

A look at new changes coming to E&M and breast coding in 2021

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The 2021 CPT Code set includes major changes to evaluation and management (E&M) coding for office and outpatient visits, as well as an overhaul to introductory guidelines and code descriptors for certain breast procedures in an effort to clarify and streamline language.

In this month’s column, we will walk you through the changes to ensure that you select the most appropriate codes based on these updates – which can help avoid audits and delayed reimbursement when coding your procedures in 2021. The basics of the new breast coding instructions are presented in this issue, with a more detailed look at many of the common situations seen in breast reconstruction slated for next month’s CPT Corner column.

E&M coding

In 2019, CMS noted that guidelines for E&M codes were outdated and a subsequent push began to simplify coding and documentation guidelines by reducing redundancies; eliminating the need to re-enter information that had been previously recorded by ancillary staff; and to remove unnecessary history and exam elements.

Initially, CMS proposed a simplified code system based on what was to be considered required documentation. The agency also proposed an elimination in pay differentials between the previous levels of service. However, the AMA, along with various medical specialties, objected to the CMS proposal and instead developed a new proposal that maintained the current five levels of outpatient service – but still streamlined reporting requirements.

The changes to the 2021 CPT Code set for E&M services represent the first major overhaul of office visit and outpatient E&M coding in more than 25 years. These have the potential to reduce payer audits, promote greater payer consistency and ensure payment is “resource based,” and that no one specialty benefits more than others.

The most significant changes for CY 2021 involve how the level of service is determined – either by medical decision making (MDM) or time (total time spent with the patient, including non-face-to-face services). Note that medically appropriate history and/or examination remains a documentation expectation but will no longer be used in code selection.

You will also notice that 99201 has been deleted and there will no longer be a Level 1 new patient visit. In addition, there were no changes to the outpatient consult codes or any of the inpatient E&M codes. Although the acceptance of the outpatient consult codes (9924X) still varies based on insurer, reporting of this code will still be based on current E&M guideline at this point. In addition, the inpatient E&M codes will all still require the previous levels of documentation, although this is the next targeted area for revision by the CPT Panel.

Let’s take a deeper dive into the complexities of medical decision-making for the revised new and established outpatient E&M codes.

To qualify for a particular level of MDM, two of the three elements for that specific level of MDM must be met or exceeded, which is an unchanged concept from current guidelines. However, the elements themselves

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

CODE(S)	LEVEL OF MDM	RISK OF COMPLICATIONS
99211	N/A	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

CODE(S)	AMOUNT/COMPLEXITY OF DATA REVIEWED/ANALYZED	CRITERIA
99211	N/A	N/A
99202 99212	Minimal	• Minimal or none
99203 99213	Limited	• Tests/Documents – Review of external notes from unique source, unique tests or ordering of unique tests (need 2) or • Assessment requiring an independent historian
99204 99214	Moderate	• Tests/Documents – Review of external nodes from unique source, unique test, ordering of unique test, independent historian (need 3) or • Independent interpretation of a test performed by another physician/QHP or • Discussion of management or test interpretation with external MD/QHP
99205 99215	Extensive	• Tests/Documents – Review of external nodes from unique source, unique test, ordering of unique test, independent historian (need 3) or • Independent interpretation of a test performed by another physician/QHP or • Discussion of management or test interpretation with external MD/QHP • NEED 2 of 3 for Level 5

have been changed a bit, and new guidelines and definitions have been added for clarification. Most plastic surgery visits will likely have a low or moderate level of complexity. The amount of data will often be limited or moderate. Still, the risks of complications can often be moderate or high, depending on the type of care being provided. With the new requirements, it will be very important to document the specific elements required for each of these sections to ensure accurate reporting. In the tables displayed, remember that the 9920X family of codes represents new patients; and the 9921X family of codes represents established patients.

Alternatively, time may be used to select a code whether or not counseling or coordination of care dominated the service. 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.

