SPECIAL EDITION: October Update

Reporting Prior Authorization–Related Activities Within E/M Services (99203, 99204, 99205, 99213, 99214, 99215, 99358, 99452, 99080)

Prior authorization (PA) is an administrative process that requires physicians or other qualified health care professionals (QHPs) to obtain approval from a health insurance carrier before a service, supply, or medication will be authorized if provided to a patient. The process may include extensive review and discussion leading to physician attestation to affirm the appropriate care path, all of which can involve a significant amount of time and work for the physician or other QHP. This article provides information on how PA-related work performed by physicians or other QHPs is recognized within evaluation and management (E/M) office or other outpatient codes and other codes in the Current Procedural Terminology (CPT®) code set.

PA–Related Activities On the Date of an E/M Service

PA-related activities on the date of an E/M service may be accounted for within the E/M office or other outpatient codes 99203-99205 and 99213-99215.

Office or Other Outpatient Services

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 of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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 level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

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 high level of medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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

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 of medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

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 level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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 of medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

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

PA-Related Work Included in E/M Codes' Descriptions of Procedure

As part of the CPT process, a description of procedure (DoP) is created for the majority of CPT codes that are approved or revised. The DoP provides a detailed description of the work and/or the different elements that are included in the services for a typical patient for which the code would be reported. PA-related activities completed by the physician or other QHP, when performed, have been specifically delineated in the DoPs for mid- and high-level E/M codes

99203-99205 and 99213-99215. **Note that the time and effort of PA-related activities performed by clinical staff are not considered separately in code selection, as they are considered part of practice expense**. See the sample DoP for code 99215 provided below.

Description of Procedure (99215)

Day of Visit: Confirm patient's identity. Review the medical history form completed by the patient as well as the prior clinical note. Review vital signs obtained by clinical staff. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Perform a medically appropriate examination. Synthesize the relevant history, physical examination, and data elements to formulate one or more differential diagnoses, diagnostic strategies, or treatment plans (requiring high level of MDM), consulting point of care resources as needed. Discuss the diagnoses, workup options, and treatment options (including the risks, complications, and alternatives of medical and surgical treatments) with patient and family, incorporating their values in creation of the plan. Provide patient education and respond to questions from patient and/or family. Electronically prescribe medications, making changes as needed based on payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record, spending time to further refine the differential diagnosis, workup, or treatment plan. **In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed.** Coordinate care by discussing the case with other physicians and members of the health care team and write letters of

referral if necessary. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates.

Coding Tip

The time and effort spent by clinical staff performing PA-related activities may not be separately reported.

PA-Related Work Included in E/M Services and E/M Code-Selection Method

According to the E/M guidelines, when an E/M code is selected based on total time, the total time for E/M services for physicians or other QHPs includes both face-to-face and non-face-to-face time spent on the day of the encounter. As such, time spent by the physician or other QHP on PA-related work on the date of the encounter may be included in the calculation of total time for the E/M service.

Medical decision making (MDM) is affected by the changes in a patient's treatment plan. The prior authorization process has the potential to result in a change in that treatment plan. In addition, the patient's ability to meet economic requirements of these coverage decisions, such as cost sharing and copayments, may also influence decisions regarding a patient's treatment plan to facilitate patient compliance. The E/M guidelines define social determinants of health (SDOH) as "(e)conomic and social conditions that influence the health of people and communities." Economic conditions may be a consideration for uninsured and underinsured patients to choose alternative treatment options due to cost. Therefore, when cost and coverage considerations affect MDM, the PA-related activities performed by a physician or other QHP may be accounted

for under the Risk element of MDM in the moderate level category code selection as a treatment significantly limited by SDOH.

Table 1 provides an overview of the service level, total time, and inclusion of PA-related work included in the DoPs E/M office or other outpatient codes.

