AMERICAN SOCIETY OF PLASTIC SURGEONS

ASPS FAQs

2021 Guidelines for Office and Other Outpatient Services

Q: I heard there are changes coming to E&M visits for 2021. What should I be aware of?

A: Changes have been made to office and other outpatient services. In addition to updating code descriptors for CPT codes 99202-99215, CPT 2021 also provides a new prolonged service code. The new patient code 99201 for low complexity, new patients will be deleted, leaving nine new and established E&M codes.

Starting in January 2021, accurate code selection for 99202-99215 will be based on either Time or Medical Decision Making (MDM).

Q: When was the last time the Office-Based E&M services were update?

A: The last time the Centers for Medicare and Medicaid Services (CMS) updated the documentation guidelines for any E&M service was in 1997 – so over 20 years ago!

Q: Why was the change initiated?

A: Some providers thought that the E&M documentation guidelines were burdensome and difficult to understand which was leading to physician burnout and a reduced emphasis on patient care.

Q: Are the 2021 changes for E&M visits for both inpatient and outpatient encounters?

A: The changes that will become effective as of January 1, 2021 apply to office and other outpatient services only (CPT codes 99202-99215) only. Changes for 2021 will not affect Inpatient or Emergency Department visits.

Q: Based on the new guidelines for 2021 office visits, is it true that I no longer have to document a history?

A: While a History is no longer used to **select** a new patient (9920x) or established patient (9921x) visit code, it is expected that a physician will **document** a medically appropriate history for each encounter.

Q: Will all payers be required to follow the new guidelines?

A: The AMA developed these guidelines and CMS adopted them with the intent that all payers would follow them. HIPAA requires that health plans use the most recent version of the medical data code set, so they should be ready to implement the revisions on January 1, 2021.

Q: What should physicians be doing now to prepare?

A: Physician practices should confirm that their contracted health plans and EHR vendors are integrating the revised codes into their software systems and will be ready Jan. 1.

Q: Can an EHR's automatic coding application still be used?

A: Yes. But it is important to note that the physicians should confirm with their specific EHR vendor that their system's code-selection application conforms to the revised codes and descriptors. A billing provider is ultimately responsible for the appropriate coding.

Medical Decision Making & Time

Q: Will providers need to choose to code by time or MDM for all visits or will they be able to change from one encounter to another?

A: The provider will be able to choose at each new or established patient encounter to code either by time or medical decision making.

Q: What activities should be included when coding based on time? Are there activities after a patient leaves that can be included?

A: When coding for time, a provider can count all the time on the day of encounter that it took to reasonably prepare for the patient, performing the medically necessary exam and/or evaluation and any time taken for counseling and educating the patient/family/caregiver. If total time involves activities after the patient leaves the office, then you may include the time taken for those activities as long as it is the same day as the encounter.

Some activities might include:

- reviewing tests
- obtaining and reviewing any separately obtained history

- the exam and/or counseling and education
- ordering medications, tests and procedures
- referring/communicating with other qualified health professionals (QHPs)
- documenting information in the EMR
- Independently interpreting test results & communicating results

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Q: If time is cumulative throughout the day, does that also go for multiple providers?

A: Time includes physician AND other qualified health professional (QHP) time on the date of the encounter and includes both face-to-face and time spent outside of the examination room. Clinical staff time (e.g. nurse or medical assistant) is not included for code selection.

Q: How many categories of MDM must I meet to get to a code level?

A: You must meet or exceed 2 of the 3 categories for any code level.

Table I: Element of Decision Making

Code(s)	Level of MDM	#/Complexity of Problems Addressed	Amount/Complexity of Data Review/Analyzed	Risk of Complications
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal (minor problem)	Minimal	Minimal
99203 99213	Low	Low (stable, uncomplicated)	Limited	Low
99204 99214	Moderate	Moderate (moderate problems)	Moderate	Moderate
99205 99215	High	High (very ill)	Extensive	High

Table II: Number/Complexity of Problems

Code	#/Complexity of Problems Addressed	Criteria
99211	NA	N/A
99202 99212	Minimal (minor problem)	• 1 self limited/minor problem
99203 99213	Low (stable, uncomplicated)	• 2 self limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury
99204 99214	Moderate (moderate problems)	• 1 or more chronic illness with exacerbation/progression or side effects

		• 2+ stable chronic disease • 1 acute illness with systematic symptoms • 1 acute complicated injury
99205 99215	High (very ill)	• 1+ chronic illness with severe exacerbation/profession/side effects • 1 acute chronic illness or injury that poses a threat to life of bodily function

Prolonged Service

Q: What is the new prolonged services code?

A: New code 99417 will be effective January 1, 2021.

Q: How do I use CPT 99417 when coding for prolonged services?

A: If you exceed the total time recognized for codes 99205 or 99215, the new guidelines offer a way to receive a bit more reimbursement. CPT code 99417 has been created to capture each 15 minutes of critical physician/QHP work beyond time spent to reach the highest level of new or established patient office visit total time.

Q: What are the time parameters for each level of new or established patient office visit on the date of the encounter?

A:

CPT CODE	TOTAL TIME
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes
99417	each add'l 15 minutes

CPT CODE	TIME
99211	N/A
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes
99417	each add'l 15 minutes

Q: If I see a new patient for 77 minutes of total time, can I bill both 99205 and 99417?

A: No. Code 99205 reflects a total time of 74 minutes. Prolonged services of less than 15 minutes are not to be reported.

Q: In the past you could add prolonged services to any level office-based E/M service, is that still the case?

A: The use of any of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

Beginning in 2021 code 99417 is used to report ***each 15 minutes*** of total time for prolonged services beyond the minimum required total time with or without direct patient contact recognized for codes 99205, 99215 and only when billing based on time rather than MDM.

Q: Will the current prolonged service codes 99354-99355 be deleted?

A: Code 99354 or 99356 will continue to be appropriate for the first ***hour*** of prolonged service on a given date, depending on the place/type of service.

Code 99355 or 99357 will also continue to be appropriate to report ***each additional 30 minutes*** beyond the first hour, depending on the place/type of service.

Relative Value Units

CPT Code	2021 wRVU
99202	0.93
99203	1.60
99204	2.60
99205	3.50
99417	0.61
G2211	0.33

CPT Code	2021 wRVU
99211	0.18
99212	0.70
99213	1.30
99214	1.92
99215	2.80
99417	0.61
G2211	0.33