

CPT CODE 99215

OFFICE OR OTHER OUTPATIENT VISIT FOR ESTABLISHED PATIENT

FACT SHEET

Office/Other Outpatient Services (Established Patients)

Components Required: 2 of 3	99211	99212	99213	99214	99215
History & Exam					
Problem focused		•			
Expanded problem focused			•		
Detailed				•	
Comprehensive					•
Medical Decision Making					
Straightforward		•			
Low			•		
Moderate				•	
High					•
Presenting Problem (Severity)					
Minimal	•				
Self-limited or minor		•			
Low to moderate			•		
Moderate to high				•	•
Typical Time: Face-to-Face	5	10	15	25	40

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code.

For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service.

Comprehensive History

Includes:

- Chief complaint/reason for admission
- Extended history of present illness
- Review of systems directly related to the problem(s) identified in the history of present illness
- Medically necessary review of ALL body systems' history
- Medically necessary complete past, family and social history
- Four or more elements of the HPI or the status of at least three (3) chronic or inactive conditions, noting that medical necessity is ALWAYS the overarching criterion.

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of "medically necessary" for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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FACT SHEET**HPI – History of Present Illness**

A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:

- Location
- Timing
- Associated signs/symptoms significantly related to the presenting problem(s)
- Quality
- Context
- Severity
- Modifying factors

Chief Complaint

The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Diagnosis
- Problem
- Physician recommended return, or other factor that is the reason for the encounter
- Condition

Review of Systems

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Musculoskeletal
- Eyes
- Integumentary (skin and/or breast)
- Ears, Nose, Mouth Throat
- Neurologic
- Cardiovascular
- Psychiatric
- Respiratory
- Endocrine
- Gastrointestinal
- Hematologic/Lymphatic
- Genitourinary
- Allergic/Immunologic

Past, Family, And/or Social History (PFSH)

Consists of a review of the following:

- Past history (patient's past experiences with illnesses, operations, injuries, and treatments)
- Family History (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

Complex Medical Decision Making involves two of the three below:

- Extensive management options for diagnosis or treatment
- Extensive amount of data to be review
- High Risk of complications and/or morbidity or mortality

Extensive amounts of data should include, but is not limited to:

- Lab results
- Diagnostic and imaging results
- Other practitioner's notes/charts (ie PT, OT, Consultants)
- Labs or diagnostics needing to be performed

High Risk of complications and or morbidity or mortality should include, but is not limited to:

- Comorbidities associated with the presenting problem
- Risk(s) of diagnostic procedure(s) performed
- Risk(s) associated with possible management options

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Comprehensive Physical Exam

Includes:

- General, multisystem exam OR complete exam of a single organ system
- Body areas recognized:
 - Head/including face
 - Neck
 - Chest/including breasts and axilla
 - Abdomen
 - Genitalia/groin and buttocks
 - Back
 - Each extremity
- Organ systems recognized
 - Eyes, ears, nose, mouth, throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Hematologic/Lymphatic/Immunologic

Additional Information:

- Select the code for the service based upon the content of the service
 - Duration of the visit does NOT control the level of the service to be billed unless more than 50% of the face-to-face time (for non-inpatient service) or more than 50% of the floor time (for inpatient service) is spent providing counseling or coordination of care as described in CMS Publication 100-04 (link provided in reference section of this Fact Sheet)
- Practitioner's choosing to use time as the determining factor:
 - MUST document time in the patient's medical record.
 - Documentation MUST support in sufficient detail the nature of the counseling
 - Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection.
- Face-to-face time refers to the time with the physician ONLY. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by other staff is NOT considered in selecting the appropriate level of service
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf>) You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/>)

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[Downloads/MM6698.pdf](#)) A sample attestation statement is available on the CGS website. (http://www.cgsmedicare.com/partb/cert/attestation_form.pdf) Guidelines regarding signature requirements are located in CMS Publication 100-08, Chapter 3, section 3.3.2.4 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>)

References:

- CMS Publication 100-04, Chapter 12, sec 30.6; Evaluation and Management Service Codes <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- Medicare Learning Network; Documentation Guidelines for Evaluation and Management (E/M) Services <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
- American Medical Association CPT (current procedural terminology) Codebook