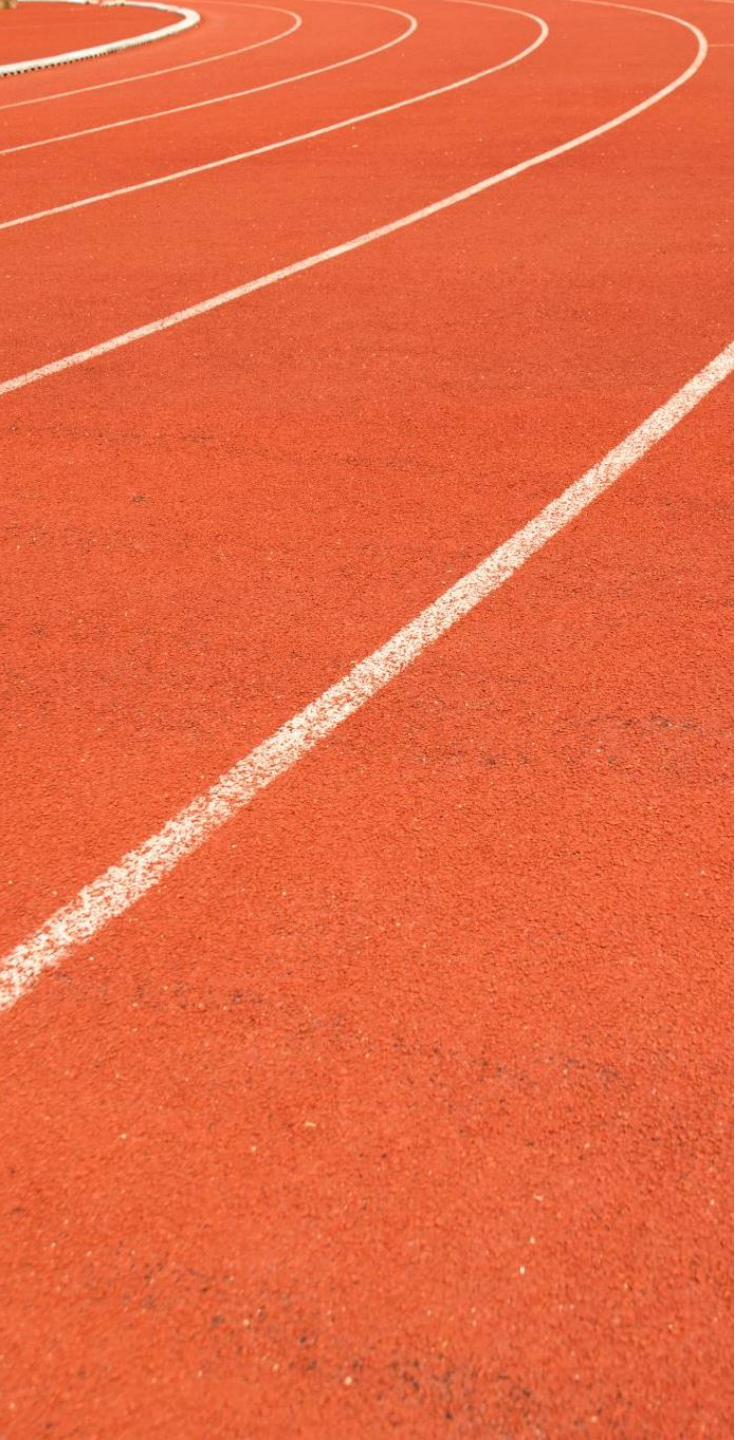

E/M Changes 2021

AN EDUCATIONAL PRESENTATION

FOR

COOPERATIVE OF AMERICAN PHYSICIANS

MARCH 2021

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Today's Agenda

- New E/M Guidelines for 2021 – which codes?
- History, exam – what do we look at?
- Medical Decision Making (MDM) Elements – how is it different from the past?
  - Number and complexity of problems
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications and/or morbidity or mortality of patient management
- Time – what counts; what doesn't count?
  - When do you bill Prolonged Services?
- **DOCUMENTATION** - *What's Important*

What Codes are Changing?

