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CPT® Evaluation and Management (E/M) Code and Guideline Changes

This document includes the following CPT E/M changes, effective January 1, 2023:

- E/M Introductory Guidelines related to Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242-99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350
- Deletion of Hospital Observation Services E/M codes 99217-99220
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines
- Deletion of Consultations E/M codes 99241 and 99251
- Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines
- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines
- Deletion of Nursing Facility Services E/M code 99318
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340
- Deletion of Home or Residence Services E/M code 99343
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines
- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 993X0 and guidelines

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Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

►The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver.

For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
  - Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◄

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Classification of Evaluation and Management (E/M) Services

►The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◄

New and Established Patients

►Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are

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working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◄

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

►Initial and Subsequent Services◄

►Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care

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professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance when a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay. ◀

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

▶The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.◀

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

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History and/or Examination

►E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.◄

►Levels of E/M Services◄

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**
2. The total time for E/M services performed on the date of the encounter.

►Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.◄

►Guidelines for Selecting Level of Service Based on Medical Decision Making◄

►Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211, 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter.***
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared

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decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported).
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).

- ***The risk of complications and/or morbidity or mortality of patient management*** . This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.◄

MDM may be impacted by role and management responsibility.

►When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services. When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 1) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient. See also the introductory guidelines of each code family section.◄

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Table 1: Levels of Medical Decision Making (MDM)

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the c*** ***ombination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ▪ **2** or more self-limited or	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)*	**Low risk of morbidity from additional**

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		minor problems; **or** ▪ 1 stable, chronic illness; **or** ▪ 1 acute, uncomplicated illness or injury; **or** ▪ 1 stable, acute illness; **or** ▪ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Category 1: Tests and documents** ▪ **Any combination of 2 from 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* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**diagnostic testing or treatment**
	Moderate	**Moderate**	**Moderate**	**Moderate risk of morbidity from**

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		■ **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	*(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from 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) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test	**additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social

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			performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** - Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	determinants of health
	High	**High** - 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** - **Any combination of 3 from the following:**	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* - Drug therapy requiring intensive

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		or ■ 1 acute or chronic illness or injury that poses a threat to life or bodily function	• 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) or **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or	monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis

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			Category 3: Discussion of management or test interpretation ▪ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	▪ Parenteral controlled substances◄

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Number and Complexity of Problems Addressed at the Encounter

►One element used in selecting the level of service is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.◄

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

►Definitions for the elements of MDM (see Table 1, Levels of Medical Decision Making) are:◄

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

►***Problem addressed:*** A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

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Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).◄

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

►*Stable, chronic illness:* A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for *self-limited or minor problem* or *acute, uncomplicated illness or injury.* Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

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Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.◄

►Amount and/or Complexity of Data to Be Reviewed and Analyzed◄

►One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.◄

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

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Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

►***Independent historian(s):*** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.◄

Appropriate source: For the purpose of the **discussion of management** data element (see Table 1, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

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►Risk of Complications and/or Morbidity or Mortality of Patient Management◄

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

►***Risk:*** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high, medium, low*, or *minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.◄

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.

Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

►***Drug therapy requiring intensive monitoring for toxicity:*** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment

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of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.◄

►Guidelines for Selecting Level of Service Based on Time◄

►Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (eg, whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time.

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Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)◄

Do not count time spent on the following:

- the performance of other services that are reported separately
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

99429 **Unlisted preventive** medicine service

99499 **Unlisted evaluation and management** service

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Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

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Evaluation and Management

Office or Other Outpatient Services

Hospital Observation Services

Observation Care Discharge Services

►(99217 has been deleted. To report observation care discharge services, see 99238, 99239)◄

Initial Observation Care

New or Established Patient

►(99218, 99219, 99220 have been deleted. To report initial observation care, new or established patient, see 99221, 99222, 99223)◄

Subsequent Observation Care

►(99224, 99225, 99226 have been deleted. To report subsequent observation care, see 99231, 99232, 99233)◄

►Hospital Inpatient and Observation Care Services◄

►The following codes are used to report initial and subsequent evaluation and management services provided to hospital inpatients and to patients designated as hospital outpatient "observation status." Hospital inpatient or observation care codes are also used to report partial hospitalization services.

