Evaluation and Management (E/M) - Documentation Requirements for Reimbursement Policy					
Policy Number	0056	**Annual Approval Date**	04/2021	**Approved By**	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This Policy describes Optum's requirements for reimbursement, when reporting Evaluation and Management (E/M) CPT codes applicable to office and outpatient encounters; specifically, new patient CPT codes 99202-99205 and established patient CPT codes 99211-99215.

This reimbursement policy describes the criteria used by Optum, when medical records are reviewed to ensure appropriate documentation of services rendered and accuracy of coding.

Reimbursement Guidelines

Documentation Requirements – Evaluation Management (E/M)
Optum will align E/M documentation requirements with CPT definitions and AMA's Documentation Guidelines for Evaluation and Management Services.

Background Information

Guidelines for Evaluation and Management Office or Other Outpatient Services

New patient CPT® codes (99202, 99203, 99204, 99205) and established patient codes (99211, 99212, 99213, 99214, 99215) are used to report evaluation and management (E/M) services provided in the office or in an outpatient or other ambulatory facility.

Effective January 1, 2021 the American Medical Association (AMA) revised the E/M code set. This revision included new guidelines and code descriptors for office and outpatient E/M codes. According to the AMA, the intent of these changes is to focus on how health care providers think and care for patients, as well as to decrease the administrative burden of documentation and reporting E/M office visits.

Summary of revisions

These changes relate only to new and established patient visits after January 1, 2021 for CPT® codes 99202—99215:

- Clinicians can choose to use either total practitioner time on the date of service or medical decision making (MDM) to select a code.
- There will be no required level of history or exam for visits 99202—99215. The level of history and exam is described as “medically appropriate” and is determined by the clinician.
- Code 99201 has been deleted (Both 99201 and 99202 represent the same level (straightforward) of MDM, only differentiated by history and exam elements).
- Time will be defined as total time spent, including non-face-to-face work done ***on that day***, and will no longer require the service to be dominated by counseling.
- Visits will have a range for time: eg, 99213 will be 20-29 minutes, 99214 will be 30-39 minutes
- CPT® has developed definitions within MDM to clarify terms in the current guidelines e.g., chronic illness with exacerbation
- The MDM calculation will be similar, but not identical, to the current MDM calculation.

Determination of Patient Status as New or Established Patient

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s).

A ***new patient*** is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An ***established patient*** is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available.

History and/or Examination

Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services.

Table 1. Office/Outpatient E/M Codes: New Patient

CPT® Code	Code Description
99201	Deleted 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.
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.
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.
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.

For services 75 minutes or longer, see Prolonged Services: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Table 2. Office/Outpatient E/M Codes: Established Patient

CPT® Code	Code Description
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. Usually, the presenting problem(s) are minimal. [No time reference]
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. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
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.
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
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.

For services 55 minutes or longer, see Prolonged Services: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Table 3. Definitions for the elements of medical decision making (MDM)

Term	Description
Problem	A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
Problem addressed	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
Minimal problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).
Self-limited or minor problem	A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. An example might be mechanical neck pain and stiffness.
Stable, chronic illness	A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.
Acute, uncomplicated illness or injury	A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.
Acute, complicated injury	Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.
Chronic illness with exacerbation, progression, or side effects of treatment	A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
Undiagnosed new problem with uncertain prognosis	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms:	An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.
Chronic illness with severe exacerbation, progression, or side effects of treatment	The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care. Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.
Tests	Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
External	External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
External physician or other qualified healthcare professional	An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.
Independent historian(s)	An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.
Independent Interpretation	The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.
Appropriate source	For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.
Risk	The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.
Morbidity	A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
Social determinants of health	Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Selecting a Level of Office or Other Outpatient E/M Service

Selection of the appropriate level of E/M services is based on either of the following:

A. The total time for E/M services performed on the date of the encounter; or
B. The level of the medical decision making (MDM), as defined for each service

Reporting Time

Beginning with CPT 2021 and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Time may be used to select a code level in office or other outpatient services whether counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional.

The appropriate time should be documented in the medical record when it is used as the basis for code selection (e.g., number of minutes; or start/end times). For coding purposes, time for office or other outpatient services (99202–99205, 99212–99215) is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter. The calculation of time includes only activities that require the physician or other qualified health care professional. Time for services and activities normally performed by clinical or administrative staff members is not included.

Physician/other qualified health care professional time includes the following activities, when performed:

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering 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) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

The intervals of total time corresponding to CPT ® codes 99202-99215 are defined in the table below for 2021 (and beyond).

Table 4. Time Intervals for Office and Outpatient E/M Codes

New Patient	Established Patient

Code	Time*	Code	Time
		99211	N/A
99202	15–29	99212	10–19
99203	30–44	99213	20–29
99204	45–59	99214	30–39
99205	60–74	99215	40–54

* Time = minutes

Reporting Medical Decision Making (MDM)

Medical decision making (MDM) includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the office and other outpatient services code set is determined by three elements:

1. Patient Complexity: The number and complexity of problem(s) that are addressed during the encounter
2. Data: The amount and/or complexity of data to be reviewed and analyzed
3. Risk: The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s)

In order to select a level of an E/M service, two of the three elements of medical decision making must be met or exceeded.

