HOLLAND FOUNDATION FOR SIGHT RESTORATION

Evaluation and Management Documentation and Coding for Ocular Surface Stem Cell Transplantation

The Holland Foundation for Sight Restoration is the only foundation created to address the significant unmet medical need of corneal transplantation for patients who have severe ocular surface disease while enabling surgeons the resources to provide the treatment across the country.

To learn more about the Holland Foundation visit, https://www.hollandfoundationforsight.org

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Clinical Information

Ocular Surface Stem Cell Transplantation (OSSCT) may be required for patients who have experienced an ocular surface injury or medical condition that resulted in a scar to the surface of the eye. In the most severe circumstances, the patient's condition may result in the loss of the skin-producing stem cells, which results in corneal scarring and then potential blindness.

When a patient needs OSSCT for an ocular surface disease, evaluation and management (E&M) office visits will be required including: the initial evaluation, pre-operative preparation, and frequent follow-up visits to monitor patient health status and effectiveness of treatment. Following the 90-day global period, some of these office visits will be billed at the highest level of E&M coding and may also include prolonged services. In these visits, pre-operative care planning is provided, along with post-operative evaluation to monitor effectiveness of medication, checking status of blood levels and many other components of care. This document provides detailed information on medical documentation and decision-making to select the appropriate E&M level to report the clinical services.

Coding for Evaluation and Management Office Visits

1995

E&M standards and guidelines were established by CMS

2021

Revised

The 2021 revision allows physicians to determine the level of care for an office visit based on medical decision making (MDM) or amount of time.

These standards have been adopted by Medicare and private health insurance companies as the standard guidelines for determining type and severity of patient conditions.
US health care providers must use E&M codes to be reimbursed for office visits outside of the 90-day global period.

Principles of Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care.

The principles of medical record documentation are applicable to all types of medical and surgical services in all settings of care. For E&M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed below may be modified to account for these variable circumstances when providing E&M services.

- The medical record should be complete and legible
- Documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Treatment plan with date and identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk
- The patient's progress, response to and changes in treatment, and revision of diagnosis
- The Current Procedure Terminology (CPT®) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

CPT® is a registered trademark of the American Medical Association.

Management of OSSCT in the Office Setting: New and Established Patients

On January 1, 2021, office-based E&M codes were redefined. The revisions helped reduce administrative burden by eliminating bullet points for the patient history and physical exam elements. History and examination elements are not used for E&M code selection, but still need to be documented as medically relevant. The physician or other qualified health care professional (QHP) can decide what is medically necessary for each history and examination.

Now, physicians or other QHP can use either medical decision-making (MDM) or total physician time to select the appropriate E&M code level.

Medical Decision Making

There are four types of MDM: straightforward, low, moderate, and high.
MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements:

1
Number and complexity of problems addressed at the encounter

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

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

Note: For CPT® code 99211 (office or other outpatient visit that does not require the presence of a physician or other QHP), the concept MDM level does not apply.

See appendix for detailed descriptions of MDM levels.

When time is used to report E&M visits, the amount of time defined in the service descriptors is used for selecting the appropriate code level. These E&M services require a face-to-face encounter between the physician or other QHP and the patient and/or family/caregiver.

For appropriate level and coding purposes, time is based on the total amount of time on the day of the encounter. It is inclusive of both the face-to-face time with the patient and/or family/caregiver, and non-face-to-face time, personally spent by the physician and/or other QHP. It should not include time for activities normally performed by clinical staff.

Qualifying Time

The CPT® E&M guidelines outline activities that can be counted toward total time. These should be used to determine the substantive portion, when performed by a physician and whether the activities involve direct patient contact:

- 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, or caregiver

Physicians cannot count time spent on:

- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

The table below outlines the time ranges and MDM levels for new and established patients.

Time Ranges and MDM Levels: New and Established Patients

	NEW PATIENTS				ESTABLISHED PATIENTS				
Time Range	**15+ Minutes**	**30+ Minutes**	**45+ Minutes**	**60+ Minutes**	**NA**	**10+ Minutes**	**20+ Minutes**	**30+ Minutes**	**40+ Minutes**
CPT Code	99202	99203	99204	99205	99211†	99212	99213	99214	99215
MDM* Level	**Straight forward**	**Low**	**Moderate**	**High**		**Straight forward**	**Low**	**Moderate**	**High**

Note: For services 75 minutes or longer, use prolonged services code (99417 or G2212)

Note: For services 55 minutes or longer, use prolonged services code (99417 or G2212)

*See appendix for detailed descriptions of MDM levels.

