

HEALTH POLICY

E/M CODING UPDATES: WHAT HAS CHANGED FOR 2020 AND WHAT IS SLATED TO CHANGE IN 2021

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Payment for clinical services is driven by the Medicare Physician Fee Schedule (PFS). The pricing of each service is established the first day of January each year by the Centers for Medicare & Medicaid Services (CMS). All service codes of the PFS are valued relatively to one another as required by Federal statute. Commercial and other government payers depend on the PFS when setting payment rates.

For decades, the AMA has had an outsized influence in this rate setting process through the CPT Editorial Panel and the Relative-value Scale Update Committee (RUC)—the former with its role in defining each service code and the latter with its recommendations for the relative values assigned to each service code.

The processes used by CMS to set payment rates have resulted in distortions in the PFS that have negatively impacted the values of cognitive evaluation and management (E/M) services. SGIM and other groups, including MedPAC, have repeatedly called for reform, urging CMS to more appropriately value primary care and other non-procedural services. In 2015, SGIM formed the Cognitive Care Alliance, an association of likeminded internal medicine subspecialties, including endocrinology, rheumatology, infectious diseases, hepatology, hematology, and gastroenterology. Our work has highlighted the relative degradation in the PFS valuation of cognitive services over the last three decades even as the day-to-day work of primary and cognitive care has become more complex.

Our advocacy has been rewarded. CMS finalized policy to increase reimbursement and reduce the documentation burden of E/M services effective January 1, 2021.¹ The agency also implemented other changes to promote care coordination that took effect January 1, 2020.

Changes Made in 2020

CMS recognizes that improved care coordination and reduced administrative burden can yield significant health benefits for Medicare beneficiaries. The agency had already added two sets of codes to reimburse for non-face-to-face care to the PFS, but was concerned that adoption remained low. Therefore, the agency finalized changes in the CY 2020 PFS to improve the adoption of the transitional care management (TCM) and chronic care management (CCM) services. The agency also created a new set of e-visit codes to reimburse for certain types of non-face-to-face care.

Transitional Care Codes (TCMs): CMS has increased the work RVUs (wRVU) payments for the TCM codes, 99495 (face-to-face visit within 14 days) to 2.36 wRVUs and 99496 (face-to-face visit within 7 days) to 3.10 wRVUs. CMS made these changes “to support our goal of increasing medically necessary services.”

Chronic Care Management (CCM, two or more chronic conditions): The current set of 4 CCM codes, two for complex and two for non-complex will remain. The stipulations for the care plan are now more straightforward with the following required elements: (1) a problem list, (2) expected outcome and prognosis, (3) measurable treatment goals, (4) cognitive and functional assessment, (5) symptom management, (6) planned interventions, (7) medical management, (8) environmental evaluation, (9) caregiver assessment, (10) interaction and coordination with outside resources and practitioners and providers, (11) requirement for periodic review, (12) “when applicable,” revision of care plan.

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E-visits: CMS also established six new codes, three for physician services cover *patient initiated* non-face-to-face care delivered electronically, including through patient portals, email, and text, over each 7 day period, 99421, for between 5-10 minutes with 0.25 wRVUs; 99422, 11-20 minutes with 0.50 wRVUs; and 99423, 21 or more minutes with 0.80 wRVUs in 2020. There are also three for electronic care delivered by other healthcare professionals.

Countersigning Student Documentation: Attending physicians will only be required to attest to the review and verification of student documentation. There will no longer be a requirement for redocumentation.

Significant Changes in Outpatient E/M Service Code Payments and Documentation, 2021

The most profound changes in physician compensation will begin in January 2021. CMS finalized policy to improve the payments for the revised outpatient E/M family and created an “add-on” code, GPC1X, that can be applied to all E/M visits for work associated with “ongoing comprehensive care or visits related to a patient’s single, serious, or complex chronic condition.” To reduce administrative burden, CMS adopted changes to the documentation of these services.

