IDSA
Infectious Diseases Society of America

# Office/Outpatient Evaluation and Management Services Reference Guide and Clinical Examples

January 2021

*Developed by the IDSA Clinical Affairs Committee E/M Work Group:*
*Drs. Ron Devine (chair), John Fangman, Nilesh Hingarh, Alice Kim, Prashant Malhotra and Matt Shoemaker*

---

## Section One: Overview and Introduction to Concepts

### Revisions to E/M Services CPT® Codes

On Jan. 1, 2021, revised office/outpatient visit E/M CPT® codes (99202-99215) and associated documentation went into effect. The revised codes are the culmination of collaboration among the Centers for Medicare & Medicaid Services, American Medical Association and other medical specialty societies, including IDSA. The changes to these codes were the start of a multi-year, multi-phase AMA project to revise nearly all the CPT® E/M code set. The revisions are long overdue, as the codes were established nearly 20 years ago and, in that time, patient care along with how to document that care has changed. Reducing provider burden by decreasing charting requirements was also a primary driver for the revision of the codes.

### Office or Other Outpatient E/M Services CPT® Codes 99202-99215

The E/M visit CPT® codes 99202-99215 (new and established patients) were revised to decrease documentation and coding administrative burden and to ensure that E/M payment is resource-based. The revisions remove the history and physical examination as key components in choosing the appropriate E/M level of a visit. Now, code level selection for an E/M service performed is based on medical decision-making (MDM) or total time.

### Summary of Revisions

- *The revisions to the E/M documentation guidelines are only applicable to the office/outpatient new patient and established patient visit E/M codes (99202-99215).* For all other E/M services performed, such as consultations, inpatient E/M, observation E/M and critical care, services will continue to be governed by the existing E/M documentation guidelines and CPT® instructions.
- The history and physical exam elements of a visit are *not required* when making a code level selection. However, one should still perform and document these elements when medically appropriate.
- The level of code selection is *based on medical decision-making **or** total time on the date of the encounter*.
- Medical decision-making is based on three elements:
    - Number and complexity of problems addressed;
    - Amount or complexity of data to be reviewed and interpreted;
    - Level of risk of complications and morbidity/mortality.
- The definition of total time *includes face-to-face and non-face-to-face time on the date of encounter* spent by the provider, including time reviewing medical records; reviewing tests; reviewing or obtaining a medical history; ordering medications, tests and procedures; documentation in the electronic health record; and communication with the patient, family members and caregivers.
- Documentation of time spent is only required when time is used to choose the code level.
- CPT code 99201 has been deleted.

# Section Two: Descriptions, Definitions and Elements of Medical Decision Table

## Risk of Complications and Morbidity or Mortality of Patient Management

Risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s) and treatment(s):

- Includes possible management options selected and those considered but not selected;
- Addresses risks associated with social determinants of health.

Two of three elements must be met or exceeded when selecting the code level. For example, if a new patient encounter involves a low level of MDM, a limited review of data and a low level of risk, the code selected should be 99203. Table 1 below provides information on these elements for some of the more commonly used CPT® codes.

**Table 1: Abbreviated Table of Code Level Selection**

| CPT® Codes | Level of MDM | Number and/or Complexity of Problems Addressed | Amount and/or Complexity of Data Reviewed and Analyzed | Risk of Complications and/or Morbidity/Mortality |
|---|---|---|---|---|
| 99202, 99212 | Straightforward | Minimal | Minimal or None | Minimal |
| 99203, 99213 | Low | Low | Limited | Low |
| 99204, 99214 | Moderate | Moderate | Moderate | Moderate |
| 99205, 99215 | High | High | Extensive | High |

## Medical Decision-Making

MDM is composed of three elements:

1. Number and complexity of problems addressed at encounter;
2. Amount and/or complexity of data reviewed/analyzed;
3. Risk of complications, morbidity and/or mortality of patient management decisions.

There are four types of MDM (Straightforward, Low, Moderate, and High). The level of MDM is chosen based on meeting or exceeding two of the three MDM elements.

Table 2 below defines the types of complexity of clinically relevant problems addressed at the encounter. The number and complexity of problems addressed at a patient encounter is a vital component when choosing the code level.

**Table 2: Medical Decision-Making**

| Complexity | Definition |
|---|---|
| Straightforward | Self-limited |
| Low | Stable, uncomplicated, single problem |
| Moderate | Multiple problems or significantly ill |
| High | Very ill |

Table 3 highlights categories of data that are reviewed or interpreted during a patient encounter, and Table 4 provides information on which code should be selected based on total time spent on the date of the encounter for new and established patients.

**Table 3: Amount and Complexity of Data Reviewed and Interpreted**

| | |
|---|---|
| Category 1 | Tests, Documents, Orders or Independent Historian |
| Category 2 | Independent Interpretation of Tests |
| Category 3 | Discussion of Management or Test Interpretation |

**Table 4: Total Time Spent on the Date of the Encounter (New and Established Patient)**

| New Patient E/M CPT® Code | Total Time |
|---|---|
| 99202 | 15-29 minutes |
| 99203 | 30-44 minutes |
| 99204 | 45-59 minutes |
| 99205 | 60-74 minutes |
| | |
| **Established Patient E/M CPT® Code** | **Total Time** |
| 99211 | Time component removed |
| 99212 | 10-19 minutes |
| 99213 | 20-29 minutes |
| 99214 | 30-39 minutes |
| 99215 | 40-54 minutes |

For more detail, visit the CPT E/M Office Revisions Level of Decision Making. The table depicts the levels of medical decision-making coupled with the associated complexity and problems addressed, the elements required of medical decision-making for each code level and the level of risk associated with a patient encounter. The table was developed by the American Medical Association CPT Editorial Panel to assist with proper coding of office visit E/M services.

## Description of Total Time

For office/outpatient E/M visits, the element of coding by time has been changed from counting only face-to-face time when counseling and/or coordination of time dominated the visit (greater than 50% of the time to total time on the date of the encounter) to now include non-face-to-face time. The *total time* includes all activities related to the patient visit on the date of the encounter and includes:

- Preparing to see patient (e.g., review tests, medical records);
- Obtaining history;
- Performing a medically appropriate physical examination;
- Counseling and education (patient, family member, caregiver);
- Ordering medications, tests and procedures;
- Referring and communicating to other health care professionals;
- Documenting the encounter;
- Independent interpretation of tests (when not separately reported);
- Care coordination (when not separately reported).

Total time does not include any activities or time spent other than on the *date of the encounter*. To bill by time, the total time spent on patient care activities on the date of the encounter should be documented as well as activities performed. Time spent with normal activities by clinical staff and time spent on a date other than the date of encounter should not be used to calculate total time.

For shared or split visits between a physician and other qualified health care provider, such as advanced practice providers, time spent separately on the date of the encounter may be summed to equal total time, but time spent doing the same task may only be counted by one provider.

Refer to Table 4 for time requirements for each level of E/M CPT® code when total time is used to make the code level determination.

## Prolonged Service Time — New CPT® Code 99417

CPT® code 99417 is used to report additional time beyond the time periods required for office/outpatient E/M visits. Additional time includes face-to-face and non-face-to-face activities. Code 99417 may only be used when total time has been used to select the appropriate E/M visit and the highest E/M level has been achieved (i.e., 99205 or 99215). CPT® code 99417 is parsed into 15-minute increments and may be used only when the total time on the date of the encounter exceeds the minimal time for the highest-level E/M visit by 15 minutes. For example, a provider spends a total time of 83 minutes with a new patient. The time limits for a new outpatient visit E/M visit 99205 is 60-74 minutes. The 83 minutes is 23 minutes beyond the minimal time limit of 99205 of 60 minutes, and therefore the provider can bill CPT® code 99417. For each additional 15 minutes, code 99417 may be reported.

Tables 6 and 7 below provide guidance on which code(s) may be reported for new and established patient E/M services, respectively, based on service time.

**Table 6: Using Code 99417 with New Patient E/M**

| **Use with 99205 (New Patient)** | **Code(s) Reported** |
|---|---|
| Less than 75 minutes | Use appropriate E/M code |
| 75-89 minutes | 99205 x1 AND 99417 x1 |

| | |
|---|---|
| 90-104 minutes | 99205 x1 AND 99417 x2 |
| 105 minutes or more | 99205 x1 AND 99417 x3 or more for each additional 15 minutes |

**Table 7: Using Code 99417 with Established Patient E/M**

| **Use with 99215 (Established Patient)** | **Code(s) Reported** |
|---|---|
| Less than 55 minutes | Use appropriate E/M code |
| 55-69 minutes | 99215 x1 AND 99417 x1 |
| 70-84 minutes | 992015 x1 AND 99417 x2 |
| 85 minutes or more | 992015 x1 AND 99417 x3 or more for each additional 15 minutes |

## Section Three: Clinical Examples of Code Level Selection

The following clinical examples build on a base-level patient who is 65 years old with congestive heart failure, diabetes mellitus and hypertension. Patient presents with a problem in their leg. For each example, the severity of the patient's problem progresses, therefore indicating a higher level of MDM. MDM includes an increase in the number or complexity of problems to be assessed along with review of increasing amounts of complex data and an increase in the level of risk.

The notes of the case are presented first, followed by the MDM table highlighting (in red) the elements that were considered when choosing the code level. As noted previously, E/M code level selection is now based on medical decision-making or time. In the clinical examples that follow, for examples 1-4 medical decision-making was used to select the code level and for example 5 time was used to select the code level.

**Clinical Example #1: CPT Code Level 99202 (New Patient)/99212 (Established Patient)**

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema. There is no tenderness. Exam indicates signs of stasis and but no cellulitis. Advised patient to perform leg elevation and to schedule follow-up visit with primary care physician for possible adjustment of CHF medication. No antimicrobials were prescribed. Follow-up as needed.

Medical decision-making for this case is a straightforward review of a single self-limiting problem, with review of minimal data and a minimal level of risk; therefore, code level 99202 or 99212 is indicated.

| CPT Code | MDM Level | Problems (Number and Complexity) | Data Reviewed | Level of Risk |
|---|---|---|---|---|
| **99202 99212** | **Straightforward** | **1 self-limited problem or minor problem** | **Minimal or none** | **Minimal** |
| 99203 99213 | Low | > 2 self-limited/minor problems<br>OR<br>1 stable chronic illness<br>1 acute, uncomplicated illness or injury | **Limited** (must meet requirements of at least 1 of the 2 categories)<br>2 of 3 of ordering test, review of results or prior external note OR<br>Assessment requiring an independent historian | **Low** |
| 99204 99214 | Moderate | >1 chronic problem with progression/exacerbation/adverse effects of treatment OR<br>>2 stable chronic illnesses OR<br>1 undiagnosed new problem with uncertain prognosis OR<br>1 new problem or acute illness + systemic symptoms OR<br>1 acute complicated injury | **Moderate** (must meet the requirements of at least 1 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian y<br>OR<br>Independently review and interpret test/radiology<br>OR<br>Discuss management/plan with another provider | **Moderate**<br>Examples:<br>Prescription management<br>Decision for minor surgery<br>Decision for elective major surgery without risk factors, diagnosis and treatment limited by social determinants of health |
| 99205 99215 | High | >1 chronic illness with severe progression/exacerbation/adverse effects or treatment OR<br>1 acute or chronic illness or injury that poses threat to life or body function | **Extensive** (must meet the requirements of at least 2 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian OR<br>Independently review and interpret test/radiology OR<br>Discuss management/plan with another provider | **High**<br>Intensive drug toxicity monitoring<br>Elective surgery with risk factor<br>Emergency surgery<br>Hospitalization<br>Advance care directives |

**Clinical Example #2: CPT Code Level 99203 (New Patient)/99213 (Established Patient)**

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema that began four days ago. Patient indicates there is some pain in the leg and is feeling feverish; however, vital signs show no fever. Exam is suggestive of non-purulent cellulitis. Review of prior records from PCP is performed and there is no history of methicillin-resistant *Staphylococcus aureus* indicated in the patient record or in any cultures performed. The patient indicates no allergies and is prescribed a five-day course of Keflex and asked to follow-up with the ID physician in seven days.

Medical decision-making for this case is low-level with review of a single, acute, uncomplicated problem which involved the review of a prior external note and tests. Even though moderate risk level could be met, since two of the three elements are needed, code level 99203 or 99213 is indicated.

