

# 2021 Changes in E/M Codes for Office-Based Practice

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## Key Concepts:

- Decide whether it makes most sense to document and bill according to **MDM** or **Time**. For most practice patterns, it would follow that MDM will be easier to support, as the rule, and Time-based billing applied as the exception to the rule.
- MDM for a pediatric orthopaedic surgeon is driven by **Data** and **Risk**. Ensure you document well in those areas and explain the reasoning and risks associated with treatment.
- Be sure to document the presence and need for an Independent Historian.
- Be aware of any Social Determinants of Health and document, as it will benefit patient care and affect the **Risk** element of MDM.

## Introduction

It's certain that the Greek philosopher Heraclitus wasn't thinking about E/M billing when he said, "The only thing that is constant is change." Yet, there are few situations where this philosophy is more appropriate than in the world of medical coding. As CPT guidelines have changed, so must we change in order to appropriately maximize billing and remain in compliance. In this first installment of the *JPOSNA Coding Corner*, we hope to demystify the 2021 changes for an easier transition to the new coding requirements for E/M billing. Future *JPOSNA Coding Corner* topics will have a subspecialty focus on billing for different procedures.

Beginning January 1, 2021, changes to the CPT guidelines for new and established outpatient evaluation and management (E/M) codes take effect. Impacting codes in the ranges 99202-99215 (new and established office or other outpatient categories), the modifications will alter documentation requirements and will affect E/M code selection for pediatric orthopaedic surgeons.

The AMA and AAOS have published detailed explanations of the myriad definitional changes. If you have not received training on the basics of the guideline changes, consider reviewing these resources:

AMA: *CPT E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes*

<https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

AAOSNow: *The Devil Is in the Details*, August 2020

<https://www.aaos.org/aaosnow/2020/aug/managing/managing02/>

AAOSNow: *Is Time on Your Side in 2021?* November 2020

<https://www.aaos.org/aaosnow/2020/nov/managing/managing03/>

The purpose of this article is to provide a very practical application of these guidelines to impact the care of your patients immediately. The assumption is that the POSNA member has already heard about the basics of these

changes from their institution or practice manager yet are craving guidance as to how their notes should look or their E/M codes be selected.

## Rules of the Game

### **10 Essential Facts about the E/M Guideline**

#### **Changes for Codes 99202-99215**

1. Affects all providers and payors. The guideline changes are created by the AMA for CPT and are thus applicable for all payors. CMS agreed to adhere to the revised guidelines in the 2021 Medicare Physician Fee Schedule Final Rule. Medicaid plans that are a high-volume payor in pediatric specialties are also expected to comply with adoption.

2. Changes only apply to outpatient new and established patients. The guideline changes will only impact codes 99202-99215. Providers will continue to apply CPT's original rules for reporting E/M codes in the emergency department, inpatient setting, observation admissions, and for both inpatient and outpatient consultations.

3. Medical Decision-Making (MDM) or Time. When deciding how to document and bill for a visit, the provider will need to determine if they want to pursue billing based on MDM or Time.

If pursuing MDM, it is no longer required that you have to fulfill a certain number of bullet points in your history and physical exam sections. The information included instead has to be medically appropriate (the provider defines what is now appropriate) to support the MDM. Therefore, the Assessment and Plan (or equivalent) portion of your note drives the billing, not how many elements of history and physical exam anatomical locations you include.

If pursuing Time-based billing, documentation is aimed at the total time spent with the patient and their chart, both for the physician and the qualified health professional (QHP), and the specific components of the patient's record and visit that were addressed. (see #5 below)

4. MDM-based Billing. The history (HPI, PMH, Meds, ROS, SH) and physical exam no longer contribute to the mechanism for selecting a code. Therefore, choosing codes 99202-99215 based upon MDM hinges solely on criteria met for at least two of the following three elements typically summarized at the end of the note in the Assessment/Plan (or equivalent): Problems Addressed, Data Analyzed, and Risk of Patient Management. Each element receives a grade of straightforward (correlates to 99202/99212), low (99203/99213), moderate (99204/99214), or high (99205/99215) and the two elements that have the highest matched grade determine the code (Figure 1).

- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

5. Time-based Billing. There are three major changes: the provider may now include non-face-to-face time on the day of service, the time includes both the physician and a qualified health professional (QHP), and the phrase "greater than 50% of the visit was spent on counseling and/or coordinating care" is not needed.

