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

Implementing the 2021 Updates to Office Visit Evaluation & Management Documentation, Coding, & Billing Requirements

Announcer:
You're listening to Perspectives with the AMA, on ReachMD, produced in partnership with the American Medical Association. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
2020 has seen a number of changes proposed and resources built to better help physicians and their practices implement the new Evaluation and Management Codes, or E&M codes for short, for outpatient visits, taking effect on January 1, 2021. To get a better sense of the overall scope of these changes, as well as the resources now available to physicians, we're sitting down with the AMA to get the inside scoop on the latest E&M code changes for 2021. Welcome to Perspectives with the AMA, on ReachMD. I'm your host, Dr. Jennifer Caudle, and joining me today is Dr. Kathleen Blake, Vice President for Healthcare Quality at the American Medical Association. Dr. Blake, it's great to have you with us.

Dr. Blake:
Thank you so much. I'm happy to be here.

Dr. Caudle:
So, let's kick off our program with a quick overview of these E&M changes. What are the main changes we should know, and how will they affect physicians in practice?

Dr. Blake:
Well, as you mentioned earlier, Dr. Caudle, the E&M code changes are set to take effect on January 1, 2021. And just to capture the main updates, the first of these is that the coding changes eliminate the use of the history and physical as the elements for code selection. Documentation is based on what the physician determines is meaningful and necessary to evaluation and management of the patient. Second, the revisions to the codes allow physicians to choose whether their documentation coding and billing is based on Medical Decision Making or Total Time spent. For Medical Decision Making, there are extensive edits that were made to the elements for code selection, and the CPT panel revised and/or created clarifying definitions in the guidelines. For Total Time, the definition of time is now the actual time, not just the face-to-face time, that you've spent caring for the patient on the date of service.

Dr. Caudle:
So let's focus on the Medical Decision Making criteria for a moment. How have those criteria changed?

Dr. Blake:
So the criteria that are used to establish the level of Medical Decision Making have been modified in a few key ways. First of all, what we consider ambiguous terms, such as "mild" or ambiguous concepts, such as "acute" or "chronic illness with systemic symptoms" – these have been removed. Second, important terms, such as an independent historian – these have been defined. And thirdly, before January, 2021, the appropriate level of coding and billing was based on the number of data elements that you included in the encounter note. With the new coding structure, we're moving sharply away from simply adding up data entries and tasks, to focusing on the information and tasks that truly affect the management of the patient. On the subject of the CPT codes themselves, CPT code 99201 has been eliminated. Up until January, 2021, codes 99201 and 99202 were assigned to visits during which the Medical Decision Making was straightforward. The only real difference between the two codes was the number of data elements in the history and the physical examination. But now, with these revisions, because only the medically necessary elements of the history and physical exam are needed to be documented, the difference between the two codes no longer exists. And so, code 99201 has been eliminated, once again

allowing physicians to focus on what's relevant, entering only the information that matters to patient care, and to move away, we hope, from that "just checking the box" documentation. The new coding structure also uses shorter, prolonged services codes, to capture the time spent by a physician, or a qualified health provider, in 15-minute increments. Now it's worth remembering that this code should only be used when time is the primary basis for the code selection, and it should only be reported with codes 99205 and 99215.

Dr. Caudle:
So an underlying theme behind these coding changes is to help trim the fat on administrative tasks for physicians, and put more time back into patient care.

Dr. Blake:
That's absolutely correct. The goal of these coding changes is to reduce the documentation burden on providers, and to just reiterate a couple of points on that, because these new codes eliminate the history and physical exam as the determining factors for code selection, and because while significant to both visit time and medical decision making, reporting a prescribed number of elements no longer determines the code level, and as I mentioned earlier, the codes allow physicians to choose whether documentation is based on Medical Decision Making or Total Time. And it really moves us away, so that we can focus on tasks that actually affect patient care and management.

Dr. Caudle:
That's a great overview, Dr. Blake. So, with those details in mind regarding E&M code changes, what's the AMA doing to support better code implementation, preparation and continuing education on this topic?

Dr. Blake:
The AMA has been working in advance of the January 1st implementation date by developing an extensive library of resources, which includes an overview and summary of the E&M coding revision for office visits. We've produced a checklist with linked resources, to guide physician practices for a smooth transition to simpler and more flexible office visit documentation and coding guidelines. And then we've also produced CME-eligible modules, that you can find on the AMA's learning center, the AMA Ed Hub, and these include, for example, "A General Introduction to Office Evaluation and Management CPT Code Revisions." Then we take a deeper dive and have a module entitled, "Revisions to CPT E&M Office Visits: New Ways to Report Using Time," and not surprisingly, another module, which is, "New Ways To Report Using Medical Decision Making." We also have a series of video presentations entitled, "Implementing CPT Evaluation Management Revisions," and these offer step-by-step guidance to help you hit the ground running, with these new office visit changes. Furthermore, AMA is partnered with Nordic on a three-part educational series. These feature AMA's Dr. Barbara Levy, who is one of the leaders in developing these new codes, as well as Nordic's Chief Medical Officer, Dr. Craig Joseph. So I'd recommend to anyone interested in learning more about this subject to check out that series, because these programs were developed by and for physicians. AMA is also working to dispel regulatory myths, specifically almost any time we speak to an audience about the coding changes, we are asked whether commercial health plans will be required to adopt the new codes, or will it only be CMS that adopts the changes. The short answer to the question is, "Yes." Commercial plans will be required to adopt the changes. We're then often asked why that is the case. And the basis for that requirement is that the CPT code set, together with the U.S. Department of Health and Human Services, Healthcare Common Procedure Coding System, known by the acronym HCPCS, has been adopted as the nation's standard medical data code set. HIPAA requires that health plans use the most recent version of the medical data code set. So, they should be ready to implement the revisions January 1st. In informal conversations that we've had with large plans, we are hearing that they plan to adopt the revisions.

