EVALUATION AND MANAGEMENT GUIDELINE

CHANGES EFFECTIVE JANUARY 1, 2021

From the office of Coding and Documentation Compliance
September 24, 2020

The Evaluation and management guidelines as we know them are getting ready to be changed, ***effective January 1, 2021.***

This guide has been put together to help you understand the changes and get prepared for January 2021.

The new guidelines will be found first and then a review of current guidelines will follow ending with a recap of updates

On the next page (pg.2) you will find a clickable table of contents for easy referencing

If you have any questions please let me know chapman114@marshall.edu

Updated: 10/15/2020

Thanks,

Anastacia Chapman

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New E/M guidelines effective January 1, 2021

Created for educational purpose for Marshall Health billing
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New E/M guidelines 2021- HISTORY and EXAM

2021 guidelines state: History and Physical exam will no longer be scored and used to select the level of office/outpatient visit (AMA)

It is very important to continue to document the patient history and Physical exam with each encounter as you are doing currently

Documenting the patient history and physical exam will be the way you demonstrate the patient complexity and the medical necessity required to treat the patient so the History should still be documented as it is currently even though it is not being used to score the level of encounter.

NOTE:

1. Insurance audits will continue to take place and if they deem there is not enough documented to back up the level coded we could see denials.
2. Important to keep in mind that the medical record is a legal document and can be used in a court of Law, everything that is done inside the encounter should be documented

Best practice is to document the following in every encounter

- Chief complaint
- History of present illness
- Review of systems
- PFSH
- Exam

New E/M guidelines 2021- Medical Decision Making

The MDM is calculated based on

- The number of problems addressed during the encounter
- Amount of Data reviewed
    - Categories:
        - 1- tests and documents
        - 2- assessment requiring an independent historian/ independent interpretation of tests
        - 3- discussion of management or test interpretation
- Risk of complications and or morbidity/mortality

The number of problems addressed during an encounter is the number of diagnoses made or managed during the encounter

The amount of data reviewed is now broken up into categories

- **Category 1:** Tests and documents
    - Review of prior external notes from each unique source
    - Review of the results of each unique test
    - Ordering of each unique test
- **Category 2:** Independent interpretation of tests
    - Independent interpretation of a test performed by another physician or other qualified health care professional not separately reported
- **Category 3:** Discussion of management options or test interpretation
    - Discussion of management or test interpretation with external physician or other qualified health care professional

The risk of complications and or morbidity/mortality when managing patient care between the present encounter and the next encounter

There are 4 levels of risk; minimal, low, moderate, and high

- See table of risk at the end to see more details

New E/M guidelines 2021 – Important changes in 2021

Important changes to take note of for 2021

- Providers can choose how their encounters are scored and coded based on either
  - Medical decision making
  - Solely based on time
- Times in the code book have changed and are now listed as a range of time
  - 99201- code has been deleted
  - 99202- 15-29 minutes
  - 99203- 30-44 minutes
  - 99204- 45-59 minutes
  - 99205- 60-74 minutes
  - 99211- no time documented
  - 99212- 10-19 minutes
  - 99213- 20-29 minutes
  - 99214- 30-39 minutes
  - 99215- 40-54 minutes
- The face-to-face element in documentation and billing for time has been removed and now the times above will include TOTAL time
  - Any time spent reviewing tests or notes prior to encounter
  - Face-to-face time during the encounter
  - Any time spent documenting after encounter same day
- There is no longer a 99201
- There is a new table of risk (a copy will be at the end of this packet for your review
- Concept of Medical Decision Making(MDM) does not apply to 99211
- Time documentation does not apply to 99211
- Updated E/M valuations meaning the new valuations include some significant increases in work RVUs for these E/M codes
- New code for prolonged office visits for time based documentation 99XXX for each additional 15 minutes spent
- New add on code for more complex patients GPC1X

New E/M guidelines 2021- Code changes

Code description GPC1X

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patients single, serious, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and management visit, new or established patient.

Total time: 11 minutes

Work RVUs- 0.33

In order to code GPC1x

There must be specific documentation to back up the medical necessity it took to spend that additional time with the patient prior to, during or after the encounter.

