PAYMENT POLICY ID NUMBER 21-070

Original Effective Date: 01/01/2021

Revised: 01/09/2025

Evaluation and Management for Office or Other Outpatient Services

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OF THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

New reporting guidelines were implemented for office/outpatient visits provided on or after January 1, 2021. CPT® codes (e.g., 99202-99215) no longer require the three key components or reference typical face-to-face time. Code selection for office/outpatient E/M services is based on a medically appropriate history and/or examination and medical decision-making (MDM) level or total time spent on that date.

This policy is intended to address office/outpatient E/M services and applies to all services reported on a CMS-1500 form or its electronic equivalent. Services and subsequent payment are pursuant to the member's benefit plan document, medical necessity review, where applicable, and provider contract.

REIMBURSEMENT INFORMATION:

Office or Other Outpatient E/M Services (99202-99215)

As stated in *Current Procedural Terminology (*CPT®*), Professional Edition*, the appropriate level of E/M service is based on the following:

- The level of the MDM as defined for each service; ***or***
- The total time for E/M services performed on the date of the encounter

History and/or Examination

E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. Physician or other qualified health care professionals determine the nature and extent of the history and/or physical examination. Guidelines for office or other outpatient E/M services and other E/M services no longer quantify history and/or physical examination elements. Therefore, code selection does not depend on the level of history or exam.

Medical Decision Making (MDM)

The AMA CPT® guidelines include four levels of medical decision making (i.e., straightforward, low, moderate, high) and the three elements of medical decision making (i.e., 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) when selecting the most appropriate level of office or other outpatient E/M service based on MDM.

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

The Elements of MDM for office/outpatient visits include the following:

1) **The number and complexity of the problem or problems the provider addresses during the E/M encounter.** Multiple new or established conditions may be addressed at the same encounter and may affect MDM. Comorbidities/underlying diseases 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 (#2 below) or the risk of complications and/or morbidity or mortality of patient management (#3 below). Diagnosis is not the only factor used to determine the complexity or risk. For example, patient may have several lower severity problems that combine to cause higher risk, or the provider may have to perform an extensive evaluation to determine a problem is of lower severity.

2) **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. Data includes 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 are divided into three categories:

    - tests, documents, orders, or independent historians;
    - independent test interpretation; and
    - discussion of management or test interpretation with external providers or appropriate source.

    The lower level CPT® codes 99202, 99211, and 99212 do not have categories for the amount and/or complexity of data. CPT® codes 99203 and 99213 requires at least one of two categories be met. For CPT® codes 99204 and 99214 one of three categories is required. The highest-level CPT® codes 99205 and 99215 requires two of three categories.

3) **The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit.** Possible management options considered, but not selected, after shared MDM with the patient and/or family, are a factor for determining the risk of complications, morbidity, and/or mortality of patient management. Examples include deciding against hospitalization for a psychiatric patient with sufficient support for outpatient care or choosing palliative care for a patient with advanced dementia and an acute condition**.** Four levels of risk are identified:

    - Minimal risk of morbidity from additional diagnostic testing or treatment
    - Low risk of morbidity from additional diagnostic testing or treatment
    - Moderate risk of morbidity from additional diagnostic testing or treatment
    - High risk of morbidity from additional diagnostic testing or treatment

AMA's CPT® Level of Medical Decision Making table (Table 1) may be used as a guide to assist providers in selecting the level of medical decision making for reporting office or other outpatient E/M services.

Below is a link to Table 1.

AMA's CPT® Level of Medical Decision Making Table 1

Time for Office/Outpatient E/M services

Time alone may be used to select the correct code for office/outpatient E/M services 99202-99205 and 99212-99215.

Total time on the encounter date includes both face-to-face and non-face-to-face time spent by the reporting practitioner. Time should be documented in the patient's medical record.

The total time does not include time for services the clinical staff typically performs.

Time spent on services reported separately is not included when counting time for selecting an office/outpatient E/M service. For example, care coordination reported using a separate CPT® code is not included in the time for the E/M code.

Below are several examples of activities physicians and other qualified health care professionals may include when using time to report an office/outpatient E/M service.

- preparing to see the patient (e.g., 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 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) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Shared or split visit is defined as a physician and one or more other qualified healthcare professionals performing the face-to-face and non-face-to-face work for an E/M visit. Shared or split visits based on time must include the sum of the time spent by the physician and other qualified healthcare professionals to get a total time. Time spent together to meet with or discuss the patient should be counted only once.

Time: Office and Other Outpatient E/M Services

New Patient Office/Outpatient E/M Service	
CPT® code	**Total Time**
99202	15 met or exceeded
99203	30 met or exceeded
99204	45 met or exceeded
99205	60 met or exceeded
Established Patient Office/Outpatient E/M Service	
CPT® code	**Total Time**
99212	10 met or exceeded
99213	20 met or exceeded
99214	30 met or exceeded
99215	40 met or exceeded

Note: Time is not listed for CPT® code 99211 in the descriptor.

Pelvic Examination (99459)

Code 99459 has been created to account for extra resources in pelvic examinations, which are required for preventive medicine or E/M services for individuals needing pelvic exams. This code covers Practice Expense (PE) only.

Code 99459 is an add-on code and should be used in conjunction with 99202-05, 99212-15, 99242-45, 99383-87, or 99393-97).

When a pelvic examination is performed in conjunction with a gynecologic procedure, as a necessary part of the procedure or as a confirmatory examination, the add-on code for pelvic examination is not separately reportable. The pelvic pack and pre-procedure evaluation time has already been accounted for in the practice expense relative value assigned to the gynecologic procedures. Therefore, add on code 99459 should not be reported when an E&M service is provided on the same date of service as a gynecological procedure.

Prolonged service (**HCPCS code G2212)**

Florida Blue aligns with CMS and requires Healthcare Common Procedure Coding System (HCPCS) code G2212 when billing prolonged service for office or other outpatient E/M visits instead of CPT® code 99417.

Florida Blue concurs with CMS and requires G2212 to be reported for prolonged service beyond the maximum required time for the primary procedure. See **Prolonged Office/Outpatient E/M Visit Reporting** tables below.

Reporting of CPT® code 99417, after the minimum time for a level 5 visit (i.e., 99205, 99215) is exceeded by at least 15 minutes, would result in double counting time (e.g. practitioner spent 55 minutes of time, reporting CPT® code 99215 and CPT® code 99417 (15 minutes) would result in double counting of 14 minutes included in the service described by CPT® code 99215).

Prolonged office or other outpatient E/M service that requires at least 15 minutes or more of total time either with or without direct patient contact by the physician or other qualified health care professional on the date of the primary E/M service (i.e., CPT® codes 99205 or 99215) are reported with HCPCS code G2212.

HCPCS code G2212 may be reported in conjunction with office or other outpatient service codes 99205 or 99215 if the codes were selected based on the time alone and not medical decision making.

Prolonged service of less than 15 minutes additional time on the date of the office or other outpatient service (i.e., 99205, 99215) is not reported.

Prolonged service HCPCS code G2212 should not be reported in conjunction with 99415 or 99416 (Prolonged clinical staff services). Therefore, CPT® codes 99415, and 99416 will be denied when reported with HCPCS code G2212 on the same date of service.

Prolonged Office/Outpatient E/M Visit Reporting

New Patient - Office or Other Outpatient Services (99205)	
CPT®/HCPCS Code	**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
99205 X 1 and G2212 X 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Established Patient- Office/Outpatient E/M Service (99215)	
CPT®/HCPCS Code	**Total Time Required for Reporting**
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

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Visit Complexity Inherent to Certain Office E/M (HCPCS Code G2211)

The office and outpatient (O/O) E/M visit complexity add-on code reflects the complexity inherent when practitioners serve as the focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or complex condition.

Commercial Lines of Business

No additional payment will be provided for HCPCS code G2211. G2211 is not separately reimbursable. The compensation payable for the O/O E/M code constitutes payment for the services provided.

Medicare Advantage

Florida Blue aligns with CMS policy and will allow appropriately reported HCPCS code G2211 for Medicare Advantage. HCPCS code G2211 is an add-on code that should only be reported with O/O E/M services (codes 99202-99205, 99211-99215). In accordance with CMS, G2211 will be denied when an associated O/O E/M visit (codes 99202-99205, 99211-99215) is reported with Modifier 25 to the same patient by the same provider or if it is not otherwise appropriately reported.

BILLING/CODING INFORMATION:

CPT®/HCPCS Codes

Code	Descriptor
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
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.
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
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 minutes must be met or exceeded.
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time each 15 minutes of total time (List separately in addition to the code of the outpatient evaluation and management service)
99459	Pelvic examination (List separately in addition to code for primary procedure) (Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397)

Code	Descriptor
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT® codes 99205, 99215 for office or other outpatient evaluation and management services)

Note: CPT® code 99201 was deleted CY 2021. CPT® code 99201 required straightforward MDM, as does CPT® code 99202. Therefore, CPT® code 99201 was deleted. CPT® code 99211 does not include a time reference. CPT® code 99211 is used if clinical staff members perform the face-to-face visit under the supervision of the physician or other qualified healthcare professional.

RELATED MEDICAL COVERAGE GUIDELINES OR PAYMENT POLICIES:

Prolonged Services 16-048

REFERENCES:

1. American Medical Association (AMA), *Current Procedural Terminology (CPT®), Professional Edition*, 2021.
2. American Medical Association (AMA), CPT® E/M Level of Medical Decision Making (MDM), AMA's CPT® Level of Medical Decision Making Table 1
3. Centers for Medicare and Medicaid Services (CMS), *Final Rule with Comment Period, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2021*, https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-p
4. American Medical Association (AMA). (2019). *CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes.* https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
5. Centers for Medicare & Medicaid Services website. Internet Only Manual, Pub. 100-04 Medicare Claims Processing Manual, Chapter12, Section 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits and 30.6.15.2 Prolonged Office/Outpatient E/M Visits https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

GUIDELINE UPDATE INFORMATION:

01/01/2021	New policy established
01/13/2022	Annual review – Minor verbiage changes under Description and Reimbursement Information
01/01/2023	Revision – Policy revised to align with new reporting guidelines for E/M services.
01/01/2024	Annual review – Policy revised to align with new reporting guidelines for E/M services. CPT® code 99459 and HCPCS code G2211 added. References reviewed and updated.

10/17/2024	Revision: Added clarifying language for Pelvic Examination (99459).
01/09/2025	Annual review – The Prolonged service (HCPCS code G2212) section has been revised. References reviewed and updated.