Activities could include:

- Reviewing tests
- Obtaining and reviewing any separately obtained history
- Exam and/or counseling and education
- Ordering medications, tests and procedures
- Referring/communicating with other QHPs
- Documenting information in the EMR
- Independently interpreting test results and communicating results

If you exceed the total time, the new guidelines offer a way to receive a bit more reimbursement. New CPT code 99417 has been created to capture each 15 minutes of critical physician/QHP work beyond time spent in the office. This code can only be used when the new/established code was selected based on time and can only be reported in conjunction with CPT codes 99205 and 99215.

Note that to bill a 99202 using time, the patient would have had to spend 15-29 minutes with the provider. In contrast, to bill a 99202 based on medical decision-making, a patient

with a minor problem pretty much meets that level just by entering the exam room.

CMS is planning to update RVUs noted in Table VI for E&M services when not included in the “global surgery” value of a code. However, CMS has currently proposed to not make the equivalent increase in valuation for those visits that are bundled in the global period. This incongruity is being actively addressed by all surgical specialties, including ASPS.

Breast coding

Over the past 18 months, ASPS worked with the AMA CPT Panel as well as the RUC Panel to clarify coding for breast reconstruction services. Although the reporting of these codes was generally understood by our specialty, there was significant confusion from coders and others leading to the specific request by the CPT Panel to provide better instructions and descriptors for these codes, including ones with ambiguous descriptors.

Updates include using common language throughout the sections (e.g., the use of “breast implant” instead of “mammary implant”); updates to long descriptors and parentheticals; and the addition of 14 new paragraphs to the introductory guidelines in the CPT book for the breast section. Some of these codes went through the RUC survey process, as the changes were deemed more than editorial, resulting in re-valuation. Although the valuation for many of these codes is expected to change based on the RUC recommendations to CMS, those changes are still in flux pending CMS release of the Final Rule, which was not available at PSN press time. However, it will be highlighted in next month’s CPT Corner.

Table VII presents the most basic changes to each of the relevant code descriptors. The introductory language in the CPT book along with the additional parentheticals for some of the codes are too lengthy for print, but they can easily be found in the CPT book. However, we have attempted to highlight the most significant changes.

CPT 11960 – Insertion of TE, Non-Breast

Although this code is not breast related, it was included in this process at the request of CPT due to proximity to 11970-71 and because the most common diagnosis associated with this code indicated inappropriate usage in a balloon carpal tunnel procedure. After discussions with hand surgeons, a new parenthetical was added that states 11960 should not be reported in conjunction with CPT codes 11971, 13160, 29848 and 64702-26 to avoid this misuse.

CPT 19325 – Breast Augmentation

The code descriptor for CPT 19325 has been updated to simplify and streamline language. A parenthetical has also been added to direct users to use codes 15771 and 15772 when fat grafting is performed in conjunction with a breast augmentation with implant.

It’s important to note that CPT 19324 – mammoplasty, augmentation without prosthetic implant – has been deleted. Fat grafting to the breast can now be reported with CPT codes 15771 and 15772.

CPT Codes 19316 & 19318 – Mastopexy & Reduction

No significant changes have been made to the descriptors of these two codes. CPT 19316 remains unchanged, and in an effort to simplify and streamline language throughout the section, the descriptor for CPT 19318 changed from “reduction mammoplasty” to “breast reduction.”

TABLE IV: AMOUNT/COMPLEXITY OF DATA REVIEWED		
CODE(S)	AMOUNT/COMPLEXITY OF DATA REVIEWED/ANALYZED	CRITERIA
99211	N/A	N/A
99202 99212	Minimal	• Minimal or none
99203 99213	Limited	• Tests/Documents – Review of external notes from unique source, unique tests or ordering of unique tests (need 2) or • Assessment requiring an independent historian
99204 99214	Moderate	• Tests/Documents – Review of external notes from unique source, unique test, ordering of unique test, independent historian (need 3) or • Independent interpretation of a test performed by another physician/QHP or • Discussion of management or test interpretation with external MD/QHP
99205 99215	Extensive	• Tests/Documents – Review of external notes from unique source, unique test, ordering of unique test, independent historian (need 3) or • Independent interpretation of a test performed by another physician/QHP or • Discussion of management or test interpretation with external MD/QHP • NEED 2 of 3 for Level 5

