**The Revised 2021 Medicare Physician Fee Schedule (MPFS)**

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Important 2021 Large-Scale Coding Changes for E/M Office Outpatient Codes
Affects Outpatient CPT Codes 99201 – 99215

1. H&P eliminated /no longer required as an element for code selection
Requires H&P documentation only as Medically Appropriate for visit
2. Documentation and Reimbursement for services rendered:
Entirely based upon Medical Decision Making (MDM) or Time
Choose either MDM or Time to document the E&M level of the visit
E&M code selection criteria now driven by MDM and Time
3. New Patient Code 99201 has been eliminated
4. The five levels of coding for Established Patients has been retained
5. Revision of the code definitions
6. Revision of the Times and MDM process for all codes
7. Adjusted wRVU values:
An overall increase in wRVU for E&M visit codes
8. Reduction of RVU Conversion Factor by 10%
Conversion Factor will go from $36.09 to $32.26
Reduction of Conversion Factor done to maintain Budget Neutrality
Greatly affects some reimbursements; even with higher wRVU rates
9. Add-on-codes for Prolonged Services

**Conversion Factor and RVUs. “In the beginning”, there was fee for service**The question is, how did we evolve into our current 2021 Medicare Physician Fee Schedule, or MPFS? Sometimes understanding the past helps us better understand the present. Since the introduction of the 2021 MPFS, there has been an ongoing and focused disputation over the 2021 reimbursements for patient cognitive care verses non-cognitive care. The discussion is in reference to the 2021 10% reduction in the Conversion Factor used in conjunction with RVUs to determine reimbursement for E&M codes. The reduction in the Conversion Factor is coupled with adjusted RVU values for E&M services. The changes significantly benefit some medical specialties but also decreases reimbursements for other medical specialties. But what is the “Conversion Factor” and how did “RVUs” even enter into determining physician reimbursements? Before discussing the impact of physician compensation as related to the 2021 MPFS, it might be worthwhile to see how medicine evolved into mandating “Budget Neutrality” coupled with RVUs and a Conversion Factor, all of which determine which physicians and specialties are considered by some as the 2021 ‘winners” and which are the “losers” in the 2021 CMS MPFS.

As healthcare expenses continued to escalate during the prosperous post World War 11 economy, the political environment became favorable toward ensuring medical care for senior Americans who were no longer working and did not have employment-based coverage. President Harry S Truman (1945-1953) was the first U.S. President to seek a federal healthcare program to assist senior American citizens. His efforts to develop healthcare coverage for senior Americans was unsuccessful. Several years later, on July 30, 1965, President Lynden Baines Johnson (1963-1969) signed Medicare into law. The bill was signed into law at the Truman Library in Independence, Missouri with former President Truman receiving the first Medicare card.

Initially, under Medicare legislation, physicians were reimbursed according to the “Usual, Customary and “Reasonable Rates”. There was no Medicare Physician Fee Schedule (MPFS). Doctors were paid what they charged and billed. That reimbursement plan did not last long. As healthcare expenditures continued to escalate, Congress passed legislation which ultimately restructured the way Medicare reimbursed physicians. In 1992 new legislation established the Medicare Physician Fee Schedule and the newly developed Resource Based Relative Value Scale (RBRVS) established a standardized reimbursement/payment schedule. The Evaluation and Management (E&M) model was part of the new RBRVS payment system. In addition to a new national fee schedule, updated Current Procedural Terminology (CPT) codes were published. The 1995 Documentation Guidelines For Evaluation and Management Services was released. The 1995 Guidelines were revised to include specialty specific physical examinations in 1997. Those “Guidelines” remained the template for reimbursement for E&M services for the past 25 years. But, as will be seen, much is changed in 2021.

