



Evaluation and Management (E/M) Office Visits-2021

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Agenda

- History of E/M Workgroup
- E/M Revisions for 2021: Office and Other Outpatient Services
 - New Patient (99201-99205)
 - Established Patient (99211-99215)
 - Medical Decision Making (MDM)
 - Time
 - Prolonged Services
- RUC Recommendations

How Did We Get Here?

Medicare E/M Initial 2019 Fee Schedule Proposal (Released July 2018): SUMMARY

The goal was administrative simplification and CMS perceived current E/M codes as “outdated” based on past comment letters

- Medical Necessity:
 - Eliminate the requirement to document medical necessity of furnishing visits in the home rather than office
 - Eliminates the prohibition of same-day E/M visits billing by physicians in the same group or medical specialty
 - Documentation of level 2 necessity for Office E/M is sufficient
- Documentation redundancy:
 - Eliminates the need to re-enter information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner must only document that they reviewed and verified the information.

How Did We Get Here?

Medicare E/M Initial 2019 Fee Schedule Proposal (Released July 2018): SUMMARY

1. Simplify code level selection and remove unnecessary history and examination elements
 - Physicians may choose method of documentation
 - CMS 1995/1997 Documentation Guidelines (ie, current standards)
 - MDM only, or
 - Face-to-Face time
 - Simplification included elimination of payment differentials between services

Medicare E/M Initial 2019 Proposal (Released July 2018): Summary

2. Condensing Visit-Payment Amounts

CMS calls the system of 10 visits for new and established office visits “outdated” and proposes to retain the codes but simplify the payment by applying a single-payment rate for level 2 through 5 office visits.

| CPT Code New Office Visits | CY 2018 Non-Facility Payment Rate | CY 2019 Proposed Non-Facility Payment Rate |
|----------------------------------|---|--|
| 99201 | \$45 | \$43 |
| 99202 | \$76 | \$134 |
| 99203 | \$110 | |
| 99204 | \$167 | |
| 99205 | \$211 | |

| CPT Code New Office Visits | CY 2018 Non-Facility Payment Rate | CY 2019 Proposed Non-Facility Payment Rate |
|----------------------------------|---|--|
| 99211 | \$22 | \$24 |
| 99212 | \$45 | \$92 |
| 99213 | \$74 | |
| 99214 | \$109 | |
| 99215 | \$148 | |

Medicare E/M Initial 2019 Proposal (Released July 2018): Summary

- CMS projected that the payment groups created significant impact (positive or negative) on specialties as a whole and might not address complexity adequately
- CMS proposed solutions to address this with a specialty add-on code (\$14) and prolonged services add-on (\$67)
- Adjustments created budget issues, which CMS addressed by reducing payment for perceived overlap when E/M is performed the same day as a procedure (50% reduction)

Medicare E/M Initial 2019 Proposal (Released July 2018)

3. Other Related Coding/Payment Proposals

- CMS identifies several specialties that often report higher level office visits
- CMS proposes offsets via the addition of \$14 to each office visit performed by the specialties listed below with a new code:
 - GCG0X, *Visit complexity inherent to evaluation and management associated with*

| Proposed Specialties Affected | |
|--|-----------------------|
| Allergy/Immunology | Neurology |
| Cardiology | Obstetrics/Gynecology |
| Endocrinology | Otolaryngology |
| Hematology/Oncology | Rheumatology |
| Interventional Pain Management-Centered Care | Urology |

Proposed Rule's Major Concerns: Comment Letter (170 Organizations Signed)

- Physicians are extremely frustrated by “note bloat”
- CMS should finalize proposals to streamline required documentation by:
 - Only requiring documentation of interval history since previous visit
 - Eliminating requirement to re-document information from practice staff or patient
 - Removing need to justify home visits in place of office visits
- CMS should not implement collapsed payment rates and add-on codes
- CMS should not reduce payment for office visits on same day as other services
- CMS should set aside office visit proposal, work with medical community on mutually agreeable policy to achieve shared goal and avoid unintended consequences

CPT/RUC Workgroup Formed

In July 2018, CMS released the 2019 Medicare Physician Payment Schedule Proposed Rule

In response, the CPT Editorial Panel Co-Chairs, Doctors Ken Brin and Mark Synovec, and the RUC Chair, Doctor Peter Smith formed a Workgroup

