Evaluation and Management Services Reference Guide

Updated February 2024

(Adjusted per CMS 2024 and 2023 changes)

Contents

Section One: Introduction

Over the past years, the Centers for Medicare & Medicaid Services has made significant revisions to evaluation and management services, allowing physicians to select the E/M visit level to bill based on either total time spent on the date of patient encounter or the medical decision making used in the provision in the visit. In 2022, changes were established for the office and outpatient setting. In 2023, reforms extended across all health care settings including hospitals, emergency departments, nursing facilities and patients' homes. 2024 brings an add on complexity code G2211 and split or shared visits.

Summary of Revisions to E/M CPT Codes

Two new changes in 2024:

- **Add-On Complexity Code: G2211:** Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

- AMA has defined **split or shared** visits when an E/M service is performed by a physician and non-physician practitioner from the same group practice. Billing is based on provider who performed the substantive portion of the visit as determined by MDM or by which professional spent the majority of time performing services.

Previous revisions to be aware of:

- The history and physical exam elements are no longer required to choose code level for a service; however, when an appropriate history and physical examination is performed, it should be documented.
- The level of code selection is *based on medical decision making or total time on the date of the encounter.*
- Medical decision making is based on three elements:
    - Number and complexity of problems addressed
    - Amount or complexity of data to be reviewed and interpreted
    - Level of risk of complications and morbidity/mortality
- The definition of total time *includes face-to-face and non-face-to-face time on the date of encounter* spent by the provider, including time reviewing medical records; reviewing tests; reviewing or obtaining a medical history; ordering medications, tests and procedures; providing documentation in the electronic health record; and communicating with the patient, family members or caregivers and any other health care professional involved in the care of the patient on the date of the encounter.
- Documentation of time spent is only required when time is used to choose the code level.
  CPT codes deleted include: 99201, 99217-99220, 99224-99226, 99241, 99251, 99318, 99324-99228, 99334-99337, 99339- 99340, 99343 and 99354-99357.

Revisions to the codes most often used by ID physicians include E/M office visit codes (99201-99215), hospital inpatient and observation care services (99221-99223 and 99231-99239), consultation codes (99242-99245 and 99252-99255) and prolonged services (99358-99259, 99415-99416 and 99417), plus the establishment of a new prolonged services (99418). The changes will provide continuity across all E/M coding and documentation.

About This Guide

This Evaluation & Management Services Reference Guide is designed to educate ID physicians on these important changes and to assist them in choosing a CPT® code that best reflects the E/M services provided to a patient. The initial version of this guide was created in 2021 to address changes in outpatient E/M codes that were implemented in 2022, and later 2023 revisions. This updated version of the guide expands on the initial version by addressing new inpatient E/M coding changes for 2024.

The guide provides real-world clinical examples of how to select the most appropriate CPT codes for inpatient and outpatient visit encounters (codes 99202-99215). Definitions of the various elements of medical decision making and time, along with other coding conventions, are covered. The clinical examples follow a single patient case, from a minor problem with a low level of medical decision making (MDM) as it then progresses to the highest level of MDM, indicating the elements that led to the code that was chosen.

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Section Two: Descriptions, Definitions and Elements of Medical Decision Table

Risk of Complications and Morbidity or Mortality of Patient Management Problems

Risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s) and treatment(s):

- Includes possible management options selected and those considered, but not selected
- Addresses risks associated with social determinants of health

Two of the three elements must be met or exceeded when selecting the code level. For example, for a new patient encounter involving moderate problems addressed, a limited review of data and a low level of risk, then the MDM would be low, and the code selected should be 99203.

Table 1 below provides information on these elements for some of the more commonly used CPT® codes.

