E/M 2021 Wrap-Up

Glenn Littenberg, MD, MACP, FASGE, AGAF
Chair, ASGE Reimbursement Committee, ASGE CPT Advisor
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
Medicare Payments Fail to Keep Pace with Inflation

2020, CF = $36.09
2021, CF = $32.26

HELP!!

2021, CF = $34.84
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