The way RBRVS works is as follows. Each medical service is represented by a CPT code. RBRVS attaches a relative monetary value, or Relative Value Unit, RVU, to each CPT code. The RVU is a numeric value that has been developed to represent three components of each medical service: 1. Physician Work (wRVU), 2. Practice Expense (peRVU) and 3. Medical Liability (mlRVU).
Total RVU= Work RVU + Practice Expense RVU + Medical Liability RVU

There is also a requirement than any RVU changes be Budget Neutral which means that for every additional dollar allocated to a given service there is a dollar less for those who do not use a given code:
Total RVUs are then multiplied by a Geographic Cost Index (GPCI)
wRVU x (GPCI) + peRVU x (GPCI) + mlRVU x (GPCI) = Total RVU

A Conversion Factor (CF) is determined by legislation every year. The CF is a multiplier which is used to “convert” the geographically adjusted RVU to determine the Medicare allowed payment amount for a particular service. The CF is a fixed dollar amount based upon a complex formula set by statue. The CF incorporates different economic indices as the Medical Economic Index, Budget Neutrality and Legislative Changes, then translates each RVU into a dollar amount. Therefore,
Payment = Total RVUs X the Conversion Factor

**2021 Reduction of the Conversion Factor: Winners and Losers**So, how is this applicable to the 2021 MPFS? Due to the Budget Neutrality mandate, any 2021 increases in Outpatient CPT codes 99202-99205 and 99211-99215 forces CMS to adjust the Conversion Factor in order to counterbalance those increases in code values that CMS implements. Thus, the 2021 CMS MPFS decreases in the Conversion Factor from $36.09 to $32.26 is to maintain Budget Neutrality. For specialties that primarily bill the office and outpatient E/M codes, the magnitude of the RVU increases in these code values outweighs the cut to the Conversion Factor—so overall, those clinical specialties will see an increase in their reimbursements. Conversely, there will be a significant number of physicians who will see reduction in reimbursements under the new 2021 MPFS. For Neurology, there is an expected 6% across the specialty increase in reimbursements with variations depending on the individual provider’s practice. Other projected payment increases of between 13% to 17% include endocrinology, family medicine, rheumatology and hematology/oncology. On the loosing side, payment cuts are projected to be between 8% and 11% for others such as surgeons, nurse anesthesiologists, chiropractors, pathologists, physical and occupational therapists, cardiac surgeons and radiologists.

Because of the disparity between “winners’ and “losers”, the CMS 2021 Physician Fee Schedule’s budget neutrality requirements appears to shift funds from one specialty to another which many colleagues believe is an inappropriate discrimination among physician specialties. Cognitive E&M visits have historically been undervalued as compared to procedural visits, a factor which was presumably weighed when the 2021 MPFS was being developed. There are many physician colleagues and organizations who believe that if CMS cannot obtain a budget neutrality waiver from Congress, there should then be a delay in implementation of the revaluation of E/M and related code visits and the 2021 MPSF should be rolled back to 2020 values.

We neurologists have all received recent emails and communications from The American Academy of Neurology related to this issue. While most neurologists will receive a significant benefit starting in 2021 with a 6% overall increase for E&M services, because of budget neutrality there will also be an across the board cut to all other services. Indeed, some neurologists may experience payment reductions if they provide few E/M services. Thus, along with a number of other societies, the AAN is supportive of efforts to waive budget neutrality to offset cuts to reimbursements for non E/M services but the AAN also believes that any actions to waive budget neutrality should not result in a delay or in any way undermine CMS’s decision to fully implement the new E/M payment structure on January 1, 2021. Other societies and industry organizations continue to argue that E/M payment increases should not be offset by rate decreases for other services covered by the Medicare Physician Fee Schedule. Many organizations have urged CMS to work with Congress to stop penalizing doctors with the current budget neutral methodology. In an October 5, 2020 letter to Seema Verma, MPH, Administrator Centers for Medicare & Medicaid Services, from 1.4 million physician and non-physician practitioners throughout the country, representing 47 different societies, academies, associations and other professional medical organizations that signed the letter, there was strenuous objection to the budget neutrality reduction proposed by CMS in the 2021 MPFS. At the time of the writing of this report, there is much legislative and political activity regarding 2021 reimbursements for E&M services. We will wait and see the outcome but until then, for 2021, the CMS MPFS will include a 10% cut in the Conversion Factor.

