



Michael D. Maves, MD, MBA, Executive Vice President, CEO

September 17, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act
Attention: RIN 1210-AB44, Fed. Reg. 41726 (July 19, 2010)

Dear Secretaries Sebelius, Solis, and Geithner:

The American Medical Association (AMA) appreciates the opportunity to provide our comments regarding the Interim Final Rule (Rule) relating to coverage of preventive services. As a general matter, the AMA strongly supports Section 2713 of the Patient Protection and Affordable Care Act (ACA), which is designed to increase the accessibility of preventive services by requiring group health plans and health insurance issuers to cover those services, without imposing associated cost-sharing obligations on enrollees. Coverage of preventive services, as required in the Rule and delineated in its preamble, represents an enormous step forward in improving the health of our patients. However, we are concerned that the Rule does not take into consideration the practical realities of how patients typically obtain preventive services, how physicians and other health care professionals bill for those services, or how group health plans and health insurance issuers address payment for preventive services in their contracts with physicians.

The Honorable Kathleen Sebelius
The Honorable Hilda Solis
The Honorable Timothy Geithner
September 17, 2010
Page 2

Unless these practical issues are addressed, we are concerned that the laudable goal of Section 2713 will not be achieved, and indeed its intent may be subverted. Our detailed comments are set forth below.

How patients typically obtain preventive services and other practical issues raised by Section 2713 and the Rule.

As a general matter, when a patient sees his or her physician, the patient expects to have all of his or her current medical needs handled during that same office visit. Indeed, many people will not visit a physician unless they are sick or in pain. To maximize the provision of appropriate preventive services, physicians must be able to provide those services at the right time for the patient. The Current Procedural Terminology (CPT) coding system supports this flexibility by enabling physicians and other health care professionals to report accurately all the services that they provide in a single visit, including both preventive services and problem-focused services.

Unfortunately, the Rule does not appear to take into account that CPT codes, guidelines, and instructions separately address preventive medicine office visits and problem-focused office visits. Moreover, the Rule could incentivize physicians and other health care professionals to not report the specific services they provide, even though it is only through accurate reporting and recognition of preventive services that the long-term benefits of these services will be measurable. While we appreciate the intent of the Rule to ensure that the cost-sharing prohibition not be extended unduly, we believe the Rule as drafted unnecessarily jeopardizes the efficient provision of medical care and undermines the incentive for accurate reporting.

Finally, the Rule assumes that group health plans and health insurance issuers will pay for all preventive services listed in the Rule, and will also pick up the cost-sharing obligations that patients would normally have assumed prior to the ACA. However, these assumptions are far from certain. To the contrary, in the absence of protections ensuring that group health plans and health insurance issuers will indeed pay for these services, and will not shift patients' prior cost-sharing obligations to the physicians and other health care professionals who provide preventive services, it is likely that many physicians will be forced to assume the costs of providing these services, including the patients' prior cost-sharing obligations. This is because physician payment under most managed care contracts includes rampant bundling of preventive services, and also assumes the collection of patient copayments and other cost-sharing responsibilities as an integral component of physician payment. This could result in less provision of preventive medicine services by physicians, which would run counter to three of the ACA's main goals, i.e., providing more and greater access to preventive medicine services, broadening access to care, and easing the systemic burdens on primary care physicians and other health care providers.

AMA CPT Preventive Medicine Services codes, guidelines, and instructions should be followed.

The AMA and physicians have long recognized the need for preventive medicine and the health benefits of annual visits for preventive care for the asymptomatic patient. In recognition of the value of the annual preventive screening office visit, 14 codes (99381-99397) were added to CPT in 1992. These codes were derived through the consensus of physician advisors reflecting the type of preventive services that should be provided to patients based on their age category.¹

