2021 Evaluation and Management (E/M) CPT Coding Changes

On September 1, 2020 the AMA announced the release of the 2021 CPT Code Set which includes the first major overhaul in more than 25 years for evaluation and management (E/M) codes. These foundational modifications were designed to make E/M office visit coding and documentation simpler and more flexible, freeing medical prescribers and care teams from clinically irrelevant administrative burdens that led to time-wasting note bloat and box checking. The changes to CPT codes ranging from 99201-99215 are proposed for adoption by the Centers for Medicare and Medicaid Services on January 1, 2021.

The 2021 E/M office visit modifications include:

- **Eliminating history and physical exam as elements for code selection, however these are still required as medically necessary.**
- **Allowing physicians to choose code level selection based on medical decision-making (MDM) or total time*.**
- **Adding a new code for prolonged services when using time for code selection.**
- **Promoting payer consistency with more detail added to CPT code descriptors and guideline in the 2021 CPT Coding Manual.**

The AMA has developed an extensive online resource library that includes a checklist, videos, modules, guidebooks, slides on the changes, Level of MDM table, as well as other tools and resources to help transition to the revised E/M office visit codes and guidelines. The 2021 CPT Coding Manual is available for purchase.

Additionally, The National Council for Behavioral Health hosted a training MTM Services: Are You Ready to Utilize New Evaluation & Management Codes Effective January 1? that is available for review.

Steps for Organizations to Consider for a Successful Transition

- Determine necessary changes for staff, processes, IT systems
- Update appropriate policies, procedures, forms/EHR templates, and compliance documents
- Train staff on new code descriptions, revised MDM, time, and documentation best practices
- Consider a budget for additional training, coding tools, or consultation, if necessary
- Conduct a readiness review to identify any necessary operational changes
- Identify areas of improvement and timeline for changes
- Go live January 2021 with a plan to monitor and measure compliance for new guidelines

E/M CPT coding changes include:

Deletion of 99201

- Creating, deleting, or revising CPT codes is driven by the utilization of (or lack thereof) each code. The AMA elected to delete 99201, effective Jan. 1, 2021, making the lowest office-based E/M service 99202.
- Starting in 2021, AMA E/M guidance is based on time or MDM, so it makes sense to delete 99201, as it encompasses straightforward MDM, with the only current variation arising in history and exam. When eliminating history and exam in the scoring process, this variation is eliminated, thereby supporting the idea of deleting 99201.

Coding based on Medical Decision Making (MDM)

- MDM will continue to include the four types: straightforward, low, moderate, high, but definitions have been updated and in 2021 will be based on:
  - Number and complexity of problems addressed
  - Amount and/or complexity of data reviewed and analyzed
    - tests, documents, orders or independent historians
    - independent test interpretation
    - discussion of management or test interpretation with external providers or appropriate sources (non-healthcare, non-family)
  - Risk of complications and/or morbidity or mortality
- The AMA Level of MDM Table will be beneficial for providers when selecting codes
- No change was made to the criteria to qualify for a level of MDM. Two of the three elements for that level must be met or exceeded.

Coding Based on Time

- With the exception of 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes 99202-99215.
- Time may be used to select a code level for office or other outpatient services whether or not counseling and/or coordination of care dominates the service.
- For providers who wish to bill by time, the length of time corresponding to each level of visit is specified. Note that the current time rules for coding apply when counseling and/or coordination of care dominates (more than 50 percent) the encounter and includes only face-to-face time in the office. Starting in 2021, providers who wish to code by time spent may include all related activities, including non-face-to-face activities* on the day of encounter.

Prolonged Services

- 99417 is a new code for 2021 and is a 15-minute prolonged service code to be reported only when the visit is based on time *and* after the total time of the highest-level service (e.g., 99205, 99215) has been exceeded. See the next page for additional details.
- 99354 & 99355 will no longer be used for E/M codes, but will continue to be used for psychotherapy (90837).

***Using time for Office/Outpatient Visits** - In 2021, there will be two sets of time rules that govern E/M services, one set for office/outpatient codes 99202—99215, and one set for hospital, observation, ED, nursing facility, home, and domiciliary care services. When selecting an office visit code, the clinician may use either the new medical decision-making definitions, or total time spent on that date of service. You may include time spent by the billing practitioner doing the following activities:

- preparing to see the patient (e.g., review of tests, not separately reported)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported) outside of your practice
- 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)

Counseling and/or coordination of care will no longer need to dominate the service for these codes. Use the billing practitioner's time only, not other clinical or non-clinical staff time. The nature of the work must require practitioner knowledge and expertise. Waiting on hold for pre-cert authorization would not qualify; a peer-to-peer discussion with a physician at an insurance company would qualify.

2021 E/M Time Use Table		
E/M CPT Code	MDM Level	Minutes if Using Time
99202	Straightforward	15-29
99203	Low	30-44
99204	Moderate	45-59
99205	High	60-74
99212	Straightforward	10-19
99213	Low	20-29
99214	Moderate	30-39
99215	High	40-54

CPT code 99417 may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. 99417 should not be reported for a service of less than 15 minutes.			
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 minutes or more	99205 and 99417 (3x or more for each additional 15 min)	85 minutes or more	99215 and 99417 (3x or more for each additional 15 minutes)

FAQ

Q: A provider can select time-based code for one service and then complexity for the next, correct? Also, does every provider in the practice need to choose the same method?

A: Correct. The use of MDM or time is made on an encounter by encounter basis. All the providers in a practice do not have to use the same method. Organizations will need to consider their preference for the use of MDM or time and may consider policy guidance to support the system, but it is allowable to use either method for determining the code for any organization or any provider.

Q: Does talking with a case manager in my organization count toward MDM?

A: No, 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. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency

Q: Is the fee structure changing in 2021 for E/M codes?

A: There are no fee structure changes effective 1/1/2021. CMS initially signaled changes would be made to the E/M fee structure and would include blended rates for levels 2-4. However, the new fee structure was removed from changes to E/M office codes. Medicare and other payers will continue to have distinct payment rates for each office/outpatient E/M code in 2021 with higher levels receiving higher payment values compared to lower levels if fee-for-service is used.

Q: For the change in E&M documentation - are they taking away the requirement for the History and Physical Exam sections to determine the correct level of service?

A: Yes, history and physical exam are no longer required to determine the E/M code. However, they are still required as medically necessary.

Q: If a provider reviews the patient's record the day before and documents the services the day after an appointment, can this time be counted?

A: No, time can only be counted on the same day of the face-to-face encounter with the patient.

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

A: Document actual time and the activities performed.

Q: Will all payers use these guidelines?

A: Yes, the new code descriptions are in the 2021 CPT coding manual. The AMA reports that commercial payers are on board with the change and CMS is set to adopt these changes effective 1/1/2021 for Medicare. Ohio Medicaid is awaiting final regulations from CMS in order to make necessary changes and will communicate changes and update the BH Provider Manual when the information is available.