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Be Ready for 2021 Office/Outpatient E/M Coding

AMA's current CPT® code set includes guidelines on using patient history, clinical examination, and medical decision-making (MDM) to determine the correct level of E/M codes.

For example, note the references to history, examination, and MDM, as well as the typical time spent, in these 2020 CPT® code descriptors for level 3 E/M codes 99203 and 99213 (bold added for emphasis):

99203 *Office or other outpatient visit for the evaluation and management of a new patient, which* ***requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity****. Counseling and/or coordination of care 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 family's needs. Usually, the presenting problem(s) are of moderate severity.* ***Typically, 30 minutes are spent*** *face-to-face with the patient and/or family.*

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: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity****. Counseling and coordination of care 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 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.*

The 2019 MPFS final rule included substantial changes for E/M office outpatient codes 99201-99215 with a stated goal of reducing administrative burden, improving payment accuracy, and updating the code set to reflect current medical practice.

The 2019 MPFS final rule also indicated Medicare would allow practitioners to document office and outpatient levels 2 to 5 using only MDM or time starting in 2021. Providers would be allowed to continue to use the 1995 and 1997 Documentation Guidelines as the basis for their coding, if they preferred. However, as you will see, AMA's 2021 E/M code revisions eliminate the need for use of the 1995 and 1997 Documentation Guidelines for office/outpatient E/M codes.

ctaxin@links2success.biz

AMA's 2021 Office/Outpatient E/M Codes: New Patient

As an alternative to Medicare's plans, the AMA developed new guidelines and code descriptors for office and outpatient E/M codes. The effective date is Jan. 1, 2021, but because this update will have such a large impact on healthcare providers, the AMA has already posted the revised 2021 office and outpatient E/M guidelines and code descriptors for review. Let's look at the changes coming, starting with the new patient codes and descriptors.

99201: The 2021 CPT® code set will not include new patient level 1 code 99201. As you'll see below, the revised code descriptors for the remaining office and outpatient E/M codes use MDM or time to dictate code selection. Code 99201 requires straightforward MDM, the same as 99202, and having two codes requiring the same level of MDM would be redundant.

99202-99205: In 2021, new patient codes 99202-99205 will no longer require the 3 key components or reference typical face-to-face time. Instead, each service includes "a medically appropriate history and/or examination," and code selection will be based on the MDM level or total time spent on that date.

Compare the 2020 descriptor for 99203 posted earlier in this article to the 2021 code descriptor below:

> **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.*

The descriptors for 2021 codes 99202-99205 all follow the same structure as the 99203 example above. Table 1 shows the requirements for the new patient E/M codes in 2021.

Table 1: 2021 Requirements for E/M Codes 99202-99205

AMA's 2021 Office/Outpatient E/M Codes: Established Patient

The office and other outpatient E/M codes for established patients will change in line with the revisions to the new patient codes in 2021.

99211: Level 1 established patient E/M code 99211 will still be available, but its code descriptor will not include a time reference in 2021:

> **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.~~*

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99212-99215: Established patient E/M codes 99212-99215 will look a lot like the new patient codes in 2021. For instance, review the revised descriptor for 99213:

> **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.*

Table 2 shows the requirements for the 2021 established patient codes. Note the time required difference between the new patient and established patient codes.

2021 CPT® E/M Guidelines Overview

- Guidelines Common to All E/M Services
- Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care and Home E/M Services
- Guidelines for Office or Other Outpatient E/M Services

2021 CPT® E/M Guidelines for Time and Separate Services

When reviewing the 2021 Guidelines Common to All E/M Services, pay particular attention to the entries for Time and Services Reported Separately.

Time: The Time section of the 2021 E/M guidelines will include important information about proper use of the revised office and other outpatient codes. Here are the major points from the 2021 guidelines for Time:

- You will be able to use time alone to select the correct code from 99202-99205 and 99212-99215. Note that 99211 is not in that list because no time is listed in that descriptor.
- Counseling and/or coordination of care will not need to dominate an office or other outpatient E/M service for you to code the service based on time in 2021. But for other E/M services that you code based on time, you will still need to meet the threshold of counseling and/or coordination of care taking up more than 50% of the visit.
- You will use 99211 if clinical staff members perform the face-to-face visit under the supervision of the physician or other qualified healthcare professional.