In describing the types of office visits which would or would not be considered a preventive service subject to the enrollee cost-sharing prohibition, the Rule fails to reference the CPT Codes which are available to clearly distinguish these visits (See attachment 1, which lists all the preventive and problem-focused office visit CPT codes and their descriptors). By failing to include this CPT information, the Rule omits vital information that would enable patients, physicians and other health care professionals, and group health plans and health insurance issuers to clearly distinguish between non-preventive, problem-oriented office visit services and preventive services provided during an office visit. The CPT code set includes detailed guidelines that differentiate the use of the preventive medicine visit codes from the problem-oriented office visit codes. These coding guidelines are the result of the careful construction and definition of services. Prior to publication, these codes and guidelines are carefully scrutinized by the CPT Editorial Panel, the CPT Physician and Health Care Professional Advisory Committee, and the AMA Specialty Society Relative Value Update Committee (RUC) to determine that no duplication of services is supported by, or inherent in, the CPT codes. CPT guidelines are developed to assist in the distinction of services and to eliminate any inappropriate interpretation that might lead to overlaps in CPT codes for reporting purposes.

In addition, while the Rule appropriately supports the value of vaccines at appropriate ages, the additional efforts required for physician and provider vaccine administration, ordering, record maintenance, and counseling on the benefits and risks of vaccine administration that are currently reported and recognized in codes 90467-90468 are not clearly included as preventive services. However, if the goal is to ensure that necessary vaccines are provided, then the activities that are integral to the provision of those vaccines must similarly be treated as preventive services subject to Section 2713's coverage and cost-sharing requirements.

Finally, the CPT codes, guidelines, and conventions clearly indicate how physicians and other health care professionals are to bill when a preventive medicine visit as described above is

¹Note that last year, CMS proposed that two new HCPCS G codes—GXXXXA and GXXXXB—be established to report initial and subsequent annual wellness visits in conjunction with the expansion of the Medicare benefit to cover these services. However, after consideration of the existing granular code structure of the fourteen CPT codes for preventive service office visits codes for new and established patients, new HCPCS G codes were not created. Thus, CMS has already recognized the value of these preventive service office visit codes.

accompanied by additional services, whether those services are preventive services like vaccines, lab tests, or other screenings, or those services include non-preventive services, like a problem-focused office visit (see Attachment 1, CPT codes 99201-99215), or other treatments.

The cost-sharing prohibition should be extended to all services provided during the course of a preventive medicine office visit.

We believe the Rule should be revised to encourage physicians and other health care professionals to maximize the provision of appropriate preventive services, and to code all preventive and non-preventive services consistently with the CPT codes, guidelines, and conventions. As discussed above, the CPT coding system contains all the codes and modifiers necessary to create a transparent claim listing the preventive and problem-focused services that have been provided. Moreover, it is generally much more efficient for physicians to provide all services a patient needs at a single visit.

To accomplish this result, we recommend that the prohibition on cost-sharing for preventive services be revised as follows:

- 1) *Services provided during a preventive office visit* (CPT Codes 99381-99397)—no cost-sharing may be imposed for the office visit or for any preventive services or non-preventive services provided during the preventive office visit;
- 2) *Preventive services provided during a problem-focused office visit* (CPT Codes 99201-99215)—no cost-sharing may be imposed for any preventive services provided during the office visit, but cost-sharing may be imposed for the office visit and any non-preventive services provided during the visit; and
- 3) *Services provided during an office visit involving both a preventive visit and a problem-focused office visit* (CPT Codes 99381-99397 billed with CPT Codes 99201-99215)—no cost-sharing may be imposed for either office visit, or any of the preventive services provided during the office visit, but cost-sharing may be imposed for other non-preventive services provided during the visit.

We believe this approach will maximize the likelihood that preventive services are provided, increase the likelihood that these services are correctly coded, eliminate the likelihood patients will be required to make two separate appointments to handle both their preventive medicine office visits and specific medical problems they face, eliminate the possibility of placing an additional burden on physicians in providing preventive medicine services, and eliminate disputes as to whether the “primary purpose” of the visit was to deliver preventive services. While this modification may be marginally more expensive than that included in the Rule, it is not subject to substantial gamesmanship. The list of preventive medicine office visits is established in the Rule, so there is no potential that this revision test will result in preventive

medicine office visits beyond those already authorized, and presumably patients will only seek treatment for problems when they indeed have them. Moreover, so far as we are aware, physicians are never authorized to bill for more than one copayment for a single office visit, regardless of whether both preventive and problem-focused office visit services are provided. Thus, the intent of the law is better reflected in a rule that prohibits the imposition of cost-sharing whenever a preventive office visit is provided, regardless of whether other services were also performed.