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1. Patient Complexity

The first step in selecting the appropriate E/M level for an office or other outpatient service is assessing "patient complexity", which is determined by the number and complexity of the problems that are addressed at an encounter [Table 5]. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Table 5. Patient Complexity

Minimal	Low	Moderate	High
▪ 1 self-limited or minor problem	▪ ≥2 self-limited or minor problems ▪ 1 stable chronic condition ▪ 1 acute, uncomplicated illness or injury	▪ ≥1 or more exacerbated chronic illnesses ▪ ≥2 or more stable chronic illnesses ▪ 1 undiagnosed new problem ▪ 1 acute illness with systematic symptoms	▪ ≥1 or more severely exacerbated chronic illnesses ▪ 1 acute or chronic illness that poses a threat to life or bodily function

		▪ 1 acute complicated injury	

2. Data

The second element of MDM concerns the amount and/or complexity of data to be reviewed and analyzed. Data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes the interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.

Data is divided into three categories:

1. Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number) *Note: For the "Limited" level, tests/documents/orders and independent historian are viewed as separate categories.*
2. Independent interpretation of tests.
3. Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

The table below utilizes this categorical scheme to list the requirements for determining the level of data amount and/or complexity to be reviewed and analyzed, when using MDM to report office and outpatient E/M codes.

Table 6. Data Amount and/or Complexity to be Reviewed and Analyzed

LIMITED	MODERATE	EXTENSIVE
Must meet at least one of two of the following categories:	*Must meet at least one of three of the following categories:*	*Must meet at least two of three of the following categories:*
Category 1	**Category 1**	**Category 1**
Any combination of 2 of 3 items:	Any combination of 3 of 4 items:	Any combination of 3 of 4 items:
▫ Review of prior external notes from each unique source	▫ Review of prior external notes from each unique source	▫ Review of prior external notes from each unique source
▫ Review of the results of each unique test	▫ Review of the results of each unique test	▫ Review of the results of each unique test
▫ Ordering of each unique test	▫ Ordering of each unique test	▫ Ordering of each unique test
	▫ Independent historian(s) required for assessment	▫ Independent historian(s) required for assessment
Category 2	**Category 2**	**Category 2**
Independent historian(s) required for assessment	Independent interpretation of a test performed by another physician or other QHP (not separately reported)	Independent interpretation of a test performed by another physician or other QHP (not separately reported)

Category 3	**Category 3**	**Category 3**
N/A	Discussion of management or test interpretation with an external physician/other QHP/appropriate source (not separately reported)	Discussion of management or test interpretation with an external physician/other QHP/appropriate source (not separately reported)

QHP = qualified health professional

3. Risk

The third key element of MDM concerns the risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

In the context of MDM, the level of risk is based upon the potential consequences of the problem(s) addressed during the office/outpatient encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or referral. The services typically provided by chiropractors (manual therapies including manipulation, exercise programs and therapeutic modalities) are viewed as 'Low' risk.

Table 7. Risk Level Determination

Code	Level of MDM	Risk of Complications and/or Morbidity/Mortality of Patient Management
99211	N/A	N/A
99202 99212	Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment
99205 99215	High	High risk of morbidity from additional diagnostic testing or treatment

MDM = medical decision making

E/M Level Selection Matrix

The E/M Level Selection Matrix (Table 8) is intended for use as a guide to assist with reporting an office or outpatient E/M service code, whether by calculating total time or the level of MDM. The table includes the ranges of total time for new and

established patient E/M services; the four levels of MDM (straightforward, low, moderate, high); and the three elements of MDM (number and complexity of problems addressed, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). Total time and the concept of the level of medical decision making does not apply to code 99211.

To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Table8. E/M Level Selection Matrix (E/M levels are determined by time or MDM)

		Elements of MDM			
Codes	**Time[§]**	**Patient Complexity**	**Data Amount & Complexity**	**Risk**	**MDM Level[‡]**
99211	Established patient that did not require physician or QHP care				
99202 99212	15–29 10–19	Minimal	Minimal	Minimal	Straightforward
99203 99213	30–44 20–29	Low	Limited	Low	Low
99204 99214	45–59 30–39	Moderate	Moderate	Moderate	Moderate
99205 99215	60–74 40–54	High	Extensive	High	High

MDM = medical decision making; QHP = qualified healthcare provider

[§] Time in minutes

[‡] MDM level = 2 of 3 levels (patient complexity; data amount & complexify; risk) must be met or exceeded

Resources

- American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
- Centers for Medicare and Medicaid Services

History / Updates	
01/17/2008	New
10/2008	Annual review and update
02/2009	Annual review and update
04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and update
04/2015	Annual review and update
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
04/2019	Annual review and update
04/2020	Annual review and update
04/2021	Annual review; 2021 E/M guidance incorporated into policy document

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