CPT® Code 99215 Details

Code Symbols

MIPS : Merit Based Incentive Payment System

Code Descriptor

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination;**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

CPT® Advice

No data Available

Illustration

No data Available.

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2019 National Physician Fee Schedule Relative Value File, GPCI19, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2019, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	July 01, 2019
Medicare Carrier/Locality:	ALASKA** 01-02102
Conversion Factor:	36.0391

Note: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status A
A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

Medicare Fees					
	National	**Adjusted**	**26**	**TC**	**53**
Facility	$112.80	$152.91	$0.00	$0.00	$0.00
Non Facility	$147.76	$191.96	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	2.11	3.17	0.00	0.00	0.00
PE RVU:	1.84	2.06	0.00	0.00	0.00
Malpractice RVU:	0.15	0.11	0.00	0.00	0.00
Total RVU:	4.10	5.33	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	2.11	3.17	0.00	0.00	0.00
PE RVU:	0.87	0.97	0.00	0.00	0.00
Malpractice RVU:	0.15	0.11	0.00	0.00	0.00
Total RVU:	3.13	4.24	0.00	0.00	0.00

Global & Other Info		
	Global Split	
Preoperative %:	0	
Intraoperative %:	0	
Postoperative %:	0	
Total RVU:	0	
Global Period (days):	XXX	

XXX = The global concept does not apply to the code.

Radiology Diagnostic Tests :	99

99 = Concept does not apply

PC/TC Indicator :	0

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

Endoscopic Base Code : None

Modifier Guidelines		
	Modifier	**Rules(Click on rules for Details)**
MULT PROC	51	No multiple procedure payment adjustment

51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes

0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

BILAT SURG	50	No 150% bilateral payment boost

50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.

0 = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.

ASST SURG	80	Assistant payment allowed when supported

80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

CO-SURG	62	Co-surgeons not permitted

62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

0 = Co-surgeons not permitted for this procedure.

TEAM SURG	66	Team surgeons not permitted
66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.		
0 = Team surgeons not permitted for this procedure.		
MINIMUM ASST SURG	81	Assistant payment allowed when supported.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment allowed when supported.
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2019 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: July 01, 2019

Services	MUE	MAI	MUE Rationale
Practitioner Services	1	3	Clinical: Data
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	2	3	Clinical: Data

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy

MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

LCD Details

LCD Details for 99215

The chosen state has no LCD for this code/title. Please search All States to see if another state has an LCD for this code/title.

Article Details for 99215

The chosen state has no Article for this code/title. Please search All States to see if another state has an Article for this code/title.

NCD

No data available.

MEDICARE CCI

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

Col B Code	Reason Edit	Modifier Indicator
0362T	Misuse of column two code with column one code	1
0373T	Misuse of column two code with column one code	1
0469T	Misuse of column two code with column one code	0
36591	CPT Manual or CMS manual coding instructions	0
36592	CPT Manual or CMS manual coding instructions	0
43752	Misuse of column two code with column one code	1
80500	Standards of medical / surgical practice	0
80502	Standards of medical / surgical practice	0
90863	CPT Manual or CMS manual coding instructions	0

90940	Standards of medical / surgical practice	0
92002	More extensive procedure	0
92004	More extensive procedure	0
92012	More extensive procedure	0
92014	More extensive procedure	0
92227	CPT Manual or CMS manual coding instructions	1
92228	CPT Manual or CMS manual coding instructions	1
92531	CPT Manual or CMS manual coding instructions	0
92532	CPT Manual or CMS manual coding instructions	0
93561	Misuse of column two code with column one code	1
93562	Misuse of column two code with column one code	1
93792	CPT Manual or CMS manual coding instructions	1
93793	CPT Manual or CMS manual coding instructions	0
94002	CPT Manual or CMS manual coding instructions	0
94003	CPT Manual or CMS manual coding instructions	0
94004	CPT Manual or CMS manual coding instructions	0
94660	CPT Manual or CMS manual coding instructions	0
94662	CPT Manual or CMS manual coding instructions	0
95831	Standards of medical / surgical practice	0
95832	Standards of medical / surgical practice	0
95833	Standards of medical / surgical practice	0
95834	Standards of medical / surgical practice	0
95851	Standards of medical / surgical practice	0
95852	Standards of medical / surgical practice	0
96020	CPT Manual or CMS manual coding instructions	1
96105	Standards of medical / surgical practice	1
96116	CPT Manual or CMS manual coding instructions	1
96125	Standards of medical / surgical practice	1

