

### Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/perspectives-ama/changes-reporting-evaluation-and-management-office-visits-how-prepare-2021/11147/>

### ReachMD

www.reachmd.com  
info@reachmd.com  
(866) 423-7849

---

## Changes to Reporting Evaluation & Management Office Visits: How to Prepare for 2021

Announcer:

Welcome to a special edition of Inside Medicare's New Payment System on ReachMD. This special program titled "Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021" is brought to you by The American Medical Association.

Here's Dr. Barbara Levy & Peter Hollmann

Dr. Levy:

A hundred and seventy organizations came together and wrote a comment letter signed on to CMS outlining the problems with this proposed rule. It is true, physicians were extremely upset with the no bloat and the problems related to the electronic medical record that we all understand was built in order to help us with all the little bulleted guidance for the 95 and 97 guidelines. We all said that CMS should finalize some of their proposals that streamline care, um, only requiring documentation at an interval history and physical level so that we don't have reams and reams of notes that cut and paste and reproduced the same thing over and over again. Um, removing the need to justify home visits. All of those things were very, very positive. But we were very strong; the entire House of Medicine, in saying that CMS should not implement the collapsed payment and these add-on codes. And that they should not reduce payment for office visits on the same day of other services; that that would disenfranchise efficient care for our patients for their beneficiaries. And that they should set aside this proposal and give us a chance to work on it, and that was what we lobby for. So in response to that proposed rule, AMA, CPT, and RUC chairs decided to pull together a work group to see what we could do to respond to CMS's challenge really, and to say, could we simplify the structure of the evaluation and management services in a way that created the appropriate documentation for patient care without burdening physicians in the checkboxes and all of those things? And Dr. Brin, who was chair of CPT at that time, and Dr. Peter Smith, formed this work group with a lot of attention to the membership of the work group to be sure that we had representation from people who were really knowledgeable; both about payment policy and about coding structure, that we had good representation from surgical and procedural specialty societies, intensivists, as well as strong representation on the primary care side, and these are the members of the group. Again, the idea was to capitalize on the CMS proposal and make it better. To take that challenge and to do something really positive with it, and to act really quickly so that we were able to respond to CMS in a timely fashion. So what CMS is we went and lobbied said was, 'Well, okay, but we want a proposal by basically the summer so we have time to put it together through this, uh, CPT and RUC process so that they would have it ready for the proposed rule and the final rule for this year for 2019.' Those of you who know the CPT and RUC process may know that it's fairly deliberative, and it takes awhile to get consensus across the House of Medicine. So, um, we met frequently, and we spent a lot of time pulling this together. We had a lot of open meetings. Um, and we worked hard as really collaboratively in the House of Medicine. I can't say how proud I am of my co-chair and of the AMA staff who did an enormous amount of work to pull this all together. So the work group held seven open calls, two hours each, and one face-to-face meeting between about, um, August and November. We had, on average, about 300 participants on every call, uh, representing medical specialty societies, commercial payers, CMS, policy staff. We had five surveys in between the calls as we developed questions and there was discussion about issues. We staff developed surveys that were distributed to all of the specialty societies to try to get input – as much input as we could possibly get from everyone. And those – the results of those surveys that informed the agenda for the next call. And then that was an iterative process to get us to where we are right now. So our definitions of time and medical decision-making came about through that consensus process and through that iterative process.

Dr. Hollmann:

Good. Thanks a lot. Um, I do want to say right up front that it was impressive that there were specialties that were, uh, estimated to do

