99202-99205 NEW PATIENT | 99211-99215 SUBSEQUENT

FACT SHEET

CPT Codes

CPT Code 99202

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

CPT Code 99203

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

CPT Code 99204

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

CPT Code 99205

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

CPT Code 99211

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

CPT Code 99212

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

CPT Code 99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

CPT Code 99214

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

CPT Code 99215

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Providers

- MD, DO, NP, PA

Medical Necessity

Providers may choose E/M visit level based on either medical decision making or total time.

Time

- Total time includes both face-to-face and non-face-to-face spent relative to beneficiaries care on the actual date of the encounter.
  - Time spent separately by clinical staff is not included in calculating time.
  - Reviewing medical history, test results, or other sources on another date will not count towards total time on the date of the encounter.
- Share or split visit when physician and other qualified healthcare professional jointly provide face-to-face and non-face-to-face work related to the visit.

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  - Only distinct time (time of one professional) can be counted when meeting jointly with the beneficiary or to discuss treatment. Double counting minutes is not allowed.
- Physician/other qualified health care professional time includes the following activities when performed:
  - Preparing to see patient (eg, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing medically appropriate examination and/or evaluation
  - Counseling and educating patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in health record
  - Independently interpreting results (not separately reported) and communicating results to patient/family/caregiver
  - Care coordination (not separately reported).

Medical Decision Making (MDM)

- Medical decision making includes establishing diagnoses, assessing status of condition, and/or selecting management option. Medical decision making in office and other outpatient services code set is defined by three elements. Level of MDM is based on meeting two out of three elements:
  1. Number and complexity of problem(s) that are addressed during encounter
  2. Amount and/or complexity of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter
     > Includes information obtained from multiple sources or interprofessional communications that are not separately reported
     > Ordering a test is included in the category of test result(s) and review of the test result is part of the encounter and not subsequent encounter
     > Actual performance and/or interpretation of diagnostic tests/studies during patient encounter are **not included** in determining the level of E/M services when reported separately. If it is billed separately, cannot receive credit for order and interpretation in MDM. (see below in services reported separately)
     > Data is divided into three categories:
       - Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet threshold number)
       - Independent interpretation of tests
       - Discussion of management or test interpretation with external physician, other qualified healthcare professional, or appropriate source
  3. Risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with patient's problem(s), diagnostic procedure(s), treatment(s)
     > This includes possible management options selected and those considered, but not selected, after shared medical decision making with patient and/or family.
- Four types of MDM levels - straightforward, low, moderate and high.

Services Reported Separately

- Any specifically identifiable procedure or service performed on the date of E/M services may be reported separately.
- The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are **not included** in determining the levels of E/M services when reported separately. If it is billed separately, cannot receive credit for order and interpretation in the MDM.
- Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code.
- Physician's interpretation of test results (ie, professional component) with preparation of separate distinctly identifiable signed written report may also be reported separately, using appropriate CPT code and, if required, with modifier 26 appended.
- If a test is independently interpreted in order to manage patient as part of E/M service, but is not separately reported, it is part of medical decision making.

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Component(s) for Code Selection	Office or Other Outpatient Services–CPT codes 99202-99215
History and Examination	As medically appropriate. Not used in code selection.
Time	May use MDM or total time on date of encounter. Review of medical records on another date will not count towards total time.
Medical Decision Making (MDM)	May use MDM or total time on date of encounter
MDM Elements	• Number and complexity of problems addressed at encounter • Amount and/or complexity of data to be reviewed and analyzed (each unique source/test) • Risk of complications and/or morbidity or mortality of patient management

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care.	Limited (Must meet requirements of at least 1 out of 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 independent interpretation of tests and discussion of management or test interpretation, see moderate or high).	Low risk of morbidity from additional diagnostic testing or treatment

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Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/ or Morbidity or Mortality of Patient Management
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	(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 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

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Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/ or Morbidity or Mortality of Patient Management
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 threat to life or bodily function	(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 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 or escalation of hospital level care • Decision not to resuscitate or to deescalate care because of poor prognosis • Parenteral controlled substances

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Codes for Billing Prolonged Office or Outpatient E/M Visits

Codes	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
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 minutes	99 or more

Billing & Documentation

- Use modifier FS (Split or Shared E/M Visit) on claims to report these services. This indicates that even though the claim was submitted under 1 provider's NPI, more than 1 provider performed the visit.
- No matter where the split (or shared) visit took place, the medical record must include:
  - Identity of both providers who perform the visit with the one providing the substantive portion signing and dating the medical record
  - Submit claim using NPI for the provider who performed the substantive portion of the visit.
- Clear and concise medical record documentation is critical to getting correct and prompt payment for services. Medical records chronologically report patient's care and records related facts, findings, and observations about the patient's health history.
- Required documentation to make sure a service is consistent and to confirm:
  - Site of service
  - Medical necessity and appropriateness of diagnostic or therapeutic services
  - Services are reported correctly.
- General principles of medical record documentation apply. These general principles help make sure medical record documentation is correct for all E/M services:
  - Documentation of each patient encounter that includes: Reason for the encounter, Relevant history, Physical examination findings, and Prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
  - Past and present diagnoses
  - Identification of appropriate health risk factors
  - Documentation of patient's progress, response to and changes in treatment, and revision of diagnosis
  - Documentation in medical record should report diagnosis and treatment codes reported on the health insurance claim form.

Appropriate Signatures

- Signature and credentials of person performing services must meet CMS requirements.
- Amendments/corrections/delayed entries properly identified.

For more information regarding signature requirements, please view the following resources:

- CGS Administrators, LLC, J15 Part B Medical Review
  https://www.cgsmedicare.com/partb/mr/signatures.html
  https://www.cgsmedicare.com/partb/cert/signatures.pdf
- CMS MLN Fact Sheet, *Complying with Medicare Signature Requirements*.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf

CMS IOM Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, *Signature Requirements*.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

References

MLN Evaluation Management Service Guide
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

CMS Medicare Program Integrity Manual (Pub. 100-08), Chapter 3, Section 3.3.2.4
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf

Definition of "Medically Necessary": Social Security Act (SSA), Section 1862 (a)(1)(A)
https://www.ssa.gov/OP_Home/ssact/title18/1862.htm

Medicare Benefit Policy Manual 100-02 | CMS
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

Medicare Claims Processing Manual 100-04 | CMS
https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

MR Activities Medical Review Activity Log (cgsmedicare.com)
https://www.cgsmedicare.com/partb/mr/activity_log.html

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