E/M prep: Avoid these pitfalls in move to new office-visit codes

NOV 19, 2019

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New Medicare office-visit coding guidelines take effect Jan. 1, 2021, and are designed to be more intuitive and make unnecessary documentation tasks go away. Experts believe the transition will be smooth, especially if practices prepare in advance and avoid some clearly identified pitfalls.

The new evaluation and management (E/M) office visit code-selection criteria remove complex counting systems for history, exam and data that sometimes varied by payer. Physicians can decide whether to code by the total time—including nonpatient-facing activities on the day of service—or medical decision-making related to the visit.

In addition, ambiguous terms, such as “mild” were removed and previously ambiguous concepts—such as “acute or chronic illness with systemic symptoms”—were clearly defined.

Preparation will be key for a smooth transition and the AMA provides advice on how to do it. An AMA Ed Hub™ module, "Office Evaluation and Management (E/M) CPT Code Revisions," will help practices understand how these foundational changes will affect their work.

The AMA also has a detailed description of the changes and a table illustrating revisions related to medical decision-making documentation.

Recently released by the Centers for Medicare & Medicaid Services, the new coding for office-based E/M codes mostly follows the recommendations of an AMA-convened workgroup representing its Current Procedural Terminology (CPT®) Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC). The workgroup was led by Barbara Levy, MD, a former RUC chair, and Peter Hollmann, MD, former chair of the CPT Editorial Panel.

The workgroup co-chairs and an AMA preparation checklist highlight the following as mistakes to avoid when implementing the code revisions.

Forgetting to check the calendar. “One of the most important things to remember is that it’s for 2021,” said Dr. Hollmann, perhaps only half joking. “I just want to make sure that nobody thinks the rules suddenly change effective Jan. 1 of next year.”

Failing to appreciate the impact. The other key he noted illustrates how a small adjustment can have a big impact. Dr. Hollmann referred to the “limited range” to which the E/M code change applies: Office and outpatient services.

“I say it’s a ‘limited code range,’ but they are the codes that account for something like 20% of Medicare spending,” he explained, so practices need to prepare accordingly.

To that end, you should understand the guidelines in advance and perform a prospective financial analysis to estimate the potential impact on your practice. This may help you anticipate a dip or rise in revenue and help with other business decisions in your practice. The AMA has resources on engaging external advisers on business issues.

Not thinking about the medical liability aspect. The AMA checklist emphasizes that, although requirements around outpatient E/M documentation have been reduced and have been made more flexible, physicians should still carefully document the work being done and why.

Medical liability suits can turn on information included in the medical record, so physicians should ensure that medical care is being documented for clinical purposes—even when such documentation is not required by the new E/M guidelines.

- **Failing to guard against inadvertent coding errors that could raise red flags about possible fraud and abuse.** Requirements that create note bloat or lead to irrelevant box checking have gone away, but—the checklist notes—it remains important to comply with federal and state fraud-and-abuse laws. Practices need to be mindful that, although new office E/M coding guidelines allow greater flexibility, it is important to continue to document appropriately and guard against inadvertent overbilling.
- Reserving time to educate practice staff on total time documentation is recommended. Conversely, proper documentation can help if a practice bills appropriately, but still receives an overpayment demand. The AMA has resources to help navigate audit and appeal processes.
- **Continuing to do only what is *clinically* required.** To reiterate, the rules are simpler and more flexible. But adequate and accurate documentation is still necessary and can help

adjudicate payment disputes and legal matters.

But Drs. Hollmann and Levy both warn physicians against continuing to do the unnecessary documentation that they are forced to do now.

“Mostly what physicians will be doing is undoing certain ingrained habits for documentation that were created by the CMS documentation guidelines,” Dr. Hollmann said. “At some point, they’ll be saying ‘Why am I still doing this?’”

Dr. Levy agreed.

“If coding for medical decision-making, it’s about clearly stating what you’re treating and that’s not difficult for us because that’s what we’re doing in the encounter,” she said. “The most important thing is to document what you’re actually taking care of and not just listing all the other problems a patient has but you’re not dealing with that day.”