Prolonged time E/M codes

99XXX- prolonged office visits for time documented leveling

At least 15 minutes of additional time spent on Level 5 encounters

99358-99359- Prolonged evaluation and management without direct patient contact will no longer be used

Deleted code

99201

New E/M guidelines 2021- Time Documentation

TIME DOCUMETNATION GUIDELINES

Providers must document the time spent on the encounter specifically. Making use of the time statement in the template is fine as long as it specifies time spent with the patient, before the encounter and after the encounter

TIME DOCIMENTATION EXAMPLE:

Prior to the September 24th appointment I personally spent 15 minutes reviewing lab work that was ordered last encounter (3/24/2020), during the encounter I reviewed the lab results with the patient as well as reviewed the chronic conditions the patient has, the encounter lasted 45 minutes and after the encounter I spent 25 minutes reviewing the glucose monitor data and 10 minutes documenting the encounter. Total time: 95 minutes

NOTE ABOUT TIME DOCUMENTATION:

The above is just an example and obviously does not have to look exactly like it but should be specific as to how much time was spent doing tasks associated with the encounter. Simply documenting the encounter was 95 minutes ***will not be sufficient*** and will likely flag for an insurance audit.

Level of codes based on time

- New patient
  - 99202-15-29 minutes
  - 99203- 30-44 minutes
  - 99204- 45-59 minutes
  - 99205- 60-74 minutes
- Established patient
  - 99211- not a time based code
  - 99212- 10-19 minutes
  - 99213- 20-29 minutes
  - 99214- 30-39 minutes
  - 99215- 40-54 minutes

What constitutes TIME?

- TIME spent on the Date of Service ONLY: not the days leading up to the encounter nor days following the encounter can be counted
    - Prepping to see the patient
    - Obtaining history or reviewing history
    - Performing medically appropriate exam evaluation
    - Counseling with patient/family and or caregiver
    - Ordering meds, tests, procedures medically necessary for the encounter
    - Communicating with other health care professionals
    - Documenting clinical info pertaining to the encounter
    - Independently interpreting results

Everything done for the encounter should be documented in the note, this will prove the medical necessity for the time spent on the patient.

Whose TIME can be counted?

- TOTAL TIME can only be counted from
    - Physicians(MD, DO)
    - Physician Assistants(PA)
    - Nurse Practitioner(NP)
- Ancillary staff time cannot be counted as TOTAL time

Documentation changes:

There is no need to document >50% of time spent on counseling and coordinating care

New E/M guidelines 2021-Table of Risk

Code	Level of MDM	Number and complexity of problems addressed	Amount and/or complexity of Data to be reviewed	Risk of complications and or morbidity/mortality of patient management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**MIMIMAL** 1 self-limiting or minor problem	MINIMAL OR NONE	MINIMAL risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	**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 following ○ Review of prior external note from each unique source ○ Review of the result(s) of each unique test ○ Ordering of each unique test **OR** **CATEGORY 2:** Assessment requiring and independent historian (moderate or high)	LOW risk from additional diagnostic testing or treatment
99104 99214	Moderate	**MODERATE** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment Or 1 undiagnosed new problem with uncertain prognosis Or	(must meet the requirements of at least 1 of the 3 categories) **CATEGORY 1**: tests and documents • Any combination of 2 from following	

		1 acute illness with systemic symptoms Or 1 acute complicated injury	○ Review of prior external note from each unique source ○ Review of the result(s) of each unique test ○ Ordering of each unique test ○ Assessment requiring and independent historian **OR** **CATEGORY 2:** Assessment requiring and independent historian • 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/ or other qualified health care professional\ appropriate source(not separately reported)	
99205 99215	High	**HIGH** 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment	(must meet the requirements of at least 2 of the 3 categories) **CATEGORY 1**: tests and documents	HIGH risk of morbidity from additional diagnostic testing or treatment

		Or
		1 acute or chronic illness or injury that poses a threat to life or bodily function
			• Any combination of 2 from following
			  ○ Review of prior external note from each unique source
			  ○ Review of the result(s) of each unique test
			  ○ Ordering of each unique test
			  ○ Assessment requiring an independent historian
			OR
			CATEGORY 2: Assessment requiring and independent historian
			• 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/ or other qualified health care professional\ appropriate source(not separately reported)	

Current E/M guidelines effective through December 31, 2020

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Current E/M guidelines 2020- Overview

Just for a refresher and so you will be able to compare the current guidelines effective now through December 31, 2020 with the new set of guidelines effective January 1, 2021

E/M levels of coding

- 99201-99205 New patient office encounters
- 99211-99215- established patient office encounters

Elements of E/M coding

Evaluation and management has 3 elements that need to be documented in the patient's chart this is how an encounter is coded at different levels.

- **History**
  - Chief complaint
  - History of Present Illness
  - Review of Systems
  - Past Family and Social History
- **Exam**
- **Medical Decision making**
  - Number of diagnoses
  - Amount and complexity of data
  - Risk to the patient

New versus established patients

- ***New patient*** E/M codes require all three elements of E/M to be met in order to code the level
- ***Established patient*** E/M codes requires 2 of the 3 key elements of E/M to be met in order to code the level

Current E/M guidelines 2020- HISTORY

Chief complaint- a complete concise statement explaining why the patient is being seen

History of present illness- the HPI expands on the chief complaint, explaining in the patient's own words what brings them to see the provider, for a follow up exam this would be where each chronic condition that is being managed is reviewed, for new patients it is an explanation of signs and symptoms or the explanation of a chronic condition the patient may have.

Review of systems- An interview of sorts between the provider and patient, reviewing the systems helping the provider narrow down a potential diagnosis

Past Family social history- This is a review of pertinent history the patient has both personal history and family history (this information pulls forward with each encounter)

**Current guidelines requires the following to be documented for each level **

Code	Chief complaint	HPI	ROS	PFSH
99201	**required**	**1-3 elements**	**0**	**0**
99202	**required**	**1-3 elements**	**1 system reviewed**	**0**
99203	**required**	**4+ elements**	**2-9 systems reviewed**	**1 element of history**
99204	**required**	**4+ elements**	**10+ systems reviewed**	**3 elements of history**
99205	**required**	**4+ elements**	**10+ systems reviewed**	**3 elements of history**
99211	**required**	**N/A**	**N/A**	**N/A**
99212	**required**	**1-3 elements**	**0**	**0**
99213	**required**	**1-3 elements**	**1 system reviewed**	**0**
99214	**required**	**4+ elements**	**2-9 systems reviewed**	**1 element of history**
99215	**required**	**4+ elements**	**10+ systems reviewed**	**3 elements of history**

Current E/M guidelines 2020- EXAM

Problem focused exam- Documenting of examining of 1-4 bullets from 1 or more organ systems

Expanded problem focused exam- Documenting of examining of at least 6 bullets from 1 or more organ systems

Detailed exam- Documentation of examining of at least 12 bullets from any organ system

Comprehensive exam- Documentation of examining of at least 2 bullets from each of nine organ systems

Example of exam bullets:

System to examine

<Cardiovascular

Available bullets to examine

* Palpation of the heart (location, size, thrills)
* Auscultation of the heart with notation of abnormal sounds and murmurs
* Assessment of lower extremities for edema and/or varicosities
* Examination of the carotid arteries (e.g., pulse amplitude, bruits)
* Examination of abdominal aorta (e.g., size, bruits)
* Examination of the femoral arteries (e.g., pulse amplitude, bruits)
* Examination of the pedal pulses (e.g., pulse amplitude)

Current E/M guidelines 2020- Medical Decision Making

Medical decision making is made up of

- Number of diagnoses
- Amount and complexity of data
- The risk to the patient

In order to hit a MDM level two of the three (# of Dx, amount of data, risk) must be met

Code	# of Diagnoses	Amount of data	Risk
99201	**1**	**1**	**Straightforward**
99202	**1**	**1**	**Straightforward**
99203	**2**	**2**	**Low**
99204	**3**	**3**	**Moderate**
99205	**4**	**4**	**High**
99211	**N/A**	**N/A**	**N/A**
99212	**1**	**1**	**Straightforward**
99213	**2**	**2**	**Low**
99214	**3**	**3**	**Moderate**
99215	**4**	**4**	**High**

New Evaluation and management guidelines 2021- RECAP

- ***Starting in 2021*** Providers will be able to choose how their Office/ Outpatient encounters are scored
    - Either based on Medical Decision making or based on time

- It is important to continue documenting every element of the encounter to back up medical necessity to treat the patient as well as prove the complexity of the patient.

- The office/outpatient encounter will no longer be scored from the documentation in the history and physical exam portion of the notes

- Time is now a range of time and is total time not just face-to-face time
- 99201 has been deleted
- Prolonged services at a level 5 will now be coded as 99XXX for each 15 minute increment in addition to the level 5 time frame
- A more complex patient can be coded with GPC1X to help accommodate the provider for the extra work and time associated with caring for the patient.

References

- Centers for Medicare and Medicaid Services
- American Medical Association
- OPTUM 360 coding reference books, CPT book

If you have any question about coding or documentation please let me know Chapman114@marshall.edu

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