Ensuring that group health plans and health insurance issuers—not physicians and other providers of preventive services—assume the costs of the provision of these services.

As discussed above, the AMA is strongly supportive of the provision of preventive care and strongly supports the intent of this interim rule to increase the incentive for patients to obtain preventive care services. However, without mandated safeguards, the unintended consequences of this rule will be another unfunded mandate on primary care physicians. To protect physicians and other providers of preventive services against this result, two protections are necessary:

- 1) Group health plans and health insurance issuers must be required to assume the financial obligations of the cost-sharing requirements for preventive services which were previously the responsibility of the patient, rather than shift those responsibilities to physicians or other health care providers, and
- 2) Group health plans and health insurance issuers must be prohibited from paying nothing for preventive services by bundling those services into other services, contrary to the rules set forth in the CPT code book.

Ensuring that health plans do not shift the patient cost-sharing obligation to physicians.

Most managed care contracts mandate that physicians collect any mandated copayment or other cost-sharing obligation from patients, and further reduce the health plan's obligation to pay on the fee schedule by the mandated cost-sharing amount. For example, the following provision is taken from a base contract offered to physicians by a health plan doing business on a national scale:

“Payments for Covered Services will be the lesser of the billed charge or the applicable fee schedule under Exhibit C, subject to the Payment Policies and minus any applicable Copayments, Coinsurance, and Deductibles.”

Arguably, the elimination of any cost-sharing responsibilities pursuant to Section 2713 would not harm physicians with this contract, because there would be no “applicable Copayment, Coinsurance or Deductibles” associated with preventive services. However, many contracts have fee schedules which have already been reduced by the expected copayment or coinsurance

amounts. Other contracts will be ambiguous as to whether the reduction in patient responsibility required by the rule will be borne by the group health plan or health insurance issuer rather than by the physician or other provider of preventive services. Thus, to the extent the Rule prohibits the imposition of a copayment or other cost-sharing obligation on patients for preventive services, it will likely be the physicians providing those services who will bear the financial impact, not the group health plans and health insurance issuers. Moreover, the loss of the income associated with the elimination of copayments or other patient responsibility for preventive services would be significant to most primary care practices.

Clearly, if the intent of the Rule is to increase the provision of preventive services, physicians and other providers of these services must be protected against bearing such a financial loss. We urge amendment of the Rule as follows:

1. Any provision in a managed care contract between a group health plan or health insurance issuer and a physician or other health care provider which requires the provider to collect copayments or other cost-sharing obligations from enrollees for preventive services are void; and
2. Group health plans and health insurance issuers must hold physicians and other health care providers harmless for any reduction in income resulting from the implementation of the patient cost-sharing prohibition for preventive services by increasing payments to those physicians and other providers by an amount equal to the amount the physician or other health care provider was authorized to collect from the patient prior to the implementation of the patient cost-sharing prohibition.

Ensuring that health plans do not shift the cost of providing preventive services to physicians.

Private payers have made it extremely difficult for physicians to provide preventive care, even when it is a covered benefit. This is because private payers routinely “bundle” all the preventive medicine services into the office visit. For example, if a mother brings a baby in for its 4-month check-up as listed on the Health Resources and Services Administration (HRSA) guidelines, but the baby has a fever that also needs to be evaluated, many health plans will pay for the office-visit charge associated with the evaluation of the fever, but will not pay anything for the developmental, behavioral, vision, or hearing screening, vaccine administration or other required preventive services. Thus, physicians must either provide these services without compensation, or physicians must inconvenience the mother and require that she make a second appointment on a different day to receive the preventive services.

A medical payment policy from a major health insurer demonstrates this phenomenon with respect to adult preventive services. As the language excerpted below indicates, this policy

inappropriately bundles the majority of screening services into the preventive medicine office visit code:

“Screening services include cervical cancer screening; pelvic and breast examination (G0101); prostate cancer screening; digital rectal examination (G0102); and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory (Q0091). These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day for members age 22 years and over.”

