E/M Office Visit Revisions for 2021: An Overview

For Current Procedural Terminology (CPT®) 2021, the office or other outpatient visit evaluation and management (E/M) guidelines and code descriptors will be significantly revised. Due to the widespread use of these codes and the scope of the changes, information is being distributed early to facilitate familiarization in advance of the effective date. This first of a series of articles provides clarification and guidance about the code revisions and guideline changes.

Background

E/M CPT codes are among the most complex CPT codes to accurately report because of the demanding documentation and reporting requirements. In the CY 2019 Medicare Payment Schedule proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposed a major set of initiatives to revise the documentation requirements and payment levels for office or other outpatient E/M visit codes. The proposed revisions were part of a broader "Patients over Paperwork" initiative, which included administrative simplification as a key goal.

In response to the CMS proposal, the AMA convened a CPT and Specialty Society Relative Value Scale (RVS) Update Committee (RUC) E/M Workgroup (Workgroup) to provide a comprehensive set of recommendations based upon input from major national medical specialties providing E/M services. The Workgroup's primary goals were to simplify documentation for providers while retaining principles of resource-based care. Four guiding principles were established:

- Decrease administrative burden of documentation and coding
- Decrease the need for audits via the addition and expansion of key definitions and guidelines
- Decrease unnecessary documentation in the medical record that is not needed for patient care; and
- Ensure that payment for E/M services is resource-based and has no direct goal of payment redistribution among specialties.

The CPT Editorial Panel ultimately approved the recommendations of the CPT/RUC E/M Workgroup for publication in the CPT 2021 code set; this represents the first time these codes have been revised in over 25 years. On November 1, 2019, CMS finalized their decision to accept and implement the revisions to the CPT office or other outpatient E/M visit codes, as approved by the CPT Editorial Panel. These changes will go into effect on January 1, 2021.

Revision Overview

Revisions to the 2021 office or other outpatient E/M visit codes include:

- Deletion of code 99201
- Revisions of the code descriptors for 99202–99205, and 99211–99215;
- Addition of a shorter prolonged services add-on code;
- Elimination of history and/or physical examination as a component for code selection;
- Allowing the use of medical decision making (MDM) or time for code level selection;
- Changes in the definitions of MDM and time when used to report these codes; and
- Extensive E/M guideline additions, revisions, and restructuring.

Revised 2021 E/M Office or Other Outpatient Code Descriptors

A list of the revised descriptors for codes 99202-99205 and 99211-99215 is provided below. It is important to note that further CPT Editorial Panel or Executive Committee actions may affect these codes and/or descriptors. For this reason, code numbers and/or descriptor language in the CPT code set may differ at the time of publication. In addition, further CPT Editorial Panel actions may result in gaps in code number sequencing. Users should consult the CPT 2021 code set, when available, for final code descriptors.

New Patient

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

★▲**99202** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15–29 minutes of total time is spent on the date of the encounter.

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

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

★▲**99204** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using time for code selection, 45–59 minutes of total time is spent on the date of the encounter.

★▲**99205** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
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, use prolonged services 99XXX)◄

Established Patient

▲**99211** **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

★▲**99212** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using time for code selection, 10–19 minutes of total time is spent on the date of the encounter.

★▲**99213** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
When using time for code selection, 20–29 minutes of total time is spent on the date of the encounter.

★▲**99214** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using time for code selection, 30–39 minutes of total time is spent on the date of the encounter.

★▲**99215** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using time for code selection, 40–54 minutes of total time is spent on the date of the encounter.

►(For services 55 minutes or longer, use prolonged services 99XXX)◄

Creation of Shorter Prolonged Services Add-on Code

A shorter prolonged services add-on code to report additional physician and/or QHP time in 15-minute increments has been approved for CPT 2021. This five-digit CPT code 99XXX (which has not yet received a final CPT code assignment) will only be reported with the codes with the longest time ranges (99205 or 99215) and used only when time is the basis for code selection.

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)◄

Code-selection Components Streamlined

One of the most significant changes for office or other outpatient E/M visit codes are the components used to select the appropriate code for the level of service provided. Prior to 2021, the descriptors for the levels of service of office or other outpatient E/M visit codes recognize seven components, six of which could be used in defining the service level:

- History
- Examination
- MDM
- Counseling
- Coordination of care (CC)
- Nature of presenting problem (NPP)
- Time

The first three of these components (history, examination, and MDM) are considered key components in selecting a level of E/M service; time is the controlling factor only when counseling and/or coordination of care dominates (ie, accounts for > 50% of) the encounter with the patient and/or family. In addition, only face-to-face time on the date of the encounter is to be used in determining the service level for office, outpatient, or ambulatory time-based coding.

Effective January 1, 2021, selection of the appropriate service level for office or other outpatient E/M visit codes will be based on:

- The level of the MDM as defined for each service; or
- The total physician or other qualified health care professional (QHP) time for the E/M services on the date of the encounter.

History and examination should still be performed and/or documented as medically appropriate but it will no longer be used for code selection. CPT code 99201 will be deleted from the CPT 2021 code set because both codes 99201 and 99202 incorporate a straightforward level MDM and are differentiated presently only by history and examination elements.

Revisions to Definition of Time

Effective January 1, 2021, time will be calculated based on the *total* physician or QHP time spent on the date of the encounter. Total time includes both face-to-face and non-face-to-face services. Clear, nonoverlapping time ranges will be included in each code descriptor.

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 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)
- 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)

Revisions to MDM Elements and Definitions

The MDM elements will undergo significant revision, and extensive clarification will be provided in the guidelines to define each element. Clarifications and/or new concepts include:

- Removal of ambiguous terms (eg, “mild”) and definitions for previously ambiguous concepts (eg, “acute or chronic illness with systemic symptoms”).
- Defined important new terms (eg, “Independent historian”).
- Redefinition of the data element to expand beyond simply summing the number of tasks performed, to also distinctly acknowledge independent interpretation of tests, as well as discussions of management or test interpretations with an external physician or other QHP or appropriate source.

The changes described above pertain only to office or other outpatient E/M visit codes, and not to other E/M service codes. Table 1 outlines the key differences in code-selection components between the two groups of E/M codes; users should ensure the appropriate set of criteria and guidelines for reporting the services provided are used.

Table 1. Overview of Major E/M Revisions for CPT 2021: Components for Code Selection for Office or Other Outpatient Services Compared with Other E/M Codes

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

Future Articles

Future articles in the E/M 2021 series will provide detailed information and guidance regarding the following topics:

- In-depth analysis of the changes in the definition of time, including a detailed discussion of elements included in calculating time, clarification of time ranges, and use of time with other E/M services.
- In-depth analysis of the changes in MDM, including new guidelines and definitions to clarify each type of problem addressed.
- Instructions for the new prolonged services code that will be used with codes 99205 and 99215, including code purpose, structure, and proper reporting.◆