THOMAS WEIDA, MD, FAAFP, AND JANE WEIDA, MD, FAAFP

CME

# Outpatient E/M Coding Simplified


**Getting clear on the new coding rules can help you eliminate bloated documentation and improve reimbursement to reflect the value of your visits.**

In 2021, significant changes were adopted for the documentation guidelines for outpatient evaluation and management (E/M) visit codes. Most notably, medical decision making or time became primary drivers of visit level selection, rather than the number of history and physical exam bullets.

In this article, we review the context for these changes, describe them briefly, and offer a quick reference tool to help physicians apply the new rules in practice.

## HOW WE GOT HERE

In the 2019 Medicare physician fee schedule final rule, released in November 2018, the Centers for Medicare & Medicaid Services (CMS) adopted revisions to the outpatient E/M codes in order to reduce administrative burden. (See https://www.cms.gov/newsroom/

**ABOUT THE AUTHORS**

Dr. Thomas Weida is chief medical officer, associate dean for clinical affairs, and professor at the University of Alabama College of Community Health Sciences. He is also a member of the American Medical Association's Relative Value Scale Update Committee (RUC). Dr. Jane Weida is chair of the Department of Family, Internal, and Rural Medicine, and professor at the University of Alabama College of Community Health Sciences. Author disclosures: no relevant financial relationships.

fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year.) Originally scheduled for implementation in 2021, these changes would have combined visit levels 2-4 into a blended payment rate (e.g., one rate for 99202-99204 and one rate for 99212-99214), among other changes.

In response, the American Medical Association (AMA) convened a joint CPT Editorial Board and Relative Value Scale Update Committee (RUC) workgroup to build on the changes and propose some alternatives. The workgroup's goals were to decrease administrative burden, payer audits, and unnecessary medical record documentation while ensuring that payment of E/M services is resource-based.

The workgroup approved significant revisions to the outpatient office visit E/M codes. Code 99201 was deleted. The history and/or physical examination and the counting of bullets were eliminated as components for code selection (although history and/or physical examination documentation should still be performed as medically appropriate). Medical decision making (MDM) or time could be used for code level selection. Changes were made to the code descriptors for 99202-99205 and 99211-99215, the definition of medical decision making, and the calculation of time, and a shorter prolonged services add-on code was created. CMS adopted these new E/M coding guidelines. As a result of the changes to medical decision making and time-based coding, the RUC revised the 2021 relative value units (RVUs) for office visit E/M codes. Most of the values increased, yielding an overall increase of more than 10%.

## CODING BASED ON MEDICAL DECISION MAKING

For outpatient E/M coding, medical decision making now has three components:

- 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.

There are four levels of decision making for each of these components: straightforward, low complexity, moderate complexity, and high complexity.

To determine the level of code for a visit, two of the three components must meet or exceed that level of coding. (See the table on page 28.) For example, if the patient has multiple problems addressed at the encounter, but the data is limited and the risk of complications is low, then the level of medical decision making would be low. New patient codes 99202-99205 and established patient codes 99212-99215 use the same components and levels of decision making for code selection.

> If a test is ordered, the review of that test is included with the ordering, even if the review is done at a subsequent visit.

Determining medical decision making usually starts with identifying the number and complexity of problems addressed and then determining the data or risk components that support that medical decision making. If a second component does not meet or exceed the problem component, then a lower level of decision making is appropriate. The set of tables on page 29 illustrate the essential concepts of these code levels. Each level has specific criteria for each component.

**Straightforward medical decision making:** Codes 99202 and 99212 include one self-limited or minor problem with minimal or no data and minimal risk.

An example of a 99202 or 99212 is an otherwise healthy patient with cough and congestion due to the common cold.

**Low complexity medical decision making:** Codes 99203 and 99213 include two or more self-limited or minor problems, one

### KEY POINTS

- The revisions to the E/M outpatient visit codes reduced administrative burden by eliminating bullet points for the history and physical exam elements.
- Code level selection is now simplified — based on either medical decision making or total time.
- The authors' one-page coding reference tool can help simplify the new rules.

## MEDICAL DECISION MAKING (MDM) COMPONENTS

2 of 3 components needed to meet or exceed MDM level:

| 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 |
|---|---|---|---|
| Straightforward | Minimal | Minimal or none | Minimal |
| Low | Low | Limited | Low |
| Moderate | Moderate | Moderate | Moderate |
| High | High | Extensive | High |

stable chronic illness, or one acute uncomplicated illness or injury.

The data component requires one of two categories to establish the level. Category 1 data requires at least two items in any combination of the following: each unique source's prior external notes reviewed, each unique test result reviewed, or each unique test ordered. Tests include imaging, laboratory, psychometric, or physiologic data. A clinical lab panel, such as a complete blood count, is a single test. Of note, if a test is ordered, the review of that test is included with the ordering, even if the review is done at a subsequent visit. Tests ordered outside of an encounter may be counted in the encounter in which they are analyzed. Category 2 data includes significant history given by an independent historian. Parents giving the history for their child is a typical example.

The risk component is low. There is low risk of morbidity from additional diagnostic testing or treatment.