Workgroup Members

| Name | CPT/RUC | Specialty | Other |
|---------------------------------------|---|----------------------------|------------|
| Peter Hollmann, MD Co-Chair | RUC, AMA Alternate Representative CPT Editorial Panel, Former Chair | Geriatric Medicine | AMA HoD |
| Barbara Levy, MD Co-Chair | CPT Editorial Panel Member RUC, Former Chair | Obstetrics & Gynecology | AMA HoD |
| Margie Andreae, MD | RUC Member | Pediatrics | |
| Linda Barney, MD | CPT Editorial Panel | General | |
| Patrick Cafferty, PA-C | CPT Editorial Panel Member (former) Health Care Professionals Advisory Committee | Physician Assistant | |
| Scott Collins, MD | RUC Member | Dermatology | |
| David Ellington, MD | CPT Editorial Panel Member (former) Chair of Previous CPT E/M Workgroup | Family Medicine | AMA HoD |
| Chris Jagmin, MD | CPT Editorial Panel Member Medical Director, Aetna | Family Medicine | |
| Douglas Leahy, MD | RUC Member | Internal | |
| Scott Manaker, MD | RUC Member Chair, PE Subcommittee | Pulmonary Medicine | |
| Robert Piana, MD | CPT Editorial Panel Member | Cardiology | |
| Robert Zwolak, MD | RUC Member (Former & Present Alternate) | Vascular | |

CPT/RUC Workgroup Charge

- Capitalize on the CMS proposal:
 - The Workgroup will solicit suggestions and feedback on the best coding structure to foster burden reduction, while ensuring appropriate valuation.
- Act quickly to present CMS with a tangible alternative
 - A coding proposal may be submitted by early November 2018 for consideration at the February 7-8, 2019 CPT Editorial Panel meeting
 - Demonstrate the effectiveness of and follow the CPT and RUC processes

Workgroup Process: –Focus On Transparency & Inclusion

- The Workgroup held 7 open calls and 1 face-to-face meeting to discuss issues
- On average, 300 participants participated on each call, representing medical specialty societies, commercial and government payers, and CMS policy staff
- The Workgroup conducted five surveys designed to collect targeted feedback from the large, interested-party community and those results were summarized by AMA staff and presented to the Workgroup and call-in participants
 - On average, the surveys received nearly 60 unique responses representing stakeholder organizations
- Many of the major decisions by the Workgroup including, the definition of time and key definitions of MDM criteria, were based on these stakeholder-surveys results

Workgroup Process: Focus On Transparency & Inclusion

Workgroup established Guiding Principles from the beginning:

The CPT/RUC Workgroup on E/M is committed to changing the current coding and documentation requirements for office E/M visits to **simplify** the work of the health care provider and **improve the health** of the patient.

Guiding Principles:

1. To decrease administrative burden of documentation and coding
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource based and has no direct goal for payment redistribution between specialties.

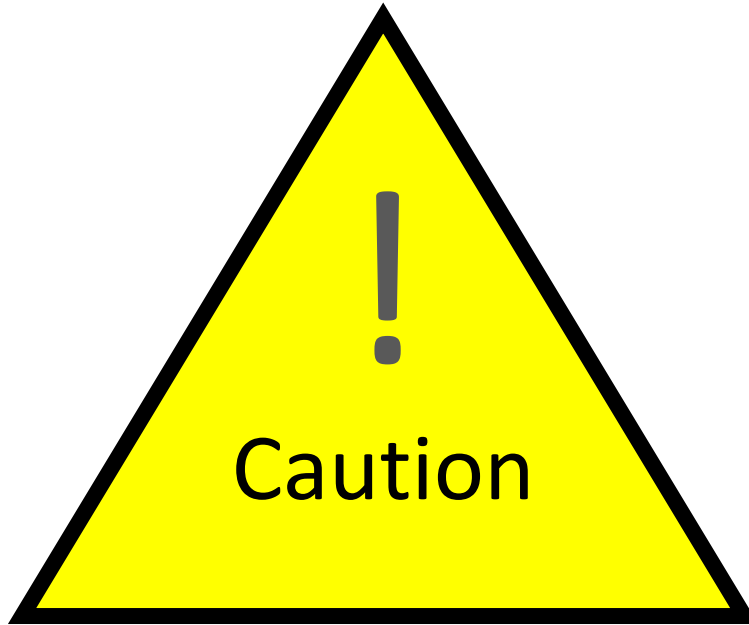
Guiding Principles: Reduce Burden

| PRINCIPLE | ACTIONS |
|--|---|
| Decrease administrative burden | Remove scoring by History and Examination Code the way physicians/other qualified health care professional (QHP) think |
| Decrease needs for audits | More detail in CPT codes to promote payer consistency if audits are performed and to promote coding consistency |
| To decrease unnecessary documentation that is not needed for patient care in the medical record | Eliminate History and Examination scoring Promote higher-level activities of MDM |
| To ensure that payment for E/M is resource based and has no direct goal for payment redistribution between specialties | Use current MDM criteria (CMS and educational/audit tools to reduce likelihood of change in patterns) |

A photograph of three healthcare professionals, two women and one man, all wearing white lab coats and stethoscopes. They are gathered around a tablet computer, looking at the screen with focused expressions. The image has a purple tint. The text "Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services" is overlaid in white serif font.

