2021 E&M Overview

Shannon O. DeConda
CPC, CPMA, CEMA, CMSCS
President NAMAS
Partner DoctorsManagement
These changes impact office and outpatient services only

99201-99215
2019 Prepped Us....

- Interval level history
- Refer-back documentation
- Relaxations to HPI
Policies are needed on 2019 before 2021
Straightforward Change?

Deletion of 99201
Is this really that straightforward?

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>RVU</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>0.48</td>
<td>$46.56</td>
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<tr>
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<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>0.93</td>
<td>$77.23</td>
</tr>
</tbody>
</table>
Impactful Changes

• Medical Decision Making or Time-Based encounters
  • No longer SCORE History
  • No longer SCORE Exam
• New Medical Decision Making Table
<table>
<thead>
<tr>
<th>Carrier</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGS</td>
<td>“For categories/subcategories, two of the three key components (history, exam, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E&amp;M services; established…” Medical decision making (at any level) refers to the complexity of establishing a diagnosis and/or selecting a management option.”</td>
</tr>
<tr>
<td>First Coast</td>
<td>No published guidance, but utilizing their online interactive E&amp;M calculator and omitting an exam, the tools still score the appropriate established E&amp;M code</td>
</tr>
<tr>
<td>NGS</td>
<td>Within the CERT Review finding error, it was noted that NGS included the following: Missing and/or incomplete documentation (i.e., no exam or history, no content of counseling). This could indicate that they ARE requiring some amount of documentation for each component.</td>
</tr>
<tr>
<td>Noridian</td>
<td>If one of the established patient E&amp;M components is missing (history, exam or medical decision making), is the documentation still billable? Yes, it is still billable, but if one of those components is missing, the medical necessity of the service (which is the overarching criterion) may not be met.</td>
</tr>
<tr>
<td>Novitas</td>
<td>No published guidance. An FAQ states that an E&amp;M error occurs only when a required key component is not appropriately documented, suggesting that if it is not required, it need not be documented.</td>
</tr>
<tr>
<td>Palmetto</td>
<td>No published guidance</td>
</tr>
<tr>
<td>WPS Medicare</td>
<td>All three elements are required, even when only two are used in choosing a procedure code. We took this question to CMS which stated: “The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For E&amp;M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient’s status.”</td>
</tr>
</tbody>
</table>

What does your MAC currently say about missing key components?
2021: E&M Re-Constructed

• What will the impact of the changes be?
• Are these changes a good thing?
Discussion: 2020 vs. 2021

- Consider the current key components:
  - History
  - Exam
  - Medical Decision Making

- For each component we will:
  - Define each component
  - Discuss current controversies
  - Recognize the impact of the components of 2021
  - Recommended considerations for 2021 training
The Overall History:

Severity of the Patient According to the Patient

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past Family Social History (PFSH)
Chief Complaint

• Define: The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter

• Current Controversies:
  • Double dipping
  • How to score a note without a chief complaint
  • Simplistic chief complaints (e.g., follow-up)
Chief Complaint

• 2021 Impact: Chief Complaint is part of the history and effective 2021
  • ...Services include a medically appropriate history...
  • What is a medically appropriate chief complaint?
  • Will services be deemed non-reimbursable if a concise chief complaint is not identified?
2021 Teaching & Policy Considerations

- Require a chief complaint
- Throw out current misconception rules of chief complaint
- Make sure we can identify the reason for the encounter
History of Present Illness (HPI)

• Define: The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present

• Current Controversies:
  • Who can document it and perform the work?
  • Double dipping
  • Interpreting the elements (e.g., quality, location, etc...)
  • Status of three
  • Combining 1995 and 1997
2021 Impacts on HPI

• ...Services include a medically appropriate history...
• What is a medically appropriate HPI?
• If there is no HPI, will we be able to support the medical complexity associated with the encounter?
2021 Teaching & Policy Considerations

• Require an interval level HPI
• Throw out current scoring processes of HPI
• Update current templates to recognize the use of an interval level history
  • Encourage providers to refrain from Copy & Paste
  • Encourage providers to refrain from Refer-Back
  • Update templates to add the verbiage “Interval Level History”
Review of Systems (ROS)

• Define: A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced

• Controversies:
  • Double Dipping
  • Relevance to the encounter
  • All other systems are negative
  • Constitutional organ system
  • Contradictions in the ROS
2021 Impact on Review of Systems

- Services include a medically appropriate history...
- What is a medically appropriate ROS?
- Will the lack of requirement negate the need for documenting ROS?
2021 Teaching & Policy Considerations

• Throw out current scoring processes of ROS
• Update current templates to encourage inclusion of any applicable ROS to demonstrate complexity
  • Encourage providers to refrain from Copy & Paste
  • Encourage providers to refrain from Refer-Back
• Explain the need to no longer document for the sake of documenting
Past Family Social History (PFSH)

• Define: The PFSH consists of a review of three areas:
  • past history (the patient's past experiences with illnesses, operations, injuries and treatments);
  • family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
  • social history (an age appropriate review of past and current activities).

