Evaluation & Management 2021

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- While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal or business advice.
- All coding should be aimed at individual patients and payer needs and requirements.
- The speaker and the corporation they represent accepts no liability for coding decisions made by individuals.
- All models, methodologies and guidelines are undergoing continuous change. This presentation can contain information that may not be valid.

Agenda

- Learning Objectives
- Goals of This Presentation
- What's New in 2021?
- Other Things of Note in 2021
- Criteria: Medical Decision-Making
- Criteria: Time
- Add-on Code
- Prolonged Services: 99417, G2211
- E/M Values: Proposed
- Projections
- Other E/M Services

Learning Objectives

- Learn what will change and what will not change in 2021; understand that not ALL E/M codes have changed.
- Understand that clinicians can choose one of two criteria to assign codes in the 99202 – 99215 code range.
- Describe how Time and Medical Decision Making - the two main E/M criteria - have been modified for 2021.

Goals of the CPT E/M 2021 Presentation

- Should be a spark for you and members of your clinical staff to carefully read the CPT 2021. Why?
  - Criteria for office and HOPD visits have been much more well defined in terms of clearer explanations. These should be read.
  - There is a need to compare and contrast criteria for 99202-99215 with other E/M services – these changes DO NOT apply to all E/M services.
  - Understand both criteria (Time and MDM) for these visits thoroughly and make the choice based on what fits each clinician's documentation strengths.
  - Know where CMS differs from the AMA.
- Should also be a catalyst to meet with your EMR vendor to see what they are doing to help.

E/M Changes for 2021

- Effective January 1, 2021, the CPT Editorial Panel adopted revisions to the office/outpatient E/M code descriptors, and substantially revised both the CPT prefatory language and the CPT interpretive guidelines that instruct practitioners on how to bill these codes. This approach is detailed in full on the AMA website at https://www.ama-assn.org/cpt-evaluation-and-management and in CPT 2021.
  - Much of what we knew over the last 2 years has been upheld, but there are changes and modifications from CMS.
  - CPT is the HIPAA-approved coding system for procedural codes used by all payers.

New in 2021

Summary of CPT Guideline Differences

***CPT 2021 Professional Edition*, American Medical Association**

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	As medically appropriate Not used in code selection	Use key components (history, examination, MDM)
Medical Decision Making (MDM)	May use MDM or total time on the date of the encounter	Use key components (history, examination, MDM)
Time	May use MDM or total time on the date of the encounter	May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service *Time is NOT a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

Other Things of Note in E/M 2021

- No more 99201
- 99211 is for clinical staff
- Changes are for 99202-99215 ONLY; all other E/M stays the same
- 1995 and 1997 documentation guidelines are gone for Office and Outpatient E/M, but not for other services
- New definition of Medical Decision Making
- Visit times are in ranges and not in exact numbers
- Prolonged services are used for Level 5 visits only; 99205 and 99215; CMS and AMA differ

Established Patient

▲99211	**Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
★▲99212	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
★▲99213	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
★▲99214	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
★▲99215	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99XXX)

A Preview of Office/ Outpatient Codes

Criteria: Medical Decision Making

One of two E/M Criteria for 99202-99215

E/M Definition (2021): Medical Decision Making (MDM) American Medical Association

- MDM includes establishing the diagnoses; assessing the status of a condition; and/or selecting a management option.
- MDM is defined by these three elements:
  - The number and complexity of problems that are addressed during the encounter.
  - The amount and/or complexity of data to be reviewed/analyzed. These data may include medical records, tests, and/or other data that must be analyzed or interpreted by the treating professional or in consultation with other providers.
  - The risk of complications and/or comorbidities or morbidity associated with the patient's problem, the diagnostic procedures or prospective treatment options.

