Highlights of the CMS Evaluation and Management Office/Outpatient Visit Changes for 2019 & 2021

2019

- 1995 or 1997 guidelines still apply as sole factor to determine levels of service
- Chief complaint and/or HPI can be recorded by ancillary staff just like ROS, PFSH
- History and/or exam don't have to be re-recorded if they're documented on a previous visit, and update is sufficient
- Two new G codes for services to determine if a patient needs to be seen for an office visit
    - **G2012** Brief communication technology-based service, e.g. virtual check-in; 5-10 minutes of medical discussion
    - **G2010** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours
        - For both codes:
            - Patient must be established
            - Patient consent (due to cost-sharing) must be documented each time
            - Services would be initiated by patient
            - Service must be provided by a physician or other qualified health care professional who can report evaluation and management services
            - Service should not be originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

2021

- Levels 2-4 will have the same wRVU values and same payment rate
- Complexity add-on codes will be available to capture additional work and reimbursement with levels 2-4
- In addition to 1995 or1997 guidelines, providers can determine level of service with medical decision-making only (regardless of new/established patient and regardless of levels of history, exam)
    - Alternatively, providers can select their level based on time, but doesn't require > 50% be spent on counseling coordination of care.

This currently applies to Medicare, and codes 99201-99205 and 99212-99215 only

TABLE 24B: Comparison of 2018 and 2021 Estimated National Payment Amounts for Visits

	Complexity Level under CPT	Visit Code	Visit Code	Visit Code With Either Primary or specialized care add-on code*	Visit Code with New Extended Services Code
New Patient	Level 2	$76	$130	$143	$197
	Level 3	$110			
	Level 4	$167			
	Level 5	$211	$212		
Established Patient	Level 2	$45	$90	$103	$157
	Level 3	$74			
	Level 4	$109			
	Level 5	$148	$149		

*In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

HCPCS	Physician Time	Work RVU
99201	17.00	0.48
99202	34.43	1.76
99203	34.43	1.76
99204	34.43	1.76
99205	67.00	3.17
99211	7.00	0.18
99212	30.26	1.18
99213	30.26	1.18
99214	30.26	1.18
99215	55.00	2.11

HCPCS	Descriptor
GPC1X	Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)
GCG0X	Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

https://www.cms.gov/About-CMS/Story-Page/Clinician-Letter-Reducing-Burden-Documentation-and-Coding-Reform-.pdf

https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf see pages 554-635