†CPT code 99211 is intended for the evaluation and management of a patient that may not require the presence of a physician or other QHP, therefore MDM and total time do not apply.

Defining the New and Established Patient E&M Codes

New Patient E&M Codes

A new patient is one who has not received any professional services from the physician or QHP, or another physician or QHP of the same specialty/ sub-specialty who belongs to the same group practice, within the past three years.

There are four levels of E&M codes for a new patient visit.

CPT® Code	Description	Medicare Provider Payment*
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	**$71.05**
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** medical decision making	**$109.69**
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** medical decision making	**$164.38**
99205	Office or other outpatient visit for the evaluation and management of new patient, which requires a medically appropriate history and/or examination and **high-level** medical decision making	**$216.77**

*2024 Medicare National Unadjusted Payment. Payment varies by geographic location.

Established Patient E&M Codes

An established patient is one who has received professional services from the physician or other QHP or another physician or QHP of the exact same specialty and subspeciality who belongs to the same group practice, within the past three years.

There are five levels of E&M codes for an established patient visit.

CPT® Code	Description	Medicare Provider Payment*
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	**$22.92**
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	**$55.67**
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** medical decision making	**$89.39**
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** medical decision making	**$126.07**
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** medical decision making	**$177.47**

*2024 Medicare National Unadjusted Payment. Payment varies by geographic location.

NOTE: E&M services should not be reported the day before surgery, nor during the 90-day global service period, as payment for these office visits are included in the bundled procedure reimbursement.

Prolonged Services

Additional care time spent managing a patient that exceeds the time specified in the E&M codes is referred to as "prolonged services". While there are many types of prolonged services, this document will focus on services provided in the office or outpatient setting for new and established patients, for both the physician and clinical staff. There are two types of prolonged services:

Prolonged...

Clinical staff services with a physician or QHP supervision

- CPT® codes 99215 and 99216

Service with or without direct patient contact on the date of an E&M visit by a physician

- Medicare: use HCPCS code G2212 (an add-on code and should always be reported with the appropriate level of E&M service)
- Commercial Payers: use CPT code 99417

Prolonged services are direct (face-to-face) services provided by a physician, QHP, or staff and includes additional non-face-to-face services during the same visit. It can be reported in addition to the designated E&M service at any level, as well as any other service provided at the same visit.

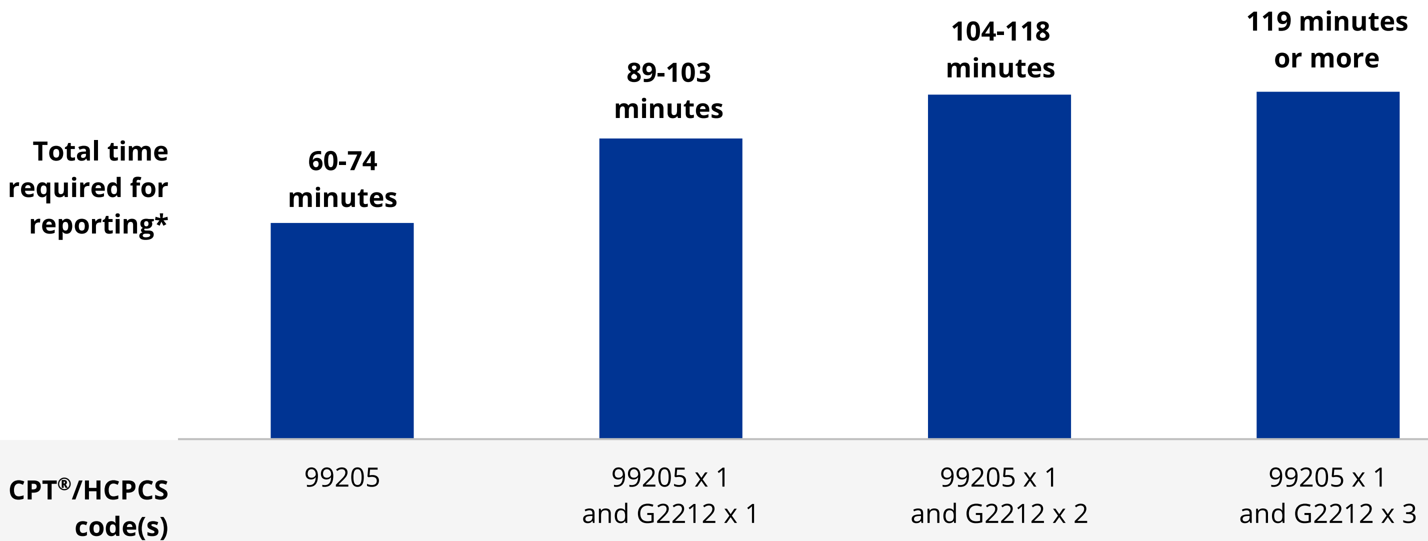
Code Descriptors

- **G2212:** Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure, per 15 minutes
- **99415:** Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an E&M service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient E&M service)
- **99416:** Each additional 30 minutes (list separately in addition to code for prolonged service)
- **99417:** Prolonged outpatient E&M 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 E&M service)

