As many of you may already be aware, for the first time in over 20 years, coding and documentation guidelines for office-based or other outpatient services will be getting a major overhaul for 2021 based on revisions to the Centers for Medicare & Medicaid Services (CMS) Physician Payment Schedule planned for implementation on Jan 1st, 2021.

What's changing

The new guidelines shift the focus of documentation (for new ambulatory patients and for followup visits, **but not for ambulatory consults**) to complexity of medical decision making and the total time spent by the provider **on the date of the encounter**. These revisions were made with modern electronic medical record (EMR) technology in mind and aim to minimize the need for repetitive documentation of HPI and physical exam elements. In fact, the HPI and exam will no longer be considered key elements to support the level of service. Instead a "medically appropriate" HPI and exam are all that will be required. The extent of history and exam necessary is at the physician's discretion. The level of service will be based on the complexity of medical decision making, or the total time spent by the provider, including both face-to-face time and pre- and post-service work, **on the date of the encounter.**

Is the MDM formula changing?

The new guidelines for determining the complexity of medical decision making will include better defined terminology and an all-new way of considering the amount and complexity of data reviewed at the current encounter. Labs, radiology, and other diagnostic testing will be weighed more heavily if the test was both ordered and interpreted **during** the encounter. Treatment options that are considered (even if not chosen in the end) will be weighed if documented that they were considered (e.g. "hospitalization was considered as an option but in the end decided against"). The focus will be on describing the thought process and the factors considered to reach a diagnosis or treatment plan.

Billing based on time

Providers will have the option of coding the level of service based on the complexity of medical decision making **or** the total time spent by the provider **on the day of the visit** (not including clinical staff time) preparing for the encounter, face-to-face with the patient, and after the encounter completing the orders and documenting the medical record. **This is a major shift from current guidelines**, in which only the time spent actually in the room with the patient is considered. Please note that according to the new guidelines, any time spent by the provider on the patient's care before or after their visit date (e.g. reviewing chart before visit date or reviewing and analysing results of studies that come after 11:59pm on the day of the visit, can not be counted in the total time spent for the patient's care. MDM billing may need to be considered instead in those encounters if more appropriate. The new 2021 guidelines will also eliminate the need for 50% of the time to be documented as "counseling or coordination of care." Please note that this only applies **to outpatient office visits**. Encounters in other places of service will still be required to have the 50% or more statement when coding by time. Because pre- and post-service work will now be included, the times associated with each level of service will be increased accordingly. Also, the 99211 and 99201 codes are eliminated from 2021 guidelines, signifying that any encounter lasting less than 10 and 15 minutes accordingly cannot be billed based on time.

Code	MDM	Time (min)
99202	Straightforward	15-29
99203	Low	30-44
99204	Moderate	45-59
99205	High	60-74
99212	Straightforward	10-19
99213	Low	20-29
99214	Moderate	30-39
99215	High	40-54

How to Prepare

Now is the time to start thinking about how these changes may impact your workflows. Consider starting to identify pre- and post-service time and how best to track and document these non-face-to-face components. Both medical decision making and time-based levels of service will be impacted, and the decision of which guideline to code by will be more involved.

Some things that will be weighed more heavily under the new guidelines that may not currently be considered include the number of unique tests, labs, or images were ordered and/or interpreted.

Look to this space in the coming months for more discussion around this topic.