**History and Physical Examination: No longer necessary?**For the past 25 years, the 16-page CMS 1995 and 49-page 1997 Medicare Documentation Guidelines For Evaluation and Management Services defined the details of how to meet the Medicare rules and regulations of E&M CPT coding. The 25-year-old and 23-year-old documents identified the (1)History, (2)Physical Examination and (3) Medical Decision Making as the three Key Components that required specific documentation guidelines to meet the requirements of CPT E&M coding as well as to determine the level of care provided. Time, which is face-to-face time, could be used for the level of E&M services when Counseling and/or Coordination of Care dominate greater than 50% of the encounter. Under the revised Medicare E&M Guidelines, which will take effect January 1, 2021, physicians will chart and select codes entirely based on either Time spent with the patient or Medical Decision Making. Prior historical key elements to define the E&M level of service provided, as defined in the 95/97 CPT E&M Guidelines, including the History and Physical Examination, will still be conducted but as and when deemed medically appropriate by the physician.

Thus, starting January 1, 2021, physicians and other professional providers, will bill for the level of outpatient E/M services based on either the newly revised MDM guidelines or Total Time. Total time will be counted as total time spent with the patient on the day of service, including non-face-to-face services. The History and Physical Examination will be eliminated as a key element for the level of code selection, but the medical encounter should still include a medically appropriate history and/or physical examination, when performed. The nature and the extent of the history and/or physical examination is to be determined by the treating physician or other qualified health care professional reporting the service. The care team may also collect historical information which may come from the patient, caregiver, by portal or questionnaire or obtained from other professionals in the office, including nurses, APPs and MAs. That patient information, which was previously the key element of the History, can be reviewed by the reporting physician or other qualified health care professional and then documented in the medical record as having been obtained and reviewed. Not being required to again perform and record a detailed and complete physical examination and neurological examination for a healthy 20 year old established patient being seen for routine headache follow up is clearly realistic and appropriate. However, while the H&P is no longer a key component in code selection or defining the level of the E&M encounter, appropriate documentation of important information in the medical records, when indicated, is still an important component of the patient’s clinical evaluation. As the saying goes, “if it was not documented, it was not done”. Documentation of appropriate historical information and/or physical examination is still a main line of defense in any medical legal matter.

**Medical Decision Making 2021: Compared to the past it can only get better!**Medical Decision Making MDM) refers to the Cognitive Complexity of establishing a diagnosis for selecting a management option. MDM includes integration of a provider’s knowledge and experience with the history, physical examination, laboratory data and other data into a process of formulating and developing a treatment plan. MDM considers the (1)number of diagnostic and management options considered and (2)the complexity of data analyzed. MDM also incorporates (3)the level of risk to the patient within the decision making process. The risk includes that of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient’s care. MDM is an assessment of not only the risk of the disease being treated but also the risk of selecting diagnostic procedures and management options, both during and following procedures or treatment.

Medical Decision Making was a new E&M coding requirement formally introduced in the 1995 CPT E&M Documentation Guidelines. While the 1995 and revised 1997 E&M Documentation Guidelines had clearly defined numerical values for the History and Physical Examination, the first two key components of CPT E&M coding, with the introduction of MDM, physicians and other health care providers were asked to quantify the “amount” of data and at the same time define the “complexity” of data required for MDM documentation with insufficient MDM coding instructions. The CMS measures did not provide specific direction in the 95/97 E/M Guidelines to quantify the data or to make these numerical determinations. There were no obvious quantifiable MDM parameters in the Guidelines to help meet compliance.

