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A review of the impact of the 2021 E/M coding changes in the office and outpatient setting

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The Centers for Medicare & Medicaid Services (CMS) changes to the final physician fee schedule,[1] which became effective January 1, have significant implications for office and outpatient healthcare professionals' operations, revenues, and compensation—and pose compliance issues.

Summary of changes to CPT E/M codes and guideline changes

CMS finalized office/outpatient evaluation and management (E/M) services visit codes 99201–99215 in the 2020 physician fee schedule rule, effective January 1, that update both the CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services and the 2019 Medicare physician fee schedule final rule. The 2021 changes include establishing a new documentation framework, where documentation of history and exam are no longer used to select the E/M code level for office/outpatient visits,[2] but rather total time or medical decision-making (MDM) are used. The history and exam components will only be performed when—and to the extent—reasonable, necessary, and medically appropriate. The term "medically appropriate" is defined in the new E/M guidelines as those E/M services that capture the nature and extent of any history or exam for a particular service.[3] This eliminates the need for the physician to perform a full review of systems for a minor medical problem and allows them to review and supplement prior histories taken of the patient, while relieving them of unnecessary paperwork.

Where time is used to select the correct E/M code, total time on the encounter date includes both face-to-face and non-face-to-face work (with the exception of 99211).

Three elements define MDM for office/outpatient visits in 2021: the number and complexity of the problem or problems addressed during the E/M encounter; the amount and/or complexity of data to be reviewed and analyzed; and the risk of complications and/or morbidities or mortality of patient management decisions made at the visit.[4] While the 2021 MDM guidelines may reflect a more precise clinical description of patient problems addressed, they create a maze of problems difficult for coders to navigate without clear documentation. The precise nature of each element listed under the three categories must be clearly detailed to ensure accurate coding of claims.

The 2021 guidelines redefine evaluation of patient risk, distinguishing risk associated with the condition addressed at the date of the encounter as different from risk of management. For example, 2021 E/M guidelines limit the scope of the problems addressed in a patient encounter to the conditions treated on a specific date. The 2020 guidelines, however, referred to problems addressed as including the "number of possible diagnoses and/or the number of management options that must be considered."[5] The 2020 guidelines also included the

evaluation of comorbidities as part of patient management options. The 2021 guidelines recognize that "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."[6]

In determining the level of MDM, the 2021 guidelines ask the question: What is the probability of an outcome, and if it occurs, what is the level of risk to the patient? A condition may have a low probability of death, but it may be a high-risk one. Multiple conditions of low severity may create a higher risk in the aggregate.[7] Even the recognition that a condition is characterized as chronic and stable can pose a significant risk of morbidity if the patient is not at their treatment goal—even though the condition has not changed and there is no short-term risk to life or function.[8] Conversely, the fact the final diagnosis does not represent a highly morbid condition, "does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion."[9]

The 2021 changes to office/outpatient coding, as with the 2020 and earlier E/M guidelines, create a table for scoring the presence or absence of elements in MDM. However, although the table appears to require a straightforward application of elements, the 2021 evaluation requires a grounding in 28 pages of new guidelines and key terms. Those guidelines are intended to redefine the complexity of the problem addressed, the risk associated with the problem, and the degree of testing required to diagnose it. Coders can accurately evaluate two columns of data involved on the scoring sheet, concerning the number of tests performed and the nature of the condition addressed, but where severity versus risk and complexity are not clearly defined in the medical records, and physician reporting of services lacks adequate documentation, the E/M services cannot be consistently or accurately coded.[10] Further, the discussion of risk in the guidelines is not consistent with the elements of decision-making table created by the American Medical Association to be used by coders.

The chief improvement brought by the 2021 E/M changes is that they have reduced overall physician documentation requirements. This has been accomplished by eliminating requirements, such as the requirement that physicians perform a full review of systems as part of the history and examination on both initial and subsequent visits.