- A shared or split visit is when a physician and one or more other qualified healthcare professionals perform the face-to-face and non-face-to-face work for the E/M visit. When you're coding these visits based on time, sum the time spent by the physician and other qualified healthcare professionals to get a total time. Any time that the providers spend together to meet with or discuss the patient should be counted only once (like you're counting the time of one individual).
- A key shift for the office and other outpatient E/M codes is that the time referenced in the 2021 code descriptors is total time. The 2020 descriptors for these codes use intraservice time.
  - The 2021 Time guidelines explain that for 99202-99205 and 99212-99215, total time on the encounter date includes both face-to-face and non-face-to-face time spent by the provider.
  - The guidelines offer the examples of preparing for the visit (such as reviewing tests); getting or reviewing a history that was separately obtained; performing the exam; counseling and providing education to the patient, family, or caregiver; ordering medicines, tests, or procedures; communicating with other healthcare professionals; documenting information in the medical record; interpreting results and sharing that information with the patient, family, or caregiver; and care coordination.
  - When you start counting time for the 2021 codes, you should not include time spent on services you report separately. For instance, if you report care coordination using a separate CPT® code, you should not include that in the time for the E/M code.
  - The total time also will not include time for activities the clinical staff normally performs.

Services Reported Separately: The 2020 CPT® E/M guidelines include information about services reported separately, but the 2021 guidelines will give this information its own heading and add some clarifications. In particular, watch for this line: "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."

2021 CPT® E/M Guidelines for Office/Outpatient History and Exam

The Guidelines for Office or Other Outpatient E/M Services will help you understand the revised E/M codes and how to apply them in 2021.

The History and/or Examination portion of these E/M guidelines explains that office and other outpatient E/M services include "a medically appropriate history and/or physical examination, when performed."

"Medically appropriate" means that the physician or other qualified healthcare professional reporting the E/M determines the nature and extent of any history or exam for a particular service. Remember that code selection does not depend on the level of history or exam. That's why the guidelines don't quantify these elements.

The history and exam guidelines for office and outpatient E/M visits also specify that the "care team" may collect information, and the patient (or caregiver) may provide information, such as by portal or questionnaire. The reporting provider must then review that information.

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2021 CPT® E/M Guidelines for MDM

Because you will use either total encounter time or MDM to select the level of office or other outpatient E/M in 2021, CPT® will clarify and expand the MDM guidelines, including the addition of a new Level of Medical Decision Making (MDM) table.

The MDM guidelines and table are under Instructions for Selecting a Level of Office or Other Outpatient E/M Service, but you'll use them together with information and definitions in Number and Complexity of Problems Addressed at the Encounter.

In the 2021 MDM guidelines, CPT® states that MDM "includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option." Three elements will define MDM for office/outpatient visits in 2021, and they are similar but not identical to the 2020 elements:

- 1. The number and complexity of the problem or problems the provider addresses during the E/M encounter.
  - In 2020, the guidelines instead refer to "the number of possible diagnoses and/or the number of management options."
- 2. "The amount and/or complexity of data to be reviewed and analyzed." The 2021 guidelines list 3 categories for data: (1) tests, documents, orders, or independent historians, (2) independent test interpretation, and (3) discussion of management or test interpretation with external providers or appropriate sources. The latter term refers to non-healthcare, non-family sources involved in patient management, like a parole officer or case manager.
  - The 2020 MDM guidelines also include the amount and/or complexity of medical records, test, and other information involved, but the 2021 guidelines expand the section significantly.
- 3. "The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit." The 2021 guidelines make it clear that options considered, but not selected, are still a factor for this element, specifically after "shared" MDM with the patient, family, or both. Examples include deciding against hospitalization for a psychiatric patient with sufficient support for outpatient care or choosing palliative care for a patient with advanced dementia and an acute condition.
  - The 2020 MDM guidelines include comparable wording, but do not include the reference to shared MDM or the examples found in the 2021 guidelines.

2021 Level of Medical Decision Making (MDM) Table

The AMA CPT® Editorial Panel used the Table of Risk that's in the CMS 1995 and 1997 Documentation Guidelines, as well as current CMS contractor audit tools, as a basis for the MDM updates.

The 2021 MDM table will have three main columns with the final column divided into 3 additional columns:

- 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
  - Risk of Complications and/or Morbidity or Mortality of Patient Management

In Tables 1 and 2 above, you saw that the MDM required for each distinct code level is the same, regardless of whether the code is for a new or established patient.

For instance, level 2 codes 99202 and 99212 both require straightforward MDM. Each row of the MDM table shows the requirements for a specific code level, with 99211 on the first row, 99202 and 99212 on the second row, and so on. The second column shows the MDM level for the codes in column 1. The final three columns represent the three elements of MDM.