An example of a 99203 or 99213 is a sinus infection treated with an antibiotic. Although the prescription makes the risk component moderate, the one acute uncomplicated illness is a low-complexity problem, and there are no data points.

**Moderate complexity medical decision making:** Codes 99204 and 99214 include two or more stable chronic illnesses, one or more chronic illnesses with exacerbation, progression, or side effects of treatment, one undiagnosed new problem with uncertain prognosis, one acute illness with systemic symptoms, or one acute complicated injury. A patient who is not at a treatment goal, such as a patient with poorly controlled diabetes, is not stable. Systemic general symptoms such as fever or fatigue in a minor illness (e.g., a cold with fever) do not raise the complexity to moderate. More appropriate would be fever with pyelonephritis, pneumonitis, or colitis.

The data component requires *one of three categories* to establish the level. Category 1 data requires at least three items in any combination of the following: each unique source's prior external notes reviewed, each unique test result reviewed, each unique test ordered, or independent historian involvement. Physicians cannot count tests that they or someone of the same specialty and same group practice are interpreting and reporting separately (e.g., electrocardiogram, X-ray, or spirometry). Category 2 data includes the independent interpretation of a test performed by another physician/other qualified health care professional (QHP) (not separately reported). For instance, if a chest X-ray was ordered and the ordering clinician included the interpretation in the visit documentation, this would qualify for data point Category 2. However, if the ordering clinician bills separately for the interpretation of the X-ray, then that cannot be used as an element in this category and would be an element for Category 1. Category 3 data includes discussion of management or test interpretation with an external physician/QHP (not separately reported).

The risk component may include prescription drug management, a decision for minor surgery with patient or procedure risk factors, a decision for elective major surgery without patient or procedure risk factors, or social determinants of health (SDOH) that significantly limit diagnostic or treatment options, such as food or housing insecurity. For prescription drug management, renewing pre-existing chronic medications would qualify. Documentation that the physician is managing the patient for the condition for which the medications are being prescribed would help establish validity in the use of this criterion for MDM.

An example of a 99204 or 99214 is a patient being seen for follow-up of hypertension and diabetes, which are well-controlled. An example using SDOH would be a patient with chronic knee pain and a positive anterior drawer test who needs imaging of the knee but cannot afford this care. Documenting that the patient cannot afford to obtain an MRI of the knee at this time, which significantly limits your ability to confirm the diagnosis and recommend treatment, adds to the risk component.

**High complexity medical decision making.** Codes 99205 and 99215 include one or more chronic illnesses with a severe exacerbation, progression, or side effects of treatment, or one acute or chronic illness or injury

# CODING OUTPATIENT E/M VISITS

**99212** Time based: 10-19 minutes
**99202** Time based: 15-29 minutes

Straightforward medical decision making (need 2 of 3):

| Problems | Data | Risk |
|---|---|---|
| • 1 self-limited or minor problem | Minimal or none | Minimal risk of morbidity from additional diagnostic testing or treatment |

**99213** Time based: 20-29 minutes
**99203** Time based: 30-44 minutes

Low complexity medical decision making (need 2 of 3):

| Problems | Data (1 of 2 needed) | Risk |
|---|---|---|
| • 2 or more self-limited or minor problems<br>or<br>• 1 stable chronic illness<br>or<br>• 1 acute uncomplicated illness or injury | Category 1 (2 needed):<br>• Each unique source's prior external note(s) reviewed<br>• Each unique test's result(s) reviewed<br>• Each unique test ordered<br>Category 2:<br>• Independent historian required | Low risk of morbidity from additional diagnostic testing or treatment |

**99214** Time based: 30-39 minutes
**99204** Time based: 45-59 minutes

Moderate complexity medical decision making (need 2 of 3):

| Problems | Data (1 of 3 needed) | Risk |
|---|---|---|
| • 2 or more stable chronic illnesses<br>or<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment<br>or<br>• 1 undiagnosed new problem with uncertain prognosis<br>or<br>• 1 acute illness with systemic symptoms<br>or<br>• 1 acute complicated injury | Category 1 (3 needed):<br>• Each unique source's prior external note(s) reviewed<br>• Each unique test's result(s) reviewed<br>• Each unique test ordered<br>• Independent historian required<br>Category 2:<br>• Independent interpretation of test performed by another physician/QHP*<br>Category 3:<br>• Discussion with external physician/QHP* | Moderate risk of morbidity from additional diagnostic testing or treatment<br>Examples:<br>• Prescription drug management<br>• Decision for minor surgery with identified patient or procedure risk factors<br>• Decision for elective major surgery without identified patient or procedure risk factors<br>• Social determinants of health that significantly limit diagnosis/treatment |