better by the CMS proposal, and they still were supportive of improving all this. So it really was a fabulous, uh, uh, getting together in the House of Medicine, which is what we all strive for in this House of Delegates so often. Uh, I did also want to say that I'm glad to see that you came here today. I know in another room they're discussing global warming, but you people truly understand that the future of humanity rests on E&M coding, and not on global warming, so, uh, I'm glad you all have your priorities right. Um, so one of the things that we did that we kind of – we stumbled onto a lot of things, to be quite candid. And thank goodness we did because they really helped us along the way. Uh, and people guided us by all their input, was that we decided that there should be some guiding principles right from the beginning. Uh, and those helped us a lot. So the first guiding principle was really an over-arching one, is that we were trying to simplify the work of clinicians so that they could spend more time improving the health of their patients. So that was the overriding principle. But we also wanted to make it clear that we are trying to decrease the administration – administrative burden of documentation and coding. We wanted to decrease the need for audits, because we felt inevitably there would be some, and we spent a lot of time talking about that. We wanted to decrease unnecessary documentation of medical record, and only retain that documentation that is necessary for patient care. And we wanted to ensure that payment for evaluation and management services is resource-based, which as Dr. Levy mentioned was not what we saw in the flat pricing. And there was no direct goal for payment redistribution between specialties, which was one of the outcomes of the flat pricing scheme. So, what did those principles mean in some of the things that we eventually developed, uh, during our work? Well, as far as decreasing administrative burden, we first of all followed CMS's lead and removed the scoring, the documentation guidelines of 95 and 97 related to history and examination. We wanted people to code the way clinicians think; whether they're physicians or other qualified healthcare professionals that report E&M. We wanted to decrease the need for audits, and one of the ways to do this was to put more detail in the codes themselves to promote payer consistency if audits were going to be performed, and also to improve coding consistency amongst ourselves. What we noticed, and I'll mention this a little bit later, as well, is that some things were fairly standard, right? There's the 95 and 97 documentation guidelines – those are across all CMS and a lot of private payers, non-Medicare payers, incorporated them as well. But there were lots of things that were payer-specific, especially when it came to the medical decision-making. And so those were areas we wanted to try to create consistency in. We wanted to decrease unnecessary documentation, and we felt that the history and physical examination bullets were one of the largest reasons for unnecessary documentation. We wanted to ensure that payment was, uh, for these services was resource based, and that there was no goal for redistribution. Uh, that meant that we were going to use some of the current guidelines and criteria other than those related to history and examination. So, as we went through this, people would say, 'Well, this is going to cause coding shifts,' or that kind of wording. And our point that we made, including at the RUC meeting and in our letters to CMS when we made our RUC recommendations is that we are using, with the exception of the history and examination, the same criteria that are being used today by CMS in medical decision-making, and our time is going to be roughly the same, as well, and Dr. Levy is going to go into time, as well. So we were not trying to create major coding redistribution; in fact, we were trying to avoid it. So, we'll go through some of the summaries. And I'll let Dr. Levy take over.

Dr. Levy:

Yeah, so just, um, very, very important – this does not take effect in a month and a half. This is January of 2021. And when we go through some of the challenges towards the end, I want that very, very clear. This is not a finished completed deal yet. This is the coding structure, the RUC recommendations are finalized. They were finalized in the rule, but there's a lot more work left to do. And I think that's very, very important for all of us in the room to know. So, number one, it's not until January of 2021. Number two, it's only for the office visit codes. So these changes to E&M are the beginning, not the end; not a completed work in – you know, it's a work in progress, it's not completed. So the major revisions for office and other outpatient services, not for hospital services, not for home visits. There were extensive guidelines, additions, revisions, and restructuring. So as you can imagine, if the structure for office visits is different from – it is – hospital visits, the definitions are different, we had to reorganize what we did with the guidelines. We ended up deciding to delete code 99201 because 99201 and 99202 both require straightforward medical decision-making. And if our hierarchy is based on medical decision-making, then there was no distinction between those two codes. So the one code that we eliminated was 99201. And then the components for code selection are a medically-appropriate history and/or examination. What that means is that we as the healthcare professionals decide what's important for us to do at a particular encounter, and document that. And if it's not important to do, we don't do it. So as a gynecologist, it's typically not important for me to look in someone's ears. And I generally don't do that. So it's eliminating those unnecessary steps that we were driven to do in order to meet requirements for coding. And then code selection can be based on one of two things; either medical decision-making or total time; time on the date of the encounter. And we heard loud and clear through the calls that the burden on physicians and qualified healthcare professionals for reviewing records – I mean the good news about an electronic medical record is that everything in theory is there. The bad news is there is an awful lot of it. And that the review of those things and the amount of work required to do that prior to the visit with the patient or after the visit with the patient was as intense and difficult as the face-to-face encounter. So there's a very new and different definition of time for the purposes

of code selection. E&M level of service then for office or other outpatient services can be based on medical decision-making, and again we used the CMS table of risk as our core, so this is intuitive to docs who have been coding forever. Most of us intuitively know if somebody is straightforward, or if it's complex medical decision-making, and we've preserved all of that. We put extensive clarification into the guidelines so that it would be very, very clear to all payers, and that they would use consistent guidelines. Because the lack of consistency is one of the things that adds significant burden to us. And then time is the total time spent with the patient on the date of the encounter, including the non face-to-face services that happen before and after, including the time for documentation, which we now know is far longer than it used to be. So, we made clear time ranges so that it's not – you don't have to think about am I halfway between this or that, but we made the increments very, very clear. And then it became obvious that sometimes it costs us even more time, and that we needed to create a prolonged services code that was a 15-minute increment, not a 30 or 60-minute increment. And that is reported only when time is used to choose the level of service, and only when you extend beyond a level 5. Because otherwise you have codes that you can use. So major revisions, here they are. What we will do in the future is just what we need to do for clinically appropriate care. And the amount of documentation we will do will be based on what we need to communicate to our colleagues and what we need for risk management. But not to count bullets. Not to count bullets in the history and not to count bullets in the physical examination. The medical decision making we think will be used most of the time for choosing a code level, but there is an alternative and that's to use time.