- Total time is made up of non-face-to-face time and face-to-face time with the patient. When the physician and QHP provide face-to-face and non-face-to-face work for the visit, their time can be combined. If the physician and QHP are with the patient simultaneously, the time may only be counted once. Some payors may have additional rules for care that is Split/Shared.
- QHP = APP, NP, PA, clinical nurse specialist. It is not a resident or medical assistant.
- Must document the exact time spent on the patient and the manner in which the time was spent – reviewing records before the visit, the history/PE performed, interpretation of tests (not separately

reported), counseling the family, and documenting in EHR.

- It is not appropriate to count time that is spent in performing separately reported procedures such as injection procedures or cast/splint application.
- Only time spent on the calendar day of the visit is credited toward the E/M service.
- There is a new 99417 prolonged service code that is applied for care that extends beyond the minimum time range for 99205 (60 minutes) and 99215 (45 minutes) codes. This code is an add-on to 99205/99215 and is applied for every 15-minute block of additional time spent.
- CPT has not defined how Time must be documented, but it's understood that the note must describe the services that are performed and by whom. Payor criteria may vary as the revised guidelines are adopted.

6. May not bill for interpretation of radiographs and count the test order/review/interpretation toward your MDM complexity. If you work in a private practice that bills for radiology, then the test will not count toward your MDM complexity. If you work in an academic center or other practice where a *different department* bills the interpretation of the radiology study, you may include it toward the MDM complexity.

7. Many pediatric orthopaedic conditions are defined by CPT as Chronic. For the purposes of E/M, CPT defines this as “A problem with an expected duration of at least a year or until the death of the patient.” Scoliosis, kyphosis, clubfoot, metatarsus adductus, femoral anteversion, limb length inequality, cerebral palsy, DDH, etc., are all chronic conditions.

8. Many pediatric orthopaedic conditions are considered by CPT to be Not Stable. ‘Stable’ for the purposes of categorizing medical decision-making, is defined by the specific treatment goals for an individual patient. A pa-

tient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. An example is a routine follow-up for scoliosis that demonstrates a non-progressive curve is still considered ‘not stable’ because they aren’t at their treatment goal.

9. Ensure you document the presence of an Independent Historian. All patients under age 18, by definition, will have a parent/guardian accompany them and provide aspects to the history. Be sure to document who the historian is (parent/guardian) and why (the patient is a child and unable to provide a complete history). This counts toward the complexity in the ‘Data’ element of MDM.

10. Social Determinants of Health can increase the complexity of Risk of Patient Management. A patient’s social situation increases the risk of any treatment and appropriately documented will be reflected in the complexity of the Risk of Patient Management. Examples include lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support, problems related to housing, and economic circumstances.

### Office E/M Selection: Practical Examples

Ok, you’ve got the Rules of the Game. You’ve read the articles. You’ve studied the definitions. Now it’s time to play.

The following examples represent common office visits for scoliosis. Let’s assume that you will not bill for radiology read.

In three of the scenarios, we compare documentation using MDM to documentation using Time; in the fourth, we use Time only.

**Figure 1** will be your roadmap through the code assigned and guiding the appropriate documentation included in your note.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	<b>Minimal</b> • 1 self-limited or minor problem	<b>Minimal or none</b>	<b>Minimal risk of morbidity from additional diagnostic testing or treatment</b>
99203 99213	Low	<b>Low</b> • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	<b>Limited</b> <i>(Must meet the requirements of at least 1 of the 2 categories)</i> <b>Category 1: Tests and documents</b> • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or <b>Category 2: Assessment requiring an independent historian(s)</b> <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	<b>Low risk of morbidity from additional diagnostic testing or treatment</b>
99204 99214	Moderate	<b>Moderate</b> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	<b>Moderate</b> <i>(Must meet the requirements of at least 1 out of 3 categories)</i> <b>Category 1: Tests, documents, or independent historian(s)</b> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or <b>Category 3: Discussion of management or test interpretation</b> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	<b>Moderate risk of morbidity from additional diagnostic testing or treatment</b>  <i>Examples only:</i> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	<b>High</b> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	<b>Extensive</b> <i>(Must meet the requirements of at least 2 out of 3 categories)</i> <b>Category 1: Tests, documents, or independent historian(s)</b> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or <b>Category 3: Discussion of management or test interpretation</b> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	<b>High risk of morbidity from additional diagnostic testing or treatment</b>  <i>Examples only:</i> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

## Scenario 1 – The Classic Patient

An 11-year-old female patient presents with her mother for scoliosis evaluation after a recent school screening and assessment by her pediatrician. The patient and mother bring the spine x-ray report and office notes that were ordered and performed by her pediatrician last month. A medically appropriate history and exam is performed, new spine radiographs are obtained, and a diagnosis of Adolescent Idiopathic Scoliosis is made with a plan for bracing and follow-up in 1 month for brace pickup.

