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Major changes of E/M office visits entered into 2021

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The most significant changes to evaluation and management (E/M) coding in many years took effect January 1, 2021.[1] The new E/M coding rules will allow you to choose from new patient codes 99202–99205 and established patient codes 99212–99215 based on either medical decision-making (MDM) or time. (Established patient code 99211 will still be valid, but the descriptor will not reference MDM or time.)

Background

Physicians and other practitioners who are paid under the physician fee schedule (PFS) bill for common office visits for E/M services using a relatively generic set of current procedural terminology (CPT®)[2] codes (Level I Healthcare Common Procedure Coding System, or HCPCS) that distinguish visits based on the level of complexity, site of service, and whether the patient is new or established. These CPT codes are broadly referred to as E/M visit codes and historically have included three key components within their code descriptors: history of present illness (history), physical examination (exam), and MDM.

There are five levels of office/outpatient E/M visits. There are five codes representing each level for new patients (CPT codes 99201–99205), and five codes representing each level for established patients (CPT codes 99211–99215). CPT code 99211 (Level 1 established patient) is the only code in the office/outpatient E/M visit code set that describes a visit that may be performed by the billing practitioner or by a qualified healthcare professional (QHP) under supervision and that has no specified history, exam, or MDM.

E/M visits billed using these CPT codes comprise approximately 45% of allowed charges for PFS services; and office/outpatient E/M visits comprise approximately 25% of allowed charges for PFS services.[3] Within the E/M visits represented in these percentages, there is wide variation in the volume and level of E/M visits billed by different specialties. According to Medicare claims data,[4] E/M visits are furnished by nearly all the specialties and represent a greater share of total allowed charges for physicians and other practitioners who do not routinely furnish procedural interventions or diagnostic tests. Generally, these practitioners include primary care practitioners and certain other specialists such as neurologists, endocrinologists, and rheumatologists. Certain specialties, such as podiatry, tend to furnish lower-level E/M visits more often than higher-level E/M visits. Some specialties, such as dermatology, tend to bill more E/M visits on the same day as they bill minor procedures.

History and exam

Under this new CPT coding framework, history and exam will no longer be used to select the level of code for office/outpatient E/M visits. (History and exam are still required as deemed appropriate by the practitioner.)

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Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent reasonable and necessary, clinically appropriate.[5]

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