TABLE V: RISKS OF COMPLICATIONS		
CODE(S)	RISK OF COMPLICATIONS	CRITERIA
99211	N/A	
99202 99212	Minimal	• Minimal risk of morbidity from additional testing or treatment
99203 99213	Low	• Low risk of morbidity from additional testing or treatment
99204 99214	Moderate	• Moderate risk of morbidity from additional diagnostic testing or treatment AMA Examples: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	Extensive	• High risk of morbidity from additional diagnostic testing or treatment AMA Examples: • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization

TABLE VI: REPORTING BASED ON TIME				
CODE(S)	2020 TYPICAL TIME	CURRENT RVU	2021 TYPICAL TIME	2021 RVU
New Patients				
99201	10 minutes	0.48	Deleted	N/A
99202	20 minutes	0.93	15-29 minutes	0.93
99203	30 minutes	1.42	30-44 minutes	1.60
99204	45 minutes	2.43	45-59 minutes	2.60
99205	60 minutes	3.17	60-74 minutes	3.50
Established Patients				
99211	5 minutes	0.18	N/A	0.18
99212	10 minutes	0.48	10-19 minutes	0.70
99213	15 minutes	0.97	20-29 minutes	1.30
99214	25 minutes	1.50	30-29 minutes	1.92
99215	40 minutes	2.11	40-54 minutes	2.80
Prolonged Services Add-On Code				
99417	+15 minutes	N/A	+15 minutes	0.61

TABLE VII: 2021 CHANGE TO BREAST CODES		
CPT CODE	2020 DESCRIPTORS	2021 DESCRIPTOR
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of prosthesis	Removal of tissue expander without insertion of permanent implant
19316	Mastopexy	Mastopexy (no change)
19318	Reduction mammoplasty	Breast reduction
19324	Mammoplasty, augmentation; without prosthetic implant	CODE HAS BEEN DELETED
19325	Mammoplasty, augmentation; with prosthetic implant	Breast augmentation with implant
19328	Removal of intact mammary implant	Removal of intact breast implant
19330	Removal of mammary implant material	Removal of ruptured breast implant, including implant contents (eg, saline, silicone, gel)
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Insertion or replacement of breast implant on separate day from mastectomy
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction with free flap	Breast reconstruction; with free flap (e.g. fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	Breast reconstruction with single-pedicle transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	Breast reconstruction with bipedicle transverse rectus abdominis myocutaneous (TRAM) flap
19366	Breast reconstruction with other technique	CODE HAS BEEN DELETED
19370	Open periprosthetic capsulotomy, breast	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Periprosthetic capsulectomy, breast	Peri-implant capsulectomy, breast, complete, including removal of all intra-capsular contents
19380	Revision of reconstructed breast	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction.)
19350	Nipple/areola reconstruction	Nipple/areola reconstruction (no change)

CPT Codes 19340 & 19342 – Implant Placement in Breast Reconstruction

Descriptors of these codes have changed slightly to again simplify and streamline language. The term “breast implant” is now used instead of “breast prosthesis.” The codes are used for placement of a new implant or replacement in mastectomy or reconstructed breast.

The code selection depends on the traditional definitions of immediate vs. delayed reconstruction, and on the relationship to the timing of the mastectomy. Valuation for these two codes is expected to be the same. Note that a new parenthetical has been added that states 19342 and 19328 should not be reported in conjunction for removal of implant in the same breast. For removal of tissue expander and placement with a breast implant, use CPT code 11970.

Codes 19340 and 19342 can both be separately reportable with a flap, including latissimus dorsi flap. Acellular dermal matrix (ADM) is separately reportable as well using CPT 15777.