### Example of a Clinic Note That Supports Moderate E/M Code

**HPI:** Megan is an 11-year-old female who is referred by her pediatrician for concerns of scoliosis. She had a school-screening and follow-up with her pediatrician who confirmed scoliosis with exam and radiographs. The pediatrician's notes and x-ray reports are available to review but not the images. Megan doesn't report any pain or difficulty related to her back, has no numbness or tingling, or bowel or bladder concerns. She is pre-menarchal.

**PMH:** None

**SH:** 5<sup>th</sup> grade. Plays volleyball. Here with her mother, who is an independent historian who provides part of the history due to the patient being a child.

**MEDS:** None

**FH:** Mother with scoliosis that never needed treatment

**ROS:** Negative

**Physical Exam:** Healthy and well-appearing female. The examination of her back demonstrates normal skin with a right thoracic prominence measuring 1.5cm. She has a level pelvis, right truncal shift, and right shoulder high. Her strength is 5/5 to all motor groups in the lower extremity and sensation is intact to light touch in L2-S1 dermatomes. She has 2+ patella reflexes bilaterally, negative clonus bilaterally, and a negative (symmetrically absent) abdominal reflex. She has normal-appearing feet and a 2+ dorsalis pedis pulse.

**Imaging:** Two views of the spine and a bone age were obtained today that demonstrate a 27 degree right thoracic curve, Risser 0, closed triradiate cartilage. Appropriate thoracic lordosis at the apex on lateral. Bone age film is a Sanders 4.

**Assessment/Plan:** 11-year-old female with Adolescent Idiopathic Scoliosis. Due to her curve magnitude and skeletal immaturity that predict for progression, she meets indications for bracing. 23-hour brace treatment was discussed with the patient and her mother and they would like to proceed. A TLSO will be measured and molded today with follow-up in 4 weeks for brace pickup and a PA spine radiograph in the brace.

<b>Problems Addressed</b>	Adolescent Idiopathic Scoliosis is a chronic illness. Because the patient is not at treatment goal, we would classify the condition as not stable. Based on the clinical scenario we'd classify the Problem Addressed as <i>1 or more chronic illness with exacerbation, progression, and side effects of treatment</i> which falls at <b>Moderate</b> for the Problems Addressed element.
<b>Data</b>	Reviewing the pediatrician's note, reviewing the outside x-ray report, ordering spine and bone age radiographs, and the presence of independent historian meets five items of Category 1 (need three) under Moderate data.

	Describing your independent interpretation of the spine and bone age radiographs that are billed by a different department would also satisfy Category 2 under Moderate data. (If your practice bills for the radiographs ordered and interpreted, then neither the order nor the interpretation will count toward MDM.) The combination of Category 1 and 2 being satisfied supports an <b>Extensive</b> level for the Data element.
<b>Risk</b>	Bracing is an item that isn't included in specific examples qualifying the risk levels. However, given the risk of wearing a brace having relatively low morbidity, it would qualify as <b>Low</b> for the Risk element.
<b>MDM/Code</b>	This encounter would support <b>Moderate MDM</b> . As two of the three categories (Problems and Data) had documentation supporting or exceeding moderate MDM, this code is chosen. If the patient is new to the practice, this encounter would support 99204. If established, code 99214 would apply.
<b>Discussion</b>	<b>Problems Addressed:</b> To qualify for a 'High' level, the diagnosis would have to satisfy " <i>severe exacerbation, progression, or side effects of treatment.</i> " The documentation to support a severe scoliosis would include, for example, evidence of pulmonary compromise or other impact on <i>bodily function</i> . <b>Data:</b> Given the satisfaction of Category 1 and 2, the Data element is already 'Extensive.' Examples of satisfying Category 3 would be calling a colleague in a different practice, discussing interpretation of radiographs and documenting conversation. <b>Risk:</b> Social determinants of health, recommending minor surgery, or major surgery <i>without</i> discussing the risks would all qualify as 'Moderate' under the Risk element.

**Example of a Note That Would Justify Billing for Time**

(The clinical elements of the note would be included to the level that the provider felt appropriate to communicate to herself and others the purpose of the visit and document the findings and discussion).

Megan is an 11-year-old female presenting for scoliosis identified at a school screening. She is an otherwise healthy 5<sup>th</sup> grader who enjoys playing volleyball. PMH/MEDs/SH/ROS are otherwise unremarkable.

**PE:** Healthy and well-appearing. Right thoracic prominence, normal neurologic examination.

**Imaging:** 27 degree right thoracic curve, Risser 0, closed TRC. Sanders 4.

**A/P:** 11-year-old female with adolescent idiopathic scoliosis. Plan for TLSO, F/U in 4 weeks for x-ray in brace.

The clinical nurse specialist spent 10 minutes reviewing the outside pediatrician notes and radiology record.

The physician spent an additional 5 minutes reviewing records and the new radiographs obtained on day of visit.

The physician spent 20 minutes with the patient performing HPI, physical exam, reviewing findings and counseling patient to treatment and prognosis.

The clinical nurse specialist spent an additional 15 minutes with the patient teaching the family about brace-wearing, counseling regarding wear-rate and life in a brace.

The physician spent 5 minutes documenting in the EHR.

Total time with the patient on day of service was 55 minutes, supporting code 99204.

<p><b>Scenario 2 – The Quick Follow-up</b></p> <p>An 11-year-old female patient with adolescent idiopathic scoliosis is here for a brace check. She picked up the brace six weeks ago and it did not fit perfectly. She is sent back to the brace shop for an adjustment and with plans for F/U in 4 months for a scoliosis x-ray and bone age.</p>	
<p><b>Example of a Clinic Note That Supports Moderate E/M Code</b></p> <p><b>HPI:</b> Megan is an 11-year-old female with AIS returning for a brace check. She picked up the brace six weeks ago and it did not fit perfectly and has had challenges with increasing her wear rate. Megan’s mother is present with her and is an independent historian given the patient is a child.</p> <p><b>Physical Exam:</b> Megan has some very mild redness over her right thorax where the brace has been rubbing. No skin breakdown or wound present.</p> <p><b>Assessment/Plan:</b> 11-year-old female with AIS who will require an adjustment. She will meet with the brace shop today for that and she will F/U in 4 months with a PA spine radiograph and bone age.</p>	
<b>Problems Addressed</b>	Adolescent Idiopathic Scoliosis is a chronic illness. Because the patient is not at treatment goal, we would not consider this stable. Based on the description we’d consider the Problem Addressed to be <i>1 or more chronic illness with exacerbation, progression, and side effects of treatment</i> , which falls as <b>Moderate</b> .
<b>Data</b>	No data is viewed but two separate radiographs are ordered and won’t be billed by provider (PA spine and bone age). The physician documents a parent providing supplemental history. These three items satisfy Category 1 in the Data element for the <b>Moderate</b> level.
<b>Risk</b>	The brace is considered <b>Low</b> risk.
<b>MDM/Code</b>	This encounter would support <b>Moderate MDM</b> , as an established patient code 99214 would be used.
<b>Discussion</b>	This scenario drives home two points relative to the Data element. Even though no tests are interpreted, two unique tests are ordered AND the independent historian was used and documented. Meeting the criteria for Category 1 is one way to qualify as Moderate for the Data element.
<p><b>Example of a Note That Would Justify Billing for Time</b></p> <p>Megan returns for a brace check and isn’t wearing her brace well due to it not fitting properly. We will send her to the brace shop for modifications and F/U in 4 months with spine and bone age radiographs.</p> <p>10 minutes were spent by the physician with the patient discussing proper brace wear and examining the patient.</p> <p>The clinical nurse specialist spent an additional 20 minutes with the patient strategizing methods for increasing brace compliance.</p> <p>The physician spent 5 minutes documenting in the EHR.</p> <p>Total time on day of service was 35 minutes, supporting code 99214.</p>	

### Scenario 3 – The Surgical Discussion

A 13-year-old male patient presents to an academic practice for follow-up of scoliosis diagnosed over a year ago. Due to Covid-19, he has not been able to come to clinic for a year and his 29-degree curve has progressed to 55 degrees. The family wants to know why it progressed, are asking for an MRI, and the next steps toward surgical treatment options.

#### Example of a Clinic Note That Supports Moderate E/M Code

**HPI:** Terrence is a 13-year-old male with adolescent idiopathic scoliosis that returns to clinic after missing his past two visits due to Covid-19. His father accompanies him and provides independent history due to his son being a child. He mentions that he has noticed a significant change in the appearance of his hump. Terrence isn't really bothered by the change and hasn't noticed any difference in pain or ability to be active. No change in his symptoms.

**Physical Exam:** Well-appearing male with a significant right thoracic prominence of ~4.5cm. He has some mild back acne but otherwise benign skin. Strength, sensation, and reflexes are normal.