- 99201 has been deleted

- 99202 – 99215
  - The codes are the same
  - The guidelines have **changed** – *there are pages of introductory guidelines in your CPT book – get a book for 2021!*

- New Prolonged Service Code 99417
  - For use with 99205 and 99215 ONLY
  - Medicare has different code and different guidelines – G2212

- All other E/M codes and guidelines remain the same!!!!

CPT 99202 - 99215

- **Level may be selected on Medical Decision Making (MDM)**

or

- **Time**

Risk	Presenting Problems (with examples)	Diagnostics	Examples of Management
Minimal	**Self-Limited/Minor**: Insect bite, cold (at most 1 problem)	Labs, XR, EKG, Echo, Ultrasound	Rest, bandage, gargles
Low	**Acute, Uncomplicated**: Simple sprain, cystitis **≥2 Self-Limited Problems**	Imaging w/ contrast ABG	Minor surgery IV fluids, over the counter medication, PT/OT
Moderate	**Acute with Systemic Symptoms**: Pyelonephritis, pneumonia, colitis **Acute, Complicated Injury**: Head injury with loss of consciousness **New Dx w/ Uncertain Prognosis**: Breast mass **Chronic w/ Exacerbation**: COPD, CHF	Lumbar puncture Thora/paracentesis	Prescription drug Reduction/ splinting IV fluids w/ additives
High	**Threat to Life or Bodily Function**: MI, PE, suicidality, change in neuro status, severe respiratory distress, polytrauma, peritonitis, acute renal failure **Chronic Illness w/ Severe Exacerbation**	--	IV controlled substance Drug therapy requiring monitoring DNR decision

MDM vs. Time

Code	MDM	Time (Minutes)
99202	Straightforward	15 - 29
99203	Low	30 - 44
99204	Moderate	45 - 59
99205	High	60 – 74
99211	NA	NA
99212	Straightforward	10 - 19
99213	Low	20-209
99214	Moderate	30 - 39
99215	High	40 - 54

History and/or Examination

- No longer a key components for selecting a new or established patient visit (99202 – 99215)

- Nature and extent of history and/or physical exam is determined by clinician
  - Should be done – document same elements as before
  - Should be medically appropriate

- Care team may collect information
  - Clinician must document reviewed, and agree/add info
  - Does not count toward determining time

Medical Decision Making

- Requires two of three elements (as before)
  - Number and complexity of problems addressed
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications and/or morbidity or morality of patient management
- There is a new MDM Table – see *next slide*
  - ***Similar to, but not identical*** to the current CMS Risk Table

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		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
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

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:
			  • 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)
			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)
			
			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)
			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)
				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

Medical Decision Making Table

MDM 2020
Number of Diagnoses or Management Options
Amount and/or Complexity of Data to be Reviewed
Risk of Complications and/or Morbidity or Mortality

MDM 2021
Number and ***Complexity of Problems Addressed at Encounter***
Amount and/or Complexity of Data to be Reviewed ***and Analyzed***
Risk of Complications and/or Morbidity or Mortality ***of Patient Management***

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

Code	Level of MDM	Number and Complexity of Problems Addressed
99202 99212	Straight-forward	1 self-limited or minor problem
99203 99213	Low	2 or more self-limited or minor problems; **OR** 1 stable chronic illness; **OR** 1 acute uncomplicated illness or injury
99204 99214	Moderate	1 or more chronic illness with exacerbation, progression or side effects of treatment; **OR** 2 or more stable chronic illnesses; **OR** 1 undiagnosed new problem with uncertain outcome; **OR** 1 acute illness with systemic symptoms; **OR** 1 acute complicated injury
99205 99215	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

Number & Complexity of Problems

- Multiple new and established problems may be addressed at one encounter
- Co-morbidities/underlying conditions considered only if addressed at visit and presence increases amount of and/or complexity of data or risk of complications/morbidity
- Final diagnosis does not in itself determine the complexity of risk
  - The nature of the presenting problem may require a higher level of evaluation than indicated by the final diagnosis