Table 3 shows the row for codes 99203 and 99213 along with column headings from the new MDM table to give you an idea of the structure. Pay attention to the note in the Level of MDM column reminding you that your final choice for the MDM level should be based on meeting requirements for two out of the three elements. (In 2020, you need to meet two out of three elements in the much smaller table CPT® provides for that code set.)

To use the 2021 MDM table properly, you'll also need to be familiar with the use of categories in the column for Amount and/or Complexity of Data to be Reviewed and Analyzed.

As Table 3 shows, for 99203 and 99213 you will have to meet the requirements for at least one of two categories. For codes 99204 and 99214, you'll have to meet the requirements for one of three categories. For the highest-level codes 99205 and 99215, you'll have to meet the requirements for two of three categories. The lower level codes don't have categories in that column.

Table 3: Sample Column from 2021 E/M Table for MDM Level

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
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:** o Review of prior external note(s) from each unique source*; o review of the result(s) of each unique test*; o 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*	**Low risk of morbidity from additional diagnostic testing or treatment**

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making
		management or test interpretation, see moderate or high)

Number and Complexity of Problems Addressed at the Encounter

The 2021 CPT® guidelines will include a heading for Number and Complexity of Problems Addressed at the Encounter. This part of the guidelines includes a brief discussion about how the problems addressed may affect code level selection. Under this header, you'll also find many definitions that are important to MDM.

One important point the 2021 guidelines make is that the final diagnosis isn't the only factor when you determine the complexity or risk. A patient may have several lower severity problems that combine to cause higher risk, or the provider may have to perform an extensive evaluation to determine a problem is of lower severity.

The 2021 guidelines also take a 2020 rule and expand it, clarifying that you should not consider comorbidities and underlying diseases when you select the E/M level "unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management."

2021 MDM Terms and Definitions

For you to use the 2021 level of MDM table properly, you will need to know CPT®'s definitions for many terms. In fact, you'll need to know almost three pages of definitions. Below is an overview of those terms, but you should still review the guidelines to prepare for the 2021 E/M transition.

To qualify as a **problem addressed** (or managed), the provider must evaluate or treat the problem. Consideration of further testing that is decided against because of risks involved or patient choice counts as addressed. But a simple note that another professional is managing a

problem does not count as addressed. There must be additional assessment or care coordination. Another area that does not qualify as addressing the problem is referral without evaluation (using history, exam, or diagnostic studies) or considering treatment.

A **self-limited or minor problem** is defined almost identically by the 2020 and 2021 E/M guidelines, but the 2021 guidelines will delete the crossed out text: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status ~~OR has a good prognosis with management/compliance~~. This term is relevant for straightforward MDM codes 99202 and 99212.

Risk is related to probability of something happening, but risk and probability are not the same for E/M coding purposes. High probability of a minor adverse effect may be low risk, depending on the case. The terms high, medium, low, and minimal risk are meant to reflect the common meanings used by clinicians. For MDM, base risk on the consequences of the addressed problems when they're appropriately treated. Risk also comes into play for MDM when deciding whether to begin further testing, treatment, or hospitalization.

An **external physician or other qualified healthcare professional** is someone who is not in the same group practice or is classified as a different specialty or subspecialty. Review of external notes is included in the office/outpatient E/M codes for levels 3 to 5. Discussion with an external provider is included in levels 4 and 5.

An **independent historian** is a family member, witness, or other individual who provides patient history when the patient can't provide a complete history or the provider thinks a confirmatory history is needed. Assessment requiring an independent historian is included in office/outpatient E/M levels 3 to 5.

Social determinants of health (SDOH) are economic and social conditions that influence health. SDOH is something you may be familiar with from ICD-10-CM coding, specifically categories Z55.- to Z65.-, Persons with potential health hazards related to socioeconomic and psychosocial circumstances. But the 2021 MDM table references SDOH as an example of moderate risk from additional diagnostic testing or treatment because SDOH, like housing insecurity, may limit those options.

Drug therapy requiring intensive monitoring for toxicity is in the 2021 CPT® MDM table as an example of high risk of morbidity from additional diagnostic testing or treatment. To be sure the case you're coding qualifies as intensive monitoring for toxicity, review these conditions listed in the guidelines:

- The drug can cause serious morbidity or death.
- Monitoring assesses adverse effects, not therapeutic efficacy.
- The type of monitoring used should be the generally accepted kind for that agent, although patient-specific monitoring may be appropriate, too.
- Long-term or short-term monitoring is OK.
- Long-term monitoring occurs at least quarterly.