Code	Level of MDM 2 or 3 elements	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straight forward	**Minimal** □ 1 self-limited or minor problem	**Minimal or none**	**Minimal risk** of morbidity from additional diagnostic testing or treatment
99203 99213	Low	**Low** □ 2 or more self-limited or minor problems; or □ 1 stable chronic illness; or □ 1 acute, uncomplicated illness or injury	**Limited** (Must meet the requirements of at least **1 of the 2 categories**) □ **Category 1**: Tests and documents **Any combination of 2 from the following:** o __Review of prior external note(s) from each unique source*; o __Review of the result(s) of each unique test*; o __Ordering of each unique test* OR □ **Category 2**: Assessment requiring an independent historian(s)	**Low risk** of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	**Moderate** □ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or □ 2 or more stable chronic illnesses; or □ 1 undiagnosed new problem with uncertain prognosis; or □ 1 acute illness with systemic symptoms; or □ 1 acute complicated injury	**Moderate** (Must meet the requirements of at least **1 out of 3 categories**) □ **Category 1**: Tests, documents, or independent historian(s) **Any combination of 3 from the following:** o __Review of prior external note(s) from each unique source* o __Review of the result(s) of each unique test*; o __Ordering of each unique test* o __Assessment requiring independent historian(s); or □ **Category 2**: Independent interpretation of tests Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or □ **Category 3**: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**Moderate risk** of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	**High** □ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or □ 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least **2 out of 3 categories**) (in the field right above,)	**High risk** of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Sooo, let's break it down…

MDM: Number and Complexity of Problems

- Comorbidities and/or chronic problems are only considered in medical decision-making if they are addressed during the encounter. If these are being addressed by another provider without an independent assessment, they are not counted.
- Comorbidities are not considered unless the status changes or unless they directly impact data reviewed or treatment decisions.
- Multiple problems of lower severity may in the aggregate create higher risk in decision-making.
- Threats to life or limb must be part of the encounter in which you are billing, not long term.
- The final diagnosis does not necessarily drive the MDM; it is more the process to reach the diagnosis.

Levels of Medical Decision Making Criteria Number and Complexity of Problems

Code Levels	Level of MDM	Number & Complexity of Problems
99202 99212	Straight Forward	• 1 Self Limited Problem
99203 99213	Low	• 2 or more Self-limited or Minor problems • 1 Stable Chronic Illness • 1 Uncomplicated Illness or Injury
99204 99214	Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)
99205 99215	High	• 1 or more chronic illnesses with severe exacerbation, side effects of treatment, or progression • 1 acute or chronic illness which pose a risk to life and/or bodily function

Another Look at Criteria #1
Number and Complexity of Problems

Number and Complexity of Problems Addressed			
Code	**Number/Complexity of Problems**	**Definitions**	**Examples**
99211	NA	NA	• PPD reading • BP check follow-up (normal)
99202 / 99212	**Minimal (Straightforward)** • 1 self-limited or minor problem	Self-Limited/Minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.	• Uncomplicated mosquito bites • Uncomplicated diaper rash • Follow-up resolved condition that was low severity
99203 / 99213	**Low (choose 1)** • 2 or more self-limited or minor problems; • 1 stable chronic illness; • 1 acute, uncomplicated illness or injury	Stable, chronic illness: expected duration of at least a year or until death. 'Stable' is defined by the *specific treatment goals* for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition is unchanged and there is no short-term threat to life or function. Risk of morbidity w/o treatment is significant. Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity treatment, and full recovery without functional impairment. A problem that is normally self-limited or minor, but is not resolving in a definite and prescribed course.	• Follow-up mild chronic asthma (controlled) • Uncomplicated pharyngitis Uncomplicated viral syndrome • Simple sprain/strain • Allergic rhinitis • Allergic conjunctivitis • Uncomplicated otitis media
99204 / 99214	**Moderate (choose 1)** • 1 or more chronic illnesses w/ exacerbation, progression, or side effects of treatment; • 2 or more stable chronic illnesses; • 1 undiagnosed new problem with uncertain prognosis; • 1 acute illness with systemic symptoms; • 1 acute complicated injury	Chronic illness with ....: A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or attention to treatment for side effects (excludes hospital care). Undiagnosed new problem with uncertain prognosis: Problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity w/o treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, (see 'self-limited or minor 'or 'acute, uncomplicated.')Systemic symptoms may not be general, but may be single system. Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.	• Worsening headaches/migraines • Otitis media presenting with fever or as recurrent • CBC results with high WBCs and low RBCs requiring further work up • Concussion with brief LOC • Strep throat presenting with fever • Pneumonia • Injuries resulting from an MVA that include multiple systems
99205 / 99215	**High (choose 1)** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Chronic illness with severe exacerbation....: Have significant risk of morbidity and may require hospital level of care. Acute or chronic illness or injury that poses a threat to life or bodily function: Pose a threat to life or bodily function in the near term w/o treatment. Typically, hospital care is needed.	• Depression with suicide ideation • Severe respiratory distress • Renal failure • Treatment for refractory migraine pain • New seizure onset

