E/M 2021 Wrap-Up

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Death Valley 2019

American Gastroenterological Association

American Society for Gastrointestinal Endoscopy

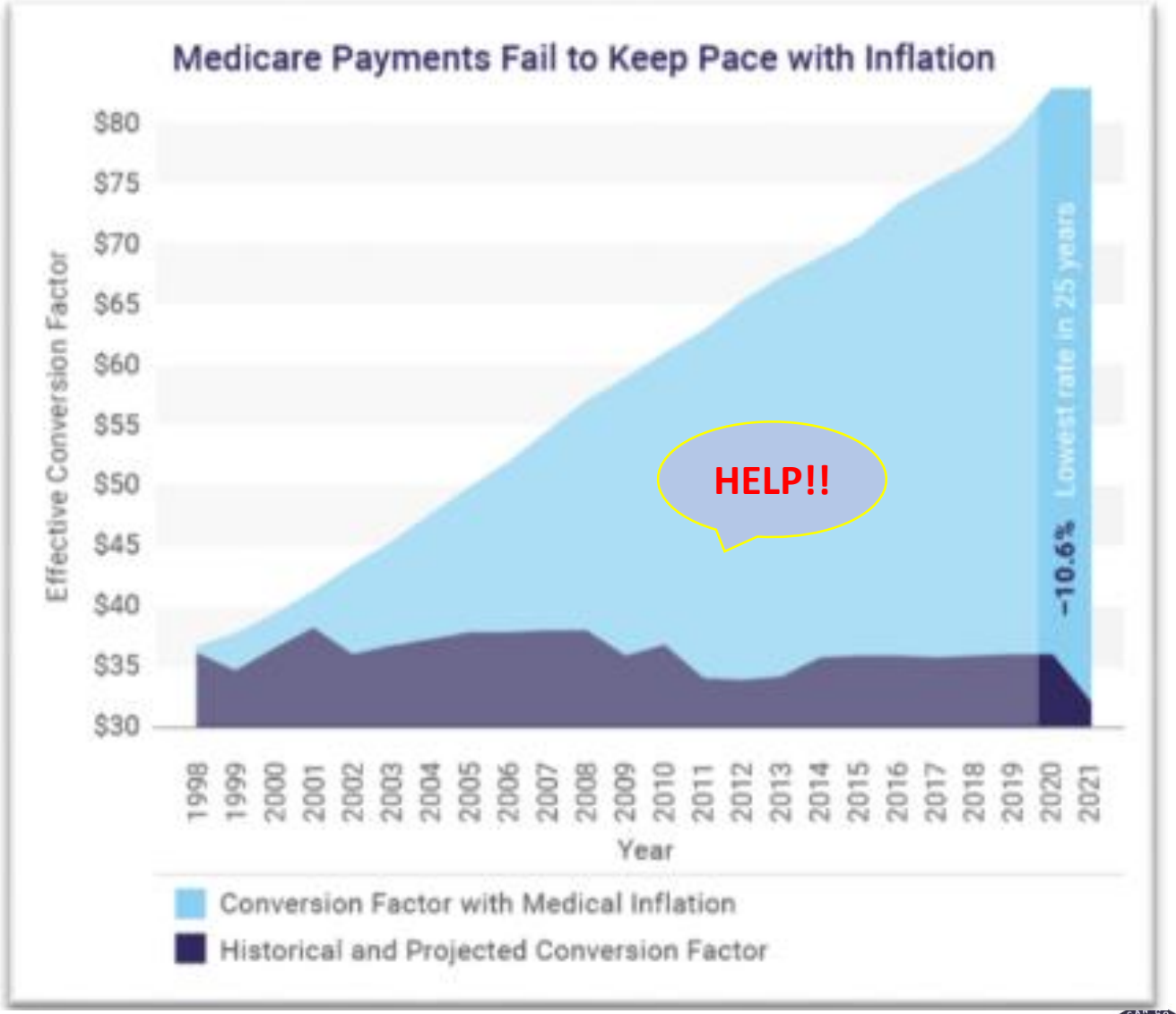
The GOOD, the BAD, the INDIFFERENT

- GOOD:
- Largely meets CMS, CPT Panel goals
  - Simpler documentation
  - Less likely subject to <bad> audits
  - MAYBE frees up some time during and across encounters
- Clarifies MDM for what you're doing during the encounter, less focus on the patient's inherent condition
- Allows in MDM for social determinants of health impact on patient care; and explicit about the 'road not taken' when subject to shared decision making

BAD

- Endoscopy not clearly positioned in the MDM table of risk
  - OUR VIEW: typical endoscopy in typical range of patients is moderate risk; high risk endoscopy and/or high risk patient from doing the endoscopy is high risk
  - Analogy: prescription medication is moderate risk; prescription needing intensive surveillance is high risk
- Time based still must clearly count/document and account for it
- MDM likely requires more overt discussion in the chart note, not just implicit <might be good, remains to be seen>
- Doesn't at all make up for 25 years of conversion factor erosion relative to inflation
- Two systems for these versus other E/M codes 1 year? 2 years?
- Parity for telehealth: telephone-only max after PHE ends:

G2252 Brief check-in by md/qhp, 11-20 min $26.87



2020, CF = $36.09

2021, CF = $32.26

➔ $34.84

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Indifferent

- MAY or MAY NOT allow for historical distortion of low percent reporting of level 5 complexity patients by GI
- May be confusing for some time to decide when better to code by time, when by MDM especially in a busier practice
- Will time based coding reward the slow and penalize the efficient?
- Budget neutrality axe