff normally performs.
- A shared or split visit, according to CPT® 2021 guidelines, is when a physician and one or more other qualified healthcare professionals perform the face-to-face and non-face-to-face work for the E/M visit. When you code these visits based on time, you will sum the time spent by the physician and other qualified healthcare professionals to get a total time. Any time that the providers spend together to meet with or discuss the patient counts only once (as if you are counting the time of one individual).

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Code Descriptor Structure

The 2020 code descriptors for 99202-99205 and 99212-99215 follow a set formula, specifying the number and level of key components required and the typical face-to-face visit time. The 2021 descriptors instead will include the MDM level and time range relevant for the code. The descriptors below offer a comparison (bold added for emphasis).

Code	2020 Descriptor	2021 Descriptor
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: • A detailed history; • A detailed examination; • Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter

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Level-one established patient E/M code 99211 will still be available in 2021, but the code descriptor will no longer include the time reference crossed out below. Note that, in 2021, 99211 will not refer to either an MDM level or a range of total time spent, making it different from the other revised codes.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Reporting Prolonged Services

With the role of time changing for office and other outpatient E/M codes in 2021, the AMA plans to revise reporting of prolonged services. The changes include a new code for 2021, temporarily known as +99XXX:

+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, 99215 for office or other outpatient Evaluation and Management services)

As the descriptor specifies, the appropriate primary codes will be only 99205, which represents the longest time among the new patient codes, and 99215, which represents the longest time among the established patient codes.

New guidelines that will accompany +99XXX state that you should not report the code for any time period less than 15 minutes. For instance, 99205 will represent 60-74 minutes in 2021. According to a table with the guidelines, to report 75-89 minutes, you will assign 99205 and +99XXX. Once the total time reaches 90-104 minutes, you will report 99205 and two units of +99XXX.

Focus Area 2: Applying Different Sets of Guidelines to Different E/M Service Types

On initial review, the upcoming changes to the office/outpatient E/M codes and guidelines appear to offer a simpler approach, making CMS' complicated 1995 and 1997 Documentation Guidelines obsolete. But the reality for 2021 is that coders and providers will be applying the new guidelines for office/outpatient services and still applying the CMS 1995 or 1997 Documentation Guidelines to other types of E/M services. Additionally, coders will have to be alert for any variations in rules that private payers apply to their claims.

To eliminate confusion, organizations should offer education about when and how to apply each set of guidelines when reporting E/M services. This may seem straightforward, but remember that even the definition of "time" will vary depending on the type of E/M service performed in 2021, with office/outpatient visits using total time and other services using intraservice time.

Reviewing the complete 2021 CPT® E/M section guidelines, once they are available, will be an important step to ensure coders and providers understand how the office/outpatient changes fit into the larger E/M section. According to the February 2019 CPT® Editorial Summary of Panel Actions, the guidelines will be restructured into these three sections:

- Guidelines Common to All E/M Services
- Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care and Home E/M Services
- Guidelines for Office or Other Outpatient E/M Services

Focus Area 3: Evaluating the Organization-Specific Financial Impact of These Changes

A change of this magnitude to a service as common as office/outpatient E/M may have consequences for an organization's bottom line. Investing in training and preparation will help prevent productivity drops and payment delays in the early days of implementation. But there is also the issue of estimating the financial impact on your individual organization based on your historical E/M code distribution.

Same Services, Different Codes?

Healthcare organizations can analyze a sampling of recent E/M charts to assess whether the changes to the guidelines will result in their providers reporting different codes (with different payment levels) for identical services in 2020 and 2021. Experts expect that, in many cases, an identical service will garner the same code in both 2020 and 2021. A welcome change for 2021 will be that the provider and coder will not have to work through the long checklists in the 1995 and 1997 Documentation Guidelines to prove the service met a specific office/outpatient E/M level.

Assessing current documentation also gives organizations an opportunity to check for deficiencies and to provide training to eliminate those issues while informing providers about the new guidelines. This step helps ensure the final E/M code choice reflects the work the provider performed.

