

Adult Current Procedural Terminology® Coding Case Scenarios



■ Background

In an effort to address the continuing problem of administrative burden for physicians in nearly every specialty, recent changes to the Evaluation and Management (E/M) office visit Current Procedural Terminology (CPT®)¹ codes (99201-99215) code descriptions and documentation standards have been approved for use by the American Medical Association (AMA) and are finalized in the 2020 Medicare Physician Fee Schedule Final Rule, effective 2021. These new codes, **effective January 1, 2021**, are designed to be more intuitive and reduce administrative burden by removing complex counting systems for history, exam and data.² A chart of the codes prior to the change relative to the current change is provided in *Appendix 1*.

The revisions relevant to documenting an immunization office visit are based on a simplification of the guidelines, which allow for the use of “Total Time” or the use of “Medical Decision Making”³ as key contributing factors, for the basis of payment for vaccination counseling and administration. Coding based on time is well suited for immunization counseling as there is often low medical decision making involved for implementing Advisory Committee on Immunization Practices (ACIP) recommendations. The definition of time, under these new revisions, is total time, not typical time, and represents total physician/qualified health profession (QHP) time on the date of service. The use of date-of-service time allows for the billing of work involved in non-face-to-face services like care coordination and review of immunization records.

The code level selection process has changed in common immunization-related scenarios from previous documentation standards for history and physical in level selection. Under the 2021 guidelines:

1. Although a *medically necessary* history and exam should be performed as appropriate, only medical decision-making or time may be used to select the level of service performed.
2. The time requirements have changed in that, rather than face-to-face time with the patient, the physician’s total time on the date of the encounter is summed.

The new codes, which now allow for billing total time, seek to decrease administrative burden of documentation and coding while ensuring payment for E/M is resource-based. For a complete description of the code changes, and numerous educational modules, see the American Medical Association website (www.ama-assn.org/cpt-office-visits).

The following case studies are designed to provide guidance on appropriate coding and billing for a range of scenarios for providers who care for adults.

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² American Medical Association. CPT© Evaluation and Management. www.ama-assn.org/cpt-evaluation-and-management

³ The medical decision-making components for the revised office visits can be found at www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf. The subject of this brief is about the coding relative to use of “total time”

CASE 1

OFFICE VISIT: Low complexity, vaccine counseling with no vaccine administration

A 48-year old patient with private insurance visits his provider for his annual comprehensive health and wellness visit, which includes a review of patient past medical history, an annual physical exam, and coordination of follow-up monitoring of high cholesterol and pre-diabetes. This patient is an established patient and is indicated for an influenza vaccine and a tetanus, diphtheria, pertussis (Tdap)/ tetanus and diphtheria (Td) booster.

The physician spends 5 minutes prior to the visit, on the date of encounter, reviewing the patient's history, including looking for prior immunizations for this patient in the state immunization information system (IIS). At the visit, the provider counsels the patient on the booster recommendation and the importance of annual influenza vaccination. The patient decides not to get either vaccine. The total time spent on the encounter lasts 35 minutes (30 minutes visit and 5 minutes of work prior to the visit).

Item Coding	CPT Code	Comment
Established Patient Preventive Medicine Services Visit	99396 age 40–64	For cholesterol and pre-diabetic condition and vaccine counseling (35 min)
		No additional billing for counseling

Explanation of code selection

Because no vaccine was administered, vaccine administration codes cannot be used for vaccine counseling. The correct code is the preventive visit code which is linked to age [99395 (age 18-39), 99396 (age 40-64), 99397 (age 65 and older)]. No specific times are associated with this code. Because these codes are not time-based, no changes are required relative to the AMA changes.

Under the new coding rules, the non "face-to-face" time spent on the date of the encounter can be counted regardless of the fact that the total time results in the same code being previously chosen (i.e., the time calculation has changed.)

CASE 2

PREVENTIVE VISIT: With separately identifiable E/M performed, vaccine counseling with no vaccine administration

A 30-year old patient with private insurance makes an appointment for her annual comprehensive preventive visit and to request a hepatitis B vaccination in order to comply with new employee requirements. This patient is an existing patient and is indicated for hepatitis B given low titers upon laboratory results. At the visit the provider conducts a comprehensive preventive exam and counsels the patient on age-appropriate screening labs and tests that the patient should consider. The patient is also diabetic, but stable. The physician provides appropriate counseling on properly managing the patient's diabetes.