CPT 19357 – Placement of TE in Breast Reconstruction

CPT 19357 is used for tissue expander placement in breast reconstruction; includes subsequent expansion(s); and is separately reportable if used in flap reconstruction. There’s now clear language that the placement of a TE is separately reported with a lat dorsi flap (19361). This will allow for more accurate reporting, compared to when 19340 was used for the tissue expander, and will reflect the additional postoperative work.

CPT 11970 – TE to Implant Exchange

CPT 11970 has had a slight change in descriptor, changing the word “prosthesis” to “implant” to simplify and streamline language throughout the section. This code includes

the removal of the expander; minor revisions to the capsule; and placement of the new breast implant. Note that CPT 19370 may be reported if more-extensive capsular revisions are performed. Do not report CPT 11971 in conjunction with 11970.

CPT 19370 – Revision of Breast Capsule

The biggest change for CPT 19370 is that it’s no longer used just for capsulotomies but for revisions of peri-implant capsule including capsulotomy, capsulorrhaphy and/or partial capsulectomy. CPT 19342 can be separately reported when placing a new implant. CPT 19370 can be reported with tissue expander exchange if significant capsular work is performed. Note that you cannot report 19370 in conjunction with CPT 19328 for removal and replacement of the same implant to access the capsule.

CPT 19371 – Complete Capsulectomy

The descriptor for CPT 19371 has been updated to become more descriptive of the procedure. CPT 19371 is for a complete capsulectomy and includes the removal of all intra-capsular contents. It cannot be reported with CPT 19328 and 19370; however, 19342 can be separately reported for replacement of a new implant.

CPT 19380 – Revision of Reconstructed Breast

CPT 19380 is used when a revision is made to an already reconstructed breast that includes significant removal of tissue; re-advancement and/or re-inset of flaps in autologous reconstruction; or significant capsular revisions combined with soft-tissue excision in implant-based reconstruction.

The exchanges for a new or different size, shape or type of implant (CPT 19342), or autologous fat-grafting for increased volume

or contour irregularities (CPT 15771, 15772), may be separately reportable.

19380 should not be reported in conjunction with the following codes; 12031, 12032, 12033, 12034, 12305, 12306, 12307, 13100, 13101, 13102, 15877, 19316, 19318, 19370, for the same breast.

CPT 11971 – Removal of a Tissue Expander

The only change in the descriptor for 11971

is the word “prosthesis” for “permanent implant.” Use CPT 11971 for removal of a tissue expander without insertion of an implant. Note that this code can be used for both breast and non-breast usage. CPT 11971 and 11970 should not be reported together. For removal of a breast tissue expander and replacement with a breast implant, use 11970.

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CPT 19328 – Removal of Intact Breast Implant

Again, in an effort to streamline and simplify language, the only change made to the descriptor for CPT 19328 is changing the word “mammary” to “breast.” Use this code for removal of an intact breast implant.

This code is not reported when an implant is being replaced with another implant and is included in the code for complete capsulectomy (CPT 19371).

CPT 19330 – Removal of a Ruptured Breast Implant

The major update for CPT 19330 is that it now includes both the implant and the implant contents such as saline, silicone or gel. This code is not separately reported with a complete capsulectomy if all contents are intracapsular; however, the placement of a new implant during the same operative session (CPT 19342) can be separately reported. Remember that this is for removal of the implant and implant contents if ruptured, and should not be reported for the removal of a ruptured tissue expander. If a tissue expander has ruptured and is being replaced with a breast implant, use CPT 11970. For removal of a ruptured tissue expander without replacement, use CPT 11971.

CPT 19361 – Latissimus Dorsi Flap

Updates for 19361 include clarification on reporting and implant and/or tissue expander at the same time as a flap. For insertion of a breast implant with latissimus dorsi flap on the same day as a mastectomy, report CPT code 19340. For insertion of a breast implant with latissimus dorsi flap on a day separate

from mastectomy, use CPT 19342. Insertion of a tissue expander with a latissimus dorsi flap should be reported using CPT 19357.

