What the #@^&* Is Going on with E/M Code Levels?

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After 25 years of utilizing the 1995 evaluation and management (E/M) coding guidelines, the E/M world changed on January 1, 2021.

The COVID-19 pandemic, coupled with new E/M coding guidelines and constantly changing regulations, has changed the way we deliver urgent care. With all that happened over the past 12 months, how do we even begin to figure out the impact?

Let's break it down! It is not as easy as comparing 2020 coding levels to our 2021 data. Again, the culprit is the pandemic.

During 2019 before the pandemic, national urgent care coding levels were very steady and predictable. On a national basis, new patient E/M levels averaged 3.4. At the same time, established patient E/M visits averaged 3.6.

During the pandemic, urgent care visits changed dramatically as most centers pivoted to deliver critical COVID-19 testing in offices and in parking lots. Providers began to embrace telemedicine in new ways to manage patient volume and mitigate risk.

This shift had a major impact on coding levels prior to the 2021 American Medical Association coding changes. The complexity of these testing visits is much lower than a traditional urgent care visit. The national lockdown and subsequent local rules restricting youth sports reduced visits (and revenue) for historically bread-and-butter ailments like sprained ankles, and the number of people presenting with flu during 2020 dropped significantly—in fact, in some areas, flu was virtually nonexistent.

Many clinics saw patients for the first time when they presented seeking COVID-19 tests. Data from Experity indicate that the percent of new patients grew from 39% of total volume to nearly half of all visits.

For many urgent care operators, the impact of lower-acuity visits was offset by this increase in new patients. The increased volume offset the reduced levels and resulted in an overall increase in total revenue. Through marketing efforts and best practices for continued patient engagement, these new patients can become returning patients helping to secure higher visit volumes moving forward.

Table 1. National CMS Rates

CPT	2020	2021	Difference	Percent change
New Patient Codes				
99202	$77.23	$73.97	-$3.26	-$4.22%
99203	$109.35	$113.75	+$4.40	+$4.02%
99204	$167.10	$169.93	+$2.83	+$1.69%
99205	$211.12	$224.36	+$13.24	+$6.27%
Established Patient Codes				
99212	$46.20	$56.88	+$10.68	+$23.12%
99213	$76.15	$92.47	+$16.32	+$21.43%
99214	$110.43	$131.20	+$20.77	+$18.81%
99215	$148.33	$183.19	+$34.86	+$23.50%
Total	$945.91	$1045.75	+$99.84	+$10.55%

Experity has been tracking these changes very closely. Our data from almost 3,000 urgent care centers across the United States show that in January 2021 average coding levels fell 18% to 20%.

During the month of February, most centers saw a rebound upward of 8% to 10%. The nonscientific explanation of this rebound could be the result of a learning curve as providers adjust to the new AMA coding rules.

On the surface, a 10% potential decrease in revenue looks terrible. Don't throw in the towel, though, as there is a glimmer of hope and the actual financial impact of this change is likely much less.

Effective January 1, 2021, the Centers for Medicare & Medicaid Services posted revised allowables by increasing the work-ex-

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pense portion of relative value units (RVUs) for each of the coding levels. (National rates are displayed in **Table 1**.)

On average, new-patient allowables increased by just 1.94% while existing patient allowables increased by 21.7%. While these rates apply to most government payers, we believe that most commercial payers will follow on their own schedules, as many fee schedules are based on a percentage of Medicare.

As we move back to normalcy and experience a shift back to traditional urgent care visits, we expect visit acuity to return to pre-COVID-19 levels (reduced by the 10% estimated impact of the new AMA rules).

If historical new/existing distribution of patients returns (approximately 50/50) and third-party payers adopt the CMS-revised allowables per E/M, we expect that Average Revenue Per Visit (ARPV) should follow, making all this chaos negligible from a financial perspective.

It should also be noted that the new COVID-19 patients seen during 2020 will all be considered existing patients on their next visit. Thus, you could see increased reimbursement on these patients as the average reimbursement per-code on the existing patients increased around 20%.

Experity will continue tracking both coding and reimbursement levels and keep you posted periodically. ■

For More Information

Monte Sandler has written extensively for *JUCM* about changes in coding guidelines for 2021, going back into 2020. Following are some highlights for your reference, including citations for accessing those articles:

- Looking Forward to 2021. *JUCM*, November 2020. Available at: https://www.jucm.com/looking-forward-to-2021/
- FAQ: New E/M Guidelines. *JUCM*, January 2021. Available at: https://www.jucm.com/faq-new-e-m-guidelines/
- Last Minute Coding Changes for 2021. *JUCM*, February 2021. Available at: https://www.jucm.com/last-minute-coding-changes-for-2021/
- New Technical Corrections Issued by the AMA Explained. *JUCM*, April 2021. Available at: https://www.jucm.com/new-technical-corrections-issued-by-the-ama-explained/

In addition, the American Medical Association published a document entitled CPT Evaluation and Management (E/M). Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes. It's available at https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.