Medicare Reimbursement Updates

Organizations also should factor Medicare's expected reimbursement changes for office/outpatient E/M visits into their financial impact analysis. In the 2020 MPFS final rule, Medicare finalized the 2021 work relative value units (wRVUs) for 99202-99205 and 99211-99215. The table below compares the first quarter (Q1) 2020 wRVUs for these codes with the expected 2021 wRVUs. The 2021 wRVUs are based on AMA/Specialty Society RUC recommendations, which the 2020 MPFS final rule describes as reflecting a "rigorous and robust approach, including surveying over 50 specialty societies."

Note that the "% Increase" column shows only the expected difference in wRVUs, not the fees, for 2020 and 2021. Final reimbursement from Medicare also will depend on factors like the code's practice expense RVUs and malpractice RVUs, as well as the 2021 conversion factor and the geographic location of the service.

Expected Changes to Office/Outpatient E/M Work RVUs

Code	Q1 2020 wRVU	2021 wRVU	% Increase
New Patient			
99202	0.93	0.93	0%
99203	1.42	1.6	13%
99204	2.43	2.6	7%
99205	3.17	3.5	10%
Established Patient			
99211	0.18	0.18	0%
99212	0.48	0.7	46%
99213	0.97	1.4	34%
99214	1.50	1.92	28%
99215	2.11	2.8	33%

Focus Area 3: Evaluating the Organization-Specific Financial Impact of These Changes

Add-On Code Opportunities

To maximize reimbursement, organizations also should assess how often they expect to report two new add-on codes for these E/M services. You have already read about +99XXX, the planned new code for prolonged office/outpatient E/M services. The 2020 MPFS 2020 final rule lists a wRVU of 0.61 for this code.

The 2020 MPFS final rule also includes a new HCPCS Level II G code for 2021 to represent the intensity and complexity typical of certain E/M services, such as primary care visits. The code is temporarily referred to as GPC1X:

GPC1X Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

The 2020 MPFS final rule indicates there will be no specialty restriction on use of GPC1X, and it is possible some specialties will report GPC1X as an add-on code with every office/outpatient visit, bringing an additional 0.33 wRVUs with it.

Information on proper use of this code is still emerging. Organizations need to have a strategy for staying current on Medicare announcements related to GPC1X, including whether the code will be added to the 2021 HCPCS Level II code set as planned. Some private payers also may cover this code, so organizations should track which payers will offer reimbursement for GPC1X.

What Can You Do to Prepare for These 2021 E/M Changes?

Implementation of these extensive changes to office/outpatient E/M requirements will require significant time and preparation. But this work is necessary because E/M services are a substantial revenue source for providers, and accurate reimbursement hinges on proper coding and documentation. Below is a summary of how healthcare organizations can ensure they are ready.

Education: In advance of the 2021 changes, healthcare organizations should provide office/outpatient E/M documentation training for providers, and coding and guideline training for medical coders. The use of realistic cases as part of the training is a smart approach, ensuring that providers and coders gain the skills and knowledge they need to hit the ground running Jan. 1, 2021. Additionally, this hands-on approach allows trainers to assess where additional education is needed and to correct problem areas before implementation.

Documentation review: Training will be more effective if it includes review of current documentation practices, such as analyzing 10 reports per provider. Assessment should focus on identifying areas for improvement under the new E/M coding and documentation guidelines. After this analysis, educators can customize training to focus on deficiencies in documentation, rather than spending valuable time on areas that are not problematic.

Financial impact assessment: Documentation review also provides an opportunity to evaluate the likely financial impact of the new 2021 updates on the individual organization. Reviewers can compare which codes the documentation supports under

Focus Area 3: Evaluating the Organization-Specific Financial Impact of These Changes

both the old and new guidelines, and compare the reimbursement expected.

Updating resources: One final area of implementation that organizations must not overlook is careful updating of medical coding resources, auditing tools, and electronic health record (EHR) templates. Any organization that went through the transition to ICD-10-CM in 2015 can testify to the value of providing clinicians and coders with updated resources that support accuracy and efficiency. A consultant can help streamline this process by ensuring that each relevant item is included and that changes are complete, correct, and advantageous to the end user.

Careful preparation now is essential to avoiding reimbursement and compliance issues for office/outpatient coding in 2021, but the benefits do not end there. Inpatient hospital care and other forms of E/M are expected to see similar coding and documentation changes in the coming years. The work organizations put in today will lay a strong foundation for minimizing disruption from the wave of related changes anticipated in the near future.