The CPT Editorial Panel has recently approved revisions to the Current Procedural Terminology (CPT) Evaluation and Management (E/M) office or other outpatient services codes, which will have significant implications on coding and documentation for these vital services. Learn more about these changes and how they will impact your work. The changes are scheduled to go into effect January 1, 2021. In addition, CMS has approved updated Relative Value Unit settings for the E/M code set.

The CPT changes are designed to reduce administrative burden and more accurately capture physician work involved in providing the services.

Previously established changes include:

- For an outpatient visit with an established patient, a provider can record only what has changed since the last visit and need not re-record the history and exam if there is documentation that the practitioner reviewed and updated the information in the medical record.
- For an outpatient visit with a new or established patient, the billing provider does not need to redocument a chief complaint or history that was recorded in the medical record by ancillary staff. This includes the chief complaint and any other part of the history, history of present illness, past family social history, and review of systems. The billing provider can review the information and update as necessary.
- The billing provider should document in the medical record that information entered by ancillary staff or the patient has been reviewed.

More extensive changes will go into effect on Jan. 1, 2021, including:

- extensive E/M guideline additions, revisions, and restructuring deletion of code 99201 and revision of codes 99202–99215
- code level selection should be based on:
    - medical decision-making (MDM) or total time on the date of the encounter
    - creation of a 15-minute prolonged service code to be reported only when the visit is based on time and after the total time of the highest-level service (e.g., 99205, 99215) has been exceeded.
    - Note: Although the history and physical exam elements are recorded, they do not factor into the level of service.

The American Medical Association (AMA) has created new CPT code descriptors for office or other outpatient services (new and established patients) that can be based upon the level of MDM or the time spent by the provider on the encounter.

For each code descriptor for these services in CPT, all references to level of history and physical examination are removed. Instead, it is specified that there must be a medically appropriate history and/or physical examination and a specified level of MDM.

For providers who wish to bill by time, the length of time corresponding to each level of visit is specified. Note that the current time rules for coding apply when counseling and/or coordination of care dominates (more than 50 percent) the encounter and includes only face-to-face time in the office. Starting in 2021, providers who wish to code by time spent may include all related activities on the day of encounter.

Medical Decision Making (MDM) has always been part of the algorithm for choosing a level of service but will now be the sole determinant of level of service (unless the provider intends to bill based on time).

MDM in 2021 will be based on:

- number and complexity of problems addressed
- amount and/or complexity of data reviewed and analyzed
- risk of complications and/or morbidity or mortality

The greater the number and complexity of problems addressed at the encounter, the higher the applicable level of decision-making. This ranges from straightforward to low, moderate, and high. Several specific problem level options are listed. They range from self-limited or minor problem to acute or chronic illness or injury that poses a threat to life or bodily function. For many physicians, it may not be clear what constitutes a "self-limited or minor problem." For this reason, specific definitions have been developed by the AMA and CPT so as to limit confusion.

- Amount and/or complexity of data to be reviewed and analyzed. This category attempts to quantify the amount of data, efforts to gather data, and communications utilized to evaluate a patient. Collection of more data leads to a higher level of MDM.
    - Levels include minimal or none, limited, moderate, and extensive. Data are divided into three categories:
        - 1: tests, documents, orders, and review of prior external note(s) from each unique source or independent historian(s)—each unique test, order, or document is counted to meet a threshold number category
        - 2: independent interpretation of tests not reported separately category
        - 3: discussion of management or test interpretation with external physician/other qualified healthcare provider/appropriate source (not reported separately)

Risk of complications and/or morbidity or mortality is an assessment of the relative danger of patient management—whether from treatment or further work-up. Levels are minimal, low, moderate, and high. Some treatments are relatively risk-free, such as over-the-counter medicines and dressing changes. Some are highly risky, such as a decision about emergency major surgery. To estimate the risk of complications, morbidity, or mortality, it may be helpful to become familiar with the definitions—for example, risk, morbidity, social determinants of health, and drug therapy requiring intensive monitoring for toxicity. The definitions are available on the AMA website. Once the level of the presenting problem is established, data are reviewed, and risk management is determined, the overall level of MDM can be determined. To qualify for a particular level of MDM, two of the three elements for that level of decision-making must be met or exceeded. That will determine the level of E/M service.

