

EM Coding Alert

Countdown to 2021: Begin the Countdown to 2021 by Taking These 2 Steps

Now's the time to get ready for the new office/outpatient E/M coding changes.

In just 12 short months, the way you code 99202-99215 (Office or other outpatient visit for the evaluation and management of a new/established patient ...) is going to change dramatically.

Throughout the year, E/M Coding Alert will inform and update you about how the changes will affect your E/M coding. Right now, though, you should be preparing for the changes with these two simple suggestions, which you can put in place right away to make your life less complicated when 2021 comes around.

Step 1: Streamline Your Documentation by Avoiding Duplication

You should already be following the documentation reduction guidelines that the Centers for Medicare & Medicaid Services (CMS) implemented in the Physician Fee Schedule (PFS) 2019 final rule, effective Jan. 1, 2019. This means your provider should be focusing their documentation "on what has changed since the last visit or on pertinent items that have not changed, rather than redocumenting a defined list of required elements such as review of a specified number of systems and family/social history" (Source: s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf).

Similarly, if a patient or ancillary staff has documented the patient's history of present illness or chief complaint, your provider does not need to re-enter that information into the medical record. Instead, just a simple acknowledgement that the provider has reviewed and verified that information is all that needs to appear in the patient's record.

Providers that are teaching physicians can also provide similar acknowledgments in a patient's medical record of notations residents or other medical team members have made in that record. Additionally, beginning Jan. 1, 2020, CMS extended that guideline to physician's assistants (PAs) and advanced practice registered nurse (APRN) preceptors, including other nonphysician practitioners (NPPs) such as NPs, clinical nurse specialists (CNSs) and certified nurse-midwives (CNMs).

Don't forget (1): Since Jan. 1, 2019, you also no longer have to document medical necessity for a home visit instead of an office visit.

Step 2: Put Your 2021 E/M Plan in Place

Failing to plan, as the old saying goes, is planning to fail. So, initiating a plan for your E/M documentation in 2021 will be crucial.

Exactly what that plan will look like will depend upon your own practice's context and resources. But a good place to start is to prepare a checklist such as the one suggested by the American Medical Association (AMA), which you can find at www.ama-assn.org/practice-management/cpt/10-tips-prepare-your-practice-em-office-visit-changes.

At the very least, that plan should cover three crucial elements that your practice will need to address in the weeks and months to come.

Contact Your Carriers

While the coding community has generally viewed the relaxed E/M documentation guidelines as a good thing, the changes have also brought anxiety about how they will be taken up by Medicare and private payers alike. "I would like to

know how the Medicare Administrative Contractors [MACs] are going to view the documentation," says **Suzan Hauptman, MPM, CPC, CEMC, CEDC**, director, compliance audit, Cancer Treatment Centers of America. "What exactly will they be looking for?" Hauptman asks.

In other words, now is a good time to begin the process of "contacting your carriers to discover what will be required by each," advises **Jan Blanchard, CPC, CPMA**, pediatric solutions consultant at Vermont-based PCC.

Change Your Recording

No matter how you currently record your E/M encounters, 2021 presents a unique opportunity to rethink what needs to be in your medical record and what can be discarded. As MDM will be one of only two criteria you will use to determine the E/M level for a given office/outpatient encounter, this means you should now start to "review your office encounter forms/protocols to reassess the necessity of all clinically unnecessary tasks in your history and physical exam templates," Blanchard suggests. In other words, "if you're suffering an undue documentation burden, look for opportunities to do away with things that do not serve to illustrate clinical judgment and MDM," Blanchard adds.

But if templates aren't your thing, you will still have to decide on the best way for your providers to document MDM. "I have been a strong advocate in documenting the actual service as performed, as it helps physicians, and it illustrates the true content of the visit," says Hauptman. "MDM will look different than it does now. There will be a lot more meat in the data section. This will help physicians illustrate their actual work for the patient as it often takes place when not actually face-to-face with the patient," Hauptman notes.

Don't forget (2): Only the office/outpatient E/M codes 99202-99215 will be affected by CMS's decision to allow E/M levels to be based on MDM or time. Other E/M codes will still be chosen based on history, exam, or MDM, unless counseling or coordination of care dominates the encounter.

Capture Time Correctly

Lastly, as time will be the other factor you could use to justify E/M levels, you will need to review your timekeeping procedures to assess their accuracy. To do this, you will have to "perfect a workflow which lets clinicians record the time spent on each patient independently," suggests Blanchard. "This is could be anything from adding fields to capture start and stop times, or multiple sets of time ranges for interrupted care, to adopting an electronic medical record [EMR], which will discretely capture those things," Blanchard concludes.

Don't forget (3): Whatever method you decide to use to capture time, remember that time spent on the date of service related to the visit, and not just the provider's face-to-face time with the patient, will count toward the visit.