2021 CPT® Evaluation and Management Office and Outpatient Services Code & Guideline Changes

Questions & Answers from the Live Session

Tuesday, November 24, 2020

1. We have an in-house CLIA certified lab and most labs are done in-house. If the provider orders labs to be done in 3 months, is this counted at that office visit? When the patient returns in 3 months for follow up, does the provider get credit then?

When ordering labs, a provider will get credit for ordering the tests on the day of the encounter. But he will not be able to take credit again when the labs are reviewed on the subsequent visit. They can't get credit for both. Often providers in practices, such as an internal medicine practice, will order lab tests in advance because the patient is returning in three months for their physical exam. Again, you cannot take credit for ordering the lab test and reviewing the same lab tests 3 months later. You can only take credit once. If one provider in the practice orders the tests and then the tests are reviewed by another provider on a subsequent encounter, both can take credit.

2. Did they do away with CPT code 99211?

No, 99211 is still a billable service. It is still considered a nurse visit. It does not require a physician to see the patient. 99211 just does not have any medical decision-making requirements. Your practice may have protocols in place for your nurse visits. This service is a 5-10 minute visit where the nurse documents the reason for the visit and the medical necessity for the patient's treatment. This CPT code is unchanged in 2021.

3. Is the new CPT code 99417 billed as time or MDM and not a mixture of both?

Slide 34 of the webinar presentation refers to prolonged service code 99417, which is an add-on code used to report prolonged combined total time (with or without direct patient contact) provided by a clinician on the date of the E/M service when time for codes 99205 / 99215 have been exceeded. 99417 is only used when the E/M service has been based on time and only after the total time of the highest-level service (99205 or 99215) has been exceeded. If time is the determining factor for the E/M level, the MDM criteria does not have to be met.

4. Our office has the AMA CPT Code 2021 Professional Book. It is our understanding that this webinar today is actually a review of E/M changes. Correct?

Yes, the purpose of this webinar is to review the 2021 revised E/M office and outpatient services CPT codes.

5. If you decide to use time factor for coding, does it have to be documented in the chart?

Yes, the total time MUST be documented in the encounter note. Remember that TIME BASED services include both face-to-face and non-face-to-face activities on the ***day of the encounter***. Documentation should read – ***Total Time of visit = XX minutes***

6. If we figure out how to track and document, it seems that going by time would be the best way to go, correct?

Practices must decide if it is feasible as well as beneficial to use TIME BASED coding. Tracking the time for the non-face-face activities may be challenging for some practices. I recommend contacting your EMR vendor to discuss the functionality of your system. As vendors are updating their systems to accommodate the revised E/M guidelines, they may also be adding additional time tracking elements.

7. Have the consultation codes of 99242, 99243, 99244 and 99245 been eliminated?

The AMA's 2021 E/M revisions do not include consultation codes. Coverage for consultation services are a payer specific issue. Medicare stopped covering consultations years ago. In the past year, United Health Care and Cigna have followed suit and will no longer reimburse CPT codes 99241-99255. Check with your individual commercial payers for their specific consult coverage.

8. Do I understand correctly that the provider can use both MDM or time to code an encounter? Or does the provider have to choose MDM or time and use it consistently?

Yes, the overall level of an E/M visit may be determined by **either** MDM or time. There is no restriction on which method is used. The rendering provider can decide which method is more beneficial for that particular encounter.

9. Do these CPT changes apply to Home Visits and Assisted Living/Group Home Visits?

No, these revisions ONLY apply to office/outpatient services **– 99202 – 99215**.

10. Can you clarify the inability to count reviewing test results if we order them, even if it is at the next visit?

Per AMA 2021 Revised E/M Guidelines - Amount and/or Complexity of Data Reviewed and Analyzed: *This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained*

from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. ***Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and NOT a subsequent encounter****.*

11. Are there replacement codes for 99354 and 99355? We use them for observation when we administer medication and patients need to be monitored in the office

- Prolonged service codes 99354, 99355, 99356 and 99357 are still billable services in 2021, but have been revised to restrict reporting with E/M services (99202-99215).
- CPT codes **99354 and 99355** are used when a physician or other qualified health care professional provides prolonged service(s) involving **direct patient contact** that is provided beyond the usual service in either the inpatient, observation or outpatient setting, **except with office or other outpatient services (99202 – 99215).**
- CPT codes **99356 and 99357** are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.
- CPT codes **99415 and 99416** are used when a prolonged evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged **clinical staff face-to-face time** beyond the typical face-to-face time of the E/M service, as stated in the code description. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided **at the same session as E/M services**.
- CPT codes **99415 and 99416** are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, **even if the time spent by the clinical staff on that date is not continuous**. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Please refer to the AMA's 2021 Revised ***Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision*** for specific time criteria.

12. Can we order, assess and review the results of an EKG on the same day? Does that count toward the credit for data for MDM? This was mentioned in the assessing and reviewing topic.

Using an EKG as an example – If you order an EKG that is done in-house and interpreted by the rendering physician, you can count the EKG as a unique test ordered under the Data Reviewed and Analyzed Category 1, BUT you cannot count it as an interpretation of a test, because you are billing for the EKG service separately.

Per AMA 2021 Revised E/M Guidelines: *The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. 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.*

13. Are all of these changes mandatory in one month?

Yes - these changes will go into effect January1, 2021. CMS announced in the 2019 Final Rule that changes to E/M services would be initiated in an attempt to alleviate the administrative burden the current guidelines presented to providers. Within 6 months of the CMS announcement, the AMA announced that it would be revising the office / OP E/M code set 99201 – 99215 effective January 1, 2021. So, these revisions have been in the works for the past year and a half.

14. Is it possible to get a copy of the charts shown in the presentation?

References that were used to create the presentation are available as handouts for download on Quality Insights' website: https://qppsupport.org/Events/Archived-Events.aspx. They are available under the heading "2021 CPT® Evaluation and Management Office and Outpatient Services Code & Guideline Changes, held on November 24, 2020."

15. I have heard these changes are not set in stone yet. Are they now?

Yes, all of these changes are confirmed and effective January 1, 2021.

16. As a dermatology practice, we do an E/M and when we find a suspicious spot, we do a biopsy during the visit. We also see other diagnoses as well. Do I count the D48.5 as an undiagnosed new problem that we had to do MDM for during the visit?

Per Medicare, if a procedure has a **global period of 000 or 010 days**, it is defined as a minor surgical procedure. Both punch biopsies (Ex: CPT Code 11104) and incisional biopsies (Ex: CPT Code 11106) have a 0 day global period. Excisions (ex: CPT codes 11400 – 11446) have a 10 day global period.

In general, E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. If the E/M visit supports a separate and identifiable encounter with additional problems addressed – *in this case*, *other than the neoplasm of uncertain behavior* – *because that diagnosis would be linked to the procedure*, the E/M visit would be supported. But documentation would clearly have to indicate the separate and identifiable problems addressed and support the medical necessity for the E/M.

Of course, if the procedure was done on a separate encounter, then both the E/M and the procedure can be billed. The procedure would be done on a subsequent encounter.

Quality Insights
Quality Payment Program Support Center

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support Center for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-120120a