It is clear that this new method of determining the level of E/M service will require major changes to physician behavior and documentation. Providers will need detailed instructions, system changes, and practice using the new E/M codes.

What can be done to prepare for these changes?

- Learn about the proposed changes by reading online, attending coding courses, and watching webinars.
- Determine whether your electronic health record templates need to be changed to de-emphasize bullet points for history and exam and emphasize elements of MDM.
- Become familiar with the definitions of problem types, risks, and other elements of services that will be needed to substantiate levels of MDM.
- Learn to routinely document items within notes that will be used to score MDM, including ordering tests or X-rays, interpreting tests and X-rays, requesting review of outside documents, having discussions with other healthcare providers, and using independent historians aside from the patient.
- Test-drive some notes to see how they would score using the new MDM parameters.

MEDICARE PHYSICIAN FEE SCHEDULE VALUES

CMS, in the 2021 Medicare Physician Fee Schedule Final Rule published their final changes in payment for the revised office E/M codes for CY 2021.

The table below shows current (2020 Medicare total payment) and the proposed 2021 Medicare total payment.

CPT Code	Descriptor	2021* Total Payment	2020** Total Payment	Difference $	% Difference
99202	Office/outpatient visit new Level 1	$ 69.04	$ 46.56	$ 22.48	48%
99202	Office/outpatient visit new Level 2	$ 69.04	$ 77.23	$ (8.19)	-11%
99203	Office/outpatient visit new Level 3	$ 106.14	$ 109.35	$ (3.21)	-3%
99204	Office/outpatient visit new Level 4	$ 159.36	$ 167.09	$ (7.73)	-5%
99205	Office/outpatient visit new Level 5	$ 210.66	$ 211.12	$ (0.46)	0%
99211	Office/outpatient visit est Level 1	$ 22.26	$ 23.46	$ (1.20)	-5%
99212	Office/outpatient visit est Level 2	$ 54.20	$ 46.19	$ 8.01	17%
99213	Office/outpatient visit est Level 3	$ 86.78	$ 76.15	$ 10.63	14%
99214	Office/outpatient visit est Level 4	$ 122.91	$ 110.43	$ 12.48	11%
99215	Office/outpatient visit est Level 5	$ 172.27	$ 148.33	$ 23.94	16%
99354	Prolonged Services 1st 30 min	$120.97	$132.09	$ (11.12)	-9%

99355	Prolonged Services Additional 30 min	$90.33	$100.33	$ (10.00)	-11%

*2021 Conversion factor=32.26
**2020 Conversion Factor=36.09

These calculations are based on the announced Medicare conversion factor of 32.26 which is an 11% reduction from the current Medicare conversion factor. This is due to CMS applying budget neutrality from the increased RVUs for the office E/M codes. Medical societies, including NANS, have strongly advocated to Congress to maintain the current conversion factor. If it is maintained at the 2020 level of 36.09, the payments for E/M procedures would see further increases.

AMA AND CMS RESOURCES

The AMA has posted several helpful powerpoints and summary documents. Please see the following links for more information and resources from the AMA.

- https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- https://www.ama-assn.org/practice-management/cpt/em-prep-your-house-practice-checklist-2021-transition
- https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions
- https://edhub.ama-assn.org/cpt-education/interactive/18057429
- https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- https://www.ama-assn.org/practice-management/cpt/10-tips-prepare-your-practice-em-office-visit-changes

In addition, CMS has links and information as well. Please see the following links for more information and resources from CMS

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
- https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-p
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf