Part B Insider (Multispecialty) Coding Alert

E/M 2021: Get a Handle on E/M 2021 with 3 FAQs

Tip: Comprehensive documentation is key to claims success.

With 2021 around the bend, it's a good time to start preparing for the E/M changes effective Jan. 1. Updating your protocols and understanding the E/M 2021 nuances is critical to ensure coding success.

Review three top questions that readers submitted about the changes, along with expert answers.

1. What Are the Time Guidelines?

Medical practices are well aware of the fact that in 2021, you'll select new and established outpatient E/M codes based on the level of medical decision making (MDM) your provider uses/documents during the encounter or based on the total time of the encounter. But one reader wrote and asked whether both time and MDM will be required for calculating the correct code.

The answer is no. For instance, suppose a gastroenterologist meets a new gastritis patient in the office who is presenting with weight loss and intermittent vomiting for the past two months, and the visit consists of moderate medical decision making and lasts 45 minutes. If that's the case, you'll report 99204 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components...). Note that time here is the entirety of time spent on the day of encounter, not the face-to-face time as in the past.

"You do not need both MDM and time," says **Raemarie Jimenez, CPC, CIC, CPB, CPMA, CPPM, CPC-I, CCS,** senior vice president of product at AAPC and coding liaison to the AMA CPT® Editorial Panel. In other words, you could look at either the time in this example (45 minutes) or the level of MDM (moderate level), and this will direct you to 99204.

Remember that for the highest new patient E/M code (99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components...) time threshold only goes up to 74 minutes, but if you exceed that time, you'll be able to report a prolonged services add-on code that is temporarily referred to as +99XXX. "You can report 99205 with the prolonged services code when 75 minutes is reached," Jimenez says.

2. What Type of Documentation Is Necessary?

Another reader asked whether the documentation requirements will change effective January 1.

Although the government isn't mandating specific documentation changes, you will have to ensure your providers include enough in their documentation to allow you to select codes under the new parameters.

Remember, however, that your documentation should be thorough whether you're billing based on MDM or on time. "A doctor should document correctly regardless of the E/M coding and billing implications, says **Henry Borkowski MD,** CEO of OmniMD. "If you're documenting the right way now, it will make code selection easier down the line."

If coding is based on time for the day, your providers may sometimes need to go back into a locked note if they spend more time on behalf of the patient the same day after their note is "complete" and update the total time, which should be recorded someplace in the note.

3. Will the Table of Risk Remain Status Quo in 2021?

Anyone who calculates MDM is familiar with the table of risk, which allows coders to select the appropriate MDM level, says **Deena Wojtkowski, CPC, CEMC, CCP,** vice president of client services with Ebix, Inc. But several readers have wondered whether that table of risk will remain the same next year.

The short answer is no. To replace it, you'll find a table of elements, which includes several updated options. For instance, the existing "Number of diagnoses or management options" element has merged with CMS's "Presenting problem(s)" to become "Number and complexity of problems addressed" in the new chart.

The second element, labeled "Amount and/or complexity of data to be reviewed and analyzed" has been completely redefined. Each level in this element has two to three categories, each comprised of various combinations of tests, documents, interpretations, and so on. So, too, has the third element, which will become "risk of complications and/or morbidity or mortality of patient management."

The American Medical Association (AMA) has also used this E/M overhaul to examine the terminology it has traditionally used to define the codes. Taking a mid-level code (such as 99203/99213) as an MDM example, that means clearing up confusion surrounding a concept like "morbidity," which the AMA now defines as "a state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment."

Similarly, the AMA has pinned down the term "independent historian," which it defines as "an individual (e.g., 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 (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary."

Hopefully, such definitions will make these 2021 revisions to office and outpatient E/M levels easy to implement when they take effect on Jan. 1 and better allow the coder/auditor to clearly educate physicians and apply the MDM guidelines to the auditing process.

Resource: To review the new MDM table, visit www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.