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2021 E/M Outpatient Office Visit Codes FAQ

MEMBER TOOL - DECEMBER 10, 2020

CODING & DOCUMENTATION

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MGMA Staff Members

Q. Do the 2021 E/M changes only apply to Medicare? What about Medicaid, private payers and workers comp?

A. According to the AMA, commercial payers are required to adopt the CPT® code set as stated by HIPAA. HIPAA requires the code set, but not the guidelines FYI. However, it is likely that plans will also adapt new guidelines along with the code set. (Read more)

Q. Is the final rule set by Dec. 1?

A. Yes, the final rule is published.

Q. What is the link to the Bucshon and Bera/"Holding Providers Harmless" bill?

A. Track the status of the Holding Providers Harmless From Medicare Cuts During COVID-19 Act for 2020 via Congress.gov.

Q. What is the site for the Burgess neutrality waiver bill?

A. Visit Congress.gov to track the status of HR 8505, which would amend Title XVIII of the Social Security Act to provide for a one-year waiver of budget neutrality adjustments under the Medicare Physician Fee Schedule (PFS).

Q. Will Medicare Advantage plans have to adopt the 2021 E/M changes?

A. Yes, the Centers for Medicare & Medicaid Services (CMS) and AMA published required adoption of the revisions along with descriptors and documentation obligations to meet each level of E service. It directly impacts outpatient services 99202-99215.

Q. Could it affect a patient with Medicare who changes to a Medicare Advantage plan or other payer?

A. It should not affect a change in coverage from one payer to another since all payers will have to adopt the changes.

Q. Is it recommended when documenting time to capture an E/M under the 2021 guidelines to document in the patient's chart?

A. Yes, the provider must document elements of time in the patient's chart to substantiate time-based coding.

Q. Will the 2021 changes come to fulfillment on Jan. 1, 2021?

A. Yes, it was finalized as of Dec. 1, 2020, and go into effect at the start of the year. For CMS, most changes were finalized in the 2020 PFS.

Q. Does history and exam still need to be documented?

A. History and exam are still important elements in determining medical necessity and should still be documented. While not required, documenting both elements provide quality of care by maintaining continuity in assisting other healthcare providers in a team effort.

Q. What code should be used in 2021 for nurse visits?

A. 99211 will be used by nurses who perform face-to-face visits under physician supervision or other qualified healthcare professional. CPT defines 99211 as *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.*

Q. Does medical assistant (MA)/nurse time documenting clinical information (e.g., allergies, medical history, etc.) count toward total time?

A. An MA or nurse can document allergies and past family social history, but the provider must review the information and notate as reviewed.

Q. Does MGMA have resources on medical decision making (MDM) for outpatient E/M codes?

A. Yes, we most certainly do.

Q. What if I have two separate labs, a urinalysis and CBC for Category 1. It states "at least three of the following" for a Level 4. Would this example satisfy that requirement?

A. MDM will be based on categories of tests, documents, independent historian(s), independent interpretation of tests, discussion of management or test interpretation. MDM **must** meet the requirements of the level of E/M service. In the example of 2 separate labs: If one lab was ordered and one was reviewed, you'd still need another element from Category 1, such as *review of prior external note from each unique source or assessment requiring an independent historian* in order to fulfill the requirements for moderate MDM.

Q. Is the new complexity add-on code, GPC1X, only to be used by primary care providers?

A. GPC1X has been replaced by G2211 add-on code used with an E/M on Medicare patients to identify complexity inherent to primary care services. This code is intended for CMS to capture complex chronic care. CMS defines G2211 as:

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

Q. Please provide information on when to use GPC1X, such as examples and specialties that may use the code.

A. GPC1X has been replaced by **G2211**. CMS said they are not confining use of code to any specialty, but does assume that certain specialties furnished these types of visits more than others (see Page 275 of the final rule), such as: family medicine, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease.

Q. Does the provider need to document time as "From" and "To" or total elapsed time work?

A. No need to document time as “from” and “to” for time-based coding in 2021 since time is based on total time on date of the encounter which the provider utilizes. Example: *A total of 25 minutes was spent on this visit, with 20 minutes spent reviewing previous notes, counseling the patient on DM and HTN, ordering tests, refilling meds, and documenting the findings in the note. An additional 5 minutes was spent on tobacco cessation counseling, discussing the importance of quitting, options for medications and a quit plan.*

Q. How will specialties be impacted by the change in RVUs? Is there a list?

A. See Table 106 (Page 1,660) for the updated list.

Q. Is there a list of proposed RVUs?

A. The list is included in this ZIP file from CMS of PFS addenda.

Q. Please review CPT code 99417.

A. 99417 is the new CPT code for prolonged services. CPT defines the code as:
99417-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.)

