

January 11, 2021

## Fact Sheet - Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits

Effective January 1, 2021, for PFS payment of office/outpatient E/M visits (CPT codes 99201 through 99215), Medicare generally adopts the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA's CPT Editorial Panel (available at the following website: <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>).

Practitioners will no longer use history and exam to select the office/outpatient E/M visit level. Instead, an office/outpatient E/M visit includes a medically appropriate history and exam, when performed. Practitioners should perform history and exam to the extent clinically appropriate, and reasonable and necessary.

The CPT Editorial Panel eliminated CPT code 99201 (Level 1 office/outpatient visit, new patient). For levels 2 through 5 office/outpatient E/M visits, practitioners report visit level based upon either the level of medical decision-making as revised in the AMA/CPT guidance, or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time).

### ADD-ON CODE FOR PROLONGED VISITS

When the practitioner selects a visit level using time, the practitioner may report prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). Practitioners should not report prolonged office/outpatient E/M visit time using CPT codes 99354 and 99355 (Prolonged service with direct patient contact), 99358 and 99359 (Prolonged service without direct patient contact), 99415 and 99416 (Prolonged clinical staff services), or 99417 (Prolonged office/outpatient E/M services with or without direct patient contact). The following table provides reporting examples.

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

\*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

*HCPCS code G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services). (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).*

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## **ADD-ON CODE FOR VISIT COMPLEXITY**

Medicare established payment for HCPCS add-on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition.

*HCPCS code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).*

The Consolidated Appropriations Act delays PFS payment for this code until January 1, CY 2024 or later. Practitioners may report this code for qualifying visits furnished on or after January 1, 2021, although we assigned a PFS payment status indicator of "B" (Bundled) until 2024.

- HCPCS code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.
- Reporting is not restricted based on specialty, but certain specialties will likely furnish these types of visits more than other specialties. HCPCS code G2211 may be reported with any visit level.
- *Example 1:* In the context of primary care, HCPCS code G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team.
- *Example 2:* In the context of specialty care, HCPCS code G2211 could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals.

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- *Example 3:* We do not expect reporting of HCPCS code G2211 when the office/outpatient E/M visit is reported with payment modifiers such as a modifier -24, -25 or -53.

### **MEDICAL REVIEW WHEN PRACTITIONERS USE TIME TO SELECT VISIT LEVEL**

Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.

### **RESOURCES**

CY 2020 MPFS final rule

CY 2021 MPFS final rule (84 FR 62844 through 62860)

Consolidated Appropriations Act (December 2020)

Office Evaluation and Management (E/M) CPT Code Revisions (<https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>)