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• coding •

E/M coding changes require education and technology updates

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Evaluation and management (E/M) services occur in the hospital as inpatient or observation visits. They also occur in nursing homes, physicians' offices, emergency departments and even in the home. Between 2001 and 2010, Medicare payments for E/M services increased by 48%, from $22.7 billion to $33.5 billion, according to *Coding Trends of Medicare Evaluation and Management Services*, published by the Office of the Inspector General, Department of Health and Human Services.

While there have been guidelines since 1995 and guidelines updated in 1997, both of which are still used, E/M services still have been vulnerable to fraud and abuse.

There is need for change. It has been more than 20 years since the documentation criteria has been evaluated and the guidelines are often cumbersome to interpret. With the advent of electronic health records (EHRs), documentation is also significantly different, and many elements can auto-fill or be copied forward. As a result, there may be more documentation than may be medically necessary.

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In 2021, major changes will be implemented for new and established patient office visits. Is this good news or are the changes going to increase the confusion? CMS's goal is to put additional focus on the Patients over Paperwork initiative. The goal is to reduce the administrative burden on providers so they can spend more time with patients. This is great news for providers and patients, but what does it mean to E/M coding and the role of the coder?

The American Medical Association (AMA) made recommendations to CMS in response to the original proposal to collapse the levels. CMS has agreed with the proposed changes, and they will be implemented in 2021. However, there are some immediate concerns because the changes only apply to new and established office visits. Rules and documentation requirements for all other types of E/M are not included in the change, so there will be multiple rules. In addition, at this point, there is no indication of whether commercial payers will follow the new requirements, or if they will continue to use the current 1995 and/or 1997 documentation guidelines.

The major change is that patient history and examination will no longer be key components to determine level of service. Instead, medical decision-making based on new guidance or on time will be used.

Although it does not eliminate the need to capture a history and examine a patient, it does remove the required documentation elements to allow a provider to perform only the history and examination that they deem medically necessary to appropriately treat the patient, without having to quantify the amount of documentation.

This change will also eliminate the 99201, new patient visit, E/M level, as both 99201 and 99202 levels of service currently have straightforward medical decision-making. With the implementation of the new guidelines and medical decision-making being the stand-alone element, if not billed on time, there is not a need for two different codes. The other codes, 99211-99215 for established patients and 99202-99205 for new patients, will all remain active and appropriate codes.

3 criteria

Medical decision-making will still focus on three different criteria, and providers must meet two of the three elements to establish the E/M level, which is consistent with the current guidelines. However, there is much more clarity in the elements and changes in the requirements. The elements of medical decision-making will include:

- The number and complexity of problems that are addressed.
- The amount and complexity of the data that needs to be ordered, reviewed, and/or analyzed.
- The risk complications to the patient and/or the morbidity or mortality of the patient management.

Recommended treatments and interventions, even if the patient chooses not to have the intervention or treatment can also impact the overall risk and should be considered when calculating the E/M level. Comorbid or underlying conditions are only considered to select the level of E/M when their presence increases and impacts the work done or impacts the complexity of the risk or the data that must be reviewed.

Time-based billing

Time-based billing has also been redefined to identify how time should be determined. The requirement that time can only be used to determine E/M level when more than 50% of the time is spent in counseling or coordination of care has been eliminated. Time is for the total time and has clear definitions of the time that can be utilized, which include the following:

- Preparation work to see the patient
- Review of previous records and history
- Counseling and education
- Documentation in the EHR
- Interpreting results of testing
- Care coordination
- Face-to-face time with the patient

However, if more than one provider sees the patient concurrently, overlapping time is not added together.

Relative value units

There will be changes to the relative value units of the office visits, except for 99211 and 99202. There also will still be the ability to report prolonged services, however, there will be changes to this as well, as prolonged face-to-face services will be reported in 15-minute increments and can only be utilized with the highest level of services, so either the 99205 for a new patient or a 99215 for an established patient.

E/M office visit coding will be significant, and education of all providers will be necessary. Updates to EHR systems that have current E/M calculators will need to be revised and careful attention paid to monitoring the changes and learning the new medical decision-making requirements. Understanding that this will only apply to office visits, and other E/M services will follow the current rules also needs to be clearly communicated. Stay alert, stay tuned and watch for upcoming changes. •

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