96130	Standards of medical / surgical practice	1
96132	Standards of medical / surgical practice	1
96136	Standards of medical / surgical practice	1
96138	Standards of medical / surgical practice	1
96146	Standards of medical / surgical practice	1
96150	CPT Manual or CMS manual coding instructions	0
96151	CPT Manual or CMS manual coding instructions	0
96152	CPT Manual or CMS manual coding instructions	0
96153	CPT Manual or CMS manual coding instructions	0
96154	CPT Manual or CMS manual coding instructions	0
96523	CPT Manual or CMS manual coding instructions	0
97151	Misuse of column two code with column one code	1
97153	Misuse of column two code with column one code	1
97154	Misuse of column two code with column one code	1
97155	Misuse of column two code with column one code	1
97156	Misuse of column two code with column one code	1
97157	Misuse of column two code with column one code	1
97158	Misuse of column two code with column one code	1
97802	Misuse of column two code with column one code	0
97803	Misuse of column two code with column one code	0
97804	Misuse of column two code with column one code	0
99091	CPT Manual or CMS manual coding instructions	0
99172	CPT Manual or CMS manual coding instructions	0
99173	CPT Manual or CMS manual coding instructions	1
99174	Misuse of column two code with column one code	1
99177	Misuse of column two code with column one code	1
99211	Misuse of column two code with column one code	1
99212	Misuse of column two code with column one code	1

99213	Misuse of column two code with column one code	1
99214	Misuse of column two code with column one code	1
99408	Standards of medical / surgical practice	0
99409	Standards of medical / surgical practice	0
99446	CPT Manual or CMS manual coding instructions	0
99447	CPT Manual or CMS manual coding instructions	0
99448	CPT Manual or CMS manual coding instructions	0
99449	CPT Manual or CMS manual coding instructions	0
99451	CPT Manual or CMS manual coding instructions	0
99452	CPT Manual or CMS manual coding instructions	0
99463	Mutually exclusive procedures	0
99605	Misuse of column two code with column one code	1
99606	Misuse of column two code with column one code	1
G0102	Standards of medical / surgical practice	0
G0117	Standards of medical / surgical practice	0
G0118	Standards of medical / surgical practice	0
G0245	Standards of medical / surgical practice	0
G0246	Standards of medical / surgical practice	0
G0248	Misuse of column two code with column one code	1
G0250	Misuse of column two code with column one code	1
G0270	Misuse of column two code with column one code	0
G0271	Misuse of column two code with column one code	0
G0396	Standards of medical / surgical practice	1
G0397	Standards of medical / surgical practice	1
G0406	Mutually exclusive procedures	0
G0407	Mutually exclusive procedures	0
G0408	Mutually exclusive procedures	0
G0425	Mutually exclusive procedures	0

G0426	Mutually exclusive procedures	0
G0427	Mutually exclusive procedures	0
G0442	Standards of medical / surgical practice	1
G0443	Standards of medical / surgical practice	1
G0444	More extensive procedure	1
G0445	More extensive procedure	1
G0446	More extensive procedure	1
G0447	More extensive procedure	1
G0459	Standards of medical / surgical practice	0
G0473	More extensive procedure	1
G0508	Mutually exclusive procedures	0
G0509	Mutually exclusive procedures	0
G2011	Standards of medical / surgical practice	1

HCPCS Crossref

G0463 : Hospital outpatient clinic visit for assessment and management of a patient
G0467 : Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit
G0501 : Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)
G0511 : Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
G0512 : Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month
G9868 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes
G9869 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes
G9870 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes

Modifier Crossref

24 : Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25 : Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
27 : Multiple Outpatient Hospital E/M Encounters on the Same Date
32 : Mandated Services
33 : Preventive Services
57 : Decision for Surgery
80 : Assistant Surgeon
81 : Minimum Assistant Surgeon
82 : Assistant Surgeon (when qualified resident surgeon not available)
95 : Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
99 : Multiple Modifiers
AF : Specialty physician
AG : Primary physician
AK : Non participating physician
AQ : Physician providing a service in an unlisted health professional shortage area (hpsa)
AS : Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
CR : Catastrophe/disaster related
EP : Service provided as part of medicaid early periodic screening diagnosis and treatment (epsdt) program
ET : Emergency services
FP : Service provided as part of family planning program
G0 : Telehealth Services For Diagnosis, Evaluation, Or Treatment, Of Symptoms Of An Acute Stroke
GA : Waiver of liability statement issued as required by payer policy, individual case
GC : This service has been performed in part by a resident under the direction of a teaching physician
GF : Non-physician (e.g. nurse practitioner (np), certified registered nurse anesthetist (crna), certified registered nurse (crn), clinical nurse specialist (cns), physician assistant (pa)) services in a critical access hospital
GJ : "opt out" physician or practitioner emergency or urgent service
GR : This service was performed in whole or in part by a resident in a department of veterans affairs medical center or clinic, supervised in accordance with va policy
GV : Attending physician not employed or paid under arrangement by the patient's hospice provider
GW : Service not related to the hospice patient's terminal condition
HA : Child/adolescent program
HB : Adult program, non geriatric
HC : Adult program, geriatric
HD : Pregnant/parenting women's program
HU : Funded by child welfare agency
KX : Requirements specified in the medical policy have been met
PD : Diagnostic or related non diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days
Q0 : Investigational clinical service provided in a clinical research study that is in an approved clinical research study
Q1 : Routine clinical service provided in a clinical research study that is in an approved clinical research study
Q5 : Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
Q6 : Service furnished under a fee-for-time compensation arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area