Dr. Caudle:
For those of you who are just tuning in, you're listening to Perspectives with the AMA on Reach MD. I'm your host, Dr. Jennifer Caudle, and joining me is Dr. Kathleen Blake from the AMA, to talk about the latest evaluation and management code changes for office visits, and resources available to help physicians implement them in 2021. So Dr. Blake, let's swing back to this topic of resources that physicians can draw on. I understand there are now checklists available to support better implementation. What can you tell us about that?

Dr. Blake:
So the AMA developed a checklist of ten tips to help practices prepare for these changes, and I'll summarize the ten tips here. First, it's absolutely important to identify a project lead for the transition, and ideally this is someone who's taken a deep dive into the changes, understands them well, and has strong, trusting relationships across the practice. Second, I think we have to be realistic in scheduling time to prepare, because oftentimes, this is something that will have to take place outside of the regular hours, the regular patient care time of the practice. Thirdly, it's important to update any of your practice protocols for documentation coding and billing. Otherwise, people might continue to do more documentation than is necessary. And quite frankly, we don't want them to miss the opportunity to

reduce burden. Fourth, you might want to consider obtaining additional coding support, recognizing that everyone will be on a learning curve. And a project lead may want to train what I would call a cadre, or super-users, to serve as a resource for their peers. Fifth, because we know that the medical record is a legal document, it's important to be aware of medical malpractice liability. And particularly, we ant you to be sure that your notes continue to include the information that informed your decision making, what you told the patient about their condition, and what you recommended in terms of follow-up. So, we don't want physicians to misinterpret the change in the documentation requirements to mean that they don't need to document pertinent history, exam and thought processes, because that still needs to be done. Sixth, it's important to guard against fraud and abuse law infractions, and it's just as important as ever to document what's needed to justify the code selected. Seventh, update a compliance plan – the plan in your practice. And that might include, for example, implementing a process for reviewing claims initially and until the person who's done the coding has demonstrated a very high level of proficiency and accuracy. As an eighth step, it's important to confirm with your EHR vendor when and how they will, so to speak, flip the switch for the updated codes. It's also important that if you plan to use an application within your EHR to assist with code selection, definitely you want to confirm that it's been updated to align with the new code descriptors. Ninth, I think you can now start to do some preliminary estimates of financial impact, positive or negative, on revenue and expenses. CMS estimates that what it will be paying for E&M visits will go up, but that will vary depending on your patient population. And number ten, it's important to understand the additional employer, payer or medical liability carrier requirements, and confirming that they, too, are ready for the coding changes. In particular, it's important to ensure that everybody knows that notes will look different – shorter, we hope, more focused on medical decision making, and more useful as a record of the care that you've provided to your patients. I think lastly, I would be remiss if I didn't remind our listeners to keep in mind that patients will soon have open access to their medical records. This has been true at some health systems and practices for quite some time, but it's going to become a requirement nationwide, likely in 2021. And although the federal government pushed out the original November, 2020 deadline for compliance, to some time next year, physicians should already be thinking about the patient as their primary audience – the primary reader of the encounter note while it is being written.

Dr. Caudle:
Well, those tips on their own are enough for us to chew on for awhile. But before we close, Dr. Blake, are there any other takeaways you'd like to share with our audience?

Dr. Blake:
So, I hope it's clear to everyone that we are absolutely committed at the AMA to supporting physicians during this coding transition. Also, that we believe properly done, the new approach has a high likelihood of improving notes and reducing what we call, "note bloat," and giving physicians more time to focus on what matters to them and to their patients. But we also want to hear from you – people such as today's listeners, and have you share with us your feedback and journey by using our "Subscribe For Updates" button on the CPT Evaluation and Management landing page on the AMA website. Also, just a reminder that all of the resources I highlighted in today's episode can be found on that same CPT web page, at the AMA website.

Dr. Caudle:
Well, with that in mind, I'd like to thank my guest, Dr. Blake, for joining me to share updates and resources available to help physicians implement the E&M code changes in 2021. Dr. Blake, it was great having you on the program.

Dr. Blake:
Thank you very much.

Announcer:
The preceding program was produced in partnership with the American Medical Association. To revisit any part of this discussion, and to access other episodes in the series, visit reachmd.com/AMA. Thank you for listening. This is ReachMD – be part of the knowledge.