Evaluation and Management Guidelines Updates

By Terri Scales, CPC, CCS-P

At the 2018 NAOHP National Conference, I gave a sneak peek of the proposed Centers for Medicare & Medicaid Services (CMS) rules regarding the updating of the evaluation and management (E/M) guidelines. At the time of the conference, they were in a "proposed" state for updating the office/outpatient code set. Now there has been a final determination.

Because the E/M codes were established in 1995 and revised in 1997, CMS decided it was time to re-look at the documentation requirements for the E/M codes. This code set was outdated and needed to be revised and revalued to account for significant changes in the disease burden of the Medicare patient population and changes in healthcare practice to meet the Medicare population's healthcare needs. Currently for coding and billing E/M visits to Medicare, practitioners may use one of two versions of the E/M documentation guidelines for a patient encounter, referenced based on the year of their release: the 1995 or 1997 E/M documentation guidelines. Over the years, CMS has been told the guidelines are complex, ambiguous, fail to meaningfully distinguish differences among code levels, and are not updated for the changes in technology, especially electronic health records (EHR) use. Prior attempts to revise the E/M guidelines were unsuccessful or resulted in additional complexity.

In recent years, CMS sought public comment on potential changes to the E/M documentation rules, deferring making any changes to E/M coding itself in order to immediately focus on revision of the E/M guidelines to reduce unnecessary administrative burden.

We now have a final rule from CMS, which will be implemented January 1, 2019. For calendar year (CY) 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits, and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits. We will continue to use CPT codes 99201, 99202, 99203, 99204, and 99205 for new patient visits and 99211, 99212, 99213, 99214, and 99215 for established patient visits.

> **CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.**

For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit or on pertinent items that have not changed and do not need to rerecord the defined list of required elements if there is evidence the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record they have done so.

Additionally, CMS clarified for E/M office/outpatient visits for new and established patients practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record he or she reviewed and verified this information.

That is the information for the next two years. Although for CY 2021, CMS will be finalizing additional changes. One change that will be finalized is there will be a reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients.

Additionally, practitioners will be permitted to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines. Alternatively, practitioners could continue using the current framework.

Also, to be finalized is the implementation of add-on codes. These add-on codes will describe the additional resources inherent to visits for primary care and particular kinds of non-procedural specialized medical care. They would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements.

We will also be on the look for the adoption of a new "extended visit" add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021. There is quite a bit more to come on this topic for the next few years. NAOHP will keep you updated as the documentation and coding rules get updated and become final.

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