Reporting Times

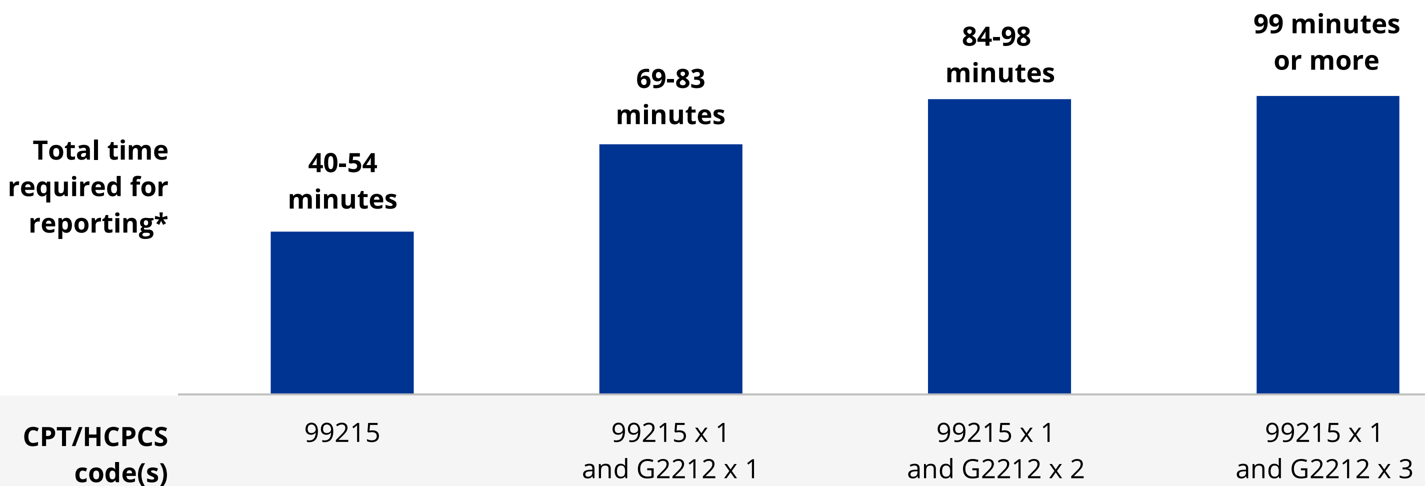
The following tables provide reporting examples for prolonged services provided by a physician, when used to bill Medicare.

New Patient



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

Established Patient



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

Medicare Reimbursement for Prolonged Services by a Physician

HCPCS Code	Descriptor	Medicare Provider Payment*
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, 99483 for office or other outpatient evaluation and management services; do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). Do not report G2212 for any time less than 15 minutes	**$31.76**

*2024 Medicare National Unadjusted Payment. Payment varies by geographic location.

Coding and Billing for Prolonged Services by a Physician: Commercial and Medicare Advantage Health Plans

Commercial and Medicare Advantage plans, unless otherwise indicated in their coverage policy, will likely require use of the CPT® code 99417.