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

It is not 2021 yet and this is ONLY E/M Office codes



Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

- Extensive E/M guideline additions, revisions, and restructuring
- Deletion of code 99201 and revision of codes 99202-99215
 - Codes 99201 and 99202 currently both require straightforward MDM
- Components for code selection:
 - Medically appropriate history and/or examination
 - MDM or
 - Total time on the date of the encounter

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

- E/M level of service for office or other outpatient services can be based on:
 - MDM
 - Extensive clarifications provided in the guidelines to define the elements of MDM
 - Time: *Total* time spent with the patient on the date of the encounter
 - Including non-face-to-face services
 - Clear time ranges for each code
- Addition of a shorter 15-minute prolonged service code (99XXX)
 - To be reported only when the visit is based on time **and** after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded.

Overview of Major E/M Revisions for 2021: Office or Other Outpatient Services Compared to Other E/M Codes

| 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 | <ul style="list-style-type: none"> As medically appropriate. Not used in code selection | <ul style="list-style-type: none"> Use Key Components (History, Examination, MDM) |
| Medical Decision Making (MDM) | <ul style="list-style-type: none"> May use MDM or total time on the date of the encounter | <ul style="list-style-type: none"> Use Key Component (History, Examination, MDM) |
| Time | <ul style="list-style-type: none"> May use MDM or total time on the date of the encounter | <ul style="list-style-type: none"> May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates. <p><i>Time is not a descriptive component for E/M levels of emergency department services</i></p> |
| MDM Elements | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Number of diagnoses or management options Amount and/or complexity of data to be reviewed Risk of complications and/or morbidity or mortality |

Office or Other Outpatient Services (99201-99215)



Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/~~New Patient~~

★99201 ~~Office or other outpatient~~ visit for the evaluation and management of a new patient, which requires these 3 key components:

- ~~A problem focused history;~~
- ~~A problem focused examination;~~
- ~~Straightforward medical decision making.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.~~

►(99201 has been deleted. To report, use 99202)◀

Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/~~New Patient~~

★▲99202 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~ a medically appropriate history and/or examination and straightforward medical decision making.

- ★—~~An expanded problem focused history;~~
- ★—~~An expanded problem focused examination;~~
- ★—~~Straightforward medical decision making.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.~~

▶When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.◀

Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/**New Patient**

★▲99203 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~a medically appropriate history and/or examination and low level of medical decision making.

~~•—A detailed history;~~

~~•—A detailed examination;~~

~~•—Medical decision making of low complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~

▶ When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. ◀

Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/**New Patient**

★▲99204 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~ a medically appropriate history and/or examination and moderate level of medical decision making.

- ★—~~A comprehensive history;~~
- ★—~~A comprehensive examination;~~
- ★—~~Medical decision making of moderate complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.~~

▶ When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. ◀

Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/**New Patient**

★▲99205

Office or other outpatient visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~ a medically appropriate history and/or examination and high level of medical decision making.

- ~~*—A comprehensive history;~~
- ~~*—A comprehensive examination;~~
- ~~*—Medical decision making of high complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

▶(For services 75 minutes or longer, see Prolonged Services 99XXX)◀

Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/**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. ~~Typically, 5 minutes are spent performing or supervising these services.~~

Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/~~Established Patient~~

★▲99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~ a medically appropriate history and/or examination and straightforward medical decision making.

- ~~*—A problem focused history;~~
- ~~*—A problem focused examination;~~
- ~~*—Straightforward medical decision making.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 10 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/~~Established Patient~~

★▲99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a medically appropriate history and/or examination and low level of medical decision making.

- ~~*—An expanded problem focused history;~~
- ~~*—An expanded problem focused examination;~~
- ~~*—Medical decision making of low complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/~~Established Patient~~

★▲99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a medically appropriate history and/or examination and moderate level of medical decision making.

▪—~~A detailed history;~~

▪—~~A detailed examination;~~

▪—~~Medical decision making of moderate complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/~~Established Patient~~

★▲99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~ a medically appropriate history and/or examination and high level of medical decision making.