• Controversies:
  • Relevance to the encounter
  • Cloning and Copy & Paste Concerns
  • Not using PFSH correctly
2021 Impact on Past Family Social History

• ...Services include a medically appropriate history...
• What is a medically appropriate PFSH?
• Will the lack of requirement negate the need for documenting PFSH?
2021 Teaching & Policy Considerations

• Throw out current scoring processes of PFSH
• Update current templates to encourage inclusion of any applicable PFSH to demonstrate complexity
  • Encourage providers to refrain from Copy & Paste
  • Encourage providers to refrain from Refer-Back
• Explain the need to no longer document for the sake of documenting
The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- **DG:** Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.

- **DG:** Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.

- **DG:** A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

- **DG:** The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.

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**Exam**

- **Define:** The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s)

- **Controversies:**
  - NOTE the definition that has always existed for the exam
  - 1995 vs. 1997
  - Relevance to the encounter
  - Cloning and Copy & Paste Concerns
2021 Impact on Exam

- ...Services include a medically appropriate exam...
- What is a medically appropriate Exam?
- Will this lead to records with no exam at all?
2021 Teaching & Policy Considerations

• Throw out current scoring processes for exam
• Consider changes to the templated exams
• Explain the need to no longer document for the sake of documenting
Medical Decision Making: Simplify the Process
Medical Decision Making (MDM)

- 2020 Guidelines have 3 components to the MDM
- 2021 Guidelines have 3 components to the MDM
- The 3 components are essentially the same titles
  - Number and Complexity of Problems Addressed
  - Amount and/or Complexity of Data to be Reviewed and Analyzed
  - Risk of Complications and/or Morbidity or Mortality of Patient Management
Is there REALLY change in the MDM?
Number and Complexity of Problems Addressed

Define:

• Multiple new or established conditions may be addressed at the same time and may affect medical decision making

• Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition

• Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services 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

• The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower
## Controversy Eliminated With Definitions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Problem addressed</th>
<th>Minimal problem</th>
<th>Self-limited or minor problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable, chronic illness</td>
<td>Acute, uncomplicated illness or injury</td>
<td>Chronic illness with exacerbation, progression or side effects of treatment</td>
<td>Undiagnosed new problem with uncertain prognosis</td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td>Acute, complicated injury</td>
<td>Chronic illness with severe exacerbation, progression, or side effects of treatment</td>
<td>Acute or chronic illness or injury that poses a threat to life or bodily function</td>
</tr>
</tbody>
</table>
2021 Impact on Number & Complexity of the Problem Addressed

• Definitions will have a significant impact in 2021
• Written guidance that only diagnoses made relevant through the documentation are counted in the scoring process
2021 Teaching & Policy Considerations

- Use Benchmark standards for provider specialty and educate each definition into common conditions seen and the definition they must meet
  - Example: Established patient follow up Rheumatology
  - Equating the table this would be a moderate level
    - Chronic problem exacerbated, progressing, or side effects of treatment
    - 2 or more stable chronic problems
    - Acute complicated problem
    - Undiagnosed new problem with uncertain prognosis

- Providers MUST demonstrate the actual acuity of the condition in their documentation
So is there really change to this portion of the MDM for 2021?
Amount and/or Complexity of Data to be Reviewed and Analyzed

Define:

This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.
Established Definitions for 2021

- Test
- External
- External physician or other qualified healthcare professional
- Independent historian
- Independent interpretation
- Appropriate source
Controversy for 2021

• As of the date of this presentation, there are still confusions and controversies to this portion of the MDM

