Issue Brief: Medicare Policy Updates on Evaluation and Management Visits

Executive Summary

Over the past two years, the Centers for Medicare and Medicaid Services (CMS) has proposed and finalized several policies that will affect documentation, coding, and payment for certain evaluation and management (E/M) visits. Many of CMS' final policies adopt recommendations from the AMA CPT Editorial Panel and the Relative Value Scale Update Committee (RUC), which reflect broad agreement across the House of Medicine. CMS has also finalized policies that seek to minimize site-of-service differentials for office visits provided in office versus hospital outpatient settings.

Medicare Physician Fee Schedule Updates to Office and Outpatient E/M Visits – Effective January 2021

In the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) final rule, CMS finalized several policies that affect payment for office and outpatient E/M visits starting in 2021. CMS largely left these policies intact in its CY 2021 MPFS final rule, with some key exceptions noted below.

Documentation Requirements and Selection of E/M Visit Level

Effective for office and outpatient E/M service furnished starting January 1, 2021, CMS finalized the following changes that adopt revisions to documentation requirements recommended by the CPT Editorial Panel for office and outpatient E/M visits. CMS believes these changes will reduce documentation burden, including:

- Discontinuation of use of history and physical as determinants for selecting code level
- Level selection and documentation requirements can be determined based on either Medical Decision Making (MDM) or time.
    - MDM criteria have been modified to increase clarity and redefine data elements.
    - Minimum time requirements are identified in Table 1 below for the listed codes.

Additional details on the MDM and time revisions, including guidance for level selection, are included on the AMA website.

Available Codes

CMS largely adopted the CPT Editorial Panel's recommendations for coding office and outpatient E/M visits, including eliminating coding for Level 1 new patient visits.[1] Select office and outpatient codes for 2021 are included in Table 1 below, and a full discussion of the 2021 CPT recommended changes are included on the American Medical Association (AMA) website.

[1] While CMS also finalized the addition of a separate add-on G-code for CY 2021 to address complexity for certain types of E/M services that reflect ongoing, longitudinal care (G2211/formerly GPC1X), the Consolidated Appropriations Act of 2021 (PL 116-260) prohibited CMS from making payment for this code prior to January 1, 2024. Additional information on CMS' expectations for use of G2211 – as released prior to the enactment of the Consolidated Appropriations Act of 2021 – can be found in the preamble of the CY 2021 MPFS final rule.

At the same time, CMS finalized some deviations from the CPT Editorial Panel's recommended changes regarding prolonged services. In the CY 2020 MPFS final rule, CMS originally adopted CPT code 99417[2] for prolonged services for time spent by the billing practitioner on the date of service, when selecting level based on time and exceeding the time associated with a level 5 visit. However, in the CY 2021 MPFS final rule, CMS updated this policy and instead adopted a modified version of the CPT prolonged service code (G2212; see Table 1), rather than 99417; this new G-code requires the maximum amount of time for a level 5 office/outpatient E/M visit to be exceeded by at least 15 minutes before the code can be billed. Additionally, in the CY 2020 MPFS final rule, CMS prohibited the use of two existing prolonged services codes, 99358 and 99359, in conjunction with office and outpatient E/M visits starting in 2021, given the Agency's concerns about duplication with CPT's prolonged services code and lack of clarity regarding the use of the code.

Table 1: Select Office and Outpatient E/M Codes and Updated Descriptions and Work RVUs, Effective 1/1/2021

Code	Descriptor	Work RVU
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.	0.93
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.	1.6
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.	2.6
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, see Prolonged Services 99XXX[3])	3.5

[2] The code descriptor for 99417 (formerly 99XXX), which CMS did not finalize for 2021, is *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).*

[3] Here and throughout, references to 99XXX in code descriptors reflect original CPT coding, as finalized in 2019. See on the AMA website here. These references do not take into account the more recent assignment by the CPT Editorial Panel of code 99417 to this service, nor CMS' final policy to replace 99417 with G2212.