QJ : Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 cfr 411.4 (b)
TH : Obstetrical treatment/services, prenatal or postpartum

CPT® Lay Terms

When selecting an E/M service level for an established patient office visit, there are two key components that must be met in order to report the code appropriately. These components are in addition to the medical necessity for performing the procedure(s).

Clinical Responsibility

For CPT® code 99215, the provider spends an average of 40 minutes face–to–face with an established patient. A patient is considered to be established if the same physician or qualified healthcare practitioner, or any physician or qualified healthcare practitioner in the group practice (or any physician or practitioner of the same specialty who is billing under the same group number), has seen the patient for a face–to–face service within the past 36 months.

There must be at least two of three key components met to support the service level.

Tips

Two of the three key components that need to be satisfied are:

1. A comprehensive history

2. A comprehensive examination

3. Medical decision making of high complexity

Note: Usually, the presenting problem(s) are of moderate to high severity.

The appropriate E/M service level is based on the medical necessity of performing the key components and also reviewing documentation of the key E/M criteria of the history, exam, and medical decision–making (MDM) elements.

Use time as the controlling factor to report an office and/or other outpatient visit if more than 50% of the total visit time is comprised of counseling and coordination of care.

Report a separate and significant E/M service on the same day as another service or procedure. In most of these cases, it is appropriate to append a modifier to the E/M service code.

Additional Info

E/M Terms Easy Reference Guide:

CC: Chief Complaint: According to the CPT® manual, this is a concise statement, usually in the patient's words, explaining the main reason for the appointment. Look for a symptom, problem, condition, or diagnosis.

Dx: Diagnosis

Hx: History

HPI: History of Present Illness: These eight areas contribute to determining HPI:

Location is the place on the patient's body where the symptoms exist (the lower back, for instance). **Context** is what the patient was doing when the problem occurred (such as patient had lower back pain after standing on his feet all day). **Quality** represents the chief complaint or signs or symptoms. So if a patient reports with a sharp pain in her shoulder, sharp is the quality. **Timing** is the time of day the patient experienced the signs and symptoms. If the notes say, pain after standing for long periods, last two weeks, then after standing for long periods is the timing. **Severity** shows just how serious the patient's condition is. Physicians often show severity in their notes with a scale of 1, representing the least painful, to 10, representing the most painful. **Duration** is how long the patient's signs and symptoms have been present (for instance, patient has had sharp/severe shoulder pain, lasting three weeks). **Modifying factors** are what the patient did herself to alleviate pain –– or exacerbate the symptoms (for example, patient's low back pain was worsened by continuing to stand for long periods or pain improved when patient sat for 15–20 minutes). **Associated signs and symptoms** are any other problems the patient has in addition to the chief complaint (such as blurred vision, an associated symptom of migraines).

For most upper–level E/M codes, the physician must cover and document in the HPI documentation a minimum of four of these points.

MDM: Medical Decision Making: After gathering information, the clinician must decide what to do. That thinking process, which takes into account risk factors, is MDM.

PFSH: Past Family and Social History

Past history can be medical history, surgical history, and other personal history.

Family history includes medical events in the patient's family line, such as hereditary diseases that put the patient at risk.

Social history reviews the individual's past and current activities. Smoking history, alcohol history, sexual history, a whole lot of things get thrown in there, experts say.

ROS: Review of Systems: An ROS is an inventory of body systems or symptoms about which the provider asks the patient, to help the physician establish a diagnosis.

CPT® breaks the body into these systems:

Constitutional symptoms; eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary: skin and/or breasts; neurologic; psychiatric; endocrine; hematologic/lymphatic; allergic/immunologic.

CPT® Guidelines

Section Specific Guideline

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 16) or initial nursing facility care (page 26).

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

Upcoming and Historical Information

01-01-2013	Code Changed

Previous Descriptor

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

01-01-2008	Code Changed

Previous Descriptor

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

01-01-2007	Code Changed

Previous Descriptor

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

01-01-1992	Code Added