The MDM Table on page 43 of the 1997 revised E&M CPT Guidelines was the template for MDM coding but the text provided no clearly defined formula for how to use or navigate the table. Thus, while the 95/97 Guidelines supplied numerical values to determine the level of History and Physical Examination performed, MDM documentation essentially referred to “Qualitative” metrics without providing “Quantitative” metrics of measurement. There were no definitions in the MDM Table nor in the MDM descriptive text to help explain what “Minimal”, “Limited”, “Multiple”, or “Extensive” specifically meant related to a diagnosis nor what “Amount” and “Number” meant in numerical quantitative measures. Subsequently different MDM Scoring System methodology had been developed by private organizations and while none were officially endorsed or validated by CMS, certain scoring systems became the “industry standard”. As an example, one of the most commonly used scoring systems was the independently developed Marshfield Clinic Scoring Tool which became the template for most other MDM scoring systems nationally.

There has been much momentum to simplify Medicare CPT E&M coding over the years. It was thought the EHR would make documentation easier and more standardized, but the issues with EHR, including documentation and coding, also frequently included templates which maximized H&Ps and even MDM levels of care to the highest levels of codes for service provided. The number of level 4 and level 5 codes submitted for reimbursement has greatly increased over these last few years. In addition, the physician administrative burden of documentation and coding and additional physician time spent on data entry and meeting the various coding rules and regulations was for many, laborious. Since E/M services represent approximately 40% of the billed charges annually, there is much incentive to maximize the efficiency and accuracy related to E&M coding and subsequent provider reimbursements. After much focused negotiation in 2019 and 2020 between the CMS and the AMA and other medical industrial representatives, it was agreed that the most efficient and effective way to define the reimbursable components of an E&M doctor/patient encounter was to allow physicians to choose whether to document the visit based on restructured Medical Decision Making or Total Time with an H&P not included in determining the level of the code but defined as appropriate for the encounter.

The agreement between CMS and the AMA which led to the 2021 MPFS was a monumental undertaking. In response to the initial CMS proposal to “collapse” and “blend” CPT level of service codes 2 – 4 into one total payment amount, a change which would have resulted in significant economic loss for numbers of physicians, the chairs of the AMA CPT Editorial Panel and the AMA Relative Value Scale Update Committee (RUC) created a 12 member CPT/RUC Workgroup of E/M. In addition to the 12 Workgroup Members, about 300 stakeholders from National Medical Specialty societies participated in the decision making process In addition to changing the definition of “Time” from “Typical Times” to “Total Times” associated with each E&M CPT code, the entire MDM Guidelines were redeveloped and updated with criteria being made specific to the individual E&M office visits codes 99202-99215. While the Workgroup did not materially change the three current MDM sub-components listed in the 95/97 Documentation Guidelines, there were extensive edits to the elements for code selection and numerous revised criteria clarifying definitions which were not clearly defined in the 95/97 Guidelines.

The new 2021 MDM table used for E&M coding features a redesigned format. The ambiguous terms are replaced with more descriptive language. The data elements in the old table were re-defined and coding moved away from adding up tasks to now focusing on tasks that actually affect the management of the patient. Where the old MDM table was driven by formulating a complicated point system derived from the number of diagnosis or treatment options and the amount and/or complexity of data reviewed, the 2021 MDM table will use improved guidelines to help code the level of service performed as correlated with each E/M encounter. The “Risk” component of the 2021 table does still use similar nomenclature as found in the “Table of Risk” on page 47 of the revised 1997 Guidelines, but the terminology is more clearly defined and more applicable to the actual patient encounter.

To navigate the new 2021 level of MDM table properly, the physician or other healthcare providers will need to learn and understand the CPT’s definitions for different terms. For example, knowing the MDM definitions for terms as problem addressed and what a self-limited or minor problem as compared to problems of moderate or high complexity will be mandatory for the accurate selection of the proper level of service performed. Providers will need to comprehend the different levels of risk as applied to MDM and different levels of risk as applied to treatment and management options such as drug therapy which may require intensive monitoring for toxicity. Other terms as morbidity as applied to the definitions of acute and chronic illnesses which themselves are referenced in a variety of ways in the “Number and Complexity of Problems Addressed” column.