- ~~*—A comprehensive history;~~
- ~~*—A comprehensive examination;~~
- ~~*—Medical decision making of high complexity.~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~

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)◄

Related Revisions (99201-99215)

Guidelines and parenthetical notes throughout the code set have been updated to reflect the deletion of code 99201.

- Evaluation and Management Section
- Surgery Section
- Medicine Section

A smiling female healthcare professional with curly hair and glasses, wearing a blue scrub top and a stethoscope, is sitting in a clinical setting. She is holding a tablet computer. The background shows medical equipment, a sink, and a paper towel dispenser. The entire image has a purple tint.

Selecting a Level of Service (Office or Other Outpatient E/M Service)

Selecting a Level of Service (Office or Other Outpatient E/M Service)

2019

The appropriate level of E/M service is based on the following:

- Key components
 - History
 - Examination
 - MDM

Or

- Time

Selecting a Level of Service (Office or Other Outpatient E/M Service)

2019

Time Rules:

- When counseling and/or coordination of care dominates (more than 50%) of the encounter with the patient and/or family
- Only face-to-face time in the office on the date of the encounter

Selecting a Level of Service (Office or Other Outpatient E/M Service)

Effective January 1, 2021

The appropriate level of E/M service is based on the following:

- The level of the MDM as defined for each service; **or**
- The total time for E/M services performed on the date of the encounter.

A close-up, shallow depth-of-field photograph of a person's hand typing on a silver laptop keyboard. The hand is wearing a white long-sleeved shirt. The background is a bright, out-of-focus indoor setting, likely a medical office or clinic, with a window visible. The text "Medical Decision Making (MDM)" is overlaid in the center of the image.

Medical Decision Making (MDM)

Medical Decision Making (MDM)

Modifications to the criteria for MDM:

- Create sufficient detail in CPT code set to reduce variation between contractors/payers
- Attempt to align criteria with clinically intuitive concepts
- Use existing CMS and contractor tools to reduce disruption in coding patterns

Workgroup came back to real-life examples in their deliberations

Medical Decision Making (MDM)

Modifications to the criteria for MDM:

- Current CMS Table of Risk used as a foundation to create the Level of Medical Decision Making Table
- Current CMS Contractor audit tools also consulted to minimize disruption in MDM level criteria
- Removed ambiguous terms (eg, “mild”) and defined previously ambiguous concepts (eg, “acute or chronic illness with systemic symptoms”)

TABLE OF RISK

| <i>Level of Risk</i> | <i>Presenting Problem(s)</i> | <i>Diagnostic Procedure(s) Ordered</i> | <i>Management Options Selected</i> |
|----------------------|---|--|---|
| <i>Minimal</i> | <ul style="list-style-type: none"> One self-limited or minor problem, eg, cold, insect bite, tinea corporis | <ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep | <ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings |
| <i>Low</i> | <ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain | <ul style="list-style-type: none"> Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies | <ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives |
| <i>Moderate</i> | <ul style="list-style-type: none"> 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, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness | <ul style="list-style-type: none"> Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis | <ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation |

CMS Table of Risk from the Documentation Guidelines

(minimal to moderate shown)

- Two or more self-limited or minor problems
- One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH
- Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain

Definition Examples

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Definition Examples

Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). “Stable” for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently, poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

Definition Examples

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Medical Decision Making (MDM)

Effective January 1, 2021

Level of Medical Decision Making Table

- Guide to assist in selecting the level of MDM
- Used for office or other outpatient E/M services only
- Includes 4 levels of MDM (**unchanged from current levels of MDM**)
 - Straightforward
 - Low
 - Moderate
 - High

Medical Decision Making Table

| MDM 2019 | | MDM Effective January 1, 2021 |
|---|---|---|
| Number of Diagnoses or Management Options | → | Number and Complexity of Problems Addressed at the Encounter |
| Amount and/or Complexity of Data to be Reviewed | → | Amount and/or Complexity of Data to be Reviewed and Analyzed |
| Risk of Complications and/or Morbidity or Mortality | → | Risk of Complications and/or Morbidity or Mortality of Patient Management |

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|---|---|---|
| | | Number and Complexity of Problems Addressed at the Encounter | Amount and/or Complexity of Data to be Reviewed and Analyzed <i>* - Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i> | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | | | |
| 99202 99212 | Straightforward | | | |
| 99203 99213 | Low | | | |

MDM: Number and Complexity of Problems Addressed at the Encounter

- Based on CMS Documentation Guidelines' Table of Risk
- New guidelines and numerous definitions added to clarify each type of problem addressed in the MDM table
 - Stable, chronic illness
 - Acute, uncomplicated illness or injury
- Removed examples
 - Some were not office oriented
 - Examples in guidelines to make MDM table less complex