The code may only be reported with 99205 or 99215 and if it exceeds time, respectively.

Total Duration of a New Patient Office or Other Outpatient Level 5 Service (99205)		Total Duration of an Established Patient Office or Other Outpatient Level 5 Service (99215)	
Time	Codes	Time	Codes
Less than 75 minutes	Not reported	Less than 55 minutes	Not reported
75-89 minutes	99205 and 99417 (1x)	55-69 minutes	99215 and 99417 (1x)
90-104 minutes	99205 and 99417 (2x)	70-84 minutes	99215 and 99417 (2x)
105 or more	99205 and 99417 (3x or more for each additional 15 min)	85 or more	99215 and 99417 (3x or more for each additional 15 minutes)

Use G2212 as of Jan. 1, 2021, for new or established **Medicare** patients as indicated by CMS fir rule. This new code is defined as: **G2212- Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which h...**
been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416) (Do not report G2212 for any time unit less than 15 minutes)

99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)

Note: Prolonged services for commercial services would use 99417, and Medicare payers will use G2212.

Q. Please clarify whether MDM or time can be used to determine the level of E/M since there are specialties that rely heavily on MDM.

A. The AMA has created new CPT® code descriptors for office or other outpatient services on both new and established patients that can be based upon the level of MDM or the time spent by the provider on the encounter.

Q. What is the definition of "independent historian"?

A. 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 qualified healthcare professional 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.

Q. Does the time have to be face-to-face time with the patient?

A. No. Time-based coding elements will include **both** face-to-face and non-face-to-face activities as long as they are performed on the same date of service.

Time-based coding elements (when any of the bulleted points is performed and documented as reason for total time spent on **date of encounter** as face-to-face or non-face-to-face)

- Reviewing patient's record prior to visit
- Obtaining/reviewing separately obtained history from someone other than patient
- Performing a medically appropriate history and examination
- Counseling/educating the patient/family/caregiver
- Ordering prescription medications, tests, or procedures
- Referring and communicating with another healthcare provider(s) when not separately reported during the visit
- Documenting clinical information in the patient's electronic health record
- Independently interpreting results
- Communicating results to the patient/family/caregiver
- Coordination of care for the patient

Q. For total time, does the provider have to document what was discussed, performed, etc.?

A. Yes, the provider must incorporate activities performed into the documentation to establish medical necessity but to also provide high quality of care.

Q. Please provide information on using 99417 for prolonged services. The guidelines vary between CMS and CPT.

A. The final rule states to use 99417 for payers who use CPT (commercial payers) and G2212 for Medicare patients.

Q. Can a provider count time for things you do that are billed separate, such as an EKG?

A. Time can be counted if an EKG is ordered or reviewed but not if the provider bills for an EKG.

...time can be counted if an EKG is ordered or reviewed by the provider and for an EKG, which includes performing the EKG and interpretation.

Q. Are there any resources available of Visit Note examples of the different scenarios for coding based on MDM?

A. Examples as if performed on date of encounter by performing provider:

- Independent interpretation of a chest X-ray by the surgeon
- PCP discussing EKG results cardiologist as discussion of test interpretation with external physician
- Orthopedic surgeon coordinating physical therapy as patient management
- Review of CBC results prior to visit

Q. How do you suggest notating care coordinator efforts? Can we include their time?

A. Yes, coordinating care is an element of patient care management as it involves healthcare providers of different skills participating in meeting the needs of the patient. The provider can use it as an element of time given that the information is documented appropriately.

Q. Any updates on 99072? CMS is covering as a bundled code.

A. CMS revealed on Oct. 27, 2020, that 99072 is considered bundled and will not pay. Some commercial payers are paying, such as some of the Blues, Advocate-Aurora Health Plan and UHC Texas. As reported by *ICD-10 Monitor*:

- Blue Cross North Carolina commercial member (fully insured, state health plan, inter-plan program host members) providers can include code 99072 on the claim; however, payment will be considered “incident to” the course of diagnosis or treatment of a condition (i.e., furnished as an integral, although incidental, part of the physician’s personal professional services). As such, it will not be paid separately.
- BCBS of Illinois is approving and allowing \$50 for 99072 but has no contract RVU. They are requiring it to be billed with the physician office visit as a separate line item. Further, they have made coverage retroactive to Sept. 1, 2020.
- Advocate-Aurora Health Plan announced that for its commercial HMO plans, it will allow \$10 beginning Jan. 1, 2021.
- UHC Texas has stated on its website that it will “consider” all reasonable PPE charges up to \$15 with the 99072 code.

Learn more

- This resource is part of the **MGMA 2021 E/M Coding, Billing and Auditing Toolkit**.



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