**99215** Time based: 40-54 minutes
**99205** Time based: 60-74 minutes

High complexity medical decision making (need 2 of 3):

| Problems | Data (2 of 3 needed) | Risk |
|---|---|---|
| • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment<br>or<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | Category 1 (3 needed):<br>• Each unique source's prior external note(s) reviewed<br>• Each unique test's result(s) reviewed<br>• Each unique test ordered<br>• Independent historian required<br>Category 2:<br>• Independent interpretation of test performed by another physician/QHP*<br>Category 3:<br>• Discussion with external physician/QHP* | High risk of morbidity from additional diagnostic testing or treatment<br>Examples:<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision for elective major surgery with identified patient or procedure risk factors<br>• Decision for emergency major surgery<br>• Decision for hospitalization<br>• Decision not to resuscitate or to de-escalate care due to poor prognosis |

*Not separately reported

### Total Time

Total time is the sum of all time — face-to-face and non-face-to-face, including prolonged time — spent by the reporting clinician on the date of service.

| New patient | Time (minutes) | Established patient | Time (minutes) |
|---|---|---|---|
| 99202 | 15-29 | 99212 | 10-19 |
| 99203 | 30-44 | 99213 | 20-29 |
| 99204 | 45-59 | 99214 | 30-39 |
| 99205 | 60-74 | 99215 | 40-54 |

**Prolonged services – Medicare**

| New patient | Time (minutes) | Established patient | Time (minutes) |
|---|---|---|---|
| 99205 + G2212 | 89-103 | 99215 + G2212 | 69-83 |
| 99205 + G2212 X 2 | 104-118 | 99215 + G2212 X 2 | 84-98 |
| 99205 + G2212 X 3 or more for each 15 minutes | 119 or more | 99215 + G2212 X 3 or more for each 15 minutes | 99 or more |

**Prolonged services – CPT**

| New patient | Time (minutes) | Established patient | Time (minutes) |
|---|---|---|---|
| 99205 + 99417 | 75-89 | 99215 + 99417 | 55-69 |
| 99205 + 99417 X 2 | 90-104 | 99215 + 99417 X 2 | 70-84 |
| 99205 + 99417 X 3 or more for each additional 15 minutes | 105 or more | 99215 + 99417 X 3 or more for each additional 15 minutes | 85 or more |

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

Developed by Thomas Weida, MD, and Jane Weida, MD, based on the 2021 Evaluation and Management (E/M) Services Guidelines, https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Related article: https://www.aafp.org/fpm/2022/0100/p26.html.

that poses a threat to life or bodily function.

The data component requires *two of three categories* to establish the level. These data categories are the same as those for 99204 and 99214, and they follow the same rules.

The risk component may include drug therapy requiring intensive monitoring for toxicity. Decisions regarding elective major surgery with patient or procedure risk, emergency major surgery, hospitalization, or "do not resuscitate" orders are also high risk. Intensive prescription drug monitoring is typically supported by a laboratory test, physiologic test, or imaging, and is done to evaluate for complications of the treatment. It may be short-term or long-term. Long-term monitoring is at least quarterly. An example would be monitoring for cytopenia during antineoplastic therapy. Monitoring the therapeutic effect of a treatment, such as glucose monitoring during insulin therapy, is not considered intensive prescription drug monitoring.

An example of a 99205 or 99215 is a patient with severe exacerbation of chronic heart failure who is admitted to the hospital.

## TIME-BASED CODING

An alternative method to determine the appropriate visit level is time-based coding. A major change is that total time now includes both face-to-face and non-face-to-face services personally performed by the physician/QHP on the day of the visit. Additionally, time-based coding is no longer restricted to counseling services. Instead, it includes the following:

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

Time spent by clinical staff cannot count toward total time. However, time spent by another physician/QHP (not a resident physician) in the same group can be included. If a nurse practitioner performs the initial intake and the physician provides the assessment and plan, both of those times can be counted, although only one person's time can be counted while they are discussing the case with each other. The visit should be billed under the clinician who provided the substantive portion (more than half) of the time, although both clinicians need to be identified in the medical record. Time spent must be documented in the note. It is advisable to specifically document the time spent and the activities performed both face-to-face and non-face-to-face.

The amount of total time required for each level of coding changed under the new time-based coding guidelines. (See the "Total time" table on page 30.)

## PROLONGED VISIT CODES

When time on the date of service extends beyond the times for codes 99205 or 99215, prolonged visit codes can be used. The AMA CPT committee developed code 99417 for prolonged visits, and Medicare developed code G2212. These are added in 15-minute increments in addition to codes 99205 or 99215. Code G2212 can be added once the *maximum* time for 99205 or 99215 has been surpassed by a full 15 minutes, whereas code 99417 can be added once the *minimum* time for 99205 or 99215 has been surpassed by a full 15 minutes. Less than 15 minutes is not reportable. Multiple units can be reported. Prolonged visit codes cannot be used with the shorter E/M levels, i.e., 99202-99204 and 99212-99214. (See "Prolonged services" tables on page 30.) Clinicians should consult with individual payers to determine which code to use — G2212 or 99417.

## SIMPLIFIED CODING AND DOCUMENTATION

The revisions to the outpatient E/M visit codes reduced administrative burden by eliminating bullet points for the history and physical exam elements. Only medically appropriate documentation is required. Code level selection is simplified — based on either medical decision making or total time. By applying these changes, primary care clinicians can eliminate bloated documentation and improve reimbursement reflecting the value of the visit. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.