Another important part in using the new 2021 MDM Table is that simply selecting a diagnosis from a drop-down menu will not be applicable. Compliance for the diagnosis and management portion of the new table will require that physicians and other healthcare providers link each MDM diagnosis with some type of action, be it a prescription, a test, counseling or some other patient related function. Stating that the diagnosis is being managed by another provider will not meet the new MDM compliance rules.

While some of the above 2021 MDM requirements may seem daunting or labor intensive to some, the key, as outlined above, will be to learn how to navigate the newly revised AMA Medical Decision Making Table and to understand the definitions of the terminology used in the table. While much of the terminology is derived from the earlier 95/97 E&M Guidelines, a precise understanding of the thirteen or fourteen important terms used in the AMA Table will be needed to be compliant when using MDM for E&M coding services. There are excellent resources for learning how to use the new table on the AAN website, the AMA website and the CMS website. A printable copy of the revised AMA MDM Table can also be found on those websites as well as on line. In addition, there are case studies and tutorials which can be found at aan.com/EM which illustrate examples of billing using MDM or Total Time.

**Total Time: It’s about time!**To finally be financially compensated for the non-face-to-face time physicians have been spending on behalf of their patients and in the care of their patients is something many colleagues feel is long overdue. While the inclusion of time has been part of the 95/97 E/M Guidelines, it was only recognized if the time spent was greater than 50% of the visit was face-to-face-time spent in Consultation and Coordination of Care. Starting in January 2021, Total Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Total time will include both face-to-face and non-face-to-face time that the physician or other healthcare provider personally spends before, during and after the visit.

The total time spent on patient care does not need to be consecutive but is cumulative time within the day of the patient’s visit starting 12:00 am and ending 11:59 pm. Thus, the discussion of a patient with the referring physician the day before the consultation or reviewing an MRI with the Neuroradiologist the day after the visit would not be included in Total Time because it would be outside the 12:00 am – 11:59 pm window. Other such things as having the patient wait in the office for their eyes to dilate for a funduscopic examination would also not fit the definition of Total Time.

In addition, services that are done separately, such as an EMG or the interpretation and reporting of the EEG on the same day would not apply toward the E/M level because separate CPT codes exist for the test or procedure and the actual E&M visit. To bill a code for the performing the tests and interpreting the results plus charge an additional E&M visit code for the performance and interpretation of those tests on the same day would be considered “double dipping”. A shared or split visit, which is defined as a visit in which the physician and other healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit, the time spent by the physician and the other healthcare provider(s) in assessing and managing the patient’s visit, is summed together to define total time. Thus, when two or more individuals act together as within a team provider approach to patient care, only the time of the one primary provider, usually the physician, should be counted. Conversely, if a test or study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, that service may be considered part of Medical Decision Making under “ Amount and/or Complexity of Data to be Reviewed and Analyzed”. Also, Total Time does not include staff time.

Other examples of time based billing on the day of service would include:
Preparing to see the patient (eg., review of the chart and tests)
Obtaining and/or reviewing separately obtained history
Performing a medically appropriate examination and/or evaluation
Counseling and educating the patient/family/caregiver
Ordering medications, tests or procedures Referring and communicating with other healthcare professionals (when not separately reported}
Documenting clinical information in the electronic or other health record
Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
Care coordination (when not separately reported)

Keeping track of the total time spent on behalf of a patient’s care on the entire day of the visit could be burdensome. While some EHRs have timers that automatically track when you are logged in to a patient’s chart, most systems that have this feature ae still far from perfect. But in most E&M instances, the complexity of the patient’s visit is often clear relatively early in the encounter. Also, different Neurologists have variable times allotted to new patient visits and established patient visits. Generally, on an average, new patient visits for Neurologists will range from 30 minutes to 60 minutes while an established visit will range from 15 minutes to 30 minutes. While, under the current 2021 E/M rules and regulations physicians are not required to itemize their time spent with patients, it is reasonable to anticipate that in the future there may be some type of documentation that will be required, presumably utilizing the EHR. But to date, and at the time of writing this report, actual documentation of the time spent in calculating Total Time for the E&M level of the patient encounter is not a requirement.