The table summarizes the changes in the E/M code values and the values including the complexity add-on code, GPC1X, that would be combined with every primary care outpatient new or established patient E/M code:

Documentation for the outpatient E/M codes will be based on either (1) the level of medical decision making (MDM) which will be little changed from the existing conventions (the three subcategories will remain: number and complexity of problems, amount and/or complexity of data, risk of complications and/or

New Patient Codes					
	2021 wRVUs	Increase	2021 wRVUs + GPC1x	Increase with GPC1x	Time (minutes)
99202	0.93	0%	1.26	35%	15-29
99203	1.60	13%	1.93	36%	30-44
99204	2.60	7%	2.93	21%	45-59
99205	3.50	10%	3.83	21%	60-74
Established Patient Codes					
99212	0.70	46%	1.03	115%	10-19
99213	1.30	34%	1.66	71%	20-29
99214	1.92	28%	2.25	50%	30-39
99215	2.80	33%	3.13	48%	40-54

morbidity or mortality) or (2) total time spent on the date of service. All time spent related to a specific encounter (pre-visit, face-to-face, post-visit conversations with family, documentation, etc.) on the date of service will count toward code level selection.

CMS will also allow the use of an extend service code, 99XXX, for every 15 minutes of time beyond the upper limit for the 99205 and 99215 codes. This code will have a wRVU value of 0.61 and can be added after the first minute of addition service time and repeated indefinitely for each 15-minute interval. For example, for an established patient, the 99XXX could be used when the total time on a day exceeds 54 minutes and then again if the total time exceeds 70 minutes.

Implications for GIM Practices

TCM codes are critical to reestablishing continuity of care following hospitalization or facility-based rehabilitation. Many practices still do not have the workflows established and EHR support for the documentation. The enhanced CMS payments provide significant incentives to improve practice infrastructure. Likewise, CCM codes remain underutilized and the work delivered by the non-physician staff is frequently not billed.

The option to bill for e-visits offers intriguing possibilities but, like the new E/M time documentation requirements, tools will need to evolve to substantiate billing, especially for several interactions over a 7-day interval.

It remains unclear if commercial payers will adopt CMS’ new and established outpatient E/M changes. In the past, outpatient E/M changes have been adopted. Importantly, CMS could make further changes in the CY 2021 PFS rulemaking cycle and many stakeholders are advocating for changes and possible elimination of the GPC1X add-on code..

The documentation changes may not reduce administrative burden as much as CMS anticipates. Though there will be no need to record a patients’ history, family history, social history, ROS, physical examination for billing purposes, the incentive to “cut and paste” readily accessible data to support inflated levels of MDM will continue unchecked.

The tabulation of time to support the level of service code billing will need to evolve. Medicare will expect MDs to tally up the total time spent on the calendar day of the encounter spent with all activities, such as chart review, face-to-face time, post visit time for ordering and charting, time spent with staff

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discussion, and so forth. EHR time tags could provide assistance but these will have to be designed to be both accurate and flexible enough to accommodate times that are difficult to capture, such as a staff discussion or a long conversation in the waiting room with a patient's family.

The final changes to E/M payments will depend on how CMS implements these policies to meet budget neutrality requirements. The RVU value is established every January 1st and is known as the *conversion factor* (CF). Changes in the relative values for the service codes of the PFS are not accompanied by new Medicare dollars unless Congress chooses to fund added expenditures. The agency has not stated how it intends to conform with these require-

ments. Therefore, any increase in the RVUs for outpatient E/M services will require CMS to reduce the RVUs for other PFS services or change the value of the CF. Outpatient E/M comprises 27 percent of PFS spending so the redistributive impact will be significant. CMS has conducted additional research to address other distortions in the PFS. Recent published studies have questioned whether the current bundling of E/M service codes into 10- and 90-day payments for procedures should continue. Much of the paid for care is never delivered.²

These changes offer promise for primary care. Though there is more that needs to be done and though ongoing accuracy of the PFS remains suspect, the long overdue upgrades

in outpatient E/M code payment breathe new life into primary care and move our compensation closer to parity.

References

1. CMS. CMS-1715-F. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F>. Accessed March 15, 2020.
2. Mulcahy AM, Merrell, K and Mehrotra A. Payments for services rendered—Updating Medicare's valuation of procedures. *New Eng J Med.* 2020; 382:303-306. DOI: 10.1056/NEJMp1908706.

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