Two physicians who helped to overhaul evaluation and management (E/M) office-visit documentation and coding continue their campaign to explain why the changes matter and to help promote a national standard interpretation and consistency to their use.

The landmark reforms took effect last year and were followed by technical correction updates to the Current Procedural Terminology (CPT®) code set published by the AMA that added clarity and answer lingering questions.

A guiding philosophy behind the changes was “to eliminate the hassle factor” and “to make it easy to do what’s clinically relevant and appropriate,” said Barbara Levy, MD, a former chair of the AMA/Specialty Society RVS Update Committee (RUC) and a current member of the CPT Editorial Panel.

Dr. Levy co-chaired the joint CPT/RUC work group that developed the changes with Peter Hollmann, MD, a former chair of the CPT Editorial Panel and now vice chair of the RUC.

Guiding principles behind changes

They appeared together during a session of the CPT and RBRVS 2022 Annual Symposium, which was held virtually due to the COVID-19 pandemic.

The process was directed by guiding principles, of which “the absolute no. 1” was to reduce the administrative burden of documentation and coding and align CPT with CMS in that process, Dr. Levy said.
Other principles were:

- Reduce the need for audits.
- Reduce unnecessary documentation in the medical record that leads to repetitive note bloat.
- Ensure that payment for E/M is resource based.

“The key issue was that you could select an appropriate level of service based on either medical decision-making (MDM) or the total time on the date of the encounter,” said Dr. Levy, a gynecologist and health care consultant in San Diego.

“We changed the concept of time to total time spent on the date of the encounter, recognizing that the nonface-to-face services physicians and other qualified health care professionals do are all quite intense and that they're equally intense to the time that we spend face to face,” she added.

“The goal was to simplify things, but another major goal was really to better reflect and incentivize activities that really represent better patient care,” said Dr. Hollmann, a geriatrician and chief medical officer of the Brown Medicine faculty medical group.

“We really were hoping that—by getting rid of the note bloat and unnecessary documentation and letting people focus on things that really mattered—we were going to have better patient care taking place,' he added.

No need to repeat burdens

Unintended consequences, however, included some practices replacing their old, burdensome checklists and templates with new ones.

“Our goal was not to have people creating detailed templates that would actually just make that documentation burden as bad as it was before,” Dr. Hollmann said. “We were a little disappointed that, in some cases, that actually did occur.”

This led to the release of the technical corrections that clarified lingering questions along with issuing definitions that also provided more clarity. These included definitions of “analyzed,” “test,” “unique test,” “major” versus “minor” surgery, and clarifying what is meant by “discussion” between physicians and other qualified health professionals.

“A technical correction means it was the intent of what we were writing all along,” Dr. Hollmann said. “It essentially answers the questions that people have been asking in a more formal method. It is not fundamentally changing things.”
The technical corrections also helped fine tune the language used.

“There were ways that we could describe things a little more clearly and promote a national standard for interpretation and consistency across everything,” Dr. Hollmann said.

The 2021 code changes apply only to E/M in outpatient and office settings—but not to inpatient, home care or nursing home E/M. Changes for E/M services in those settings are expected to be released this year and will take effect in 2023.

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