For patients designated/admitted as "observation status" in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc), these codes may be utilized if the patient is placed in such an area.

For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.

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Total time on the date of the encounter is by calendar date. When using MDM or total time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one calendar date. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service.◄

►Initial Hospital Inpatient or Observation Care◄

New or Established Patient

►The following codes are used to report the first hospital inpatient or observation status encounter with the patient.

An initial service may be reported when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.◄

For admission services for the neonate (28 days of age or younger) requiring intensive observation, frequent interventions, and other intensive care services, see 99477.

►When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date.

In the case when the services in a separate site are reported and the initial inpatient or observation care service is a consultation service, do not report 99221, 99222, 99223, 99252, 99253, 99254, 99255. The consultant reports the subsequent hospital inpatient or observation care codes 99231, 99232, 99233 for the second service on the same date.

If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or other qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233). This instruction applies whether the consultation occurred on the date of the admission or a date previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.

For the purpose of reporting an initial hospital inpatient or observation care service, a transition from observation level to inpatient does not constitute a new stay.◄

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▲99221 **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

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

▲99222 **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a 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, 55 minutes must be met or exceeded.

▲99223 **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a 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, 75 minutes must be met or exceeded.

►(For services of 90 minutes or longer, use prolonged services code 993X0)◄

►Subsequent Hospital Inpatient or Observation Care◄

★▲99231 **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

★▲99232 **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a 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, 35 minutes must be met or exceeded.

★▲99233 **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

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When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

►(For services of 65 minutes or longer, use prolonged services code 993X0)◄

►Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)◄

►The following codes are used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.

For patients admitted to hospital inpatient or observation care and discharged on a different date, see 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239.

Codes 99234, 99235, 99236 require two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter. For a patient admitted and discharged at the same encounter (ie, one encounter), see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed on the same date.◄

►(For discharge services provided to newborns admitted and discharged on the same date, use 99463)◄

▲99234 **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low 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.

▲99235 **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, 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, 70 minutes must be met or exceeded.

▲99236 **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, 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, 85 minutes must be met or exceeded.

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►(For services of 100 minutes or longer, use prolonged services code 993X0)◄

►Hospital Inpatient or Observation Discharge Services◄

►The hospital inpatient or observation discharge day management codes are to be used to report the total duration of time on the date of the encounter spent by a physician or other qualified health care professional for final hospital or observation discharge of a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.

Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family/caregiver and coordination of post-discharge services may be reported with 99231, 99232, 99233.◄

▲99238 **Hospital inpatient or observation discharge day management**; 30 minutes or less on the date of the encounter

▲99239 more than 30 minutes on the date of the encounter

►(For hospital inpatient or observation care including the admission and discharge of the patient on the same date, see 99234, 99235, 99236)◄

(For discharge services provided to newborns admitted and discharged on the same date, use 99463)

Consultations

►A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.

A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

A "consultation" initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (eg, non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes.

The consultant's opinion and any services that were ordered or performed must also be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.◄

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If a consultation is mandated (eg, by a third-party payer) modifier 32 should also be reported.

►To report services when a patient is admitted to hospital inpatient, or observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient or Observation Care** or **Initial Nursing Facility Care**.◄

Office or Other Outpatient Consultations

New or Established Patient

►The following codes may be used to report consultations that are provided in the office or other outpatient site, including the home or residence, or emergency department. Follow-up visits in the consultant's office or other outpatient facility that are initiated by the consultant or patient are reported using the appropriate codes for established patients in the office (99212, 99213, 99214, 99215) or home or residence (99347, 99348, 99349, 99350). Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits or home or residence services.◄

►(For an outpatient consultation requiring prolonged services, use 99417)◄

►(99241 has been deleted. To report, use 99242)◄

★▲99242 **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

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

★▲99243 **Office or other outpatient consultation** for a new or 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, 30 minutes must be met or exceeded.

★▲99244 **Office or other outpatient consultation** for a new or 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, 40 minutes must be met or exceeded.

