December 21, 2020

2021 E/M Changes: Winners, Losers and Audits

After three years in the making, the Centers for Medicare & Medicaid Services (CMS) is implementing revisions to certain evaluation and management (E/M) CPT codes (identified below) effective January 1, 2021 (85 FR 50074). The changes to these E/M codes increase the work relative value units (wRVUs), which, in turn, increases the subsequent reimbursement. Because all fee schedule changes are required by law to be budget neutral, CMS decreased the conversion factor (CF) used in the fee schedule, resulting in lower reimbursement for other services. Lastly, CMS introduced two new codes, which will likely result in new focuses for coding audits.

2021 Code Changes

The 2021 changes involve only the 99201 to 99215 range of (E/M) CPT codes for new and established patient visits ("Revised E/M Codes"). The changes do not include other E/M codes, such as inpatient, skilled nursing facility, or emergency-department-based E/M codes. Changes to those codes will be addressed in future guidelines.

CMS determined that 99201, the lowest level of new patient E/M code, was no longer relevant, so it was deleted.

Based on the fee schedule preamble, CMS took the position that history and physical examination (H&P) requirements were outdated. Therefore, as long as the H&P is documented, medical decision making (MDM) and time are more important to determine the selection of the appropriate E/M level. As such, the elements of the Revised E/M Codes no longer require the documentation of how many body systems are involved. These new definitions and changes will be incorporated in the 2021 CPT Manual, making the coding changes applicable not only to Medicare, but also the entire healthcare industry.

Most important, the wRVUs were increased for the Revised E/M Codes. The wRVUs account for the time, technical skill, physical effort, mental effort, judgment, and stress involved in providing a service.

Because all CMS fee schedule changes must be budget neutral, CMS decreased the CF that is multiplied by the applicable relative value units (including the wRVUs), which is used to calculate the level of reimbursement, by 10.6%.

For more information on changes to the E/M Codes change, see here.

Impact on Reimbursement

Practices whose volume is based primarily on established patient visit E/M codes (99212 through 99215) will see the most significant increase in Medicare revenue. However, the CF's negative adjustment to the remainder of the CPT and HCPCS codes will have a negative impact on reimbursement for practices generating the majority of their revenue from procedural services, such as surgical specialties.

Not only will these changes impact Medicare reimbursement, but they will also affect the reimbursement from commercial payor that base their fee schedules or payment methodologies on the Medicare provider fee schedule.

New Codes

CMS introduced two new codes, which may complicate billing and create a new focus for coding audits:

- E/M code 99417 for **prolonged service** is to be used for time (in 15-minute increments) spent in excess of the time associated with a level 5 visit;
- HCPCS code GPC1X to designate **visit complexity** is to be used as a modifier with E/M codes 99202 through 99215 related to complex ongoing care.

Takeaways

The changes to the E/M codes will have several downstream consequences:

- Medical decision-making or time will now be used as the basis for code selection, so there will be more focus on the clinical status of the patient and complexity of the visit. This change may make the clinician's job of documentation easier and auditing their work significantly harder. It is yet to be seen how CMS auditors will adapt and change their audit tools or whether they will continue to demand documentation that is no longer required under the Revised E/M Codes.
- As with the implementation of any new codes, auditors will be looking for over-utilization of the new codes, E/M code 99417 and HCPCS code GPC1X.
- Any clinician whose compensation is based on wRVUs will have a potential increase in compensation if their practice includes E/M codes 99202 through 99215.
- Conversely, any clinician whose practice is procedure-based will be adversely impacted by the decrease in the CF applied to procedure codes.
- This shift in wRVUs and the CF may require re-evaluation of existing physician compensation arrangements for fair market value compliance, as required under state and federal fraud and abuse laws.

Initially, we suggest that clinicians consider performing a second-level clinical review for MDM or time to support the appropriate E/M coding level under the new definitions, particularly if the new prolonged services code or complexity codes is used.

Lastly, during the transition period, in the event of an audit, clinicians should seek legal counsel before responding to the audit, given the new definitions for the Revised E/M Codes. It could be possible that auditors might not have updated their audit tools and algorithms.

Authors

Alexandra MacKenzie Pearsall

Senior Associate

Parsippany, NJ | (973) 966-8154

apearsall@daypitney.com

Erin Magennis Healy

Partner

Parsippany, NJ | (973) 966-8041

ehealy@daypitney.com

Susan R. Huntington

Partner

Hartford, CT | (860) 275-0168

Washington, D.C. | (202) 218-3909

shuntington@daypitney.com