| CPT Code | MDM Level | Problems (Number and Complexity) | Data Reviewed | Level of Risk |
|---|---|---|---|---|
| 99202<br>99212 | Straightforward | 1 self-limited problem or minor problem | **Minimal or none** | **Minimal** |
| **99203**<br>**99213** | **Low** | > 2 self-limited/minor problems OR<br>1 stable chronic illness<br>**1 acute, uncomplicated illness or injury** | **Limited** (must meet requirements of at least 1 of the 2 categories)<br>2 of 3 of ordering tests**, review of results or prior external note** OR<br>Assessment requiring an independent historian | **Low** |
| 99204<br>99214 | Moderate | >1 chronic problem with progression/exacerbation/adverse effects of treatment OR<br>>2 stable chronic illnesses OR<br>1 undiagnosed new problem with uncertain prognosis OR<br>1 new problem or acute illness + systemic symptoms OR<br>1 acute complicated injury | **Moderate** (must meet the requirements of at least 1 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian<br>OR<br>Independently review and interpret test/radiology<br>OR<br>Discuss management/plan with another provider | **Moderate**<br>Examples:<br>**Prescription management**<br>Decision for minor surgery<br>Decision for elective major surgery without risk factors, diagnosis and treatment limited by social determinants of health |
| 99205<br>99215 | High | >1 chronic illness with severe progression/exacerbation/adverse effects or treatment OR<br>1 acute or chronic illness or injury that poses threat to life or body function | **Extensive** (must meet the requirements of at least 2 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian OR<br>Independently review and interpret test/radiology OR<br>Discuss management/plan with another provider | **High**<br>Intensive drug toxicity monitoring<br>Elective surgery with risk factor<br>Emergency surgery<br>Hospitalization<br>Advance care directives |

**Clinical Example #3: CPT Code Level 99204 (New Patient)/99214 (Established Patient)**

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema that began four days ago. Patient indicates there is some pain in the leg and is feeling feverish; however, there is no fever on vital signs. Exam is suggestive of purulent cellulitis. Records from PCP are reviewed and reveal history of MRSA. The patient indicates no allergies. A complete blood count, comprehensive metabolic panel and a wound culture are ordered. The patient is prescribed five days of oral doxycycline. Adverse effects of doxycycline are discussed with the patient. The case and management are also discussed with patient's PCP. Patient is to return to office in one week or sooner if problem worsens.

Medical decision-making for this case has now progressed to a moderate level. The problem is now a single new problem that involved discussion with another provider and review of historical records. The risk has now increased to a moderate level given the patient was given a prescription that may often lead to side effects; therefore, code level 99204 or 99214 is indicated.

| CPT Code | MDM Level | Problems (Number and Complexity) | Data Reviewed | Level of Risk |
|---|---|---|---|---|
| 99202<br>99212 | Straightforward | 1 self-limited problem or minor problem | **Minimal or none** | **Minimal** |
| 99203<br>99213 | Low | > 2 self-limited/minor problems OR<br>1 stable chronic illness<br>1 acute, uncomplicated illness or injury | **Limited** (must meet requirements of at least 1 of the 2 categories)<br>2 of 3 of ordering tests, review of results or prior external note OR<br>Assessment requiring and independent historian | **Low** |
| **99204**<br>**99214** | **Moderate** | >1 chronic problem with progression/exacerbation/adverse effects of treatment OR<br>>2 stable chronic illnesses OR<br>1 undiagnosed new problem with uncertain prognosis OR<br>**1 new problem or acute illness** + systemic symptoms OR<br>1 acute complicated injury | **Moderate** (must meet the requirements of at least 1 of the 3 categories)<br>Any combination of 3 from:<br>**Order tests**<br>**Review tests**<br>**Review of records**<br>Independent historian<br>OR<br>Independently review and interpret test/radiology<br>OR<br>**Discuss management/plan with another provider** | **Moderate**<br>Examples:<br>**Prescription management**<br>Decision for minor surgery<br>Decision for elective major surgery without risk factors, diagnosis and treatment limited by social determinants of health |
| 99205<br>99215 | High | >1 chronic illness with severe progression/exacerbation/adverse effects or treatment OR<br>1 acute or chronic illness or injury that poses threat to life or body function | **Extensive** (must meet the requirements of at least 2 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian OR<br>Independently review and interpret test/radiology OR<br>Discuss management/plan with another provider | **High**<br>Intensive drug toxicity monitoring<br>Elective surgery with risk factor<br>Emergency surgery<br>Hospitalization<br>Advance care directives |

**Clinical Example #4: CPT Code Level 99205 (New Patient)/99215 (Established Patient)**

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema that began four days ago. Patient indicates there is pain in the leg. The patient is feeling very sick and is unable to provide a history. The patient's daughter is called and indicates that patient has had a fever, malaise and severe leg pain. Exam indicates a patient who appears very sick and has leg erythema and severe tenderness. Patient has no allergies. Vital signs reveal hypotension and tachycardia. Decision is made to send patient to the emergency room for hospitalization and emergent surgical evaluation for possible necrotizing fasciitis. CBC, CMP and blood cultures are ordered. It is recommended that patient is started on IV vancomycin and piperacillin-tazobactam with vancomycin level monitoring. The case is discussed with the ER and surgical attending physicians. Patient is transported to the ER for admission.

