

CPT® Evaluation and Management

E/M office visit revisions

Updated March 9, 2021

On Nov. 1, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to the Evaluation and Management (E/M) office visit CPT® codes (99201-99215) code descriptors and documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country.

Once the revisions became effective on Jan. 1, 2021, the AMA received a lot of feedback on areas causing confusion. In response, the CPT Editorial Panel's executive committee accepted technical corrections to the E/M guidelines to provide clarifications in a number of key areas. These revisions were posted March 9, 2021 and are effective as of Jan. 1, 2021.

The Panel approved clarifications include:

- Medical decision making is revised in the following ways:
 - ✍ Clarifying when reporting a test that is considered, but not selected after shared decision making.
 - ✍ Providing a definition of "Analyzed" for reporting tests in the data column.
 - ✍ Clarifying the definition of a "unique" test.
 - ✍ Clarifying what is meant by "discussion" between physicians, and other qualified health care professionals and patients.
 - ✍ Providing a definition of major vs. minor surgery.
- Clarification around which activities are not counted when reporting time as a key criterion for code level selection.

The technical corrections can also be viewed as part of the entire E/M guidelines for 2021 (PDF).

With these landmark changes, as approved by the CPT Editorial Panel, documentation for E/M office visits will now be centered around how physician think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes.

Visit the "Implementing CPT® Evaluation and Management (E/M) revisions" page for videos, webinars and other resources to help you implement the changes.

E/M office visit historical background

For decades, the physician community has struggled with burdensome reporting guidelines for reporting office visits and other E/M codes. With the proliferation of electronic health records (EHRs) into physician practices, documentation requirements for office visits has moved towards increased "note bloat" within the patient record due to the largely check-box nature of meeting the current documentation requirements.

To address this, on Feb. 9, 2019, the AMA-convened CPT Editorial Panel approved revisions to the CPT E/M office or other outpatient visit reporting guidelines and code descriptors. These revisions were in direct response to the leadership demonstrated by CMS Administrator, Seema Verma, to take on the challenge of revising the (E/M) office visit reporting guidelines.

Scope & implementation date

The scope of the AMA proposal is solely focused on revisions to the E/M office or other outpatient visits (CPT codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215). The code set revisions will be effective Jan. 1, 2021.

Administrative burden

The AMA's proposal to reduce administrative burden achieves a shared goal with CMS, truly putting patients over paperwork and improving the health system. These revisions work in lock step with the already established administrative burden relief initiatives established by CMS for 2019:

- | Elimination of the requirement to document medical necessity of furnishing visits in the home rather than office.
- | Elimination of the requirements for clinicians to re-record elements of history and physical

exam when there is evidence that the information has been reviewed and updated.

- | Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

Additional burden reduction will be seen through:

- | Simplifying code selection criteria and making them more clinically relevant and intuitive
- | Creating consistency across payers by adding detail within the CPT E/M Guidelines
- | Alignment with current documentation guidelines from Medicare and the CPT code set to ensure minimal disruption to practices.

Summary of revisions

Eliminate history and physical as elements for code selection

While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level.

- | The workgroup revised the code descriptors to state providers should perform a "medically appropriate history and/or examination"

Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time

- | **MDM:** The Workgroup did not materially change the three current MDM sub-components, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines. (See below for additional discussion.)
- | **Time:** The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and **not** MDM.

Modifications to the criteria for MDM

The Panel used the current CMS Table of Risk as a foundation for designing the revised required

elements for MDM. Current CMS Contractor audit tools were also consulted to minimize disruption in MDM level criteria.

- | Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”).
- | Also defined important terms, such as “Independent historian.”
- | Re-defined the data element to move away from simply adding up tasks to focusing on tasks that affect the management of the patient (e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP).

Deletion of CPT code 99201

- | The Panel agreed to eliminate 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.

Creation of a shorter prolonged services code

- | The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

Primary objectives of the CPT Editorial Panel revisions

The CPT Editorial Panel took seriously the charge to create revisions to the E/M office visits and outlined four primary objectives to this important work:

1. To decrease administrative burden of documentation and coding
2. To decrease the need for audits, through the addition and expansion of key definitions and guidelines
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

History of code set revisions

The AMA led a consensus-driven, open and transparent workgroup process to ensure the reimagined approach to office visits represented input from the broad array of medical specialties that perform these visits. The Workgroup was created with members who had both CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) experience. In addition, the process engaged participants with diverse medical specialty backgrounds including primary care, several surgical specialties (e.g. General Surgery, Cardiology and Vascular Surgery), private payers and qualified healthcare professionals (i.e. Physician Assistants).

The Workgroup held numerous open conference calls, where on average, more than 300 individuals participated to provide direct input. Many of the major decisions made by the Workgroup, including the definition of time and key definitions of MDM criteria, were based on targeted stakeholder survey results.

The Workgroup brought their proposal to the CPT Editorial Panel as consensus recommendations and only minor modifications were made by the Panel prior to approving them.