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|--|--|--|
| | | Number and Complexity of Problems Addressed at the Encounter | | |
| 99211 | N/A | N/A | | |
| 99202 99212 | Straightforward | Minimal <ul style="list-style-type: none"> • 1 self-limited or minor problem | | |
| 99203 99213 | Low | Low <ul style="list-style-type: none"> • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury | | |

| | | | | |
|------------------------------|-----------------|---|--|--|
| 99204 99214 | Moderate | Moderate <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; or <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; or <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; or <ul style="list-style-type: none"> • 1 acute complicated injury | | |
|------------------------------|-----------------|---|--|--|

| | | | | |
|----------------|------|--|--|--|
| 99205 99215 | High | <p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 1 acute or chronic illness or injury that poses a threat to life or bodily function | | |
|----------------|------|--|--|--|

MDM: Number and Complexity of Problems Addressed at the Encounter: Clinically Relevant

- Straightforward
 - Self-limited
- Low
 - Stable, uncomplicated, single problem
- Moderate
 - Multiple problems or significantly ill
- High
 - Very ill

MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Simplified and standardized contractor scoring guidelines
- Emphasized clinically important activities over number of documents
- Need to account for quantity of documents ordered/reviewed (as it is MDM work) and create “counting rules”

MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Data are divided into three categories:
 - Tests, documents, orders, or independent historian(s)—each unique test, order, or document is **counted** to meet a threshold number
 - Independent interpretation of tests not reported separately
 - Discussion of management or test interpretation with external physician/other QHP/appropriate source (not reported separately)

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|-------------------------------------|---|--|
| | | | Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i> | |
| 99211 | N/A | | N/A | |
| 99202 99212 | Straightforward | | Minimal or none | |
| 99203 99213 | Low | | Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents <ul style="list-style-type: none"> Any combination of 2 from the following: <ul style="list-style-type: none"> Review of prior external note(s) from each unique source*; review of the result(s) of each unique test*; ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i> | |

| | | | |
|------------------------|-----------------|---|--|
| <p>99204 99214</p> | <p>Moderate</p> | <p>Moderate</p> <p><i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following:</p> <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | |
|------------------------|-----------------|---|--|

| | | | | |
|----------------|------|--|---|--|
| 99205 99215 | High | | <p>Extensive</p> <p><i>(Must meet the requirements of at least 2 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | |
|----------------|------|--|---|--|

MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Straightforward
 - Minimal or None
- Low (one category only)
 - Two documents or independent historian
- Moderate (one category only)
 - Count: Three items between documents and independent historian; or
 - Interpret; or
 - Confer
- High (two categories)
 - Same concepts as moderate

MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Risk of complications and/or morbidity, or mortality of patient management decisions made at the visit, associated with the patient's problem(s), treatment(s)
 - Includes possible management options selected and those considered, but not selected
 - Addresses risks associated with social determinants of health

TABLE OF RISK

| Level of Risk | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | Management Options Selected |
|-----------------|---|--|--|
| <i>Moderate</i> | <ul style="list-style-type: none"> 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, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness | <ul style="list-style-type: none"> Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis | <ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation |
| <i>High</i> | <ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss | <ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography | <ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis |

- Minor surgery with identified risk factors
- Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
- Prescription drug management
- Therapeutic nuclear medicine
- IV fluids with additives
- Closed treatment of fracture or dislocation without manipulation

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|-------------------------------------|--|---|
| | | | | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | | | N/A |
| 99202 99212 | Straightforward | | | Minimal risk of morbidity from additional diagnostic testing or treatment |
| 99203 99213 | Low | | | Low risk of morbidity from additional diagnostic testing or treatment |

| | | | | |
|------------------------|-----------------|--|--|---|
| <p>99204 99214</p> | <p>Moderate</p> | | | <p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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 | | | <p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
 - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
- Low
 - Low risk (ie, very low risk of anything bad), minimal consent/discussion
- Moderate
 - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- High
 - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|---|---|---|
| | | Number and Complexity of Problems Addressed at the Encounter | Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i> | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | N/A | N/A | N/A |
| 99202 99212 | Straightforward | 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 <i>(Must meet the requirements of at least 1 of the 2 categories)</i> 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* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i> | Low risk of morbidity from additional diagnostic testing or treatment |

| | | | | |
|--------------------------------------|------------------------|--|---|---|
| <p>99204 99214</p> | <p>Moderate</p> | <p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; <p>or</p> <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; <p>or</p> <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; <p>or</p> <ul style="list-style-type: none"> • 1 acute complicated injury | <p>Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> • 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | <p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> • 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 | <p>High</p> <ul style="list-style-type: none"> 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <p>or</p> <ul style="list-style-type: none"> 1 acute or chronic illness or injury that poses a threat to life or bodily function | <p>Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <ul style="list-style-type: none"> Any combination of 3 from the following: <ul style="list-style-type: none"> 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) <p>or</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); <p>or</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | <p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <ul style="list-style-type: none"> 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 |
|----------------|------|--|--|---|

Medical Decision Making Table

To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded (**concept unchanged from current guidelines**).