The table below itemized the 2021 Total Times established for the four New Patient Codes and the five Established Patient Codes. It would pay to get familiar with the following table which defines total time for CPT 99202-99215

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| --- | --- | --- | --- |
|  New Patient Code |  Total Time (2021) |  Established Patient Code |  Total Time (2021) |
|  99202 |  15-29 minutes |  99211 |  N/A |
|  99203 |  30-44 minutes |  99212 |  10-19 minutes |
|  99204 |  45-59 minutes |  99213 |  20-29 minutes |
|  99205 |  60-74 minutes |  99214 |  30-39 minutes |
|   |   |  99215 |  40-54 minutes |

**Prolonged Service Codes. How did it get so late so soon?**Before discussing the 2021 E&M “add-on-codes”, it is first important to briefly review some of the terminology. The Healthcare Common Procedure Coding System is referred to as HCPCS. The HCPCS is divided into two principle subsystems. The two systems are referred to as Level 1 and Level 11.

Level 1 of the HCPCS constitutes the Current Procedural Terminology or CPT numeric coding system which is maintained by the American Medical Association. The AMA also publishes the CPT Codebook that is in most physician offices. The second level, Level 11 of the HCPCS, is a standardized coding system that is primarily used to identify products, supplies, and services not included in the Level 1 codes. Level 11 codes include such things as ambulance services and durable medical equipment, prosthetics, orthotics and supplies when used outside of a physician’s office. G-codes are also a part of the HCPCS national Level 11 code set. G-Codes are temporary codes that are assigned to services and procedures that are under CMS review before being included in the CPT coding system. G-codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes. While G-Codes are similar in function to CPT codes, they are separate codes managed and used by The Center for Medicare and Medicaid Services (CMS). The G-Codes allow CMS to bring a service forward quickly and support a service that the AMA CPT committees have not yet moved forward with supporting. G-Codes may also be used if CMS is not entirely happy with the way CPT has defined a service or how the CPT code is structured. In addition, G-Codes allow CMS to foster innovation as deemed appropriate by CMS.

The AMA has developed a new CPT Prolonged Service Code divided into 15 minute intervals of prolonged care. The new code is to be used when Total Time is chosen as the CPT reporting option. As with all other Total Time parameters, the 15 minute prolonged service code can only be used on the same day of service. The new code is 99417. However, CMS does not agree with the designed uses of the AMA prolonged service code 99417 and developed their own HCPCS prolonged service code. The CMS code is a G-code, G2212. The guidelines for using either code, 99417 or G2212, require reporting the codes with CPT level 5 codes 99205 and 99215.. Both codes only reflect clinician time as opposed to staff member time and again, are to be used when Total Time is used to select the code. Medicare will not accept the AMA 99417 code. We currently do not know if private insurance companies will accept the CMS G2212 code. As a general rule, private insurance companies prefer not to deal with G-codes. There are some differences in how 99417 will be used as compared to G2212.

**99417**vs **G2212**: When using 99417, the total time of 15 minutes must be met to report this code. Midpoint times, such as 7.5 minutes, will not be accepted. The entire 15 minutes must be done in order to add on 99417 for prolonged services.

