EVALUATION AND MANAGEMENT: OFFICE OR OTHER OUTPATIENT SERVICES (ON/AFTER JANUARY 1ST, 2021)

SERVICE CODES 99202-99205 AND 99212–99215

FACT SHEET

Effective January 1, 2021, providers rendering office or other outpatient evaluation and management (E/M) services may use either medical decision making as defined for each service or total time on the date of the encounter when choosing the level of service. The 1995 and 1997 E/M guidelines will no longer be used in the office or other outpatient setting.

Medical Decision Making

The complexity of MDM is based upon the following factors:

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

History and/or physical examination are not a requirement for code selection; rather these are performed when medically necessary which is dependent on the providers clinical judgement and the nature of the presenting problem. The history and examination may be necessary for a provider to address a problem and manage patient care.

Office/Other Outpatient Services

NEW Patients*	99202	99203	99204	99205
History & Exam				
When medically appropriate	●	●	●	●
Medical Decision Making				
Straightforward	●			
Low		●		
Moderate			●	
High				●
Total Time				
Minutes on the date of the encounter	15-29	30-44	45-59	60-74

* A new patient is one who **has not** received any services from the provider or another provider of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

ESTABLISHED Patients*	99202	99203	99204	99205
History & Exam				
When medically appropriate	●	●	●	●
Medical Decision Making				
Straightforward	●			
Low		●		
Moderate			●	
High				●
Total Time				
Minutes on the date of the encounter	10-19	20-29	30-39	40-54

* An established patient is one who **has** received services from the provider or another provider of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

Presenting Problems

- Includes a chief complaint which is a concise statement from the patient describing the symptom, problem, condition, diagnosis, or physician recommendation for follow up
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M level of service UNLESS their presence significantly increases the complexity of the medical decision making.

Medical Necessity

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code.

Order, Review, and Independent Interpretation

- Order and review of a test are part of the encounter and not a subsequent encounter
- If the billing entity is getting paid for the separately reported test and the E/M service, the order and review, or independent interpretation may not be included when choosing the E/M level of service.

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CPT Elements of Medical Decision Making				
Code	**Level of MDM**	**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**
99202 99212	Straight-forward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury	**Limited** (must meet the requirements of at least 1 of the 2 categories): • **Category 1: Tests and documents** 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 • **Category 2: Assessment requiring an independent historian(s)** (For the categories of)	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	Moderate	**Moderate** • **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	**Moderate** (must meet the requirements of at least 1 out of 3 categories): • **Category 1: Tests, documents, or independent historian(s)** - 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** • **Category 2: Independent interpretation of tests** - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** • **Category 3: Discussion of management or test interpretation** - Discussion of management or test interpretation with external physician/other qualified health care professional\ appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • 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	**High** • **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	**Extensive** (must meet the requirements of at least 2 out of 3 categories) • **Category 1: Tests, documents, or independent historian(s)** - 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** • **Category 2: Independent interpretation of tests** - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** • **Category 3: Discussion of management or test interpretation** - Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • 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

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Total Time

Physicians and other qualified health care providers (QHP) may include qualifying face-to face and non-face-to-face activities when performed on the date of the encounter. When two or more clinicians collaborate on the date of service, count only one person per minute. Qualifying factors of total time include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

Do not count time spent performing services that are separately reported, travel time, or teaching that is general and not limited to discussion for the management of a specific patient.

Prolonged Services

Service code G2212 may be used for 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

- Add-on code, list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services
- Do not report G2212 for any time unit less than 15 minutes

Prolonged Office/Outpatient E/M visit NEW patient	
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
99205 x 1 and G2212 x 3 or more for each additional 15 min	119 minutes or more

Prolonged Office/Outpatient E/M visit ESTABLISHED patient	
Code(s)	**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 for each additional 15 min	99 minutes or more

Ancillary Staff

The 2020 Final Rule broadened the requirements for medical record documentation in an effort to reduce provider burden and allow providers more time for patient care, rather than spending excessive time documenting in the medical record.

The billing provider, physicians or NPP, may review and verify (sign and date) information entered in the medical record by the care team rather than re-documenting information. The review and verification ensure that the information is accurate, complete, and specific to the services the provider is rendering and billing for. As always, the information entered in the medical record should clearly support the medical necessity of the services rendered.

While the medical record documentation is a flexibility for each care team, all members remain responsible to act within their scope of practice.

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Signatures, Amendments, Corrections, and Delayed Entries in Medical Documentation

Please note that ALL services ordered or rendered to Medicare beneficiaries must abide by CMS signature regulations and documentation/recordkeeping principles.

- CMS guidelines regarding signature requirements, amendments, corrections and delayed entries in medical documentation are located in the CMS Internet-only Manual (IOM) Publication (Pub.) 100-08, Chapter 3, sections 3.3.2.4 and 3.3.2.5. (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)
- All medical records MUST have a valid signature. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf)
- Providers should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters MM6698. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf)

Reminder

CMS Internet-only Manual (IOM) Publication (Pub.) 100-04, Chapter 12, Section 30.6.1, *Selection of Level of Evaluation and Management Service*:

> Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

Resources

- CMS IOM Pub. 100-02, Chapter 15, Section 30 – Physician Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- CMS IOM Pub. 100-04, Chapter 12, Section 30.6 – Evaluation and Management Service Codes – General https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- CPT Evaluation and Management 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
- CPT E/M Office Revisions Level of Medical Decision Making (MDM) table https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf
- CGS 2021 Evaluation and Management FAQs https://www.cgsmedicare.com/medicare_dynamic/faqs/faqsb/display_faqs_j15b.aspx?id=171
- 2021 CPT Book Table of Risk

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