Problems

Problem: disease, condition, illness, injury, symptom, sign, finding complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the end of encounter

- Keep in mind that symptoms of diagnosed problems (fever as a result of the flu) are not considered separate problems – symptoms that are clustered around a known diagnosis are not counted separately

Problem addressed: Evaluated or treated during the encounter

- notation that another professional is managing without additional assessment does not count as addressed;
- referral without evaluation does not qualify as addressed

Problems:

- **Minimal**: doesn't require presence of physician, NP/PA (99211)
- **Self limited or minor**: runs a defined and prescribed course, is transient
- **Stable chronic illness**: expected duration of one year or death of patient, stable defined by treatment goals for that patient, not at treatment goal is not considered stable
- **Acute, uncomplicated illness or injury**: recent or new short-term problem; little to no risk of mortality. A problem that is normally self limited or minor that is not resolving. Cystitis, allergic rhinitis, simple sprain
- **Chronic illness with exacerbation or progression**: progressing requiring additional treatments, not hospitalization

Problems

- **Undiagnosed new problem with uncertain outcome**: problem with differential diagnosis with potential for high risk of morbidity without treatment - i.e., breast lump
- **Acute illness with systemic symptoms**: illness with systems symptoms with high risk of morbidity without treatment – i.e., pyelonephritis, pneumonitis, colitis
- **Acute, complicated injury**: injury that requires evaluation of body systems not directly part of injured organ system, or injury is extensive, or treatment options are multiple - i.e., head injury with brief loss of consciousness
- **Chronic illness with severe exacerbation, progression or side effect of treatment**: significant risk of morbidity and may require hospital level care

Problems

- **Acute or chronic illness/injury poses a threat to life or bodily function**: threat in near term without treatment: MI, PE, severe respiratory distress, progressive, severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurological status

Questions:

Question: What if a patient presents with an undiagnosed new problem, and two chronic illnesses with exacerbation. Does that move element one, number and complexity of problems, from moderate to high?

Answer: No. You don't sum up the number of problems. Follow the examples in the tables. The AMA has confirmed that having multiple problems in one "box" does not move the visit to the next box.

Question: Many patients have problems that pose a threat to life or bodily function at some point in time. Is there any framework for time?

Answer: Yes. The guidelines say "in the near term." In the first element, the number and complexity of problems addressed there is "acute or chronic illness or injury that poses a threat to life or bodily function." The definition of that in the guidelines adds detail. "…..that poses threat to life or bodily function in the near term without treatment."

Questions:

Question: I am a surgeon; most of my patients are older with multiple comorbidities. Do these comorbidities count toward the number of problems addressed?

Answer: Yes, but you must clearly document that they were addressed – evaluated or treated at this encounter. Merely listing them as diagnosis without any indication that they were addressed – either through examination or consideration when considering treatment options – does not count toward "problems addressed at this encounter".

Amount and/or Complexity of Data to be Reviewed & 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 are not reported separately
- Discussion of management or test interpretation with external physician/other QHP/appropriate source (not reported separately)

Amount and/or Complexity of Data

- Data is divided into “category” and what is included in the category changes from low to moderate

- 99202 – 90212 requires **minimal** or none

- 99203 – 99213 requires l**imited** data: one of two categories

- 99204 – 99214 requires **moderate** data: one of two categories (changed definitions)

- 99205 – 99215 requires **high** data: two of three categories (same definitions as moderate)

Elements of Medical Decision Making

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

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)

Elements of Medical Decision Making

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

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 results of each unique test;
- Ordering of each unique test;
- Assessment requiring an 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 QHP/appropriate source (not separately reported)

Elements of Medical Decision Making

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

High

(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 results of each unique test;
- Ordering of each unique test;
- Assessment requiring an 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 QHP/appropriate source (not separately reported)

Tests

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.