When using 99417, the code can be selected after 75 minutes or longer for new patients where 99205 is 60-74 minutes or at 55 minutes for established patient code 99215 where the time range is 40-54 minutes. For some private payers, it appears that 99215 may be added to the lower end of the level 5 code. However, the CMS rule for using prolonged service code G2212 does not agree with CPT. For CMS, code G2212 cannot be used until after the first 15 minutes is actually added to the maximum time in the time range. So, in order to bill a Medicare prolonged service code G2212, the clinician must first meet 15 minutes of additional time to the maximum time in the time range. Thus for using the CMS G2212, if adding to a new patient code 99205, the total time required for reporting would start at 89 minutes and for code 99215 which ends at 54 minutes, G2212 could be reported at 69 minutes. The wRVUs for G2212 are 0.61 which would translate into about $31.40 payment for a national non-facility payment and about $30 for a national facility payment

|  |  |
| --- | --- |
|  CPT Code using 99417 |  Total Time Required for Reporting |
|  99205 |  60-74 minutes |
|  99205 x 1 and 99417 x 1 |  75-89 minutes |
|  99205 x 1 and 99417 x 2 |  90-105 minutes |
|  99205 x 1 and 99417 x 3 or more |  105 minutes or more |

|  |  |
| --- | --- |
|  CPT Code using 99417 |  Total Time Required for Reporting |
|  99215 |  40-54 minutes |
|  99215 x 1 and 99417 x 1 |  55-69 minutes |
|  99215 x 1 and 99417 x 2 |  70-84 minutes |
|  99215 x 1 and 99417 x 3 or more |  85 minutes or more |

|  |  |
| --- | --- |
|  CPT Code using G2212 |  Total Time Required for Reporting |
|  99205 |  60-74 minutes |
|  99205 x 1 and G2212 x 1 |  80-103 minutes |
|  99205 x 1 and G2212 x 2 |  104-118 minutes |
|  99205 x 1 and G2212 x 3 or more |  119 minutes or more |

|  |  |
| --- | --- |
| CPT Code using G2212 |  Total Time Required for Reporting |
|  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 |  99 minutes or more |

**Summary: A lot of stuff but hopefully worthwhile**Well, there you have it! There is obviously a great deal more to learn about the new 2021 E&M Medicare Physician Fee Schedule. But at this point, an attempt was made to focus upon some of the key components that will need to be mastered to initiate the use of the new guidelines, starting on January 1, 2021. To compliment the data in this report, the reader is again encouraged to go to aan.com/EM as well as the AMA CPT E/M webpage and CMS website where additional information on the new 2021 Guidelines can be found along with the new AMA MDM Table. Additional recommendations are for the practice to check with the EHR vendors to see what changes in programing may be recommended for readiness. It would also be worthwhile for the practice to review existing practice protocols such as the ability to meet the new MDM Guidelines and Total Time, and to model the new changes in coding to identify if there will be any impact to the practice reimbursement. An example to the later would be to examine current total times spent per encounter on the day of service and attempt to identify the typical level of complexity, using the new AMA MDM Table, in anticipation of any changes in the level of billing. The later includes noting how many patients each provider should see with the new emphasis on MDM and Total Time.

Also, the Billing and Coding staff will need to be educated on how to use the AMA MDM Table. It may also be worthwhile to contact the practice’s primary payers to see whether they will adopt the new 2021 MPFS. We really have no information to date but it is possible that some private payers may continue to require code selection based upon the original E&M three components: History, Physical Examination and MDM; or they may have specific requirements as they too try to navigate the new E&M coding system. It may also be productive to review some of the practice’s current patient records to see whether the data entry would support the information needed in the new MDM Table and cross check the level of E&M charged prior to January 1, 2021 with that in the new Table.

Finally, there were other E&M CPT codes which were not reviewed in this report, such as 99358 and 99359 for prolonged services on a date other than the date of the face-to-face encounter. Currently these codes must pertain to a face-to-face encounter that has occurred or will occur related to ongoing patient treatment. It appears that these codes, along with some others, are probably also undergoing review and in reviewing the literature, the status of different codes is still being determined. Thus, the focus in this report was on those codes which will be used by the majority of neurologists starting January 1, 2021.