E/M- Background and Guidelines

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Reasons to change E/M codes – CMS Perspective

- Burden reduction
- Shift time from EHR to patient contact
- Accommodate growing beneficiary load (~10,000/day) without adding proportionate number of clinicians
- Reduce burnout/stress
- But still needs to be auditable

(Attributed to G. Littenberg – ASGE Coding Course 2020)

How Did We Get Here? Brief Timeline

July 2018: CMS proposes to collapse certain E/M coding categories with a single blended-payment, as part of "Physicians Over Paperwork" initiative

Summer and Fall 2018: GI societies oppose CMS proposal and join multi-society effort to improve E/M coding (but keep coding levels)

November 2018: CMS abandons proposal to collapse E/M categories

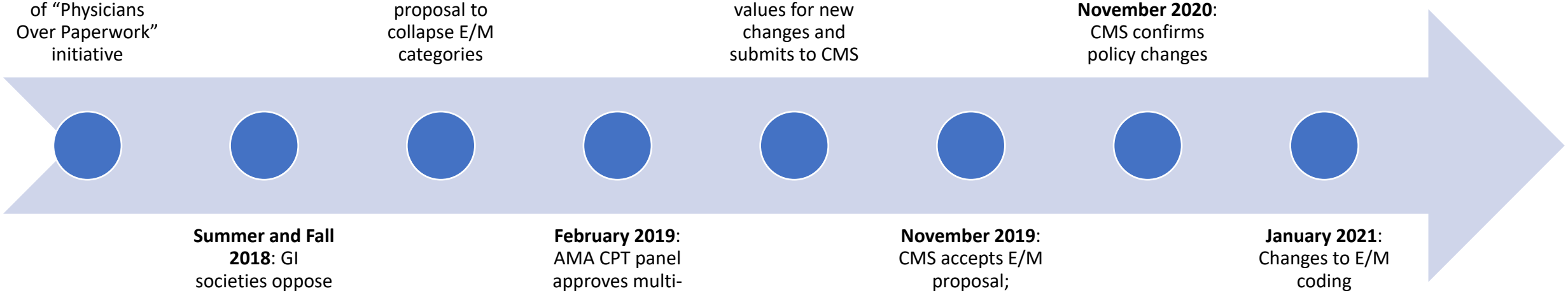
February 2019: AMA CPT panel approves multi-specialty workgroup proposal addressing changes to E/M coding

April 2019: AMA RUC approves recommended values for new changes and submits to CMS

November 2019: CMS accepts E/M proposal; beginning January 2021

November 2020: CMS confirms policy changes

January 2021: Changes to E/M coding commence



American College of Gastroenterology | aga American Gastroenterological Association | ASGE American Society for Gastrointestinal Endoscopy

Key Goals for AMA CPT/RUC E/M Workgroup

To decrease administrative burden of documentation and coding

To decrease the need for audits, through the addition and expansion of key definitions and guidelines

To decrease unnecessary documentation in the medical record that is not needed for patient care

To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

What are These Changes?

Code 99201 has been eliminated

Codes 99202-99205 and 99211-99215 descriptors and documentation standards have been revised

Eliminates H&P exam as elements for code selection/code level

Allows providers to choose whether documentation is based on medical decision-making (MDM) or total time on the date of service

Makes modifications to the criteria for MDM

Office or Other Outpatient Services: New Patient

Code	Descriptor
99201	(deleted)
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making. When using time for code selection, ***15-29 minutes*** of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***low level of*** medical decision making. When using time for code selection, ***30-44 minutes*** of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***moderate level of*** medical decision making. When using time for code selection, ***45-59 minutes*** of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***high level of*** medical decision making. When using time for code selection, ***60-74 minutes*** of total time is spent on the date of the encounter. (prolonged services code available).

Office or Other Outpatient Services: Est. Patient

Code	Descriptor
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making. When using time for code selection, ***10-19 minutes*** of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***low level of*** medical decision making. When using time for code selection, ***20-29 minutes*** of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which a requires a medically appropriate history and/or examination and ***moderate level of*** medical decision making. When using time for code selection, ***30-39 minutes*** of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***high level of*** medical decision making. When using time for code selection, ***40-54 minutes*** of total time is spent on the date of the encounter. (prolonged services code available).

Other Key Points:

The revisions only apply to outpatient office visits

Commercial payers are required to adopt the E/M office visit code revisions

- *AMA: "The CPT code set has been adopted as the standard medical data code set for physician services and other health care services in the United States. Because health plans are required by HIPAA to use the most recent version of the medical data code set, they should already be planning for implementation in 2021."*