**Imaging:** PA spine radiograph ordered today demonstrate 55-degree right thoracic curve, Risser 1.

**Assessment/Plan:** 13-year-old male with adolescent idiopathic scoliosis that has progressed to a surgical magnitude with immaturity present predicting for continued progression. Given the degree of deformity and surety of future progression, he would be indicated for posterior spinal fusion. The surgical treatment pathway was discussed with the family, specifically the risks of infection, hardware failure, re-operation, blood loss, weakness or numbness occurring, spinal cord injury resulting in paralysis or bowel/bladder loss.

<b>Problems Addressed</b>	Adolescent idiopathic scoliosis is a chronic illness. Because the patient is not at treatment goal, we would not consider this stable. Based on the description, we'd classify the Problems Addressed as <i>1 or more chronic illness with exacerbation, progression, and side effects of treatment</i> , which falls as <b>Moderate</b> .
<b>Data</b>	Documenting an independent interpretation of the x-rays that are billed by the radiologist supports Category 2 under <b>Moderate</b> Data. The physician could also take credit for the x-ray order under Category 1 and the father's input as an independent historian, but without a third item, these data do not change the Data element level.
<b>Risk</b>	A decision for elective major surgery with identified patient or procedural risk factors falls at <b>High</b> Risk of Patient Management.
<b>MDM/Code</b>	This encounter would support <b>Moderate MDM</b> , as an established patient code 99214 would be used.
<b>Discussion</b>	If the physician ordered an additional test such as an MRI to evaluate for unexplained progression, the level of Data would increase to Extensive based upon meeting both categories 1 and 2. Combined with High Risk this would support 99215.

#### Example of a Note That Would Justify Billing for Time

Terrence returns to clinic after an extended absence brought about by Covid-19. He has had significant progression of his AIS to 55 degrees and we have recommended surgery.

30 minutes were spent in discussion with the father (and mother via FaceTime) regarding the new x-rays, the progression, and the surgical discussion including the risks and benefits of surgery.

2 minutes were spent documenting in the EHR.

Total time on day of service was 32 minutes, supporting code 99214.

### Scenario 4 – The Clinic Stopper

A 17-year-old female patient has been referred for back pain and scoliosis. She has seen numerous other specialists and the family has brought a neatly organized binder with the physician notes, multiple MRIs, EMG, and physical therapy notes.

The clinical nurse specialist spends 15 minutes reviewing the records and provides a summary for the physician.

The physician spends 10 minutes reviewing the records herself, then spends 35 minutes in face-to-face time with the patient performing the history and physical exam, reviewing the imaging studies, and concluding with a plan of care.

The clinical nurse specialist, after the physician leaves, spends an additional 10 minutes with the family counseling them.

The physician spends 5 minutes documenting in the EHR.

### Example of a Note that Would Justify Billing for Time

Dominique is a 17-year-old female patient with muscular low back pain. Her scoliosis measures 9 degrees on imaging today and she is a Risser 5. There is no concern for future progression or problems related to scoliosis. We have prescribed physical therapy for her back pain and will follow-up in 6 months for a clinical check.

The clinical nurse specialist spent 15 minutes reviewing the records and provided a summary for the physician.

The physician spent 10 minutes reviewing the records herself, then spent 35 minutes in face-to-face time with the patient performing the history and physical exam, reviewing the imaging studies, and concluding with a plan of care.

The clinical nurse specialist, after the physician left, spent an additional 10 minutes with the family counseling them.

The physician spent 5 minutes documenting in the EHR.

Total time on day of service is 75 minutes, supporting codes 99215 and +99417.

While CPT guidelines and the CMS system for work RVUs are independent of one another, it is valuable to note that CMS has increased the work RVUs for seven of the nine E/M codes used in the outpatient setting. The 2021 work RVUs are displayed in Figure 2, compared to the respective values in 2019 and 2020.

## 2021 CMS Physician Fee Schedule wRVU Comparison

New Patient Code	2019 wRVU	2020 wRVU	2021 wRVU	Est. Patient Code	2019 wRVU	2020 wRVU	2021 wRVU
99202	0.93	0.93	0.93	99211	0.18	0.18	0.18
99203	1.42	1.42	1.60	99212	0.48	0.48	0.70
99204	2.43	2.43	2.60	99213	0.97	0.97	1.30
99205	3.17	3.17	3.50	99214	1.50	1.50	1.92
				99215	2.11	2.11	2.80

**Figure 2.** CMS wRVU for respective E/M codes. Increases occurred in seven of nine codes for 2021, most notably for 99204/99214 and 99205/99215.