Dr. Hollmann:

So the RUC survey was an incredible one; 51 specialty societies and other healthcare professionals surveyed the revised codes to measure the physician time, work, and direct practice costs. So these are the things that RUC does, so that includes supplies, equipment, clinical staff time. Seventeen hundred people responded to the survey. The specialties analyzed their data and presented it to the RUC in April of this year, and then immediately the recommendations were transmitted to CMS. Um, the first thing you have to do because there were recommendations for increasing the values, is you have to decide with RUC rules, is there a compelling reason to increase the values. Have the services changed, essentially? Or are the people who are doing the services different? Something different about it. RUC agreed that the services were different; the electric – electronic health record, just the coding structure itself obviously would have had different changes with pre and post time and non face-to-face time, et cetera. So it was agreed that there was compelling evidence to allow potentially values to go up. Now, the RUC process also requires that the surveys support values going up. Just having that possibility does not mean it's going to happen. So that process was gone through where everybody analyzed the results of time and work and the relativity of all the services. And the med – the recommendations were transmitted to CMS, and they, uh, uh, published their, uh, acceptance of the rule. You can also see the details of the RUC recommendations at the AMA website. So we were very, very pleased that CMS proposed to accept the coding structure and the RUC recommended values, and indeed finalized those values. So you see the current work RBU, that's for 2019 and 2020. And you see the recommended work RBU for 2021, and what CMS accepted. The last two columns are the same all the way through, so you don't really need to worry about that. And you see that it's not always that things went up. And the lowest level code in 99202, there was no change. And it's – remember, it's really collapsing 99201 and 99202, uh, uh, uh, 99201 and 99202; we didn't show you 99201 there. Here are the work changes for the, uh, established patients. And these are just the work changes, not the total fee. And you can see again that the work did increase. There was recognition that at the higher level, there was definitely more work, uh, that needed to be recognized. Uh, it had been existing for awhile; we don't know how long, but it had been existing, and so it was appropriately recognized. And again, the prolonged service had its valuation recommended, and here it is.

Well, the last thing that RUC recommended, and Dr. Levy is going to address this a little bit more, is that RUC recommended, as they typically have, is that any changes to office visit valuations be included in services with global periods that include E&M. So that is the surgical global periods. Surgical is a general term, and there are many things that are global; they don't cut open tissue necessarily, and the maternity care codes. CMS did not choose to implement this recommendation, uh, in what they proposed for final – with a finalized for 2021. But remember, last year they finalized things and said we'll work with the AMA and others over the coming year, and they actually mentioned several things that they will be working with various people over the coming year, uh, as well. And the AMA will continue to advocate for our recommendations.

Dr. Levy:

This is a really, really important point that among the 51 specialties who surveyed these codes, the values were so close among all of the specialties, and to say, well these values are applicable to some sets of codes but not other sets of codes really doesn't make sense. So we still have challenges in front of us to make sure that implementation of these new guidelines and codes are done in a way that's resource based and is appropriate. And, um, AMA is prepared to do all of that. We have a challenge with respect to budget

neutrality. Um, CMS, the implementation of the increased valuation will impact specialties differently. The impact will be positive, obviously, for specialties that perform predominantly office-based services. But for those who do not perform office visits, they will see a decrease in payment in the Medicare population. The increased valuation for stand-alone office visits and the prolonged services code represents additional spending of about 5.3 billion. And the increased valuation to the procedures with surgical global of 10 or 90 days or maternity care codes would be an additional 0.4 billion. So that's a challenge for us. We will address it. It is something that we will definitely talk with CMS over time and see if we can't articulate the issues, um, in the House of Medicine.

Announcer:

This was a special edition of Inside Medicare's New Payment System titled: "Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021" brought to you by the American Medical Association. To access other episodes of this series, visit [reachmd.com/AMA](https://reachmd.com/AMA), where you can be part of the knowledge.