Following counseling on the vaccine, the patient changes her mind after seeing on the employee health form that the hepatitis B vaccination is optional. The physician spent 15 minutes counseling the patient. As part of the visit, the patient complains of lower abdominal pain. A medically necessary physical exam is performed, and a diagnosis is reached. The physician prescribed medication and counsels the patient on risks and benefits. Following the face-to-face visit, the physician enters documentation into the electronic health record. The total time on the date of the encounter related to the **additional** office visit is 25 minutes.

Item Coding	CPT Code	Comment
Established Patient Preventive Services Visit	99395 age 18-39	For vaccine counseling (15 min)
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For complaint of lower abdominal pain. Using the E/M modifier to the office visit because of the separately identifiable E/M performed (25 min) given the primary visit was preventive.

Explanation of code selection

Because there is a separately identifiable evaluation and management service performed, the claim would include the preventive counseling CPT code (for the discussion on hepatitis B vaccination) plus a code for an office visit (for the complaint of lower abdominal pain). You would append the CPT code for the office visit (99213) with modifier 25 (Separately Identifiable E/M Service), not the preventive visit code. The CPT code 99213 is the correct choice as the time spent on the date of the encounter falls in the range for 99213 (20-29 minutes). The 25 modifier represents a distinct service, over and above what is included in the procedure code (vaccine administration). *If the problem visit E/M service had not been performed, modifier 25 would be appended to the Preventive visit (99395).*

The preventive counseling code (99401) was not used in this case because the service provided around immunizations is captured in the Preventive Visit code (99395), which includes patient specific counseling along with a patient specific history and exam and the option to order lab and diagnostic procedures. Some payors will not pay for two E/M codes during the same encounter. Practices should verify payer policy on E/M payment for two E/M services before reporting both services. The total time results in the same code as prior to the change in coding rules, though the method in which time is calculated is different.

NB: If the patient accepted hepatitis B vaccination, then the additional codes would include:

Item Coding	CPT Code	Comment
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
Hepatitis B vaccine, adult dosage, 3 dose-schedule, for intramuscular use	90746	Product Fee

CASE 3

OFFICE VISIT: Vaccine counseling with shared clinical decision-making, vaccine administered

A 28-year-old female is at her physician's office for an asthma-related matter and to get a refill on birth control. She and her physician discuss the human papilloma virus (HPV) vaccine and reasons why she should complete the vaccination series. The patient has significant concerns about the vaccine, as she recently viewed a Facebook post about negative side effects. Vaccine counseling consumes a large proportion of the visit. The patient receives the HPV vaccine. Her total visit time on the date of the encounter was 60 minutes.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99215-25: 40-54 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For Asthma
Prolonged Service	99XXX ⁴ - each 15 minutes, beyond 99215	(Bill 1 unit: 15 min) Vaccine Counseling
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine, 2 or 3 dose-schedule, for intramuscular use	90651	Product Fee

Explanation of code selection

The correct billing for this service would include the CPT E/M office visit code 99215, with a time range of 40-54 minutes. In addition, because the total time on the date of the encounter was 60 minutes, a prolonged services code is appropriate. One unit of 99XXX (15 minutes) would be added to the base time of the 99215 code (i.e. 40 minutes). Therefore, at 60 total minutes, a prolonged services code 99XXX can be reported. A separate E/M service was provided in this situation in addition to the procedure, so modifier 25 would be appended to the E/M code (99215) because vaccine administration is considered a procedure. Since the vaccine was administered, the administration code (90471) and the vaccine code (90651) are billed. Because of new coding rules one unit (15 min) of a prolonged services code can be used.