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- Lab, imaging, and physiologic tests are possible monitoring methods. History and exam are not.
- Monitoring affects MDM level when the provider considers the monitoring as part of patient management.
- An example of drug therapy requiring intensive monitoring for toxicity is testing for cytopenia (reduction in the number of mature blood cells) between antineoplastic agent dose cycles.

Morbidity is 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." Morbidity is an important term to understand for the acute and chronic illness definitions below.

Acute and chronic illnesses are referenced in a variety of ways in the "Number and Complexity of Problems Addressed" column of the CPT® 2021 level of MDM table. Table 4 will help you compare these terms for acute and chronic illnesses.

Table 4: 2021 CPT® E/M Guideline Definitions for Acute and Chronic Illnesses

Term	Description	Examples
Acute, uncomplicated illness or injury	· The problem is recent and short-term. · There is a low risk of morbidity. · There is little to no risk of mortality with treatment. · Full recovery without functional impairment is expected. · The problem may be self-limited or minor, but it is not resolving in line with a definite and prescribed course.	· Cystitis · Allergic rhinitis · Simple sprain
Acute illness with systemic symptoms	· The illness causes systemic symptoms, which may be general or single system. · There is a high risk of morbidity without treatment.	· Pyelonephritis · Pneumonitis · Colitis

Term	Description	Examples
	· For a minor illness with systemic symptoms like fever or fatigue, consider acute, uncomplicated or self-limited/minor instead.	
Acute, complicated injury	· Treatment requires evaluation of body systems that aren't part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment.	· Head injury with brief loss of consciousness
Stable, chronic illness	· This type of problem is expected to last at least a year or until the patient's death. · A change in stage or severity does not change whether a condition is chronic. · The patient's treatment goals determine whether the illness is stable. A patient who hasn't achieved their treatment goal is not stable, even if the condition hasn't changed and there's no short-term threat to life or function. · The risk of morbidity is significant without treatment.	· Well-controlled hypertension · Non-insulin dependent diabetes · Cataract · Benign prostatic hyperplasia · NOT stable: Asymptomatic but persistently poorly controlled blood pressure (pressures don't change), with a treatment goal of better control
Chronic illness with exacerbation, progression, or side effects of treatment	· The chronic illness is getting worse, is not well controlled, or is progressing "with an intent to control progression." · The condition requires additional care or treatment of the side effects. · Hospital level of care is not required.	· No examples given by CPT® guidelines

Term	Description	Examples
Chronic illness with severe exacerbation, progression, or side effects of treatment	· There is a significant risk of morbidity. · The patient may require hospital care.	· No examples given by CPT® guidelines
Acute or chronic illness or injury that poses a threat to life or bodily function	· There is a near-term threat to life or bodily function without treatment. · An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment may be involved.	· Acute myocardial infarction · Pulmonary embolus · Severe respiratory distress · Progressive severe rheumatoid arthritis · Psychiatric illness with potential threat to self or others · Peritonitis · Acute renal failure · Abrupt change in neurologic status

2021 Changes to E/M Coding for Prolonged Services

With the role of time changing for office and other outpatient E/M codes in 2021, the AMA plans to revise the Prolonged Services code section.

Codes +99354 and +99355 for prolonged E/M services requiring direct patient contact will change from applying to the office or other outpatient setting to applying to the outpatient setting. But the descriptors will state that you should not use +99354 and +99355 as add-on codes with office/outpatient codes 99202-99215. The guidelines for these prolonged services codes (and other prolonged services codes) will also see revisions to factor in a new 2021 CPT® code, temporarily known as +99XXX.

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The code descriptor is a good place to start to get to know the new code:

> **+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)*

Pay special attention to these points in the descriptor:

- Code +99XXX will apply only if you chose the primary E/M code based on time.
- The new code will include total time with and without direct patient contact on the date of service. Remember that 99202-99215 also will use total time rather than intraservice time starting in 2021.
- You will use +99XXX once for each 15 minutes beyond the primary service time.
- The appropriate primary codes will be only 99205, which represents the longest time among the new patient codes, and 99215, which represents the longest time among the established patient codes.

New guidelines that will accompany +99XXX provide the rule that you should not report the code for any time period less than 15 minutes. For instance, remember that 99205 will represent 60-74 minutes in 2021. To report 75-89 minutes, you'll report 99205 and +99XXX. Once the total time reaches 90-104 minutes, you'll report 99205 and two units of +99XXX.

