2021 E/M OUTPATIENT GUIDELINES APPLIES TO 99202 - 99215 ONLY

E/M code	Time *(mins)*	MDM *(Two out of three elements)*	Number and complexity of problems addressed	Amount and/or complexity of data to review and analyze *(Combination of two or combination of three in Category 1)*			Risk of complications and/ or morbidity or mortality of patient management *(diagnostic testing or treatment)*
				CATEGORY 1	**CATEGORY 2**	**CATEGORY 3**	
Level 1							
99211	0	N/A	N/A	N/A			N/A
Level 2			Minimal	Minimal or none			Minimal risk
99202	15-29	Straightforward	• 1 self-limited or minor problem	Minimal or no complexity and/or data reviewed			• Rest • Gargles • Bandages • Superficial dressings
99212	**10**-19						
Level 3			**Low**	Limited *(Must meet the requirements of at least 1 of the 2 categories)*			Low risk
99203	30-44	Low	• 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury	Category 1: Tests and documents **At least 2 from the following:** • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test	Category 2: Assessment requiring an independent historian(s)	**N/A**	• OTC drugs • Minor surgery without risk factors • PT/OT • IV fluids without additives
99213	**20**-29						
Level 4			**Moderate**	Moderate *(Must meet the requirements of at least 1 out of 3 categories)*			Moderate risk
99204	45-59	Moderate	• 1 or more chronic illnesses with exacerbation, progression or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	Category 1: Tests, documents, or independent historian(s) **At least 3 from the following:** • Review of prior external note(s) from each source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s)	Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified healthcare professional	Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• Prescription drug management • Decision regarding minor surgery with identified risk factors • Decision regarding elective major surgery without risk factors • Diagnosis or treatment significantly limited by social determinants of health (SDoH) [e.g., socioeconomic status, geographic location, education, employment, transportation access)
99214	**30**-39						
Level 5			High	Extensive *(Must meet the requirements of at least 2 out of 3 categories)*			High risk
99205	60-74	High	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Category 1: Tests, documents, or independent historian(s) **At least 3 from the following:** • Review of prior external note(s) from each source • Review of the result(s) of each test • Ordering of each test • Assessment requiring an independent historian(s)	Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualifi healthcare professional	Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis
99215	**40**-54						

To be Used only with either 99205 or 99215

PRIVATE PAYER TABLE FOR OUTPATIENT PROLONGED TIME: 99417

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and **99417** x 1	75 - 89 minutes
99205 x 1 and **99417** x 2	90 - 104 minutes
99205 x 1 and **99417** X3 or more for each additional 15 minutes	105 minutes or more
99215	40-54 minutes
99215 x 1 and **99417** x 1	55 - 69 minutes
99215 x 1 and **99417** x 2	70 - 84 minutes
99215 x 1 and **99417** X3 or more for each additional 15 minutes	85 minutes or more

MEDICARE PAYER TABLE FOR OUTPATIENT PROLONGED TIME: +G2212

CPT Code(s)	Total Time Required for Reporting*
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** X3 or more for each additional 15 minutes	119 minutes or more
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** X3 or more for each additional 15 minutes	99 minutes or more

***Total time is the sum of all time, with and without direct patient contact (including prolonged time), spend by the reporting practitioner on the DOS of**

Time-based **coding elements*** *(when performed and documented. Note: Bold/underline indicate updated time requirement)*

- Reviewing patient's record prior to visit
- Performing a medically appropriate history and examination
- Ordering prescription medications, tests, or procedures
- Independently interpreting results
- Communicating results to the patient/family/caregiver
- Obtaining/reviewing separately obtained history from someone other than patient
- Counseling/educating the patient/family/caregiver
- Referring and communicating with another healthcare provider(s) when not separately reported during the visit
- Documenting clinical information in the patient's electronic health record
- Coordination of care for the patient

* Time-based coding is based on total time spent on the date of the encounter.

Important notes:

- E/M code 99201 is deleted in 2021 due to low utilization.
- Documentation of history and exam will not be counted as an element, but medical necessity must be established by documenting risk and MDM relevant to management of patient's condition.
- Interpretation of tests or discussion of management with another qualified healthcare professional is considered only when not separately reported.

Effective Jan 1, 2021. For more information, please email coding@ucera.org or visit us at http://uhphawaii.org/index.php/UHPCBO