In addition, a number of health insurers’ medical payment policies state that they do not pay for a problem-focused examination when performed with a preventive medicine examination. Therefore, if a physician performs a preventive medicine examination and a problem is identified, the physician must either handle the problem without compensation, or require the patient to schedule another appointment to address the identified problem.

One of the AMA’s priorities is to encourage consistency in the use of CPT codes, guidelines, and conventions, as well as to advocate the adoption of the CPT guidelines and conventions as a HIPAA standard to accompany the CPT codes which have already been designated as a HIPAA standard. The AMA objects when health plans seek to arbitrarily and unilaterally recode or inappropriately bundle codes and services. In the example above, under CPT codes, guidelines, and conventions, modifier–25 would be appended to the preventive medicine office visit to indicate that on the day that service was performed, the patient’s condition required a significant, separately identifiable E&M service (a problem-focused visit) above and beyond the other service provided.

Instead of rewarding physicians and non-physicians for providing necessary preventive patient care efficiently during the same visit, the lack of recognition of CPT modifier-25 penalizes physicians and non-physician professionals for providing quality, efficient care to patients that is consistent with current medical guidelines and standards. The AMA is opposed to any payment policy that requires a patient to come back for a subsequent visit for necessary care when this treatment could have been provided during the original visit: this practice jeopardizes quality patient care and safety, and threatens the patient-physician relationship.

Again, if the intent of this rule is to increase the provision of preventive services, health plans must be required to pay for those services. We urge amendment of the Rule as follows:

Group health plans and health insurance issuers must pay for all preventive services identified in the Rule consistent with the CPT codes, guidelines, and conventions set forth in the CPT book, and are prohibited from refusing to recognize modifiers or otherwise apply bundling edits which have the effect of requiring physicians or other health care providers to provide these services without compensation.

Value-based health insurance plans

The agencies have interpreted the ACA as granting them authority to develop guidelines for group health plans and health insurance issuers that utilize value-based insurance designs as part of their offering of preventive health services, and have requested comments on how these guidelines should be developed to promote consumer choice of providers or services that provide the best value and quality, and ensure access to critical, evidence-based preventive services.

Value-based insurance plans may provide benefits to patients and society as a whole when they are able to provide patients with accurate and easy to understand information on maximizing quality and effective care opportunities. The AMA encourages the use of physician data to improve the quality of patient care and the efficient use of resources in the delivery of health care services. In order to protect patients covered by these value-based plans, it is imperative that the plans be required to incorporate patient protection guidelines into their plan design regarding the provision of information about, or incentives to use, specific physicians, other providers of care, treatments or health care services. The following non-inclusive guidelines will ensure that the data and data analyses used to drive the plans' provision of information or incentives are accurate, fully transparent, and do not adversely affect any patient population's access to care. These plans should:

- show commitment to improved patient care as their most important mission;
- use evidence-based quality of care measures, created by physicians across appropriate specialties;
- subject performance measures to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities;
- consider patients' health conditions, ethnicity, economic circumstances, demographics, and treatment compliance patterns when analyzing the data;
- use accurate data and scientifically valid analytical methods;
- prospectively explain, in easy to understand language, the structure and purpose of value-based programs, and how they work, to patients and communities covered by them;
- ensure that these value-based plans are not inappropriately driven by economic criteria;
- disclose, in easy to understand language, the criteria by which the health plan creates any tiered, narrow or restricted network or class of treatment or service;
- disclose the potential error rate of these programs by specialty or type of service;
- provide physicians and other care providers the opportunity to review, comment and appeal their own rating results prior to the use of the results for programmatic reasons or any type of public reporting;
- allow physicians and other providers to supplement health plan data with their own data;
- provide appropriate specialty societies with the opportunity to review, comment and appeal any recommendations, prior authorization requirements or ratings of effectiveness for specific treatments or types of health care services;