This code was not part of the group of codes that were recently surveyed, and we do not expect any changes to the value.

CPT 19364 – Free Flap Breast Reconstruction

The short descriptor for CPT 19364 now formally includes DIEPs and other flaps such as TRAM, SIEA and GAP. CPT and CMS had previously established years ago that all breast free flaps should be reported with this code but required it to now be formally listed. As before, this code includes the flap harvest; microsurgical anastomosis of one artery and two veins with use of an operating microscope (not separately reportable); flap inset as a breast mound; and donor site closure.

This code was not part of the group of codes that were recently surveyed, and we do not expect any changes to the value.

CPT 19367, 19368, 19369 – Pedicled TRAM techniques

There have been no significant changes made to the descriptors of these codes, and they were not part of the group of codes that were recently surveyed; therefore, we do not expect any change to their values.

Note that these codes include harvesting of the flap, closure of the donor site, and inset and shaping of the flap.

CPT 19366 – Other Technique

CPT 19366 has been deleted due to ambiguity in the descriptor. Partial breast reconstruction and oncoplastic procedures should be reported with the Adjacent Tissue Transfer (ATT) family of codes (14000, 14001, 14301, and/or 14302), mastopexy (19316)

or breast reduction (19318), depending on the technique used.

CPT 19350 – Nipple Reconstruction

No significant changes have been made to the descriptor for 19350 and this code was not part of the group of codes that were recently surveyed. However, we wanted to note that a new parenthetical has been added under this code that states 19350 should not be reported in conjunction with CPT codes 11920, 11921, 11922, 14001, 15100, 15200 and 15201.

Medicare conversion factor

Physicians should be aware of the proposed decrease in the conversion factor for 2021 – from \$36.0896 to \$32.2605. Under the proposed Medicare Physician Fee Schedule, CMS is proposing an almost 11 percent decrease in payment. This reduction mostly stems from adjustments that are being made to accommodate new spending resulting from implementation of the changes to the E&M payments in the budget neutral system.

ASPS submitted comments to CMS regarding the Society’s concerns that because of budget neutrality requirements, the proposed decrease and its negative redistributive effect on some – but not all – physicians increases strain on physicians and practices already feeling the negative impacts due to the public health emergency. ASPS has been working closely with Surgical Care Coalition and other physician groups to address the significant change that will occur. Additionally, we continue to advocate our concerns directly to Congress regarding the negative impact a decrease in reimbursement during a public health emergency will have on patient care. Ideally, a “fix” will occur before Jan. 1, and ASPS will continue to share updates as they become known. **PSN**

Editor’s Message

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ship. It is fulfilling to me; but that’s not the only place where I find my fit. Sometimes it’s the O.R., the lab, occasionally a wine bar, sometimes with a group of other parents at the park, but usually at home with my husband introducing our daughter to classic movies. That led to the Yoda Chia Pet she ordered this spring, which unfortunately was “lost” in the move. My husband and I love exploring a city. Although getting to know Chicago and my new partners has been limited by social restrictions, I have found connection by being present.

Like everything else during the pandemic, establishing – much less maintaining – a connection is more challenging than ever. I am a firm believer in multitasking. I would write grants during conferences, edit or review manuscripts on conference calls and sign charts between clinic visits. I got a lot done, but I was never fully engaged. Making a connection requires that you be present in the moment. That may be the only obligation.

My last Editor’s Message in the June issue of *PSN* closed with hope and admiration and, thankfully, that has not been lost – even with everything that has transpired in my life in the months in between. I am moved by the resilience of my friends, partners and family during this time. We really are taking care of each other. As it would happen, I found my own connection and resilience over these months, and I am forever grateful.

Now hopefully my sense of smell makes its way back. Be well, stay safe. **PSN**

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