2021 E&M Coding Guidelines

Society for Maternal-Fetal Medicine

Code	Time[1] (min)	MDM (2 of 3 elements)	Diagnosis[2] (no. and complexity of problems addressed)	Data[3] (amount and complexity of data to review and analyze)			Risk (complications and/or morbidity or mortality of patient management)
				CATEGORY 1 *Tests, documents, or independent historian(s)*	**CATEGORY 2** *Independent interpretation of tests*	**CATEGORY 3** *Discussion of management or test interpretation*	
LEVEL 2			**MINIMAL**	**MINIMAL OR NONE**			**MINIMAL RISK**
99202	15-29	**Straight-forward**	• 1 self-limited or minor problem	Minimal or no complexity and/or data reviewed			• Rest • Bandages • Gargles • Superficial dressings
99212	10-19						
LEVEL 3			**LOW**	**LIMITED** *(must meet the requirements of at least 1 of the 2 categories)*			**LOW RISK**
99203	30-44	**Low**	• 2 or more self-limited or minor problems; *or* • 1 stable chronic illness; *or* • 1 acute, uncomplicated illness or injury	*At least 2 of the following:* • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test	• Assessment requiring an independent historian(s)[4]	• N/A	• OTC drugs • Minor surgery without risk factors • PT/OT • IV fluids without additives
99213	20-29						
LEVEL 4			**MODERATE**	**MODERATE** *(must meet the requirements of at least 1 out of 3 categories)*			**MODERATE RISK**
99204	45-59	**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	*At least 2 of the following:* • Review of prior external note(s) from each source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s)	• Independent interpretation of a test performed by another physician/ other qualified healthcare professional[5]	• Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• Prescription drug management • Decision regarding minor surgery with identified risk factors • Decision regarding elective major surgery without risk factors • Diagnosis or treatment significantly limited by social determinants of health (SDoH - e.g., socioeconomic status, geographic location, education, employment, transportation access)
99214	30-39						
LEVEL 5			**HIGH**	**EXTENSIVE** *(must meet the requirements of at least 2 out of 3 categories)*			**HIGH RISK**
99205	60-74	**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	*At least 3 of the following:* • Review of prior external note(s) from each source • Review of the result(s) of each test • Ordering of each test • Assessment requiring an independent historian(s)	• Independent interpretation of a test performed by another physician/ other qualified healthcare professional	• Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization[6] • Decision not to resuscitate or to de-escalate care because of poor prognosis
99215	40-54						

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Code	Examples *Examples assume documentation (history, examination and data) supports level of service*	
	OB / MFM	**GYN**
LEVEL 2		
99202 **99212**	• Preconception consultation such as prior suspected IUGR with normal birth weight; sister with Down syndrome • Non AMA desires genetic options	• Contraception prescription and monitoring • STI screen no symptoms • Lost tampon with empty vagina
LEVEL 3		
99203 **99213**	• AMA with genetic options counseling • Well controlled GDM A1 • CHTN no meds • Uncomplicated di-di twins • Prior sPTD reassuring cervical length	• STI screen with symptoms • UTI with prescription • Dyspareunia • Missed ab with expectant management • Lost tampon identified as retained tampon
LEVEL 4		
99204 **99214**	• GDM A1 + CHTN no meds • GDM A2 adjusting insulin • New birth defect • New soft marker • Prior sPTD now short cervix	• Post-menopausal bleeding • Breast lump • Infertility • Recurrent UTI • Pain with concern for ovarian torsion • Menopausal symptoms • Missed ab with medical or surgical management
LEVEL 5		
99205 **99215**	• TTTS stage 3 • Anencephaly • Previable placental abruption • Preeclampsia with severe features, declines admission	• Ectopic pregnancy • Symptomatic anemia

Notes

2021 updates:

- 99201 has been deleted
- Documentation of history and examination are necessary to support medical necessity, but elements are not used when choosing a level of service.
- Prolonged service code 99417 has been added
  - This code is an add-on to Level 5 E/M (99205, 99215).
  - The time must exceed the maximum time for 99205 (60-74 min) and 99215 (40-54 min).
  - 99417 is billed in increments of 15 min (*i.e.,* 105 min new = 99205 x 1 plus 99417 x 3)
  - Time alone must be the basis for coding.

Table footnotes:

1. For time-based level of service, count time on date of service only.
2. Diagnosis: Pertains to problems addressed during this visit only; if problem managed by consultant, do not count when determining level of service.
3. Data review and order and discussion with consultants only counts if performed on date of service.
4. “Independent historian”: Someone other than the patient is providing history, such as parent to a young child or guardian to nonverbal adult; expect rare use of independent historian in OB/GYN.
5. “Interpretation of tests or discussion of management with another qualified healthcare professional” is considered only when not reported separately.
6. If high risk for complications and hospitalization is recommended same day, it may be preferable to have partner see patient at hospital and document accordingly; please refer to inpatient codes for Initial Hospital Encounter.

Definition of Time

On date of service (DOS) time includes:	*It does NOT include:*
• Preparing to see the patient • Obtaining and/or reviewing history • Medically appropriate exam • Counseling/education • Ordering: medications, tests, procedures • Documenting visit • Coordinating care	• Pre-visit work done prior to DOS • Charting on date after DOS