E/M Coding Since the 2021 Changes: It Really Is Better

SAMUEL L. CHURCH, MD, MPH, CPC-I, CRC, FAAFP

Change is difficult, regardless of how much it's needed. Learning a new system for coding office/outpatient evaluation and management (E/M) visits last year was no exception.[1]

"This is too good to be true. There must be a catch," I said to myself early on, fearing audits and wondering if it was truly safe to leave off the documentation of a few systems that I briefly reviewed but were not essential for my medical decision making.

Due to these lingering apprehensions, my notes largely looked the same in the first few months of the new coding guidelines. But with practice, I am gradually trimming them and coding with confidence. That's just one example of how the E/M rule changes have improved my professional life. As the months have gone on, it has become increasingly clear to me: It really is better.

There's more work to be done, but the new rules simplified documentation and coding criteria and should result in increased revenue.

AN END TO "NOTE BLOAT"

Many physicians believe the E/M changes were about billing, not patient care. But the changes were in line with the Centers for Medicare & Medicaid Services' "Patients Over Paperwork" initiative,[2] and in my experience there have been some real advantages in terms of documentation.

With more robust systems for managing information, it was unnecessary to require physicians to include every bit of medical history in each note. Such "note bloat" could even put patients at risk by burying pertinent information. The guidelines no longer require quantifiable elements but do require a medically appropriate history and exam. That's reasonable. Now we can make our notes more meaningful, and our documentation can simply convey the care provided.

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Some physicians have suggested there's no need for coding and documentation requirements at all. But rules of some type are here to stay. Beyond communicating a brief summary of patient encounters, there is an ongoing need to prevent fraud, waste, and abuse. Still, having notes that reflect the care provided rather than boxes checked is a burden lifted.

SIMPLIFIED CODING CRITERIA

It's easy to pick apart some nuance of the new E/M coding rules. But many cases that initially seem tricky to code using medical decision making (MDM) can meet the same or higher MDM level in easier ways. For example, it doesn't matter how many laboratory points are accrued in the data column if you have a level 4 problem, such as uncontrolled blood pressure, and a medication adjustment. With two out of three elements met, it's a level 4 visit. ➤

ABOUT THE AUTHOR

Dr. Church is a family physician practicing in Hiawassee, Ga. He is core faculty for the Northeast Georgia Medical Center Family Medicine residency program and is the American Academy of Family Physicians' advisor to the American Medical Association's CPT Editorial Panel. Author disclosure: no relevant financial relationships.

Time-based coding has also been simplified. No longer do you have to separate face-to-face time from time spent communicating with other providers, reviewing records, doing prior authorizations, counseling, etc. — now it all counts toward the E/M level (with a few basic caveats, such as excluding staff time, time spent outside the date of service, and time spent teaching).[3]

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Time spent on a visit outside the date of service can still be counted, just not as part of the E/M visit level. Codes for non-face-to-face prolonged services (99358 and 99359) can be used after 31 minutes to capture that work.

A PAY RAISE WORTH FIGHTING FOR

Many physicians were pleasantly surprised with the relative value unit (RVU) increases for the E/M codes.[4] They translated to a more than 10% gross revenue increase for Medicare patients in 2021.

But not all physician paychecks reflected these changes, according to many of my colleagues across the country. It appears that some employers have been sticking with 2020 RVUs for their employed physicians.[5] If you're in that situation, you may need to check your employment contract and renegotiate. Moving forward, perhaps it would also be appropriate to discuss modernizing compensation formulas rather than relying just on RVUs that don't always reflect payment.

The RVU increases are a positive for family physicians. Now we have to make sure they are reflected in greater take-home pay.

YOUR FEEDBACK MATTERS

As the new guidelines were implemented, thoughtful comments started rolling in to the American Academy of Family Physicians. Those concerns were consolidated and shared with the American Medical Association's CPT Editorial Panel, resulting in a number of technical updates.[6] We know that our work is not done. Together we can improve all of the codes used in family medicine.

The challenges associated with office coding have also unveiled other areas where reimbursements often fall short because we are busy caring for patients. Other work that feels "busy" includes closing care gaps and capturing hierarchical condition category (HCC) risk-adjusted codes for the year (for more on HCCs, see https://www.aafp.org/fpm/2021/1100/p6.html). So now we must continue our evolution to become true leaders of medicine, developing care plans and managing teams. I hope the updated E/M coding guidelines have freed up some time for family physicians to better balance our roles as both point-of-care clinicians and leaders in the value-based care system of the future. FPM

E/M CODING & DOCUMENTATION RESOURCES

- **AAFP E/M reference cards:** Desk-sized and pocket-sized reference cards available for $25 for AAFP members and $59 for nonmembers at https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management/e-m-coding-reference-cards1.html
- **AAFP 2021 Office Visit E/M Guidelines Module:** A resource that walks physicians through the coding changes at https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management/2021-office-visit-e-m-guidelines-module.mem.html
- **A Step-by-Step Time-Saving Approach to Coding Office Visits:** *FPM* July/August 2021 at https://www.aafp.org/fpm/2021/0700/p21.html

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