- Lab tests in the 80000 series of codes
- Diagnostic tests in the 70000 series of codes
- Medical tests in the 90000 series of codes

If it has a CPT code, it is considered a single test

Not separately reported

"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."

- If billing for an EMG, don't include the EMG as data in determining E/M, don't include time of EMG if using time

Not separately reported

"The physician's interpretation of the results of diagnostic tests/studies (ie: 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."

Not separately reported

- If the physician interpreted the test and is billing for the interpretation, do not include the test in determining the level of E/M service

- If the physician is reviewing an image but it's not billed for (separately reported) it's part of the decision making in selecting the level of service

Don't double count time or work when a service is separately reported

External records/professional

"External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization."

"An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty."

Independent

- **Historian**: provides history because patient is unable or confirmatory history is required
  - *An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in additional to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met".*

- **Independent Interpretation:** *The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other QHP is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.*

Appropriate Source

In discussion of management data element appropriate source includes:

- ✓ Professionals who are not health care professionals (lawyers, case manager)
- × Does not include family or informal caregivers

Questions:

Question: If I order and bill for a quick strep test in my office, do I count the order, the review or both?

Answer: Neither. The AMA clearly says that if you bill for the lab test, you don't count it as ordered or reviewed.

- *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. . . . . CPT 2021*

Question: What about lab results. I was away on vacation and my partner saw one of my patients and ordered labs. I saw the patient the next week and reviewed the results. Can I credit the review?

Answer: Probably not; if you are in the same specialty, you are considered a single physician and then you could not. If of a different specialty, then yes you could.

Questions:

Question: In a cardiology practice, what if my cardiology partner did the official echo report and billed for it, but then I see the patient and view the echo. Can I count that as an independent interpretation?

Answer: No. If your same specialty partner, in your practice reported the professional component, do not credit an independent interpretation when you see the patient.

Question: If I order an MRI at a visit one day and review it with the patient at a follow up visit a week later, do I count the order on the first date and the review at the second visit? I didn't bill for the MRI or the interpretation.

Answer: No, count it once, at the order. CPT says

- *"Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter."*

Risk

There are four levels of Risk recognized (same as previous)

- Straightforward
- Low
- Moderate
- High

Code	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Minimal	**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 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

Risk of complications and/or morbidity and/or mortality

Risk: probability and/or consequent of an event

"Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification of these definitions . . ."

"For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization."

Morbidity and SDOH

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."*

- Remember - there are ICD-10-CM codes that describe SDOH

Rx Drug Management

"Prescription drug management" is based on documented evidence that the provider has evaluated medications as part of a service, in relation to the patient. This may be a prescription being written or discontinued, or a decision to maintain a current medication/dosage.

Note: Simply listing current medications is not considered "prescription drug management."

. . . Program Integrity Department, CMS

Drug therapy requiring intensive monitoring

- Drug with potential to cause serious morbidity or death
- Monitoring is not primarily for assessment of therapeutic efficacy
- Intensive monitoring may be long or short term, long term is no less than quarterly
- Monitoring may be by lab test, physiologic test or imaging, not history or exam

Drug therapy requiring intensive monitoring

- Examples include monitoring for cytopenia for antineoplastic agent or short-term monitoring of electrolytes and renal function in patient undergoing diuresis

- These things do not qualify - glucose level during insulin therapy; annual electrolytes and renal function in a patient on a diuretic

Questions:

Question: I have a question about how to determine if a procedure is a major or minor procedure when assessing risk in the new E/M guidelines for office visits. I heard from a colleague that the AMA is saying it is the surgeon's judgement and not the global days that determines if the procedure is major or minor. Is that correct?

Answer: The AMA says: *"The global periods do not determine the definition. They could be part of the consideration. This is the RISK column, so procedural risk, not global periods are relevant. The clinician best understands the risk. We do not guide clinicians on this. Specialty societies may have guidance on risk and "major" and "minor."*

I recommend that the physician document risk factors that are inherent to the procedure (bleeding, puncturing the lung, paralysis) and risk factors related to co-morbidities and conditions of the patient.