★▲99245 **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

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When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

►(For services 70 minutes or longer, use prolonged services code 99417)◄

►Inpatient or Observation Consultations◄

New or Established Patient

►Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation-level patients, residents of nursing facilities, or patients in a partial hospital setting, and when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician. Only one consultation may be reported by a consultant per admission. Subsequent consultation services during the same admission are reported using subsequent inpatient or observation hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).◄

►(For an inpatient or observation consultation requiring prolonged services, use 993X0)◄

►(99251 has been deleted. To report, use 99252)◄

★▲99252 **Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

★▲99253 **Inpatient or observation consultation** for a new or 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, 45 minutes must be met or exceeded.

★▲99254 **Inpatient or observation consultation** for a new or 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, 60 minutes must be met or exceeded.

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★▲99255 **Inpatient or observation consultation** for a new or 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, 80 minutes must

►(For services 95 minutes or longer, use prolonged services code 993X0)◄

Emergency Department Services

New or Established Patient

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

►For critical care services provided in the emergency department, see Critical Care guidelines and 99291, 99292. Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes and critical care services are provided.

For evaluation and management services provided to a patient in observation status, see 99221, 99222, 99223 for the initial observation encounter and 99231, 99232, 99233, 99238, 99239 for subsequent or discharge hospital inpatient or observation encounters.

For hospital inpatient or observation care services (including admission and discharge services), see 99234, 99235, 99236.

To report services when a patient is admitted to hospital inpatient or observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient or Observation Care** or **Initial Nursing Facility Care**.

For procedures or services identified by a CPT code that may be separately reported on the same date, use the appropriate CPT code. Use the appropriate modifier(s) to report separately identifiable evaluation and management services and the extent of services provided in a surgical package.

If a patient is seen in the emergency department for the convenience of a physician or other qualified health care professional, use office or other outpatient services codes (99202-99215).◄

Coding Tip

Time as a Factor in the Emergency Department Setting

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Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

CPT Coding Guidelines, Evaluation and Management, Guidelines for Selecting Level of Service Based on Time

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▲99281 **Emergency department visit** for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional

▲99282 **Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making

▲99283 **Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making

▲99284 **Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

▲99285 **Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

Coding Tip

Emergency Department Classification of New vs Established Patient

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

CPT Coding Guidelines, Evaluation and Management, Classification of E/M Services, New and Established Patients

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Other Emergency Services

In directed emergency care, advanced life support, the physician or other qualified health care professional is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital. Direction of the performance of necessary medical procedures includes but is not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or administration of intramuscular, intratracheal or subcutaneous drugs; and/or electrical conversion of arrhythmia.

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99288 **Physician or other qualified health care professional direction of** emergency medical systems (EMS) emergency care, advanced life support

Nursing Facility Services

►The following codes are used to report evaluation and management services to patients in nursing facilities and skilled nursing facilities. These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center and immediate care facility for individuals with intellectual disabilities.

Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visit.

These services are performed by the principal physician(s) and other qualified health care professional(s) overseeing the care of the patient in the facility. The principal physician is sometimes referred to as the admitting physician and is the physician who oversees the patient's care as opposed to other physicians or other qualified health care professionals who may be furnishing specialty care. These services are also performed by physicians or other qualified health care professionals in the role of a specialist performing a consultation or concurrent care. Modifiers may be required to identify the role of the individual performing the service.◄

Two major subcategories of nursing facility services are recognized: Initial Nursing Facility Care and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients.

►The types of care (eg, skilled nursing facility and nursing facility care) are reported with the same codes. Place of service codes should be reported to specify the type of facility (and care) where the service(s) is performed.

When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a high-level MDM-type specific to initial nursing facility care by the principal physician or other qualified health care professional is recognized. This type is:

Multiple morbidities requiring intensive management: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged.◄

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Initial Nursing Facility Care

New or Established Patient

►When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, office), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date.

In the case when services in a separate site are reported and the initial nursing facility care service is a consultation service performed by the same physician or other qualified health care professional and reported on the same date, do not report 99252, 99253, 99254, 99255, 99304, 99305, 99306. The consultant reports the subsequent nursing facility care codes 99307, 99308, 99309, 99310 for the second service on the same date.

Hospital inpatient or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient or observation status on the same date of nursing facility admission or readmission, the hospital or observation discharge services may be reported with codes 99238, 99239, as appropriate. For a patient admitted and discharged from hospital inpatient or observation status on the same date, see 99234, 99235, 99236. Time related to hospital inpatient or observation care services may not be used for code selection of any nursing facility service.

Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional. Skilled nursing facility initial comprehensive visits must be performed by a physician. Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310).

Initial services by other physicians and other qualified health care professionals who are performing consultations may be reported using initial nursing facility care codes (99304, 99305, 99306) or inpatient or observation consultation codes (99252, 99253, 99254, 99255). This is not dependent upon the principal care professional's completion of the initial comprehensive services first.

An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses or physician assistants are working with physicians, they are considered as working in the exact

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same specialty and subspecialty as the physician. An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines.

For reporting initial nursing facility care, transitions between skilled nursing facility level of care and nursing facility level of care do not constitute a new stay.◄

▲99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

▲99305 Initial nursing facility care, per day, for the evaluation and management of a 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, 35 minutes must be met or exceeded.

▲99306 Initial nursing facility care, per day, for the evaluation and management of a 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, 45 minutes must be met or exceeded.

►(For services 60 minutes or longer, use prolonged services code 993X0)◄

Subsequent Nursing Facility Care

★▲99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

★▲99308 Subsequent nursing facility care, per day, for the evaluation and management of a 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, 15 minutes must be met or exceeded.

★▲99309 Subsequent nursing facility care, per day, for the evaluation and management of a 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.

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★▲99310 Subsequent nursing facility care, per day, for the evaluation and management of a 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, 45 minutes must be met or exceeded.

►(For services 60 minutes or longer, use prolonged services code 993X0)◄

Nursing Facility Discharge Services

►The nursing facility discharge management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. These services require a face-to-face encounter with the patient and/or family/caregiver that may be performed on a date prior to the date the patient leaves the facility. Code selection is based on the total time on the date of the discharge management face-to-face encounter.◄

▲99315 Nursing facility discharge management; 30 minutes or less total time on the date of the encounter

▲99316 more than 30 minutes total time on the date of the encounter

Other Nursing Facility Services

►(99318 has been deleted. To report, see 99307, 99308, 99309, 99310)◄

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

New Patient

►(99324, 99325, 99326, 99327, 99328 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, new patient, see home or residence services codes 99341, 99342, 99344, 99345)◄

Established Patient

►(99334, 99335, 99336, 99337 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, established patient, see home or residence services codes 99347, 99348, 99349, 99350)◄

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Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services

►(99339, 99340 have been deleted. For domiciliary, rest home [eg, assisted living facility], or home care plan oversight services, see care management services codes 99437, 99491, or principal care management codes 99424, 99425)◄

►Home or Residence Services◄

►The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).

These codes are also used when the residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

For services in an intermediate care facility for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, see **Nursing Facility Services**.

When selecting code level using time, do not count any travel time.

To report services when a patient is admitted to hospital inpatient, observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient and Observation Care** or **Initial Nursing Facility Care**.◄

New Patient

▲99341 **Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲99342 **Home or residence 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.

►(99343 has been deleted. To report, see 99341, 99342, 99344, 99345)◄

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▲99344 **Home or residence 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, 60 minutes must be met or exceeded.

▲99345 **Home or residence 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, 75 minutes must be met or exceeded.

►(For services 90 minutes or longer, see prolonged services code 99417)◄

Established Patient

▲99347 **Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

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

▲99348 **Home or residence 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, 30 minutes must be met or exceeded.

▲99349 **Home or residence 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, 40 minutes must be met or exceeded.

▲99350 **Home or residence 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, 60 minutes must be met or exceeded.

►(For services 75 minutes or longer, see prolonged services code 99417)◄

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Prolonged Services

Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)

►(99354, 99355 have been deleted. For prolonged evaluation and management services on the date of an outpatient service, home or residence service, or cognitive assessment and care plan, use 99417)◄

►(99356, 99357 have been deleted. For prolonged evaluation and management services on the date of an inpatient or observation or nursing facility service, use 993X0)◄

►Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact◄

►Codes 99358 and 99359 are used when a prolonged service is provided on a date other than the date of a face-to-face evaluation and management encounter with the patient and/or family/caregiver. Codes 99358, 99359 may be reported for prolonged services in relation to any evaluation and management service on a date other than the face-to-face service, whether or not time was used to select the level of the face-to-face service.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level, on a date other than the face-to-face service to which it is related. Prolonged service without direct patient contact may only be reported when it occurs on a **date other than** the date of the evaluation and management service. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient which (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.◄

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report 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.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

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►Do not report 99358, 99359 for time without direct patient contact reported in other services, such as care plan oversight services (99374-99380), chronic care management by a physician or other qualified health care professional (99437, 99491), principal care management by a physician or other qualified health care professional (99424, 99425, 99426, 99427), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/Internet/electronic health record consultations (99446, 99447, 99448, 99449, 99451, 99452), or online digital evaluation and management services (99421, 99422, 99423).◄

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

+99359 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99359 in conjunction with 99358)

►(Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 993X0, 99483)◄

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	Code(s)
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99358 X 1 AND 99359 X 1
105 minutes or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes

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Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

►Codes 99415, 99416 are used when an evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time with the patient and/or family/caregiver. The physician or other qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.

Codes 99415, 99416 are used to report the total duration of face-to-face time with the patient and/or family/caregiver spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. When face-to-face time is noncontinuous, use only the face-to-face time provided to the patient and/or family/caregiver by the clinical staff.◄

Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

►Codes 99415, 99416 may be reported for no more than two simultaneous patients and the time reported is the time devoted only to a single patient.

For prolonged services by the physician or other qualified health care professional on the date of an office or other outpatient evaluation and management service (with or without direct patient contact), use 99417. Do not report 99415, 99416 in conjunction with 99417.◄

Facilities may not report 99415, 99416.

#+99415 Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient **Evaluation and Management** service)

(Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)

►(Do not report 99415 in conjunction with 99417)◄

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#✚99416 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99416 in conjunction with 99415)

►(Do not report 99416 in conjunction with 99417)◄

►The starting point for 99415 is 30 minutes beyond the typical clinical staff time for ongoing assessment of the patient during the office visit. The Reporting Prolonged Clinical Staff Time table provides the typical clinical staff times for the office or other outpatient primary codes, the range of time beyond the clinical staff time for which 99415 may be reported, and the starting point at which 99416 may be reported.◄

►Reporting Prolonged Clinical Staff Time			
Code	**Typical Clinical Staff Time**	**99415 Time Range (Minutes)**	**99416 Start Point (Minutes)**
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120◄

►Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◄

►Code 99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services, office consultation, or other outpatient evaluation and management services (ie, 99205, 99215, 99245, 99345, 99350, 99483). Code 993X0 is used to

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report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an inpatient evaluation and management service (ie, 99223, 99233, 99236, 99255, 99306, 99310). Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service. Codes 99417, 993X0 are only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level service has been exceeded by 15 minutes. To report a unit of 99417, 993X0, 15 minutes of time must have been attained. Do not report 99417, 993X0 for any time increment of less than 15 minutes.

When reporting 99417, 993X0, the initial time unit of 15 minutes should be added once the time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (ie, 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (ie, 55 minutes) on the date of the encounter.

Time spent performing separately reported services other than the primary E/M service and prolonged E/M service is not counted toward the primary E/M and prolonged services time.

For prolonged services on a date other than the date of a face-to-face evaluation and management encounter with the patient and/or family/caregiver, see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, see 99415, 99416. Do not report 99417, 993X0 in conjunction with 99358, 99359, 99415, 99416.◄

#★+▲99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient **Evaluation and Management** service)

►(Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483)◄

►(Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)◄

(Do not report 99417 for any time unit less than 15 minutes)

#★+●993X0 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation **Evaluation and Management** service)

►(Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)◄

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►(Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359)◄

►(Do not report 993X0 for any time unit less than 15 minutes)◄

►**Total Duration of New Patient Office or Other Outpatient Services (use with 99205)**	**Code(s)**
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Office or Other Outpatient Consultation Services (use with 99245)	**Code(s)**
less than 70 minutes	Not reported separately
70-84 minutes	99245 X 1 and 99417 X 1
80-99 minutes	99245 X 1 and 99417 X 2
100 minutes or more	99245 X 1 and 99417 X 3 or more for each additional 15 minutes◄

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