• Category 1: Tests and documents
  • Any combination of 2 from the following:
    • Review of prior external note(s) from each unique source*;
    • Review of the result(s) of each unique test*;
    • Ordering of each unique test*
<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited</strong></td>
<td>(Must meet the requirements of at least 1 of the 2 categories)</td>
</tr>
<tr>
<td>Category 1: Tests and documents</td>
<td></td>
</tr>
<tr>
<td>• Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td>• Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td>• review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td>• ordering of each unique test*;</td>
<td></td>
</tr>
<tr>
<td>or Category 2: Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>(Must meet the requirements of at least 1 out of 3 categories)</td>
</tr>
<tr>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td></td>
</tr>
<tr>
<td>• Any combination of 3 from the following:</td>
<td></td>
</tr>
<tr>
<td>• Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td>• Review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td>• Ordering of each unique test*;</td>
<td></td>
</tr>
<tr>
<td>or Category 2: Independent interpretation of tests</td>
<td></td>
</tr>
<tr>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
<td></td>
</tr>
<tr>
<td>or Category 3: Discussion of management or test interpretation</td>
<td></td>
</tr>
<tr>
<td>• Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)</td>
<td></td>
</tr>
<tr>
<td><strong>Extensive</strong></td>
<td>(Must meet the requirements of at least 2 out of 3 categories)</td>
</tr>
<tr>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td></td>
</tr>
<tr>
<td>• Any combination of 3 from the following:</td>
<td></td>
</tr>
<tr>
<td>• Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td>• Review of the result(s) of each unique test*;</td>
<td></td>
</tr>
</tbody>
</table>
So is there really change to this portion of the MDM for 2021?
Risk of Complications and/or Morbidity or Mortality of Patient Management

• Define:
  The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient’s problem(s), the diagnostic procedure(s), treatment(s).

  This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.
Established Definitions for 2021

- Risk
- Morbidity
- Social determinates of health
- Drug therapy requiring intensive monitoring for toxicity
### Risk of Complications and/or Morbidity or Mortality of Patient Management

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>No additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Low</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td>- Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding minor surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding elective major surgery without identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>- Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
<tr>
<td>High</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td>Examples only:</td>
</tr>
<tr>
<td></td>
<td>- Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding elective major surgery with identified patient or procedure risk factors</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding emergency major surgery</td>
</tr>
<tr>
<td></td>
<td>- Decision regarding hospitalization</td>
</tr>
<tr>
<td></td>
<td>- Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
2021 Teaching & Policy Considerations
So is there really change to this portion of the MDM for 2021?
Time in the 2021 Encounter
Cumulative Time Allowed

- Physician/other qualified health care professional time includes the following activities, when performed:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)
Time Considerations

- Face-to-Face by the physician or qualified healthcare professional
- Combining time is allowed
- Counseling & Coordination is NO LONGER a requirement
- Greater than 50% is NO LONGER a requirement
Time Considerations

• Ancillary staff time is NOT allowed
• Total time of the encounter must be documented
  • Time in/out are not required according to AMA
• Qualification statement will still be required
• Time rules are only applicable to office/outpatient setting for the code set 99202-99215
<table>
<thead>
<tr>
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<th>Time</th>
<th>wRVU</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>99202</td>
<td>15-29</td>
<td>0.93</td>
<td>$77.23</td>
</tr>
<tr>
<td>99203</td>
<td>30-44</td>
<td>1.42</td>
<td>$109.35</td>
</tr>
<tr>
<td>99204</td>
<td>45-59</td>
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<td>$211.12</td>
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<td>N/A</td>
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<tr>
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<td>10-19</td>
<td>0.48</td>
<td>$46.19</td>
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<td>30-39</td>
<td>1.5</td>
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<tr>
<td>99215</td>
<td>40-54</td>
<td>2.11</td>
<td>$148.33</td>
</tr>
</tbody>
</table>

Consider the Total Time
2021 Teaching & Policy Considerations

• Countable time
• Total time per code change
• Time qualification statement
So is there really change to this portion of the MDM for 2021?
The Morale of the Story

This is NOT a documentation change!
Tools You Need
Additional Topics/Dates:

June 29, 2020: Defining the Differences in 2020 vs. 2021
July 27, 2020: Medical Necessity & E/M Changes
August 24, 2020: History & Exam in 2021: The Quandary
September 14, 2020: Understanding MDM in 2021: Part 1
September 21, 2020: Understanding MDM in 2021: Part 2
October 26, 2020: Training Your Providers for 2021
November 23, 2020: Hands On 2020 vs. 2021
December 14, 2020: Hands On/ Q&A
Questions?

P: 1-877-418-5564  F: 1-865-531-0722
Web: www.NAMAS.co
Email: sdeconda@namas.co

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