Questions:

Question: Can you give me an example of Social Determinants of Health?

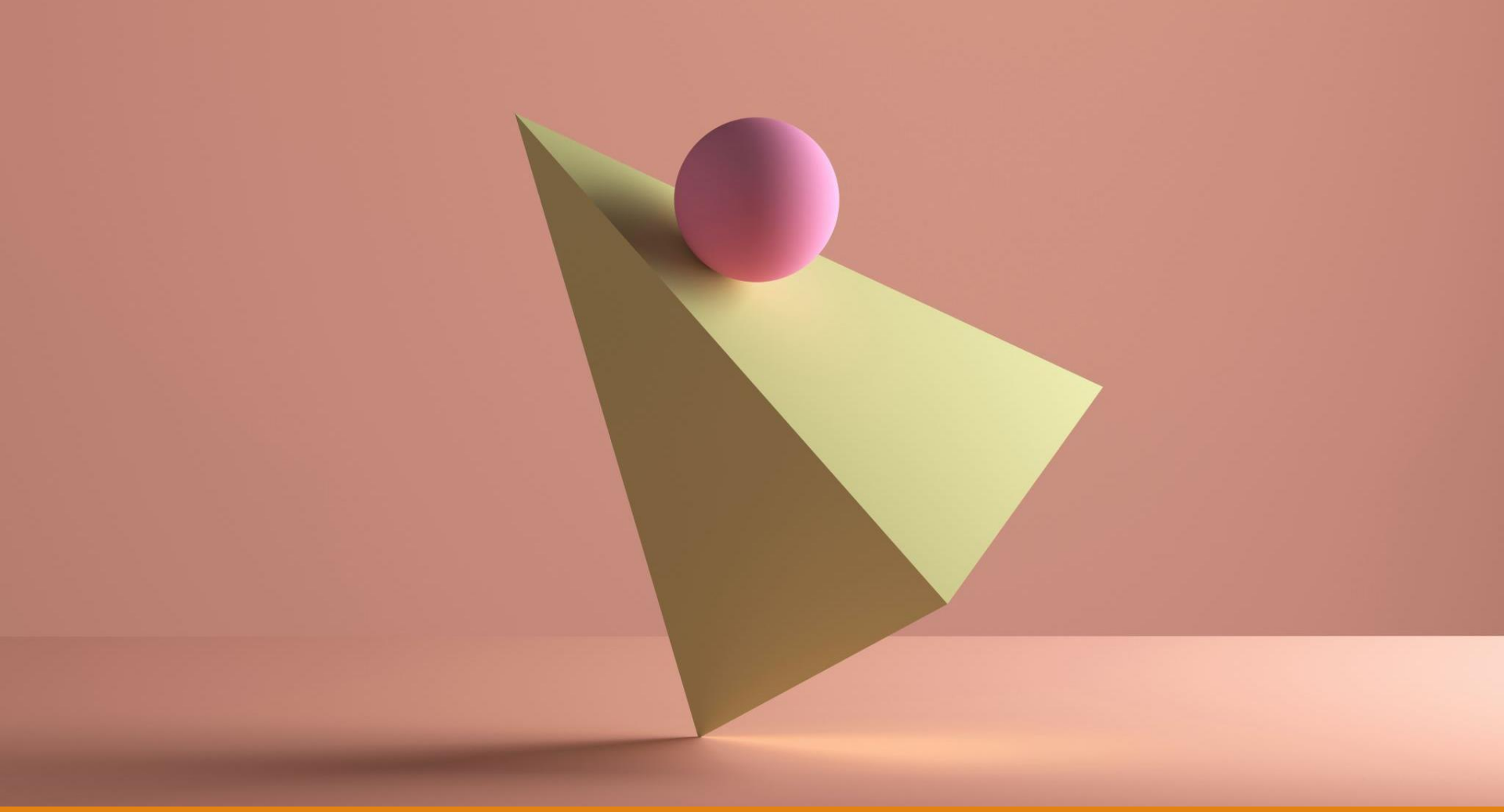
Answer: Homelessness, food insecurity, lack of access to clean water, unable to afford medications. Make sure they are identified – either with documentation and/or ICD-10 codes to support when using to determine Risk.