- keep performance measures current reflecting changes in evidence-based-clinical practice;
- allow for variance from specific performance measures that are in conflict with sound clinical judgment;
- not cause physician or treatment access problems due to a limited number of specialists in the resulting network;
- not reduce access to care, treatment options or choice of physicians for patients based on their ethnic, cultural, and socio-economic group or specific medical condition;
- not unfairly disadvantage patient care options or choice of physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural);
- reimburse physicians and other health care providers for any added administrative costs incurred as a result of collecting and reporting data requested by the health plan;
- use physician and other provider cost of care data for services, procedures, tests and prescriptions that are based on utilization of resources so that the focus of cost ratings is not on the actual charges for services;
- be subject to an independent, third party audit, at their expense to ensure compliance with these guidelines.

Summary

If we are to maximize the provision of appropriate preventive services, we need to remove the barriers for patients and physicians that exist today. To accomplish this result, we urge revisions of the Rule as follows:

1. That the prohibition on cost-sharing for preventive services be revised as follows:
 - a) *Services provided during a preventive office visit* (CPT Codes 99381-99397)—no cost-sharing may be imposed for the office visit or for any preventive services or non-preventive services provided during the preventive office visit;
 - b) *Preventive services provided during a problem-focused office visit* (CPT Codes 99201-99215)—no cost-sharing may be imposed for any preventive services provided during the office visit, but cost-sharing may be imposed for the office visit and any non-preventive services provided during the visit; and
 - c) *Services provided during an office visit involving both a preventive visit and a problem-focused office visit* (CPT Codes 99381-99397 billed with CPT Codes 99201-99215)—no cost-sharing may be imposed for either office visit, or any of the preventive services provided during the office visit, but cost-sharing may be imposed for other non-preventive services provided during the visit.

2. That group health plans and health insurance issuers be required to pay for all preventive services listed in the Rule, and assume the financial obligations of the cost-sharing requirements for preventive services which were previously the responsibility of the patient as follows:
 - a) Any provision in a managed care contract between a group health plan or health insurance issuer and a physician or other health care provider which requires the provider to collect copayments or other cost-sharing obligations from enrollees for preventive services are void.
 - b) Group health plans and health insurance issuers must hold physicians and other health care providers harmless for any reduction in income resulting from the implementation of the patient cost-sharing prohibition by increasing payments to those providers by an amount equal to the amount the physician or other health care provider was authorized to collect from the patient prior to the implementation of the patient cost sharing prohibition.
 - c) Group health plans and health insurance issuers must pay for all preventive services identified in the Rule consistent with the CPT codes, guidelines, and conventions set forth in the CPT book, and are prohibited from refusing to recognize modifiers or otherwise apply bundling edits which have the effect of requiring physicians or other health care providers to provide these services without compensation.

With the revisions to the Rule we have proposed, we believe every patient visit will truly be an opportunity for prevention. Thank you for considering our comments.

Sincerely,



Michael D. Maves, MD, MBA

Attachment

CPT Preventive Medicine and Routine Office Visit Codes

Evaluation and Management Preventive Medicine Services

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents and adults.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is NOT synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. (Refer to codes 99401-99412 for reporting those counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90465-90474. For vaccine/toxoid products, see 90476-90749.

New Patient

99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	early childhood (age 1 through 4 years)
99383	late childhood (age 5 through 11 years)
99384	adolescent (age 12 through 17 years)
99385	18-39 years
99386	40-64 years
99387	65 years and older

Established Patient

99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	early childhood (age 1 through 4 years)
99393	late childhood (age 5 through 11 years)
99394	adolescent (age 12 through 17 years)
99395	18-39 years
99396	40-64 years
99397	65 years and older

Evaluation and Management, Office or Other Outpatient Services (Problem Focused)

New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

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 self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making.

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 low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low 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 severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate 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 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate 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 60 minutes face-to-face with the patient and/or family.

Established Patient

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 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 problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

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 self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low 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 low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 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 detailed history;
- A detailed examination;
- Medical decision making of moderate 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 25 minutes face-to-face with the patient and/or family.

99215 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.