CASE 4

OFFICE VISIT: Return visit for vaccination with series, with separately identifiable E/M

The 28-year old female from Case 3 returns to her physician's office 2 months later for the second of her series of three HPV vaccines. During the visit, she reports dysuria. A medically appropriate history and exam are completed. The physician orders a urinalysis. The urinalysis result shows a urinary tract infection (UTI). The physician prescribes antibiotics and provides counseling regarding prevention of future UTIs. Prior to leaving, the patient also receives her HPV vaccine. The physician enters documentation of clinical information into the electronic health record, including her immunizations. The physician's total time on the date of the encounter was 30 minutes.

⁴ As this is a new CPT code, the AMA will not issue the official CPT code number until the official CPT code license file is released on or near August 31, 2020.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99214-25: 30-39 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Payment for separately identifiable E/M.
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine, 2 or 3 dose schedule, for intramuscular use	90651	Product Fee

Explanation of code selection

The correct E/M office visit is 99214, as the time on the date of the encounter falls within the appropriate time range (30-39 minutes). Since the vaccine was administered, the administration code (90471) and the vaccine code (90651) are billed. A separate E/M service was provided in this situation in addition to the procedure, so modifier 25 would be appended to the E/M code.

NB: If the patient comes back for the final HPV vaccine at the indicated time interval according to the ACIP guidelines (6 months after initial dose and 5 months after the second dose) and receives the vaccination as a nurse only visit with no counseling involved, this visit is coded as a vaccine only visit, as no E/M service was documented.

Item Coding	CPT Code	Comment
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine, 2- or 3-dose schedule, for intramuscular use	90651	Product Fee

CASE 5

OFFICE VISIT: Return E/M visit and extensive vaccine counseling, no vaccine administration

A 53-year-old female returns to her primary care physician's office for follow-up for diabetes and HbA1C recheck, efficacy of current blood pressure control regimen (patient has primary hypertension), and lab testing to assess appropriateness of thyroid hormone replacement dosing. A medical problem-focused history and exam are completed. During the visit, the patient reported that, while receiving her annual flu shot at a drugstore clinic the previous month, she became aware of the potential need for revaccinations for some vaccines and new vaccines given her diagnosis of diabetes. The patient had numerous concerns about what vaccines she should consider obtaining, given her specific vaccination history/timing, and whether having had certain illnesses earlier in life made a difference in the need for additional vaccinations. The physician spends significant time (40 minutes) reconstructing and reviewing the patient's vaccination history, which consisted of both electronic and non-electronic records (traveler's vaccination books, paper records from her college health clinic) as well as recollections from the patient's memory; reviewing vaccination timing (and, in some cases, the type of vaccine administered) against the known list of potential revaccinations; and recalling the incidence and specific timing of such diseases such as measles, chickenpox and shingles, and other evidence of immunity.

Following the review and consultation, the patient decides to take additional time to 'think it over'; no vaccine is administered. The physician enters clinical documentation into the electronic health record. The physician's total time on the date of the encounter was 70 minutes.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99215: 40-54 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Office visit for E/M
Prolonged Services	99XXX - each 15 minutes, beyond 99215	Bill 2 units for extensive counseling

Explanation of code selection

The correct billing for this service would include the CPT E/M office visit code 99215, with a time range of 40-54 minutes. In addition, because the total time on the date of the encounter was 70 minutes, a prolonged services code is appropriate. A unit of 99XXX (15 minutes) would be added to the base time of the 99215 code (i.e. 40 minutes). Therefore, at 70 total minutes, two units of the prolonged services code 99XXX would be reported.

The new coding rules allow for use of prolonged services codes to account for the additional time spent counseling using the 99215 base of 40 minutes + 15 minutes (for first additional unit of 99XXX) +15 minutes (for second additional unit of 99XXX) = 70 minutes. The range is designed to show the full range until one would bill the next unit of a code.

CASE 6

OFFICE VISIT: Return E/M visit, Medicare Beneficiary, Vaccine Administered

A 65-year old female Medicare beneficiary returns to her primary care physician's office for follow-up for diabetes and HbA1C recheck and her ACIP-recommended pneumococcal polysaccharide vaccine, 23-valent (PPSV). The physician spends 25 minutes discussing her diabetes care and reviewing the patient's vaccination history.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Payment for separately identifiable E/M.
Medicare Administration Code	G0009 used with Diagnosis Code: Z23 (rather than equivalent CPT code 90471)	Administration Code
Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	90732	Product Fee

Explanation of Code Selection

The correct E/M office visit is 99213, as the time on the date of the encounter falls within the appropriate time range (20-29 minutes). A separate E/M service was provided in this situation in addition to the procedure (G0009), so modifier 25 would be appended to the E/M code.