Medical decision-making for this case is at the highest level given that the patient has a very complex problem that could threaten life or body function. The data reviewed is now more complicated in nature and involves speaking with an independent historian (the patient's daughter), ordering tests and discussions with other providers. The risk has now increased to the high level given the patient needs to be hospitalized and started on IV antibiotics, and there is consideration of emergency surgery; therefore, code level 99205 or 99215 is indicated.

| CPT Code | MDM Level | Problems (Number and Complexity) | Data Reviewed | Level of Risk |
|---|---|---|---|---|
| 99202<br>99212 | Straightforward | 1 self-limited problem or minor problem | **Minimal or none** | **Minimal** |
| 99203<br>99213 | Low | > 2 self-limited/minor problems<br>OR<br>1 stable chronic illness<br>1 acute, uncomplicated illness or injury | **Limited** (must meet requirements of at least 1 of the 2 categories) of<br>2 of 3 of ordering tests, review of results or prior external note OR<br>Assessment requiring and independent historian | **Low** |
| 99204<br>99214 | Moderate | >1 chronic problem with progression/exacerbation/adverse effects of treatment OR<br>>2 stable chronic illnesses OR<br>1 undiagnosed new problem with uncertain prognosis OR<br>1 new problem or acute illness + systemic symptoms OR<br>1 acute complicated injury | **Moderate** (must meet the requirements of at least 1 of the 3 categories)<br>Any combination of 3 from:<br>Order tests<br>Review tests<br>Review of records<br>Independent historian<br>OR<br>Independently review and interpret test/radiology<br>OR<br>Discuss management/plan with another provider | **Moderate**<br>Examples:<br>Prescription management<br>Decision for minor surgery<br>Decision for elective major surgery without risk factors, diagnosis and treatment limited by social determinants of health |
| **99205**<br>**99215** | **High** | >1 chronic illness with severe progression/exacerbation/adverse effects or treatment OR<br>**1 acute or chronic illness or injury that poses threat to life or body function** | **Extensive** (must meet the requirements of at least 2 of the 3 categories)<br>Any combination of 3 from:<br>**Order tests**<br>**Review tests**<br>Review of records<br>**Independent historian** OR<br>Independently review and interpret test/radiology OR<br>**Discuss management/plan with another provider** | **High**<br>Intensive drug toxicity monitoring<br>Elective surgery with risk factor<br>**Emergency surgery**<br>**Hospitalization**<br>Advance care directives |

**Clinical Example #5: Using Time to Select Code Level**

A 58 yo male established patient with venous insufficiency and chronic edema of both legs presents with complaint of redness and pain in the right lower leg. Examination notes cellulitis of the right lower leg without any open wounds or ulcers noted as well as no abscesses or purulence identified. Patient was prescribed cephalexin and instructed to elevate his right leg. Provider also discusses with the patient the importance of elevating his leg to decrease edema to facilitate resolution of the cellulitis. Discussion also included instructions to get compression stockings and proper wear of and care for compression stockings. Total time for patient care on the date of encounter was 34 minutes.

As total time of visit on date of encounter is 34 minutes, this meets the time requirement of CPT 99214, which ranges from 30-39 minutes. **The code to report is 99214**. In this case, while the MDM was low, the actual time devoted to the patient was high, therefore using time to select the code level is a more accurate description and more appropriate way to value the physician's services.

## Section Four: Additional Resources

**E/M Coding and Documentation Resources**

AMA E/M CPT® Code Resources

AMA is the official source of CPT® code information and guidelines. This website provides information on the revised E/M codes and provides a learning module to assist physicians and their staff in navigating those changes.

CMS Evaluation and Management Services Guide

This guide from the Centers for Medicare & Medicaid Services is a comprehensive guide issued by CMS to educate providers on the appropriate use of E/M codes and the associated documentation. The guide has been updated to include the revisions to the office visit E/M codes.

To assist with questions regarding CPT® coding or other reimbursement issues, IDSA offers Ask the Coder. This service is available to IDSA members to aid in understanding and resolving medical coding issues.

For more information and general inquiries, contact IDSA staff via clinicalaffairs@idsociety.org.