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|----------------|---|---|---|---|
| | | Number and Complexity of Problems Addressed at the Encounter | Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i> | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | N/A | N/A | N/A |
| 99202 99212 | Straightforward | 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: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high) | Low risk of morbidity from additional diagnostic testing or treatment |



Time

Time: Office and Other Outpatient E/M Services

Key elements addressed regarding time:

1. Ambiguity

- “What is the exact increment of time I can move to the next code level?”
- “Which elements of my visit can be included as part of my E/M and which should be reported separately or not at all?”

2. Too restrictive

- “Why can’t E/M codes be more flexible to allow the most accurate elements to be considered for code selection?”

Time: Office and Other Outpatient E/M Services

2019

- When counseling and/or coordination of care dominates (**over 50%**) the encounter with the patient and/or family, time shall be the key or controlling factor to qualify for a particular level of E/M service
- Only face-to-face time counted

Time: Office and Other Outpatient E/M Services

Effective January 1, 2021

- Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service
- Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service

Time: Office and Other Outpatient E/M Services

Total Time on the date of the encounter

- Includes physician/other QHP face-to-face and non-face-to-face time
- Time spent by clinical staff is not included
- More than one clinician addressed (count only 1 person per minute)

Time: Office and Other Outpatient E/M Services

Total Time on the date of the encounter

- Recognizes the important non-face-to-face activities
- Uses easy to remember increments based on time data of past valuations
- Removes “midpoint” vs “threshold” by giving exact ranges
- Is for *Code Selection When Using Time*
 - Not a required minimum amount when using MDM

Code Selection *Is* Not Code Valuation

- CPT code selection is total time on the date of the encounter
- RUC valuation includes work before and after the date of the encounter

Time: Office and Other Outpatient E/M Services

Physician/other QHP time includes the following activities (when performed):

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver

Time: Office and Other Outpatient E/M Services

- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

Time: Office and Other Outpatient E/M Services—New Patient (*Total time on the Date of the Encounter*)

| New Patient E/M Code | Typical Time (2019) | Total Time (2021) |
|----------------------|---------------------|-------------------|
| 99201 | 10 minutes | Code deleted |
| 99202 | 20 minutes | 15-29 minutes |
| 99203 | 30 minutes | 30-44 minutes |
| 99204 | 45 minutes | 45-59 minutes |
| 99205 | 60 minutes | 60-74 minutes |

Time: Office and Other Outpatient E/M Services—Established Patient (*Total time on the Date of the Encounter*)

| Established Patient E/M Code | Typical Time (2019) | Total Time (2021) |
|------------------------------|---------------------|------------------------|
| 99211 | 5 minutes | Time component removed |
| 99212 | 10 minutes | 10-19 minutes |
| 99213 | 15 minutes | 20-29 minutes |
| 99214 | 25 minutes | 30-39 minutes |
| 99215 | 40 minutes | 40-54 minutes |

Related Revisions: Time

- Revised and relocated Time guidelines in the Evaluation and Management (E/M) Services Guidelines to clarify how time is used with the following services:
 - Office or other outpatient E/M services (99202-99205, 99212-99215)
 - Outpatient services (99241-99245, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99483)
 - Hospital observation services (99218-99220, 99224-99226, 99234-99236), hospital inpatient services (99221-99223, 99231-99233), inpatient consultations (99251-99255), nursing facility services (99304-99318)

A smiling female healthcare professional with curly hair and glasses, wearing a blue sleeveless top and a stethoscope, is holding a tablet. She is sitting in a clinical setting with medical equipment in the background. The image has a purple tint.

Prolonged Services (Office or Other Outpatient E/M Service)

Prolonged Services (99XXX)

- The E/M Workgroup identified the need for a prolonged service code to capture services for a patient that required longer time on the date of the encounter
- The Workgroup agreed with CMS that a shorter time was appropriate

Prolonged Services (99354, 99358, 99XXX)

2019

- Prolonged services codes with direct patient contact (99354, 99355) and without direct patient contact (99358, 99359)
 - First hour (base code)
 - Each additional 30 minutes (add-on code)
- Currently, prolonged services of 30 minutes or less beyond the *typical time* of the E/M service is not reported separately
- If criteria met, 99354 and/or 99358 may be reported on the date of service.

