E/M Coding in 2021: The Times (and More) Are A-Changin'

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PRACTICE **POINTS**

- The outpatient evaluation and management (E/M) codes have undergone substantial changes that took effect January 1, 2021.
- Outpatient E/M visits are now coded based on time or level of medical decision-making (MDM).
- Time now includes all preservice, intraservice, and postservice time the physician spends with the patient on the date of the encounter.
- Many of the key definitions used in order to determine level of MDM have been streamlined and updated.

Major revisions for commonly reported office and outpatient evaluation and management (E/M) codes were implemented on January 1, 2021, by the American Medical Association and Centers for Medicare and Medicaid Services. The goal of these changes was to simplify and streamline these service codes, with time and medical decision-making (MDM) now being the sole determinants of the overall E/M level. We present an overview of the new guidelines, requirements, and code descriptors to aid in accurate documentation and billing. Additional resources are provided if further billing and coding questions arise.

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Effective on January 1, 2021, the outpatient evaluation and management (E/M) codes underwent substantial changes, which were the culmination of multiple years of revision and surveying via the American Medical Association (AMA) Relative Value Scale Update Committee and Current Procedural Terminology (RUC-CPT) process to streamline definitions and promote consistency as well as to decrease the administrative burden for all specialties within the house of medicine.[1] These updates represent a notable change from the previous documentation requirements for this oft used family of codes. Herein, we break down some of the highlights of the changes and how they may be applied for some commonly used dermatologic diagnoses.

Time Is Time Is Time

Prior to the 2021 revisions, a physician generally could only code for an E/M level by time for a face-to-face encounter dominated by counseling and/or care coordination. With the new updates, any encounter can be coded by total time spent by the physician with the patient[1]; however, clinical staff time is not included. There also are now clear guidelines of the time ranges corresponding to the level of E/M,[1] as noted in Table 1.

Importantly, time now includes not just face-to-face time with the patient but also any time on the date of the encounter that the physician is involved in the care of the patient when not reported with a separate code. This can include reviewing notes or data before or after the examination, care coordination, ordering laboratory tests, and providing any documentation related to the encounter. Importantly, this applies only when these activities are done on the date of the encounter.

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TABLE 1. Total Visit Times by E/M Level (Updated January 1, 2021)[a]

CPT code	Time
New Patient	
99201	Deleted
99202	15–29 min
99203	30–44 min
99204	45–59 min
99205	60–74 min
Established patient	
99211	Time component removed; code by MDM
99212E	10–19 min
99213	20–29 min
99214	30–39 min
99215	40–54 min

Abbreviations: E/M, evaluation and management; CPT, Current Procedural Terminology; MDM, medical decision-making.

[a]If the total maximum time of a level 5 visit (99205/99215) is exceeded by at least 15 minutes, the new add-on prolonged services code 99417 may be used for each 15-minute increment that is surpassed.

If you work with a nurse practitioner or physician assistant (PA) who assists you and you are the one reporting the service, you cannot double-dip. For example, if your PA spends 10 minutes alone with a patient, you are in the room together for 5 minutes, the PA spends another 10 minutes alone with the patient afterward, and you do chart work for 10 minutes at the end of the day, the total time spent is 35 minutes, not 40 minutes, as you cannot count the time you and the PA spent together twice.

Decisions, Decisions

Evaluation and management coding also can be determined via the level of medical decision-making (MDM). Per the 2021 guidelines, MDM is comprised of 3 categories: (1) number and complexity of problems addressed at the encounter, (2) amount and/or complexity of data to be reviewed or analyzed, and (3) risk of complications and/or morbidity or mortality of patient management.[1] To reach a certain overall E/M level, 2 of 3 categories must be met or exceeded. Let's dive into each of these in a little more detail.

Number and Complexity of Problems Addressed at the Encounter—First, it is important to understand the definition of a problem addressed. Per AMA guidelines, this includes a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter that is evaluated or treated at the encounter by the physician. If the problem is referred to another provider without evaluation or consideration of treatment, it is not considered to be a problem addressed and cannot count toward this first category. An example could be a patient with a lump on the abdomen that you refer to plastic or general surgery for evaluation and treatment.

Once you have determined that you are addressing a problem, you will need to determine the level of complexity of the problem, as outlined in Table 2. Keep in mind that some entities and disease states in dermatology may fit the requirements of more than 1 level of complexity depending on the clinical situation, while there are many entities in dermatology that may not be perfectly captured by any of the levels described. In these situations, clinical judgement is required to determine where the problem would best fit. Importantly, whatever you decide, your documentation should support that decision.

Amount and/or Complexity of Data to Be Reviewed and Analyzed—This category encompasses any external notes reviewed, unique laboratory tests or imaging ordered or reviewed, the need for an independent historian or discussion with external health care providers or appropriate sources, or independent interpretation of tests. Some high-yield definitions in this category are outlined in Table 3.

Risk of Complications and/or Morbidity or Mortality of Patient Management—In this category, risk relates to both the patient's diagnosis and treatment(s). Importantly, for treatment and diagnostic options, these include both the options selected and those considered but not selected. Risk is defined as the probability and/or consequences of an event and is based on the usual behavior and thought processes of a physician in the same specialty. In other words, think of the risk as compared to risk in the setting of other dermatologists diagnosing and/or treating the same condition.

Social determinants of health also play a part in this category and are defined as economic and social conditions that influence the health of individuals and communities. Social determinants of health can be indicated by the specific corresponding *International Statistical Classification of Diseases, Tenth Revision* code and may need to be included in your billing according to specific institutional or carrier guidelines if they are a factor in your level of MDM.