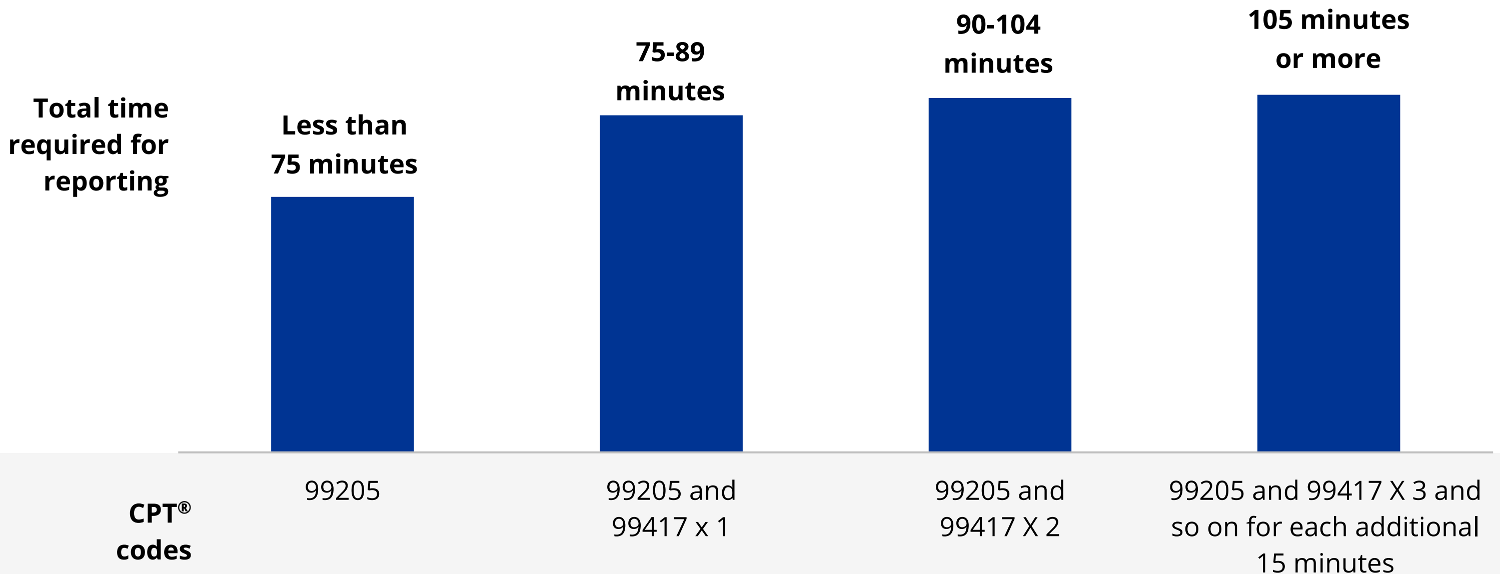
The billing guidelines for CPT code 99417 are as follows:

- Report as an add-on code, in addition to the primary E&M code
- Do not report for time less than 15 minutes
- Ensure the total time spent on the patient's care is accurately documented and supports the claim
- Only report in conjunction with the level 5 visit codes (CPT codes 99205 and 99215)

Payment from Commercial and Medicare Advantage plans will be contingent upon individual contracts and coverage policies. Providers should contact individual payers to verify coverage and payment for CPT code 99417.

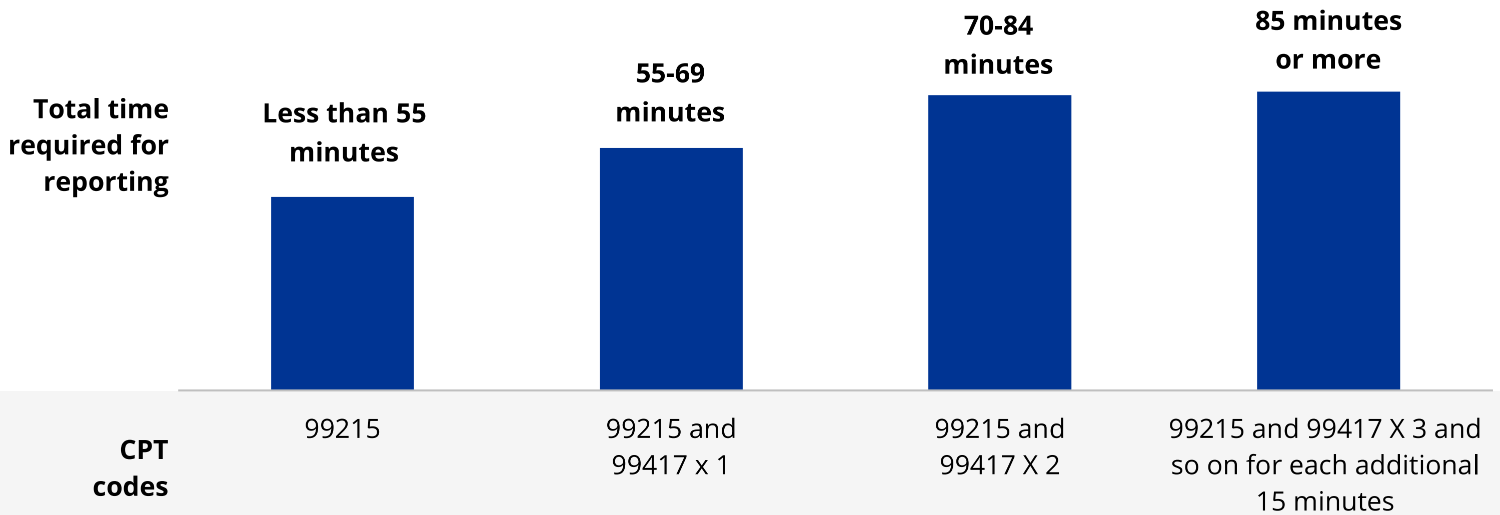
The following tables provide reporting examples for prolonged services provided by a physician, when used to bill Commercial or Medicare Advantage health plans.

