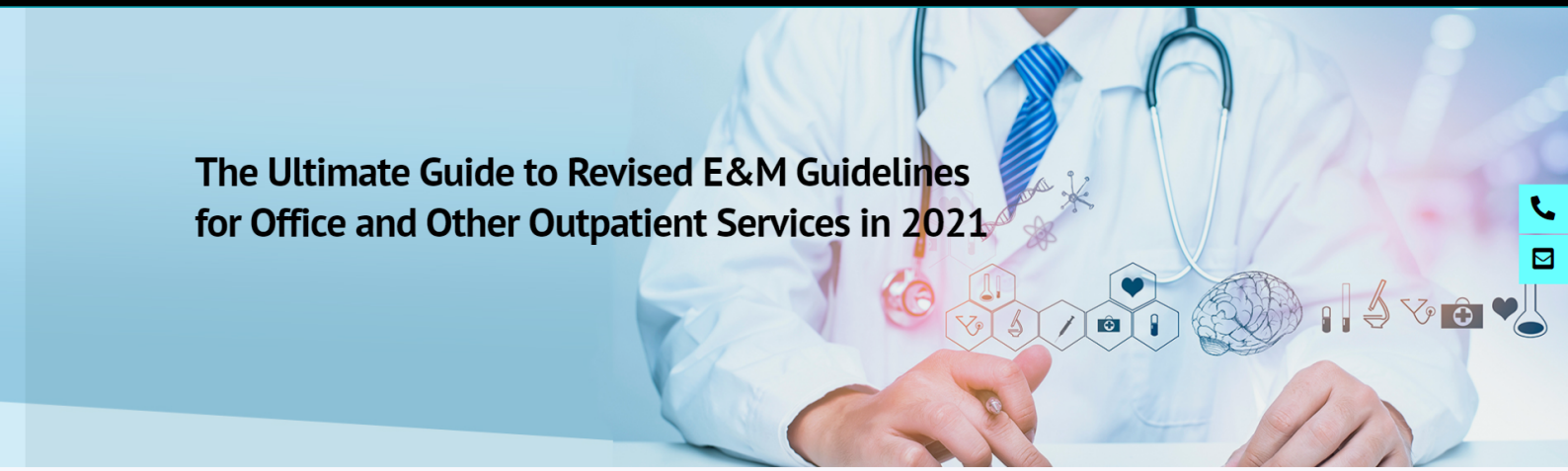

The Ultimate Guide to Revised E&M Guidelines for Office and Other Outpatient Services in 2021

Centers for Medicare and Medicaid Services (CMS) has embraced the recommendations of the AMA in regards to Evaluation and Management (E&M). Starting January 1, 2021, these changes will be applicable for coding office and other outpatient services.

Reason

In 2017, CMS brought an initiative "Patients Over Paperwork" to streamline work, increase efficiency, improve patient experience, and reduce administrative burden.

The purpose of this initiative was to revise the existing and archaic E&M coding guidelines. According to CMS, increasing paperwork and reporting tools were the main bottlenecks that kept physicians and medical practices busy.

They were required to spend more time managing administrative tasks instead of caring for patients. It resulted in poor patient experience and monumental administrative tasks that added to the cost as physicians needed to hire additional staff and comply with the government rules and regulations.

What Changes Will Take Effect

History and Tests Removed as Mandatory Elements for Coding. These two components tend to delay clinical decision making and are time-consuming as the clinicians need to document this in the patients' medical record.

Documents related to Medical Decision Making or Time

Physicians cannot use both these documentation methods for the same patient visit. They need to select either option for each patient visit.

Updated Time-Based Coding

Time is explained as "total time on the date of the encounter." It includes time spent by authorized healthcare professionals and clinicians for in-person and other modes or non-face-to-face discussions with the patient.

Revised Coding for Prolonged Services

It should be used for *time-based coding* when the duration of the encounter exceeds the defined time for 99205 and 99215 in 15-minute increments.

Updated MDM Criteria

Using the present CMS Table of Risk as a standard guideline, the MDM elements for code selection were refined and clarified to avoid complexity and increase efficiency patient management.

Restructuring of RVUs and Charges

Considering the RVU guidelines from the AMA's CPT/RUC Workgroup on E&M, CMS has stated that relative value for the codes is evaluated depending on the total duration spent by a physician from three days before patient's visit through seven days following the visit as the standard work will be same irrespective of the time when it is completed.

Source: https://www.ama-assn.org/