For the purposes of MDM, risk is stratified into minimal, low, moderate, and high. Some examples for each level are outlined in Table 4.

Putting It All Together

Once you have determined each of the above 3 categories, you can put them together into the MDM chart

TABLE 2. Levels of Complexity of Problems Addressed[1]

Level of Complexity	Description	Example
Minimal problem	May not require the presence of the physician, but the service is provided under the physician's supervision	Suture removal
Self-limited or minor problem	Runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status	Insect bite
Chronic illness	Expected duration of at least 1 year or until the death of the patient, risk of morbidity without treatment is significant; given this definition, it is important to include the duration of the problem somewhere in your documentation	Psoriasis
Stable chronic illness	A chronic illness that is not at the patient's treatment goal; a patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function; given this definition, you need to explicitly document the patient's treatment goals	Stable psoriasis at treatment goal
Acute uncomplicated illness or injury	This category encompasses 2 types of problems: (1) a recent or new short-term problem with low risk for morbidity for which treatment is considered, there is little to no risk for mortality with treatment, and full recovery without functional impairment is expected; and (2) a problem that normally is self-limited or minor but is not resolving consistent with a definite and prescribed course	Pruritic viral exanthema for which treatment is considered; inflamed or irritated seborrheic keratosis
Chronic illness with exacerbation, progression, or side effects of treatment	A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment of side effects but that does not require consideration of hospital level of care	Flaring psoriasis
Undiagnosed new problem with uncertain prognosis	A problem in the differential diagnosis that represents a condition likely to result in a high risk for morbidity without treatment	A new brown-black macule with a differential of a dysplastic nevus vs melanoma
Acute illness with systemic symptoms	An illness that causes systemic symptoms and has a high risk for morbidity without treatment; systemic symptoms may not be general but may be single system; however, this does not include systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications	Newly diagnosed leukocytoclastic vasculitis with hematuria
Acute complicated injury	Requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk for morbidity	Burn comprising 50% of the body surface area
Chronic illness with severe exacerbation, progression, or side effects of treatment	Severe exacerbation or progression of a chronic illness or severe side effects of treatment that have considerable risk for morbidity and may require hospital level of care	Flaring pemphigus vulgaris with dysphagia
Acute or chronic illness or injury that poses a threat to life or bodily function	Acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment	Toxic epidermal necrolysis

TABLE 3. High-Yield Sources of External Data to Be Reviewed[1]

Source	Description
Test	Imaging, laboratory, psychometric, or physiologic data
Unique test	Defined by the CPT code set; tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes; a unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty or a unique entity
External physician or other qualified health care professional	Not in the same group practice or of a different specialty or subspecialty
Independent historian	Individual who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history or because a confirmatory history is judged to be necessary (eg, parent/guardian, spouse)
Independent interpretation	Interpretation of a test for which there is a CPT code and an interpretation or report is customary; this does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient; a form of interpretation should be documented but need not conform to the usual standards of a complete report for the test
Appropriate source	Includes professionals who are not health care providers but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher); it does not include discussion with family or informal caregivers

Abbreviation: CPT, Current Procedural Terminology.

TABLE 4. Risk Stratification in Medical Decision-making[1]

Level	Examples and definitions
Minimal	No treatment or clinical monitoring only
Low	Over-the-counter drug management; decision regarding minor surgery without identified patient or procedure risk factors
Moderate	Prescription drug management; decision regarding minor surgery with identified patient or procedure risk factors; decision regarding elective major surgery without identified patient or procedure risk factors; diagnosis or treatment notably limited by social determinants of health; note that prescription drug management is not simply documenting a refill of current medication—you need to have a change of therapy or documentation of a discussion of why you are continuing a current medication, such as discussing expected side effects or toxicities and/or instructions for use
High	Drug therapy requiring intensive monitoring for toxicity; decision regarding elective major surgery with identified patient or procedure risk factors; decision regarding emergency major surgery; decision regarding hospitalization; decision not to resuscitate or to de-escalate care because of poor prognosis; an important definition to consider is drug therapy requiring intensive monitoring for toxicity, which for the purposes of medical decision-making is defined as long-term intensive monitoring that is at least quarterly for assessment of adverse effects; the monitoring may be by a laboratory test, physiologic test, or imaging; monitoring by history or examination does not qualify

to ascertain the overall level of MDM. (The official AMA medical decision-making grid is available online [https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf]). Keep in mind that 2 of 3 columns in the table must be obtained in that level to reach an overall E/M level; for example, a visit that addresses 2 self-limited or minor problems (level 3) in which no data is reviewed (level 2) and involves prescribing a new medication (level 4), would be an overall level 3 visit.

Final Thoughts

The outpatient E/M guidelines have undergone substantial revisions; therefore, it is crucial to

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understand the updated definitions to ensure proper billing and documentation. History and physical examination documentation must be medically appropriate but are no longer used to determine overall E/M level; time and MDM are the sole options that can be used. Importantly, try to code as accurately as possible, documenting which problems were both noted and addressed. If you are unsure of a definition within the updated changes and MDM table, referencing the appropriate sources for guidance is recommended.

Although representing a considerable shift, the revaluation of this family of codes and the intended decrease in documentation burden has the ability to be a positive gain for dermatologists. Expect other code families to mirror these changes in the next few years.

REFERENCE

1. American Medical Association. CPT® Evaluation and management (E/M) office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99417) code and guideline changes. Accessed May 14, 2021. https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Additional Resources

American Academy of Dermatology. Coding Resource Center. Accessed May 14, 2021. https://www.aad.org/member/practice/coding

American Medical Association. CPT Evaluation and Management. Updated March 9, 2021. Accessed May 14, 2021. https:/www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management