MDM: Amount and Complexity of Data

- Data is divided into “category” which is a change from the old definition of MDM
  - Category 1: Tests and Documents
    - Any combination of 2 from the following for lower levels:
      - Review of prior external notes from a unique source
      - Review of the result(s) of a unique test (count)
      - Ordering of each unique test (count)
      - Assessment requiring independent historian (Moderate/Extensive)
  - Category 2: Independent Interpretation of Tests
      - Independent interpretation of a test performed by another physician/other NPP (not separately reported)
  - Category 3: Discussion of management or test interpretation
      - Discussion with an external physician or NPP/ appropriate source (not separately reported)

“Not Separately Reported”

- This is an important concept for all E/M services and particularly under the new criteria.
- Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately. The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately.
- Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. This, of course, is subject to the usual edits. The physician’s interpretation of the results of diagnostic tests/ studies (i.e. professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.
- If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making.

Levels of Medical Decision-Making Criteria
Amount of Complexity of Data to be Reviewed

Codes	Level of MDM	Data Category
99202 99212	Straightforward	Minimal or None
99203 99213	Low	Category 1 or Category 2
99204 99214	Moderate	Must meet 1 of 3 of Category 1 (More extensive) Category 2 Category 3
99205 99215	Extensive	Must meet 2 of 3 Category 1 (More extensive) Category 2 Category 3

Criteria #2: Amount or Extent of Data Reviewed

Amount and/or Complexity of Data to be Reviewed and Analyzed			
Code	**Data Needed**	**Examples**	**Definitions**
99211	None	None	
99202 / 99212	Minimal or none (Refer to Limited if there is an independent historian)		
99203 / 99213	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** Any combination of 2 from the following: -Review of prior external note(s) from each unique source; -review of the result(s) of each unique test ; -ordering of each unique test **Category 2:** Assessment requiring an independent historian(s)	3 y/o patient: Mom historian, no tests --- 17 y/o patient: Ordered CBC, Comprehensive metabolic panel (outside lab) --- 9 y/o patient: Ordered strep test, influenza test (in-office)	Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set. External physician or other qualified healthcare professional: An external physician or other QHP is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency. Independent historian(s): An individual (eg, parent, guardian, surrogate, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage) or because a confirmatory history is judged to be necessary. Independent Interpretation: Test for which there is a CPT code and an interpretation or report is customary. Excludes when the physician or other QHP professional is reporting the service or has previously reported the service for the patient. Documentation is required, but need not conform to the usual standards of a complete report for the test. Appropriate source: An appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (eg, lawyer, case manager, teacher). Excludes discussion with family or informal caregivers.
99204 / 99214	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: -Review of prior external note(s) from each unique source -Review of the result(s) of each unique test -Ordering of each unique test -Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** -Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** -Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	15 y/o patient: Ordered CBC, T4, TSH (outside lab) --- 2 y/o patient: Spoke with Hem-One physician to discuss recent labs and course of treatment --- 6 y/o patient: Reviewed radiologic results from ED and wrote own interpretation	
99205 / 99215	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: -Review of prior external note(s) from each unique source -Review of the result(s) of each unique test -Ordering of each unique test -Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** -Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** -Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source(not separately reported)	3 y/o patient: Dad independent historian, ordered EKG and 2-D Echo, spoke with a cardiologist about appropriate course for patient --- 9 y/o patient: Ordered 2 behavioral assessments, spoke with both mom and dad as independent historians, spoke with referring school counselor regarding initial assessment and plan --- 12 y/o patient: Mom was historian to discuss black-out episode, independent interpretation of MRI done during ED visit, ordered additional labs (3)	

Levels of Decision-Making: Risk

"The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment."

