Battle, Balance, and Benefits - New 2021 Evaluation and Management Guidelines

Beginning January 1, 2021, the new Centers for Medicare and Medicaid Services ("CMS") Evaluation and Management ("E/M") guidelines will take effect for Office and Other Outpatient codes *99202-99205 and 99212-99215. Assignment of these codes will now be determined based on medical decision making ("MDM") or time. The need for an extended history and / or exam to support code assignment is eliminated. The documentation of an appropriate history and examination is left to the performing provider's judgement. In this article, a comparison of the old vs. new guidelines for establishing medical decision making will be discussed, compared, and contrasted. Below is the American Medical Association's table for reference.

2021 Medical Decision Making **Two of Three Columns Must be Met**			
99202 **99212**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low
	• **2** or more self-limited or minor problems;
	or
	• **1** stable chronic illness;
	or
	• **1** acute, uncomplicated illness or injury
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		
		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*
		or
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
			Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate
	• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• **2** or more stable chronic illnesses;
	or
	• **1** undiagnosed new problem with uncertain prognosis;
	or
	• **1** acute illness with systemic symptoms;
	or
	• **1** acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 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*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High
	• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 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*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization
			• Decision not to resuscitate or to de-escalate care because of poor prognosis

On or prior to 12/31/2020 using the 1995/1997 E/M guidelines, code 99212 is often reported for one stable condition (i.e., controlled hypertension). Even with prescription drug management, one stable established condition codes to 99212 or straightforward medical decision making. However, using the 2021 E/M guidelines, the exact same scenario will allow the assignment of 99213 or low medical decision making. Considering two of the three categories must be met or exceeded, the table below demonstrates how an assessment of one stable condition with prescription drug management will change using the 2021 E/M guidelines.

Straightforward MDM (Current-2020)	Low MDM (New-2021)
Number of diagnosis: 1 (Stable, Established Hypertension) **= Straightforward**	Number AND Complexity or Problems Addressed: 1 Stable Chronic (Hypertension) = **Low**
Data: None	Data: None
MDM: Prescription Drug Management **= Moderate**	MDM: Prescription Drug Management = **Moderate**

Since 2 of the three MDM components do not match, choose the middle component.

Continuing the comparison of E/M work-up, another patient scenario is below. Two stable chronic conditions with an order for laboratory tests; CBC, Hgb & TSH (when not separately reported) and prescription drug management currently allows assignment of 99213 using 1995/1997 E/M guidelines. Using the new 2021 E/M guidelines, the same scenario allows assignment of 99214! The new guidelines are generous enough to allow **EACH** (unique) test to be counted separately for the data component! However, when the provider is billing for the test, credit for the tests also billed by the provider CANNOT be included in the data portion of medical decision making.

Low MDM (Current-2020)	Moderate MDM (New-2021)
Number of diagnosis: 2 (Stable Hypothyroidism and DM) **= Low**	Number AND Complexity or Problems Addressed: 2 Stable Chronic (Hypothyroid and DM) = **Moderate**
Data: 1 (CBC, Hgb, TSH) **= Minimal**	Data: Category 1 Met (3 unique labs) = **Moderate**
MDM: Prescription Drug Management **= Moderate**	MDM: Prescription Drug Management = **Moderate**

Interestingly, the above scenarios also apply to new patient encounters since history and exam only require a medically appropriate level of documentation for (99202-99215) code selection.

NOTE: Since 99201 and 99202 have historically required the same MDM level, 99201 has been deleted. Without the requirement of the specific number of elements for history and examination, having two codes with the same MDM is redundant.

Time-based billing is also changing with the 2021 E/M guidelines for Office and Other Outpatient codes (99202-99205, 99212-99215). Much to the providers' delight, all activities pertaining to the patient on the date of the encounter can be included in the total time – including time spent documenting in the record! Instead of documenting the tedious 50% spent in counseling statement, providers will be allowed to document the total time with specific information on the activities provided.

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)

An example time statement could be: "Total time: 35 minutes spent on reviewing old records, talking with the caregiver, clinical documentation, and communicating with the patient and caregiver regarding treatment plan today."

CPT codes (99202-99205, 99212-99215) have revised time requirements which are presented as a time range.

Code	Current (2020)	New (2021)
99202	20 Minutes	15-29 Minutes
99203	30 Minutes	30-44 Minutes
99204	45 Minutes	45-59 Minutes
99205	60 Minutes	60-74 Minutes
99212	10 Minutes	10-19 Minutes
99213	15 Minutes	20-29 Minutes
99214	25 Minutes	30-39 Minutes
99215	40 Minutes	40-54 Minutes

Prolonged services also change in 2021. CMS and the AMA have differing opinions on prolonged services. As a result, add-on codes G2212 and 99417 have been introduced as prolonged service codes.

CMS requires 15 minutes beyond the maximum E/M time. For an established Medicare patient, a minimum time of 69 minutes would be required to report 99215 and prolonged services +G2212.

AMA implemented the additional 15 minutes be added to the minimum time or a total of 55 minutes for an established patient to report 99215 and +99417.

Some Commercial payors may follow CMS regarding prolonged services, however, confirm with the specific payors which code (+99417 or +G2212) is to be reported.

In addition to prolonged services, code +G2211 was suggested for E/M complexity but hold assigning the code in 2021, **as it has been delayed for 3 years!**

The modified guidelines (2021) will require adjustments in our thinking and providers' documentation. Key, article take-ways:

- ✓ The new guidelines apply only to codes 99202-99205, 99212-99215.
- ✓ CPT code 99201 has been deleted.
- ✓ Coding by time requires the time fall within a range rather than a typical time as in the past.
- ✓ New prolonged service codes require close attention and may differ by payor.

Provider's documentation must be clear, concise, and as detailed as possible to receive appropriate credit (i.e., the number of "unique" tests ordered, review of external records each "unique" source). Several Medicare Administrative Contractors have yet to publish information regarding

the 2021 E/M guideline changes. However, First Coast Service Options, Inc has published a FAQ (link below) and WPS has an online FAQ available through the learning center.

Resources:

2021 CPT Codebook (AMA)

AMA Code and Guideline Changes Document: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Consolidated Appropriations Act of 2021

Centers for Medicare and Medicaid 2021 Interim Final Rule

First Coast Service Options, Inc. 2021 FAQ: https://medicare.fcso.com/EM/0476893.asp