MPFS 2020 Accepts CPT® MDM Guidelines for 2021

The MPFS 2020 final rule addresses the substantial changes that the AMA plans for E/M office/outpatient codes in 2021, stating that Medicare will adopt the MDM guidelines revised by CPT® and will allow the use of time or MDM for office/outpatient E/M code selection. The final rule also states that Medicare will monitor claims to watch for shifts in visit levels billed, including whether certain specialties are affected more than others.

Medicare Will Cover E/M Add-On Codes for Prolonged and Complex Services

When you start using the revised E/M codes for office/outpatient visits in 2021, watch for opportunities to report add-on codes that represent long and complicated services.

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Prolonged services: The MPFS 2020 final rule confirms that Medicare will allow use of +99XXX in 2021 for prolonged services. The primary service (99205 or 99215) and the +99XXX work will have to occur on the same date.

Because of the creation of +99XXX, Medicare indicated in the 2020 MPFS final rule that it will not create the new "extended visit" G code described in the 2019 MPFS final rule.

Complex visits: The 2019 final rule also included a plan to create two new G codes to represent the visit complexity inherent to certain services, with one code for designated specialists and a second code for primary care providers. The 2020 MPFS final rule changed that, adopting a single new G code instead, temporarily known as GPC1X:

> **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).*

Potential Conflict Areas Between AMA and CMS E/M Rules

The MPFS 2020 final rule highlights areas where the AMA and CMS rules may differ for office and other outpatient E/M visits, including the two issues below.

Prolonged services: One area to watch relates to prolonged service codes +99XXX, 99358 *Prolonged evaluation and management service before and/or after direct patient care; first hour*, and +99359 *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service).*

The 2021 CPT® E/M guidelines, as originally posted, state that you should not use 99358 and +99359 for prolonged services on the same date as +99XXX, the code for prolonged 99205 and 99215 services. But the CPT® guidelines also state that you may use 99358 and +99359 on a date other than the date of a face-to-face encounter reported using 99202-99215.

The 2020 MPFS final rule includes a discussion of 99358 and +99359 that essentially says the CPT® rules for these codes are confusing and allowing only one add-on code for office/outpatient E/M prolonged services makes more sense. Consequently, Medicare decided "99358-99359 will not be payable in association with office/outpatient E/M visits beginning in CY 2021." It's possible the AMA will revise the 2021 codes and guidelines to address the issues Medicare raised.

Split/shared visits: In response to a comment received, Medicare briefly states it's going to review the CPT® guidelines to check for conflicts with Medicare rules on split/shared visits.

Work RVUs for 2021 Office/Outpatient E/M Codes

"E/M visits comprise approximately 40% of allowed charges for [MPFS] services, and office/outpatient E/M visits comprise approximately 20% of allowed charges for [MPFS] services," the MPFS 2020 final rule states. As a result, pricing of these codes is an important subject, both for providers and for Medicare.

Fees on the MPFS are calculated using work relative value units (RVUs), malpractice RVUs, and practice expense RVUs multiplied by a conversion factor and adjusted based on geographic location. Medicare plans to use the work RVUs for revised codes 99202-99215 and new code +99XXX recommended by AMA's Relative Value Scale (RVS) Update Committee, commonly known as the RUC.

Table 5 shows the 2021 RUC recommendations for 99202-99215 and prolonged services code +99XXX, as well as Medicare's work RVU choice for added-complexity code GPC1X. The table includes the 2020 work RVUs for 99202-99215 for comparison. Remember that the final fee will depend on more than just these work RVUs.

Table 5: 2021 Work RVUs for Office/Outpatient E/M Codes

Code	2020 Work RVU	2021 Work RVU
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
99211	0.18	0.18

Code	2020 Work RVU	2021 Work RVU
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80
+99XXX	N/A	0.61
GPC1X	N/A	0.33

Prepare for E/M 2021 Changes

The 2021 office/outpatient E/M changes planned by AMA and CMS will require careful training for all those involved in claim submission, including providers and office staff. Vendors of healthcare software and third-party payers will have to get ready, too. A seamless adjustment to the new E/M system will require steps like appointing a project leader, educating stakeholders, and confirming documentation requirements with employers, the AMA advises. For your preparations to be complete, you also will need to stay up to date on any changes that AMA and CMS may make before the Jan. 1, 2021 implementation.

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