Table 1. E/M Office or Other Outpatient Services Codes: Overview of Service Level, Total Time, and Inclusion of PA-Related Work in DoPs

CPT Code	Medical Decision Making Level of Service	Time Threshold (min) (Must Meet or Exceed)	Inclusion of Prior Authorization in Description of Procedure
New Patient			
99202	Straightforward	15	No
99203	Low	30	Yes
99204	Moderate	45	Yes
99205	High	60	Yes
Established Patient			
99211	Clinical Staff only (physician or other QHP presence is **not** required)	N/A	No
99212	Straightforward	10	No
99213	Low	20	Yes
99214	Moderate	30	Yes
99215	High	40	Yes

[H2]PA–Related Activities On a Date Other Than E/M Service

PA-related activities performed by physicians or other QHPs on a date other than the date of the E/M visit may be reported with code 99358, provided that all requirements for reporting the code are met.

Prolonged Services

99358 **Prolonged evaluation and management service** before and/or after direct patient care; first hour

Code 99358 may be reported for prolonged services related to any E/M service on a date other than the face-to-face E/M service, regardless of whether or not time is used to select the level of the face-to-face service. Note that prolonged services without patient contact must relate to a service or patient in which face-to-face patient care has occurred or will occur and relate to ongoing patient management.

This code is used to report the total duration of non-face-to-face time spent by a physician or other QHP on a given date, even if the time spent on that date is not continuous. Prolonged services of less than 30 minutes total duration on a given date are not separately reported.

Note that time accumulated over multiple days on PA-related or other activities (eg, completing or signing forms) may **not be combined** to meet the reporting requirements of code 99358.

Add-on code 99359, ***Prolonged evaluation and management service*** *before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)*, may be reported for each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Special Reports and Forms

On occasion, a physician or other QHP may need to spend time solely to complete special reports and sign forms (eg, annual PA renewal, formulary change, or a surgical pre-authorization form) that are independent of PA-related work performed on the date of an E/M encounter. The time spent working on completing those reports and forms by a physician or other QHP may be reported with code 99080.

Note that code 99080, *Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form*, describes the work involved in completing special reports and forms, and does not include the time spent on the telephone or in other conversations.

PA and Telephone, Internet, or Electronic Health Record Consultations

Code 99452, ***Interprofessional telephone/Internet/electronic health record referral service(s)*** *provided by a treating/requesting physician or other qualified health care professional, 30 minutes,* may not be reported by a treating physician or QHP for a prior authorization conversation with a health plan physician. The prior authorization conversation with a health

plan is not a consultation, but rather a conversation to determine whether a proposed treatment is covered by the patient's insurance plan.

Per CPT guidelines, an interprofessional telephone, Internet, or EHR consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other QHP requests the opinion and/or treatment advice of a physician or other QHP with specific specialty expertise (the consultant) to assist the treating physician or other QHP in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant. Code 99452 is used to report the work performed by a treating or requesting physician or other QHP to obtain all the requisite medical record information for a referral and to ensure that all the relevant clinical information is available for the reviewer.

Table 2 provides a summary of reporting guidance for reporting PA and PA-related services performed by a physician or other QHP.

Table 2. Reporting Options for Physician or Other QHP for PA-Related Services

The following are reporting options for prior authorization (PA)-related services performed by a physician or other qualified health care professional (QHP)._	
Code(s)	**Date of Service or Visit**

<table>
<tr><td rowspan="2">99203-99205 or

99213-99215</td><td>Same Date of E/M Visit

If E/M reporting is based on time:

Time spent on PA-related services should be incorporated into the total time for E/M code selection.</td></tr>
<tr><td>If E/M reporting is based on MDM:

If MDM is affected, time spent on PA-related services should be accounted for in the MDM Risk Element and level up to a moderate complexity for social determinants of health (SDOH).

Note: PA-related work provided by clinical staff may not be separately reported.</td></tr>
<tr><td>99358</td><td>On Day Other than E/M Visit

Report time spent on PA-related services once per day for the first 60 minutes, however:

1. Time spent must occur on the same day
2. Total time of less than 30 minutes is not reported.</td></tr>
<tr><td>99080</td><td>Time spent solely to complete special reports or signing forms that are not related to an E/M visit</td></tr>
</table>

AMA Staff

Orders: *ama-assn.org/subscriptions*
AMA website: *www.ama-assn.org*

The *CPT® Assistant Special Edition* information is designed to provide accurate, up-to-date coding information. We continue to make every reasonable effort to ensure the accuracy of the material presented. However, this publication does not replace the CPT® codebook; it serves only as a guide.