Since the vaccine was administered, the administration code (G0009) and the vaccine code (PPSV23) are billed for the Medicare beneficiary. Guidance for billing Medicare Part B can be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/qr_immun_bill.pdf

VACCINATION SCENARIOS THAT FALL OUTSIDE OF OFFICE VISIT CODING

CASE A: Pregnant Patient Visit with Vaccination

A pregnant 28-year old patient on Medicaid is indicated for both influenza and Tdap vaccination. The provider spends an extraordinary amount of time (30 minutes) with the patient on vaccine counseling. The patient ultimately decides to vaccinate. The total visit time is 45 minutes.

Except for Medicaid* as a payor, pregnancy in most cases is billed under a global fee. The global maternity fee encompasses maternity-related services performed by all providers in uncomplicated maternity cases. The global fee includes the treatment of routine gynecological conditions during scheduled prenatal visits, typically 13 routine antepartum visits, delivery, and the six-week postpartum visit and is not billed to insurance until after delivery. Any lab work, ultrasounds, and additional or unrelated visits are billed separately.

Administration of the vaccine and the vaccine product, if provided, should be reported separately for both Medicaid and commercial insurers. These services are not valued into the global obstetrics package. Services such as immunization counseling may be included in the global pregnancy fee as part of the general antepartum service for a pregnant patient for a commercial insurer's patient since some commercial payers define the global differently than CPT. CPT does not include these services in their definition of the global obstetrics package.

* Medicaid programs vary greatly in their requirements for billing pregnancy services. Check with specific Medicaid carriers with instructions on how to bill for immunization services.

Explanation of code selection

Because this is a routine antepartum visit, there is no additional coding included for the office visit, and the new coding revisions do not apply.

CPT Global Obstetric Package

CPT's global obstetric package includes all the services normally provided in uncomplicated maternity cases (antepartum care, delivery, and postpartum care). These services are considered bundled and are therefore not coded or reimbursed separately. Most private payers follow CPT's obstetric package definition, but some have developed their own rules. Physicians should check with their individual payers about how to report these services.

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CPT Global Obstetric Package

CPT's global obstetric package codes are:

- * **59400** (routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care)
- * **59510** (routine obstetric care including antepartum care, cesarean delivery, and postpartum care)
- * **59610** (routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care, after previous cesarean delivery)
- * **59618** (routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery)

The global obstetric codes **INCLUDE**:

Antepartum services (approximately 13 visits):

- * the initial and subsequent history
- * physical examinations
- * recording of weight, blood pressure, and fetal heart tones
- * routine urine dipstick analysis
- * monthly visits up to 28 weeks gestation
- * biweekly visits up to 36 weeks gestation
- * weekly visits from 36 weeks gestation until delivery

Delivery services:

- * admission to the hospital
- * admission history and physical examination
- * management of uncomplicated labor
- * vaginal or cesarean delivery

Postpartum services (traditionally 6 weeks; 90 days for Medicare for a cesarean delivery):

- * Routine hospital visits
- * Routine office visits during global period

The global obstetric codes **DO NOT INCLUDE**:

Antepartum services: * Treatment of complications requiring additional services or more than the usual 13 visits (e.g., gestational diabetes, pre-eclampsia, hyperemesis, observation for preterm labor) * All medically indicated laboratory examinations except a routine chemical urine analysis (e.g., obstetric panel, pregnancy test, and Pap test) * All medically indicated evaluation procedures (e.g., ultrasound examinations, biophysical profiles, fetal non-stress tests or amniocentesis) * Treatment for other conditions during the pregnancy (e.g., vaginitis, sinusitis or urinary tract infection)

Delivery services: * Hospital admission services of more than 24 hours duration for a patient that is admitted and subsequently discharged from the hospital prior to delivery. * Hospital care that is distinct from labor or delivery and rendered up to, but not including, the day of delivery * Treatment for medical problems complicating the management of labor and delivery requiring additional services * Treatment of surgical complications of pregnancy (e.g., an appendectomy or an ovarian cystectomy)

Postpartum services: * Complications requiring other services or visits during the postpartum period

NB: The issues around additional and separate payment for vaccine counseling and vaccination are outside the scope of this brief and therefore not covered.