Question: Can you clarify whether or not Warfarin is included in high-risk drug therapy requiring intensive monitoring. The PT/INR is monitored weekly.

Answer: No, please refer to slide 39. The monitoring should not be done primarily for assessment of therapeutic efficacy.

Select Your Level of Service - MDM

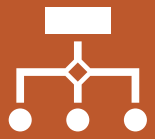
		Choose MDM Based on 2 of 3 Elements		
Code	Level of MDM	1) Number and Complexity of Problems Addressed	2) Amount and/or Complexity of Data to be Reviewed and Analyzed	3) Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 99212	**Straightforward**	Minimal	Minimal or none	Minimal
99203 99213	**Low**	Low	Limited	Low
99204 99214	**Moderate**	Moderate	Moderate	Moderate
99205 99215	**High**	High	Extensive	High



TIME

SELECTING A LEVEL OF SERVICE BASED ON TIME

Time for codes 99202 - 99215



Different categories of services use time differently. It is important to review the instructions for each category.

In 2021: may select 99202 – 99215 based on time spent on the patient encounter (counseling and/or coordination of care no longer have to dominate the visit)

Practitioner, **not** staff time

Time thresholds for 99202 - 99215

Code	Minutes
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99211	
99212	10-19
99213	20-29
99214	30-39
99215	40-54

Activities that Count

- Preparing to see the patient (eg: review of test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patent/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care 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)

Time

The activities must all be done on the **calendar day of the encounter**

What do you document?

- Document total time spent (**on day of encounter**)
  - Do not rely on EHR time and date stamp
  - Remember – DO NOT include staff time
- Summarize activities done

  "I spent 45 minutes caring for this patient today, reviewing labs, records from another facility, seeing the patent, documenting in the record and arranging for a sleep study."

- Psychotherapy and E/M (medication mgmt.) – better to use MDM for the E/M because you can't use time twice
  - *If you do use time – distinctly separate the two times and document separately*

Questions:

Question: If using time, do I need to list all the activities and the time spend doing each one?

Answer: According to the AMA, list total time and describe what activities were done.

Question: If using time to select a code, should I document a time range or actual time?

Answer: Document actual time, and the activities you performed.

Question: When using time and the clinician review the record the day before, or completes the note the day after, can I count that time?

Answer: No, only time on the calendar day of the visit may be counted.

Questions:

Question: Can I use just in and out time to determine how much time was spent on the encounter?

Answer: No, it would not be accurate. You must document the total time of the provider/clinician only - staff time does not count – and, you would use any time spent on the patient encounter before the patient checked in.

Question: When billing a telehealth visit, how do I use the time spent by my staff in getting ready for the visit?

Answer: With the new guidelines for 99202 – 99215, staff time does not count in determining the level of service.

Prolonged Care

- In 2021, may no longer use non-face-to-face prolonged care (99358, 99359) or non-face-to-face prolonged care (99354 – 99355) with 99202 – 99215

- CPT developed a new 15 minutes code for use with only 99215 and 99205 when time based
  - 99417
    - **Medicare not recognizing and has developed a HCPCS code – G2212 – to report the prolonged care with 99205 and 99215 – *to be added to the higher end of time range***

- CPT codes 99354 and 99355 have not been deleted, but **MAY NO LONGER** be used with code range 99202 - 99215

CPT / CMS Variance for Prolonged Services

	Time Range	CPT allows add-on Code 99417 when time is	CMS allows add-on code G2212 when time is
99205	60 - 74	75 minutes	89 minutes
99215	40 – 54	55 minutes	69 minutes

Questions:

Question: Are 99354 and 99355 being deleted?