Levels of Medical Decision Making Criteria
Risk of Complications and/or Morbidity or Mortality

Code Levels	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straight Forward	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Criteria #3: Level of Risk

Risk			
Code	**Risk Level**	**Examples**	**Definitions**
99211	Minimal or none		
99202 / 99212	Minimal risk of morbidity from additional diagnostic testing or treatment	•Supportive care at home: gargle, topical OTC ointment •swab for further lab testing	Risk: The probability and/or consequences of an event. Definitions of risk are based upon the usual behavior and thought processes of a physician or other QHP in the same specialty. For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. Intensive monitoring may be long- or short term. Long-term intensive monitoring is not less than quarterly. The monitoring *needs* to be a lab test, a physiologic test or imaging. *The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.*
99203 / 99213	**Low** risk of morbidity from additional diagnostic testing or treatment	•Blood draw for labs •Radiologic tests such as EKGs, x-rays	
99204 / 99214	**Moderate** risk of morbidity from additional diagnostic testing or treatment Examples only: •Prescription drug management •Decision regarding minor surgery with identified patient or procedure risk factors •Decision regarding elective major surgery without identified patient or procedure risk factors •Diagnosis or treatment significantly limited by social determinants of health	•New prescription drug for acute condition •On-going management of chronic condition through Rx management •Decision to perform minor surgery •Homelessness exacerbating patient's condition •Income issues leading to underdoing of medication	
99205 / 99215	**High** risk of morbidity from additional diagnostic testing or treatment Examples only: •Drug therapy requiring intensive monitoring for toxicity •Decision regarding elective major surgery with identified patient or procedure risk factors •Decision regarding emergency major surgery •Decision regarding hospitalization •Decision not to resuscitate or to de-escalate care because of poor prognosis		

MDM Drug Monitoring with Risk of Toxicity (AMA)

"Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold."

Criteria: Time

One of two E/M Criteria for 99202-99215

Time: A New Definition (2021)

- “Time” refers to the total time spent by the clinician on the date of service.
- The prolonged visit code CANNOT be attached to any codes except Level 5.
- Non-FTF Prolonged Services (99358-99359) cannot be billed with 99202-99215 on the day of the encounter.

What Does Time Mean?

- Physician/other qualified health care professional time includes the following activities, when performed AND these must be documented in addition to time:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other healthcare professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

Definition of Time

- This must be time spent by the billing provider, not by staff.
- Time is for all activities by this person on the day of the encounter.
- This includes pre- and post-work.
- Cannot include time being spent on other activities which ARE NOT “not separately reported”
  - Chronic Care Management billed separately
  - Performing tests or procedures billed separately
  - Preparing staff for drug administration billed separately

E/M Time Ranges 2021

New patient code	Total time (2021)	Established patient code	Total time (2021)
99202	15-29 minutes	99211	N/A
99203	30-44 minutes	99212	10-19 minutes
99204	45-59 minutes	99213	20-29 minutes
99205	60-74 minutes	99214	30-39 minutes
		99215	40-54 minutes

Established Patient

▲99211	**Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
★▲99212	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
★▲99213	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
★▲99214	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
★▲99215	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99XXX)

A Preview of Office/ Outpatient Codes

And, GPC1X Becomes G2211: The Add-on

- *"Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."*

  - *Will private payers accept this code???*

The Add-on Code: G2211

- Level II HCPCS code G2211 (formerly GPC1X): HCPCS add-on code G2211:
  - "HCPCS add-on code G2211 reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time." (Final Rule, page 276)
  - "..management of which requires the direction of a clinician with specialized clinical knowledge skill and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goal" (Final Rule, Page 277)
  - "HCPCS add-on code G2211 reflects the time, intensity, and PE associated with providing services that result in care that is personalized to the patient. Finally, we believe that the HCPCS add-on code G2211 could bolster the efforts of practitioners in rural communities, including NPPs, to deliver the comprehensive and longitudinal care that HCPCS add-on code G2211 describes." (Final Rule, Page 277)

Can be used for new or established patients, but Modifier -25 might be a long-term issue, if the service is not really considered separately identifiable. Chemo versus minor procedures??