Prolonged Services (99XXX)

Effective January 1, 2021

- Shorter prolonged services code to capture each 15 minutes of critical physician/other QHP work beyond the time captured by the office or other outpatient service E/M code.
 - Used only when the office/other outpatient code is selected using time
 - **For use only with 99205, 99215**
 - Prolonged services of less than 15 minutes should not be reported

Prolonged Services (99XXX)

- Allows for face-to-face and non-face-to-face care on the date of the encounter
- Therefore, do not report 99354 or 99358 for time on the date of the encounter
- 99358 (non-face-to-face prolonged services of 30 minutes in a single day) may be reported on a date **other than** the date of the encounter, just as it may be reported in 2019

(Per CPT, but note CMS comments in 2020 PFS Final Rule)

Prolonged Services (99XXX)

Prolonged Services/Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service

★+●99XXX Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

▶(Use 99XXX in conjunction with 99205, 99215)◀

▶(Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)◀

▶(Do not report 99XXX for any time unit less than 15 minutes)◀

Prolonged Services (99XXX)

| Total Duration of New Patient Office or Other Outpatient Services (use with 99205) | Code(s) |
|---|--|
| Less than 75 minutes | Not reported separately |
| 75-89 minutes | 99205 X 1 and 99XXX X 1 |
| 90-104 minutes | 99205 X 1 and 99XXX X 2 |
| 105 or more | 99205 X 1 and 99XXX X 3 or more for each additional 15 minutes |

Prolonged Services (99XXX)

| Total Duration of Established Office or Other Outpatient Services (use with 99215) | Code(s) |
|--|--|
| Less than 55 minutes | Not reported separately |
| 55-69 minutes | 99215 X 1 and 99XXX X 1 |
| 70-84 minutes | 99215 X 1 and 99XXX X 2 |
| 85 or more | 99215 X 1 and 99XXX X 3 or more for each additional 15 minutes |

TIMELINE



| NEW | 1-14 | 15-29 | 30-44 | 45-59 | 60-74 | 75-89 | 90-104 |
|-------------|--------------------------------|-------|-------|-------|-------|--------------|----------------------|
| | Do not use time (99202 by MDM) | 99202 | 99203 | 99204 | 99205 | 99205+ 99XXX | 99205+ 2 units 99XXX |
| | | | | | | | |
| ESTABLISHED | 1-9 | 10-19 | 20-29 | 30-39 | 40-54 | 55-69 | 70-84 |
| | Do not use time (99212 by MDM) | 99212 | 99213 | 99214 | 99215 | 99215+ 99XXX | 99215+ 2 units 99XXX |
| | | | | | | | |

Related Revisions (99XXX)

- Addition of Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service (99XXX) guidelines
- Existing prolonged service codes (99354, 99355, 99356) revised to restrict reporting with office or other outpatient E/M services (99202-99215)
- Revised Prolonged Services with Direct Patient Contact and Prolonged Services without Direct Patient Contact guidelines

Final Rule – 2021 Medicare Reporting Rules on Prolonged Services

- CMS finalized decision to adopt CPT code 99XXX to report all prolonged time spent on the date of the primary office or other outpatient E/M visit (99205/99215)
- CMS states confusion with the reporting guidelines for codes 99358, 99359
 - “The new prefatory language seemed unclear regarding whether CPT codes 99358, 99359 could be reported instead of, or in addition to, CPT code 99XXX, and whether the prolonged time would have to be spent on the visit date, within 3 days prior or 7 days after the visit date, or outside of this new 10-day window relevant.”
- Finalized Medicare 2021 reporting instructions that codes 99358, 99359 will no longer be reportable in conjunction with office or other outpatient E/M visits
 - “When using time to select office/outpatient E/M visit level, any additional time spent by the reporting practitioner on a prior or subsequent date of service (such as reviewing medical records or test results) could not count toward the required times for reporting CPT codes 99202-99215 or 99XXX, or be reportable using CPT codes 99358, 99359.”



RUC Recommendations For 2021: Office Visits

RUC Review of Valuation of Office Visits

- 51 national medical specialty societies and other health care professional organizations surveyed the revised codes to measure physician time, work, and direct practice costs (nursing staff time, supplies, equipment). 1,700 physicians responded to the survey.
- The surveying specialties analyzed the data and presented recommendations to the RUC at their April 24-27, 2019, meeting.