Code	Descriptor	Work RVU
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.	0.18
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.	0.7
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.	1.3
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.	1.92
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, see Prolonged Services 99XXX)	2.8
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has 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))	0.61

Valuation

CMS has largely adopted RUC-recommended values for the office and outpatient E/M visits. Values were based on a cross-specialty survey, reflecting increases of between 0 to 46 percent in work RVUs for the E/M codes. Finalized work RVUs, as they will apply starting in 2021, are included in Table 1.

The Consolidated Appropriations Act of 2021

With the publication of the CY 2021 MPFS Final Rule, CMS estimated that the above changes – plus payment for G2211 (see footnote 1) – would contribute to a net impact of -8.0 percent on total payments to anesthesiologists and a net impact of +7.0 percent for interventional pain management

specialists under the MFPS for 2021, relative to total payments in CY 2020. [4] These estimates included the effects of a 10.2 percent reduction in the MPFS conversion factor for CY 2021, which CMS applied to meet statutory budget neutrality requirements.

Given concerns about the impact of such a large reduction in the conversion factor, however, Congress included provisions in the Consolidated Appropriations Act of 2021 to mitigate the re-distributional effects of CMS' E/M policies. These include prohibiting payment for G2211 prior to January 1, 2024 (see footnote 1) and increasing payments by 3.75 percent for all services under the MPFS relative to what they would have been absent such a payment increase. These changes have resulted in a revised conversion factor of 34.8931 for CY 2021, which reflects a 3.3 percent reduction relative to 2020.

Additional Information on Office and Outpatient E/M Changes

As noted above, CMS finalized the office and outpatient E/M changes to take place starting January 2021. Notably, the changes above apply strictly to E/M visits furnished in the office and outpatient setting; thus, existing documentation and coding guidelines for other settings will continue to apply into 2021 and beyond.

Policies Addressing Site-of-Service Differentials for Clinic Visits Furnished in Office versus Hospital Outpatient Settings

In the CY 2019 Medicare Outpatient Prospective Payment System (OPPS) final rule, CMS finalized a policy whereby all clinic visits (i.e. HCPCS G0463) furnished in an off-campus hospital outpatient provider-based department (PBD) would generally be paid at an amount intended to eliminate the site-of-service differential for clinic visits provided in an office versus in an off-campus outpatient hospital department. This policy reduced payments for certain off-campus hospital PBDs that were previously excepted from "site-neutralized" payments based on statute. CMS finalized that the payment reduction would be phased-in over two years, with the first half of the reduction scheduled for 2019 and the second half scheduled for 2020.

This policy was challenged by a lawsuit, with an initial District Court ruling against the CMS policy [5] and an appellate decision overturning the lower court ruling. [6] Subsequent to the CMS court victory, the plaintiffs petitioned for a rehearing. The request for rehearing was denied on October 16, 2020. [7] As part of CY 2021 rulemaking, CMS stated that it will consider whether changes are required in the future as the appellants have 90 days in which to seek review from the U.S. Supreme Court.

In the CY 2020 OPPS final rule, citing its appeal rights, CMS finalized that it will move forward with the second year of the phase-in, noting that it will evaluate the rulings and consider appealing the judgment. As such, even those excepted off-campus PBDs whose reduced payments were vacated by the court ruling will receive "site-neutralized" payments for 2020. While continuing uncertainty remains given potential further legal action, in CY 2021 rulemaking, CMS stated its intent to continue the policy in the CY 2021 and beyond.

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[4] See Table 106 of the CY 2021 MPFS final rule.
[5] See *American Hospital Association, et al. v. Azar et al.,* No. 1:18-cv-2084 (D.D.C. Dec. 27, 2018).
[6] See *American Hospital Association, et al. v. Azar et al.,* No. 19-5352 (July 17, 2020).
[7] See *American Hospital Association, et al. v. Azar et al.,* No. 19-5048 (October 16, 2020).