When to NOT Use G2211

"In contrast, there are many visits with new or established patients where HCPCS add-on code G2211 would not be appropriately reported, such as when the care furnished during the office/outpatient E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature, such as a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or and when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time. Reporting the add-on code with these types of visits would be inconsistent with the code descriptor, which describes care that is a continuing focal point and/or part of ongoing care." (Page 279, Final Rule)

99417: Prolonged Services

- Beginning in 2021, there will be a new code for reporting prolonged services together with an office visit. The new code, CPT Code 99417, replaces CPT Codes 99354 and 99355. It can be used to report the total prolonged time with and without direct patient contact on the same day as an office visit. However, certain conditions apply:
  - It can only be reported in conjunction with the level 5 visit codes (CPT 99205, 99215).
  - The time must exceed the minimum time for primary E&M service.
  - Time alone must be the basis for coding.
  - Right now, CMS and the AMA disagree with how this will work.

99417: Prolonged Services

- It may not be used with any other office/ outpatient code.
- It may not be used on the same date as non-face-to-face prolonged care codes 99358, 99359 or face-to-face prolonged care codes 99354, 99355.
- And, the time reported must be 15 minutes, not 7.5 minutes. The entire 15 minutes must be done, in order to add on this new, prolonged services code to 99215 and 99205.

This new add-on prolonged services code may only be used with 99205 and 99215.

AMA Definition of 99417 Thresholds

Time Duration	What is Reported
New Patient	
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 x 1
90-104 minutes	99205 X 1 and 99417 x 2
105 or more	99205 X 1 and 99417 x 3 or more for each additional 15 minutes.
Established Patient	
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 x 1
70-84 minutes	99215 X 1 and 99417 x 2
85 or more	99215 X 1 and 99417 x 3 or more for each additional 15 minutes.

CMS' Concept of 99417 (Final Rule)

TABLE 26: Proposed Prolonged Office/Outpatient E/M Visit Reporting - New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99417 x 1	89-103 minutes
99205 x 1 and 99417 x 2	104-118 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

TABLE 27: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99417 x 1	69-83 minutes
99215 x 1 and 99417 x 2	84- 98 minutes
99215 x 1 and 99417 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Office-based Prolonged Services

Prolonged Services 2021		
Codes plus add-on	**CPT Time 99417**	**CMS Time G2212**
99205 plus add-on x1	75-89 minutes	89-103 minutes
99205 plus add-on x2	90-104 minutes	104-118 minutes
99205 plus add-on x3	> 105 minutes*	> 119 minutes*
99215 plus add-on x1	55-69 minutes	69-83 minutes
99215 plus add-on x2	70-84 minutes	84-98 minutes
99215 plus add-on x3	> 85 minutes*	> 99 minutes*

Can bill for each additional 15 minutes

Enter Level II Code, G2212

- HCPCS code G2212 is described as follows, “Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) “(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes).”
- Value is the same as 99417

CMS Imputed G2212 Thresholds

Time Duration	What is Reported
New Patient	
less than 89 minutes	Not reported separately
89-103 minutes	99205 X 1 and G2212 x 1
104-118 minutes	99205 X 1 and G2212 x 2
119 or more	99205 X 1 and G2212 x 3 or more for each additional 15 minutes.
Established Patient	
less than 69 minutes	Not reported separately
69-83 minutes	99215 X 1 and G2212 x 1
84-98 minutes	99215 X 1 and G2212 x 2
99 or more	99215 X 1 and G2212 x 3 or more for each additional 15 minutes.

