Office or Other Outpatient Evaluation & Management Coding for New and Established Patient Visits

The information included in this guide is intended to enhance your awareness of the guidelines and policies that Optum follows to help support accurate coding and billing for behavioral health services.

Office or other outpatient Evaluation and Management (E/M) codes for a new (99202–99205) or established (99211–99215) patient may be used to report E/M services provided in an office or other outpatient setting.

Per CPT® guidelines, office or other outpatient E/M codes (excluding 99211) are selected based on the total time on the date of the encounter or the level of medical decision making (MDM). A medically appropriate history and physical examination, as determined by the treating provider, should be documented, however, the level of history and exam are no longer used to determine the level of E/M service.

ONE EXAMPLE - NEW PATIENT
E/M PLUS PSYCHOTHERAPY PROGRESS NOTE
Patient Identifier: _____ Date: _____
Diagnosis: _____

E/M:

History: _____
Examination: _____
Medical Decision Making: _____

Psychotherapy:

Time spent on psychotherapy services only: _____
[Include description of type & content of psychotherapy provided]
List additional attendees, if any: _____
Legible Signature of Practitioner, Degree, Licensure:
_____

Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional (QHP) on the date of the encounter.

Effective Jan. 1, 2024, office or other outpatient E/M code descriptions specify a single time to meet/exceed instead of a time range for the encounter. See the chart below for revised times:

- Includes time for activities such as preparing to see the patient, obtaining a history, performing an exam, providing counseling or education, preparing orders, independently interpreting tests or coordinating care (if not separately reported) and documenting the health record
- Excludes time for activities performed by clinical staff, time spent performing separately reportable procedures, travel time or general teaching time

Note: Per CPT® guidelines, E/M services that are billed with a psychotherapy add-on code (90833, 90836, 90838) cannot be billed by time and must be based on MDM components.

MDM elements: To qualify for a given level of decision-making, 2 of 3 MDM elements must be met or exceeded:

1. Number and complexity of problem(s) that are addressed during the encounter

- A problem is considered to be addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service

2. Amount and/or complexity of data to be reviewed and analyzed

- Data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter (excluding interpretations that are separately reported)

3. Risk of complications and/or morbidity or mortality of patient management

- Risk is described as the probability and/or consequences of an event. For the purposes of MDM, the level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

Office E/M code	Total time in minutes (previous range in minutes)	Number and complexity of problems addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management	Level of MDM (meets/exceeds 2 of 3 MDM elements)
99202 **99212**	15 min. (15-29 min.) 10 min. (10-19 min.)	Minimal	Minimal or none	Minimal	Straightforward
99203 **99213**	30 min. (30-44 min.) 20 min. (20-29 min.)	Low	Limited	Low	Low complexity
99204 **99214**	45 min. (45-59 min.) 30 min. (30-39 min.)	Moderate	Moderate	Moderate	Moderate complexity
99205 **99215**	60 min. (60-74 min.) 40 min. (40-54 min.)	High	Extensive	High	High complexity

For more details on time or MDM, including definitions and examples, refer to the CPT® Evaluation and Management Services Guidelines appropriate for your Date of Service (DOS).

Code notes:

- **99202–99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and [straightforward, low, moderate, or high] MDM. When using total time on the date of the encounter for code selection, [15, 30, 45, or 60] minutes must be met or exceeded.
  - A new patient is one who has not received any professional services from the physician, or other QHP of the same specialty who belongs to the same group practice, within the past three years.
- **99212–99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and [straightforward, low, moderate, or high] MDM. When using total time on the date of the encounter for code selection, [10, 20, 30, or 40] minutes must be met or exceeded.
  - 99211 is exempt from MDM/time criteria and may be used when physician supervision but not presence is required.

Consultation services:

Per the Optum Consultation Services Reimbursement Policy, effective for claims with DOS on or after Mar. 1, 2020, Optum aligns with CMS and does not reimburse consultation codes 99242–99245 or 99252–99255, including when performed via telehealth. An appropriate E/M code should be reported to represent the service provided to the patient. For prior DOS, consultation codes are reimbursed in alignment with **CPT®** guidelines. See the policy for details.

Prolonged E/M services:

Per the Optum Prolonged Services Reimbursement Policy, prolonged services are reimbursed when the primary E/M service is selected based on time. Optum requires providers to list the appropriate start and stop time for prolonged services codes in the medical record in order to determine the appropriate type of prolonged services. See the policy for more details including a list of prolonged services codes with appropriate primary E/M codes for various settings applicable to commercial and Medicare plans.

- Prolonged service codes 99417 (commercial) and G2212 (Medicare) are available to report full 15-minute increments of prolonged physician/other QHP services with or without direct patient contact on the date of a high-level office or other outpatient E/M service (99205 or 99215). Less than 15 minutes is not reported separately. **Note: for G2212, the maximum required time for the primary code must be exceeded.**
- Codes 99358 (first hour) and 99359 (each additional 30 minutes) represent physician/other QHP prolonged services *without* direct patient contact that occurs on a date *other* than the related face-to-face E/M service with the patient and/or family or caregiver. These codes should not be reported on the same DOS as another E/M code. **Note: These codes are invalid for Medicare (e.g., Physician Fee Schedule status = I – Not valid for Medicare services).**
  - Report 99358 only once per date for the first hour of prolonged service (less than 30 minutes is not reported).
  - Report 99359 for each additional 30 minutes beyond the first hour or for the final 15 to 30 minutes of prolonged service on a given date (less than 15 minutes beyond the first hour/final 30 minutes is not reported separately).
- Codes 99415 (first hour) and 99416 (each additional 30 minutes) are available to report prolonged clinical staff services with direct patient contact under physician/other QHP supervision on the same DOS as an office visit (99202-99205 or 99212-99215). Less than 30 minutes total or less than 15 minutes beyond the first hour/final 30 minutes is not reported separately. Do not report these codes with 99417 or G2212.

Resources:

This overview and reminder of E/M coding guidelines is provided to help support continued improvements. Please review these additional resources for more details:

- **Optum Reimbursement Policy:** Same Day Same Service Reimbursement Policy
- **American Psychiatric Association (APA):** CPT® Coding and Reimbursement
- **American Medical Association (AMA):** CPT® Manual > Evaluation and Management (E/M) Services Guidelines
- **Centers for Medicare & Medicaid Services (CMS):** Internet-Only Manual (IOM) 100-04, Ch. 12, Sect. 30.6, and MLN006764_Evaluation_and_Management_Services_Guide_2024-09