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HALL RENDER ADVISORY SERVICES' CODING COMPLIANCE ASSISTANCE OFFICE PREPAREDNESS FOR THE E/M DOCUMENTATION GUIDELINES EFFECTIVE JANUARY 1, 2021

In just a few months, CMS is going to introduce significant changes to office or other outpatient visit coding guidelines. With a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule, CMS will attempt to address the administrative burden placed on providers and prioritize patients over paperwork. When it comes to documentation guidelines, while many payors follow CMS's lead, some commercial insurers (excluding Medicare Advantage plans) are typically slow to align. Let us look at the revisions to assess our preparedness and streamline our workflow.

- **History and Physical Exam**: The Final Rule would eliminate the history and physical from being criteria in the determination of the appropriate E/M level. However, pertinent history and/or medically appropriate exams will continue as an expected part of the patients' continuum of care.
- **CPT Level Assignment**: The Final Rule allows providers to determine the level of the E/M service based on the now more clearly defined medical decision-making ("MDM") complexity or choose the level based on total time.
- **Medical Decision-Making**: While the heart and soul of the MDM components remain intact, their revised definitions provide more clarity to previously ambiguous guidance.
- **Time**: Code-level selection based on time defines this method as total time spent by the health care provider, not typical time, and eliminates the need to document the previously required care coordination portion.

The E/M services for which these guidelines apply still require a face-to-face encounter and non-face-to-face activities on the same date of service. Per the American Medical Association's guidance, effective January 1, 2021, provider professional time will include the following activities, when performed:

- Preparing to see the patient (e.g., review of tests);
- Obtaining and/or reviewing separately obtained history;
- Performing a medically appropriate examination and/or evaluation;
- Counseling and educating the patient/family/caregiver;
- Ordering medications, tests or procedures;
- Referring and communicating with other health care professionals (when not separately reported);
- Documenting clinical information in the electronic or other health records;
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver; and
- Care coordination (not separately reported).

Times associated with E/M codes will have ranges that vary depending on the level of service and differ significantly from previous times associated with the E/M levels.

- **Deletion of 99201**: With the same straightforward MDM as 99202, and only history and exam elements differentiating them, the usefulness of 99201 expires.
- **Prolonged Services**: This set of codes received new 15-minute increments and guidance to only use them with 99205 and 99215 with

time-based code selection.

Note: The E/M changes only apply to CPT codes 99201-99215 and the implementation date of these changes is January 1, 2021.

IMPLEMENTATION TIP

Do not wait! Active assessment of preparedness will mitigate potential gaps in your workflow and gaps in your revenue, including possible impacts of RVU changes on physician compensation plans. Not only can potential gaps result in possible False Claims risks, but possible impacts to RVU calculations could also result in physician arrangements risks.

RECOMMENDED STEPS

- Audit current E/M levels assigned by providers to determine potential documentation gaps post-implementation.
- Review EMR templates for compliance with MDM and time changes.
- Furnish education to providers on the MDM revised criteria, how to properly document time and how to determine when each method would be the most beneficial.
- Perform analysis on the changes in RVU assignment to physician compensation plans, including correct assignment of E/M levels for accurate RVU calculations.
- Perform post-implementation and education audits to determine the effectiveness of education.
- Perform audits on non-office based E/M codes (hospital, ED, etc.) to ensure new guidelines are not applied to these E/M visits.
- Update the organization's compliance program to be aligned with the changes.

Hall Render's Advisory Services Coding Compliance team specializes in professional service coding and billing gap assessments, reimbursement impact and compliance program support. We analyze medical records, claims and reimbursement to identify current risk areas and potential risks with the looming 2021 office and outpatient CPT changes. Our approach simulates that of government payors to bring you the real-world assessment of your readiness and risk mitigation report card. With customizable options to meet the needs of your organization, we offer a variety of reporting options, recommendations for risk mitigation, training tools and specialized educational classes for providers and coders. We can identify and mitigate regulatory risks, as well as identify potential revenue opportunities.

Hall Render Advisory Services' Coding Compliance team members have an average of 21 years of coding compliance/health care compliance experience. As an affiliate of Hall, Render, Killian, Heath & Lyman, P.C., Hall Render Advisory Services and the Coding Compliance team are backed by over 160 Hall Render attorneys, all of whom are focused exclusively on health care.

For more information about the content detailed above or any questions related to this matter, please contact:

HALL RENDER ADVISORY SERVICES

- Kenneth Zeko at (214) 458-3457 or kzeko@HallRenderAS.com
- Delena Howard at (904) 463-7306 or dhoward@HallRenderAS.com
- Angela Deneweth at (586) 243-9857 or adeneweth@HallRenderAS.com

HALL RENDER
KILLIAN HEATH & LYMAN

- Steven Pratt at (317) 977-1442 or spratt@hallrender.com

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