CMS E/M 2021

CPT[1]/ HCPCS	Description	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]	CF	NFFee Sched Amount	Fac Fee Sched Amount
99202	Office o/p new sf 15-29 min	0.93	1.12	0.41	0.08	2.13	1.42	$32.41	$69.03	$46.02
99203	Office o/p new low 30-44 min	1.60	1.53	0.67	0.15	3.28	2.42	$32.41	$106.30	$78.43
99204	Office o/p new mod 45-59 min	2.60	2.09	1.12	0.24	4.93	3.96	$32.41	$159.78	$128.34
99205	Office o/p new hi 60-74 min	3.50	2.69	1.56	0.32	6.51	5.38	$32.41	$210.99	$174.37
99211	Office o/p est minimal prob	0.18	0.49	0.08	0.01	0.68	0.27	$32.41	$22.04	$8.75
99212	Office o/p est sf 10-19 min	0.70	0.90	0.29	0.07	1.67	1.06	$32.41	$54.12	$34.35
99213	Office o/p est low 20-29 min	1.30	1.28	0.55	0.10	2.68	1.95	$32.41	$86.86	$63.20
99214	Office o/p est mod 30-39 min	1.92	1.76	0.83	0.13	3.81	2.88	$32.41	$123.48	$93.34
99215	Office o/p est hi 40-54 min	2.80	2.32	1.26	0.21	5.33	4.27	$32.41	$172.75	$138.39
G2211	Complex e/m visit add on	0.33	0.14	0.14	0.02	0.49	0.49	$32.41	$15.88	$15.88
G2212	Prolong outpt/office vis	0.61	0.31	0.27	0.05	0.97	0.93	$32.41	$31.44	$30.14

There will now be two systems for E/M code selection and documentation…

Office or other outpatient E/M visits (99202 – 99215)…. Changing to the NEW system

Other E/M services…. Continue with the “old” system

New in 2021

Summary of CPT Guideline Differences

***CPT 2021 Professional Edition*, American Medical Association**

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	As medically appropriate Not used in code selection	Use key components (history, examination, MDM)
Medical Decision Making (MDM)	May use MDM or total time on the date of the encounter	Use key components (history, examination, MDM)
Time	May use MDM or total time on the date of the encounter	May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service *Time is NOT a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

Components of E/M Level Selection

Seven components used in descriptors of many E/M codes

- First three are “key components”: History; Examination; Medical decision making (MDM)
- Next three are contributory factors (when applicable): Counseling; Coordination of care; Nature of presenting problem
- Final: Time

Key Components for Coding Non-Office Outpatient Services

History

- Chief Complaint
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, Social History (PFSH)

Examination

- Body Areas
- Organ Systems
- 1995 and/or 1997 documentation guidelines

Medical Decision Making

- Number of Diagnoses or Management Options
- Amount and/or Complexity of Data
- Risk of Significant Complications, Morbidity and/or Mortality

Time for Counseling and/or Coordination of Care

- When counseling and/or coordination of care dominates (>50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M service.
- If the level of service is reported based on counseling and/or coordination of care, you should document the total length of time of the encounter and the record should describe the counseling and/or activities to coordinate care.
- CPT books list average time guidelines for a variety of E/M services. These times include work done before, during and after the encounter.

Take-Aways

- E/M is changing for office/ outpatient visits only. All other E/M services will stay the same.
- E/M in 2021 for 99202-99215 will be simplified in terms of documentation, once providers get used to it.
- Time and MDM are the two criteria for code selection. You can use what is best at each visit.
- Time is an acceptable criteria for E/M in 2021 but note the differences between AMA and CMS criteria for Prolonged Services.

Resources

See COA's Administrator's Network (CAN) for…

- Library of audio books for oncology coding and billing
- Medicare Impact Tool – 2020 to 2021
  - E&M
  - Infusion
  - Radiation
  - Radiology
  - With GPCIs
- New Services Model

Join CAN… https://communityoncology.org/join-coa/

Then.. **Education Library – Meetings & Webinars – Resources**

Opportunities: ASCO Practice Central

ASCO will be providing resources on ASCO Practice Central (practice.asco.org) for the remainder of 2020 and into 2021 to assist with the transition.

ASCO Guide to 2021 Evaluation & Management Changes
https://practice.asco.org/sites/default/files/drupalfiles/2020-10/EMResourcesBookOct2020.pdf

Includes:

- Changes to Evaluation and Management Codes in 2021
- Nine Essential Tips to Prepare Your Practice
- Selecting a Code Based on Time
- New Prolonged Services Code and Other Prolonged Services Changes
- Selecting an E/M code Based on Medical Decision-Making
- Sample Transition Checklist

More Resources

- https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf
- https://codingintel.com/
- https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx#:~:text=The%20MPFS%202020%20final%20rule,outpatient%20E%2FM%20code%20selection