Office or Other Outpatient Evaluation & Management (E/M) Coding for New and Established Patient Visits

Office or other outpatient E/M codes for a new (99202-99205) or established (99211-99215) patient may be used to report E/M services provided in an office or other outpatient setting.

Effective 1/01/2021, code descriptions and guidelines for office or other outpatient E/M codes were revised to allow the level of service to be based on *total time* on the date of the encounter or on the *single key component* of medical decision making (MDM). A medically appropriate history and physical examination, as determined by the treating provider, should be documented, however, the level of history and exam are no longer used to determine the level of E/M service. Note: E/M services that are billed with a psychotherapy add-on code (90833, 90836, 90838) cannot be billed by time and must be billed based on MDM components.

ONE EXAMPLE - NEW PATIENT
E/M PLUS PSYCHOTHERAPY PROGRESS NOTE

Patient Identifier: _____
Date: _____
Diagnosis: _____

E/M:
History:
Examination:
Medical Decision Making:

Psychotherapy:
Time spent on psychotherapy services only: _____
[Include description of type & content of psychotherapy provided]
List additional attendees, if any: _____
Legible Signature of Practitioner, Degree, Licensure: _____

- **Total time** for reporting these services includes *face-to-face and non-face-to-face time* personally spent by the physician or other qualified health care professional (QHP) on the date of the encounter. Code descriptions specify the time that must be met or exceeded.
  - Includes time for activities such as preparing to see the patient, obtaining a history, performing an exam, providing counseling or education, preparing orders, independently interpreting tests or coordinating care (if not separately reported) and documenting the health record
  - Excludes time for activities performed by clinical staff, time spent performing separately reportable procedures, travel time or general teaching time
- **MDM elements:** To qualify for a given level of decision-making, 2 of 3 MDM elements must be met or exceeded

1. Number and complexity of problem(s) that are addressed during the encounter
- A problem is considered to be addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service

2. Amount and/or complexity of data to be reviewed and analyzed
- Data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter (excluding interpretations that are separately reported)

3. Risk of complications and/or morbidity or mortality of patient management
- Risk is described as the probability and/or consequences of an event. For the purposes of MDM, the level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

For more details on time or MDM, including definitions and examples, refer to the CPT 2023 E/M Services Guidelines. Prior to 1/1/2023, office or other outpatient E/M codes are based on three key components (history, exam and MDM) or time if counseling and/or coordination of care dominate the visit. Refer to the guidelines appropriate to your date of service.

Code notes (see the chart on page 2 for MDM and time criteria)

- **99202–99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and (level indicated in chart) MDM. When using time for code selection, (time range indicated in chart) minutes of total time is spent on the date of the encounter (99201 was deleted effective 1/1/2021).
  - A new patient is one who has not received any professional services from the physician, or other QHP of the same specialty who belongs to the same group practice, within the past three years.
- **99212–99215** – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and (level indicated in chart) MDM. When using time for code selection, (time range indicated in chart) minutes of total time is spent on the date of the encounter.
  - 99211 is exempt from MDM or time criteria and may be used when physician supervision but not presence is required.

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Office or Other Outpatient E/M Services					
Code	**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**	**Level of MDM (meets/exceeds 2 of 3 MDM elements)**	**Time Range (minutes)**
99202	Minimal	Minimal or none	Minimal	Straightforward	15-29
99203	Low	Limited	Low	Low complexity	30-44
99204	Moderate	Moderate	Moderate	Moderate complexity	45-59
99205	High	Extensive	High	High complexity	60-74
99212	Minimal	Minimal or none	Minimal	Straightforward	10-19
99213	Low	Limited	Low	Low complexity	20-29
99214	Moderate	Moderate	Moderate	Moderate complexity	30-39
99215	High	Extensive	High	High complexity	40-54

Consultation services:

- **Effective for claims with dates of service (DOS) on or after 3/1/2020,** Optum aligns with CMS and does not reimburse consultation services procedure codes 99241-99245, 99251-99255, including when performed via telehealth. For prior DOS, Optum will reimburse consultation services in alignment with the consultation services coding guidelines published within the AMA CPT® book. See the Consultation Services Reimbursement Policy for details.

Prolonged E/M services are reimbursed when the primary E/M service is selected based on time. Optum requires providers to list the appropriate start and stop time for prolonged services codes in the medical record in order to determine the appropriate type of prolonged services. See the Prolonged Services Reimbursement Policy for details.

- Optum will reimburse for prolonged office or other outpatient E/M code 99417 beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time. 99417 must be listed separately in addition to codes 99205, 99215.
- Optum follows CMS guidelines in regard to HCPCS code G2212 which must be listed separately in addition to codes 99205 or 99215 for office or other outpatient E/M services for Medicare only.
- Effective 1/1/2023, codes 99354-99357 are deleted, and codes 99358-99359 are revised to represent prolonged services without direct patient contact that occurs on a date *other* than the related face-to-face E/M service with the patient and/or family or caregiver. For prior DOS, these codes may also be reported for non-face-to-face services provided on the same date as a related E/M service (except 99202-99205 or 99212-99215).
  - Report 99358 only once per date for the first hour of prolonged service (less than 30 minutes is not reported).
  - Report 99359 for each additional 30 minutes beyond the first hour or for the final 15 to 30 minutes of prolonged service on a given date (less than 15 minutes beyond the first hour/final 30 minutes is not reported separately).
- To report prolonged face-to-face clinical staff services provided in an office/outpatient setting with physician supervision, see codes 99415-99416. See codes 99418 and G0317 to report 15-minute increments of prolonged services with or without direct patient contact on the date of a hospital inpatient/observation E/M service.

Resources:

This overview and reminder of E/M coding guidelines is provided to help support continued improvements. Please review these additional resources for more details:

- **Optum Reimbursement Policies:** Consultation Services Reimbursement Policy, Prolonged Services Reimbursement Policy and Same Day Same Service Reimbursement Policy
- **American Psychiatric Association (APA):** CPT Coding and Reimbursement
- **American Medical Association (AMA):** CPT® Evaluation and Management and CPT Manual > E/M Guidelines
- **CMS Medicare Claims Processing Manual:** Internet-Only Manual (IOM) 100-04, Ch. 12, Sect. 30.6, Evaluation and Management Services Guide; 1995 Documentation Guidelines and 1997 Documentation Guidelines