CASE B: Medicare beneficiary at Annual Wellness visit

A 72-year old Medicare beneficiary is at her annual wellness visit (AWV) and is indicated for influenza, herpes zoster, and pneumococcal vaccines. The beneficiary receives all three vaccines. Influenza and pneumococcal vaccinations are billed under Medicare Part B and herpes zoster vaccination is billed under Medicare Part D. The visit lasts 25 minutes.

Explanation of code selection

In this visit the AWV is not considered an office visit, therefore new coding revisions do not apply. Coding remains unchanged.

We ask that organizations link to the NAIS (www.izsummitpartners.org) on their respective websites. If you have any questions, please contact L.J Tan (lj.tan@immunize.org) or Angela Shen (angela.shen@immunize.org)

**National Adult
and Influenza
Immunization
Summit**



Appendix 1: Summary of CPT code differences for Office Visit E/M Codes (2020 compared with 2021)

New Patient Visits

2020 CPT Code ¹	Code Description ¹	Medical Decision Making	Face-to-Face Time	2020 Work RVUs	2021 CPT Code	Code Description	Medical Decision Making	Total Time	2021 Work RVUs
99201	Office or other outpatient visit, new, problem-focused history & exam	Straight-forward	10 mins	0.48	99201	Deleted Code	Deleted	N/A	Code deleted
99202	Office or other outpatient visit, new, <i>expanded problem-focused history & exam</i>	Straight-forward	20 mins	0.93	99202	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Straight-forward	15-29	0.93
99203	Office or other outpatient visit, new, <i>detailed history & exam</i>	Low	30 mins	1.42	99203	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Low	30-44	1.60
99204	Office or other outpatient visit, new, <i>comprehensive history & exam</i>	Moderate	45 mins	2.43	99204	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Moderate	45-59	2.60
99205	Office or other outpatient visit, new, <i>comprehensive history & exam</i>	High	60 mins	3.17	99205	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	High	60-74	3.50

1 The full description of the CPT codes can be found in the AMA-CPT Professional code book/ 2 both the 99201 and 99202 codes are low-level visit codes whereby medical decision making is straightforward and did not change; however, the total time allocated for this code change to a range (for 99202). In the subsequent code 99203-99205 total time changed as well as the relative value unit associated with the respective codes.

Established Patient Visits

2020 CPT Code ¹	Code Description ¹	Medical Decision Making	Face-to-Face Time	2020 Work RVUs	2021 CPT Code	Code Description	Medical Decision Making	Total Time	2021 Work RVUs
99211	Office or other outpatient visit, established, <i>minimal presenting problem</i>	N/A	5 mins	0.18	99211	Office or other outpatient visit, established, that <i>may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal</i>	N/A	N/A	0.18
99212	Office or other outpatient visit, established, <i>problem-focused history & exam</i>	Straight-forward	10 mins	0.48	99212	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Straight-forward	10-19	0.70
99213	Office or other outpatient visit, established, <i>expanded problem-focused history & exam</i>	Low	15 mins	0.97	99213	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Low	20-29	1.30
99214	Office or other outpatient visit, established, <i>detailed history & exam</i>	Moderate	25 mins	1.50	99214	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Moderate	30-39	1.92
99215	Office or other outpatient visit, established, <i>comprehensive history & exam</i>	High	40 mins	2.11	99215	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	High	40-54	2.80

Source Notes: As noted in the above table for “New Patient Visits,” the change in coding for “Established Patient Visits” is in total time, which has been extended to a range of time. N/A – Not required for level selection because it is a minimal visit of 5 minutes or less. The change deletes the 5 min total time description because the visit is inherently a minimal visit (e.g., blood pressure check). Additionally, except for 99211, the RVUs associated with each CPT code (99212–99215) have increased. The medical decision-making components for the revised office visits can be found at www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

RVU = Relative Value Units