New Patient



CPT® codes	99205	99205 and 99417 x 1	99205 and 99417 X 2	99205 and 99417 X 3 and so on for each additional 15 minutes

Established Patient



CPT codes	99215	99215 and 99417 x 1	99215 and 99417 X 2	99215 and 99417 X 3 and so on for each additional 15 minutes

Prolonged Clinical Staff Services with Physician or QHP Supervision

In some cases, the clinical staff may need to spend extra time with the patient, in addition to the designated E&M service and any other services at the same session. When additional staff time is needed it can be reported with CPT codes 99415 and 99416.

Billing Guidelines for CPT® codes 99415 and 99416

- The amount of time of service must be documented in the medical record
- Requires a minimum of 30 minutes spent beyond the highest time in the range of total time of the service of the E&M service code being reported; use prolonged services codes starting at 31 minutes beyond the typical clinical staff time for ongoing assessment of the patient during the office visit
  - Prolonged service of fewer than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately
- Code 99415 should be used only once per date
- Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour, and used to report the final 15-30 minutes of prolonged service on a given date
- Must always be reported in addition to an appropriate office/outpatient E&M service (i.e., 99202-99215)
- Require the physician or QHP be present to provide direct supervision of the clinical staff
- Used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous
- Should not be reported for time spent performing separately reported services other than the E&M service, and is not counted toward the prolonged services time

Reporting Times

The following table provides reporting examples for clinical staff prolonged services.
Report the appropriate E&M code in addition to the following:

Clinical Staff Prolonged Service Coding	Less than 30 minutes	30-74 minutes	75-104 minutes	105 minutes or more
Total Duration of Prolonged Services	Not reported separately	99415 X 1	99415 X 1 and 99416 X	99415 X 1 and 99416 X 2 or more for each additional 30 minutes

Medicare Reimbursement

CPT® Code	Descriptor	Medicare Provider Payment*
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)	**$20.30**
99416	Each additional 30 minutes (List separately in addition to code 99415 for prolonged service)	**$9.50**

*2024 Medicare National Unadjusted Payment. Payment varies by geographic location.

Payment from Commercial and Medicare Advantage plans will be contingent upon individual contracts and coverage policies.

Payment for Commercial & Medicare Advantage Health Plans

Providers should contact payers directly to verify coverage and payment for CPT codes 99415 and 99416.

Appendix:
Levels of
Medical Decision Making

Levels of Medical Decision Making			
Level of MDM (based on 2 out of 3 elements of MDM) **and CPT® Code**	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to be Reviewed and Analyzed** *Each unique test, order, or documents contributes to the combination of 2 or combination of 3 in Category 1 below	**Risk of Complications and/or Morbidity of Patient Management**
Straightforward **99202** or **99212**	**Minimal** **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low **99203** or **99213**	**Low** **2** or more self-limited minor problems; or **1** stable, chronic illness; or **1** acute, uncomplicated illness or injury; or **1** stable, acute illness or injury; or **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** (Must meet the requirement of at least 1 out of 2 categories) **Category 1:** Tests and documents with any combination of 2 from the following: 1. Review of prior external note(s) from each unique source 2. Review of the result(s) of each unique test 3. Ordering of each unique test **Category 2:** Assessment requiring an independent historian(s)	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate **99204** or **99214**	**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	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1:** Tests, documents, or independent historian(s) with any combination of 3 from the following: 1. Review of prior external note(s) from each unique source 2. Review of the results(s) of each unique test 3. Ordering of each unique test 4. Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of tests performed by another physician or other qualified health professional (not separately reported) **Category 3:** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing** **Examples Only:** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High **99205** or **99215**	**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	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **Category 1:** Test, documents, or independent historian(s) with any combination of 3 from the following: 1. Review of prior external note(s) from each unique source 2. Review of the result(s) of each unique test 3. Ordering of each unique test 4. Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of a test performed by another physician or other qualified health care professional (not separately reported) **Category 3:** Discussion of management or test interpretation with external physician/ other qualified health care professional/appropriate source (not separately reported)	**High Risk of morbidity from additional diagnostic testing or treatment** **Examples only:** • 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 or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis

Reference: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1770-f. Accessed January 2024.