Answer: No, they are still valid CPT codes, but they can no longer be used with 99205 or 99215 (or anything in the code range of 99202 – 99215)

Question: Can you use the G2212 code with a 25 modifier for E/M codes for other than Medicare patients?

Answer: You would never use a 25 modifier with this code – it is an "add-on" code and does not require (nor is it appropriate) a modifier. If a payer accepts HCPCS codes, then you certainly should be able to use the G2212 appropriately.

Questions:

Question: What if I am using MDM to make my code selection, for instance for a 99213 visit, but then the time I spent on the encounter turns out to be 35 minutes – would I bill a 99213 or a 99214?

Answer: In the scenario you describe, you would be allowed to bill a 99214, using time as the factor to determine your level of service. Make sure you document well the activities that you did during the time.

Question: How do I code for prolonged services for my hospital patients?

Answer: Just as you always have – 99356 and 99357 are still valid CPT codes and should be used in the inpatient setting.

In Summary

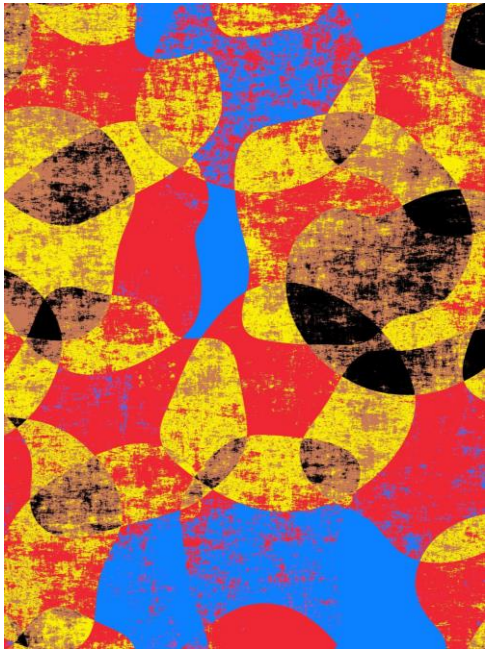
- Beginning 1/1/2021 select level of service for 99202 – 99215 using **either** Medical Decision Making or Time
  - MDM = two of the three elements
  - Time = actual time spent on patient care on date of encounter

- Time no longer needs to be based on counseling/coordination of care only
  - Document total time spent and summarize activities

Other Services

- Other E/M service guidelines are not changing
  - Inpatient Hospital – initial and subsequent
  - Consultations
  - Home Visits – new and established
  - Nursing Facility Visits
    - SNF – initial and subsequent
    - LTC – new and established
  - Emergency Department Services
  - Preventive Medicine Services – new and established

You Will Be Using Two Sets of Guidelines



Codes 99202 - 99215

REIMBURSEMENT

Re-weighting of RVUs

CPT	Pre 2021 Typical Time	Pre 2021 RVU	2021 Minimum Minutes	2021 RVU	% Variance in RVU
New Patient					
99201	10	0.48	NA – Code Eliminated		
99202	20	0.93	22	0.93	0.0%
99203	30	1.42	40	1.60	12.7%
99204	45	2.43	60	2.60	7.0%
99205	60	3.07	85	3.50	10.4%
Established Patient					
99211	5	0.18	NA	0.18	0.0%
99212	10	0.48	18	0.70	45.8%
99213	15	0.97	30	1.30	34.0%
99214	25	1.50	49	1.92	28.0%
99215	40	2.11	70	2.80	32.7%
Prolonged Service					
G2212	NA	NA	15	0.61	NA

Remember -

- CMS **accepted, in full,** the revised E/M revisions for CY 2021
- AMA survey of major commercial payers shows **100%** will be adopting the new E/M guidelines
- Providers – make sure your EHR vendor has removed any old documentation interfaces and implemented new ones
  - Connect with your vendor for changes and get them scheduled if you haven't already done so
- Educators – train for both documentation and code selection criteria NOW and continue to monitor throughout the year for compliance and re-educate/train if needed

Thanks for your attention; let's take questions!

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