RUC Review of Valuation of Office Visits

- The RUC was compelled that the current valuation of office visits was incorrect as the current data were not based on the experience of all who perform office visits, including surgeons.
- The RUC also agreed that the increased use and consolidation of EHRs have led to additional time spent on each patient. *“With increased consolidation of hospitals and EHR systems (EPIC and Cerner now have a combined 85% market share of 500+ bed hospitals), physicians have access to more patient information. The centralization of data is in the best interest of patients and will help support quality care. However, this centralization does increase the time that physicians spend reviewing patient information. The presenters argued that EHR adoption has led to a decrease in efficiency, which may never be fully regained.”*
- The time and work estimates were consistent between specialties, compelling the RUC to utilize the survey results in recommending increases to CMS.
- The RUC recommendations were submitted to CMS in May 2019.

RUC Review of Valuation of Office Visits

- In the CY2020 Medicare Physician Payment Schedule Proposed Rule, CMS announced their decision to implement the new CPT framework and RUC recommended valuation on January 1, 2021.
- Information on the detailed RUC recommendations, votes and minutes are available at <https://www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting>.

RUC Work RVU Recommendations For 2021: Office Visits—New Patient

| CPT Code | Current Work RVU | RUC Rec. Work RVU | Final CMS RVU |
|----------|------------------|-------------------|---------------|
| 99202 | 0.93 | 0.93 | 0.93 |
| 99203 | 1.42 | 1.60 | 1.60 |
| 99204 | 2.43 | 2.60 | 2.60 |
| 99205 | 3.17 | 3.50 | 3.50 |

RUC Work RVU Recommendations For 2021: Office Visits—Established Patient

| CPT Code | Current Work RVU | RUC Rec. Work RVU | Final CMS RVU |
|----------|------------------|-------------------|---------------|
| 99211 | 0.18 | 0.18 | 0.18 |
| 99212 | 0.48 | 0.70 | 0.70 |
| 99213 | 0.97 | 1.30 | 1.30 |
| 99214 | 1.50 | 1.92 | 1.92 |
| 99215 | 2.11 | 2.80 | 2.80 |

RUC Work RVU Recommendations For 2021: Prolonged Service

| CPT Code | Current Work RVU | RUC Rec. Work RVU | Final CMS RVU |
|----------|------------------|-------------------|---------------|
| 99XXX | N/A | 0.61 | 0.61 |

RUC Recommendations for Office Visits in the Surgical Global Payment and Maternity Care

- The RUC recommended that all the new valuations be incorporated into the surgical global (10 and 90 day) codes that have E/M office visits during the global period.
- CMS chose not to implement this recommendation for 2021. This is unprecedented as CMS has increased the visits in the global payment each time the stand-alone visits were increased.
- The AMA will continue to actively advocate that the visit increases be incorporated into the follow-up visits incorporated in global surgical payment and maternity codes.

Budget Neutrality within the RBRVS – Office Visits

- The CMS implementation of increased valuation of office visits will impact specialties differently. For those that perform office visits, the impact will be positive. Due to budget neutrality requirements, those that do not perform office visits will see a decrease in payment.
- The increased valuation of the stand-alone office visits (99202-99215, 99XXX) represents additional spending of approximately \$5.3 billion per year.
- The increased valuation to the procedures with a surgical global assignment of 010 or 090 days or maternity care codes would be approximately \$0.4 billion per year.

CMS Add-On Code GPCIX

- In addition to the office visit changes recommended by the RUC, CMS has finalized the Agency's own concept to enhance office visit payment.
- Code GPC1X *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, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* would be an additional \$18 payment for each office visit, based on the 2020 Medicare conversion factor (total relative value of 0.50).

CMS Add-On Code GPCIX

- CMS indicates that any specialty may report the code, however, CMS lists specific physician specialties (and nurse practitioners and physician assistants) that the Agency anticipates will report the code with 100% of their office visits.
- The budget impact of this code is \$2.6 billion in spending per year.
- Physicians who do not report this code would see a 2.7% reduction in Medicare spending, beginning in 2021, from implementation of this code.

CMS Add-On Code GPCIX

- The AMA had urged CMS not to implement this code. The AMA will continue to demonstrate to CMS that the revised office E/M coding guidelines and structure, as well as the robust RUC surveys appropriately accounted for the increased work of office E/M services.

Challenges for 2020

- Our work together for 2020 will be to advocate for inclusion of the revised office E/M values into global surgical and maternity codes, to work with CMS to prevent the major budget-neutrality redistributions that would occur with implementation of the GPCIX add-on code, and to preserve the mutual support among the specialties within the house of medicine that enabled this substantial revision to office E/M coding to reduce documentation burden.