Table 1: Abbreviated Table of Code Level Selection

Outpatient Code	**Inpatient Code**	**MDM Level** (Based on 2 of 3 MDM Elements)	**Problems (Number and Complexity)**	**Amount and/or Complexity Data Reviewed/ Analyzed**	**Level of Risk**
99202 99212 99242	99221 99231 99252	Straightforward	Minimal	Minimal or none	Minimal
99203 99213 99243	99221 99231 99253	Low	Low	Limited	Low
99204 99214 99244	99222 99232 99254	Moderate	Moderate	Moderate	Moderate
99205 99215 99245	99223 99233 99255	High	High	Extensive	High

* Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1

Medical Decision Making

MDM is composed of three elements:

- Number and complexity of problems addressed at encounter
- Amount and/or complexity of data reviewed/analyzed
- Level of risk associated with care of the patient

Some additional hints for meeting requirements for "Amount and/or Complexity Data Reviewed/Analyzed":

- If a note(s) is reviewed from another service line, specifically state the date and author or clinical service of EACH note reviewed.
- If used, document that an independent historian is used and the reason why they are required.
- Document discussions with other providers or appropriate sources (i.e., lawyer, case manager, teacher) regarding the patient that are used in medical decision making. Asynchronous (not in person) discussion can be used for MDM if initiated and completed within 1-2 days of date of encounter.
- State specific risk of complications, including morbidity and/or mortality of patient management decisions, and document if risk is high or moderate, which can affect MDM. This includes those patient management decisions considered, but not done.
- Document if surgery or intervention is needed to manage the infection and risk of such intervention in common language terms of high, medium, low or minimal risk.
- Document if social determinants of health are present and impact your decision making. Some examples include lack of reliable transportation for appointments, homeless, person who uses drugs, etc.
- Document if an infection is limb or life threatening.

Some considerations that can support "high risk of morbidity from additional diagnostic testing or treatment":

- Specifically state if a patient is receiving an antimicrobial that carries high risk of morbidity or has significant medication interactions, and clearly document in the note the risks and possible adverse effects and how frequently monitoring needs to be done. Some examples of this include:
  1. High-risk medications that require intensive monitoring: aminoglycosides, amphotericin, IV acyclovir, vancomycin, linezolid, colistin, rifampin, etc.
  2. High-risk medication interactions: azoles, antibiotics that can cause QT prolongation, especially if patient is already on other medications that also do this (e.g., antibiotic interaction with warfarin, HIV medications, rifampin, etc.).
- Note of clarification that the level of risk notes that it is the risk from the condition and not from the risk of the management.

There are four types of MDM (straightforward, low, moderate and high). The level of MDM is chosen based on meeting or exceeding two of the three MDM elements: number and complexity of problems addressed at encounter, amount and/or complexity of data reviewed/analyzed, and level of risk associated with care of the patient.

Number and Complexity of Problems Addressed at the Encounter

Per the AMA CPT code book, "A *problem* is a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter which is addressed at the encounter." A *problem* may or may not have an established diagnosis at the time of the encounter. A problem is considered *addressed* if it is evaluated or treated during the encounter. Consideration for further testing or treatment that is not elected to do is considered addressing a problem. A problem is not addressed merely by noting it in the medical record when no evaluation or treatment is considered during that encounter. A *problem* during a hospital inpatient or observation encounter is determined by the problem status on the date of encounter, which may be different than that on admission or other previous encounters. Comorbidities and underlying diseases are not considered in the selection of the E/M service unless they are addressed by the provider 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 determine the complexity or risk. An extensive evaluation of signs or symptoms may be required for the evaluation to determine a diagnosis that may not represent a highly morbid condition. Multiple problems of lower severity may cause a higher risk due to their interaction, and this interaction and increased risk should be documented. These definitions have been adapted from American Medical Association CPT® Professional 2024 edition.

Types of Problems That Affect Level Selection
The following definitions have been adapted from the American Medical Association CPT® Professional 2024 edition.

A minimal problem is a problem that may not require the presence of a physician or other qualified health care professional, but a service is still provided by a physician or other QHCP. An example is a patient who is receiving a routine injection (i.e., testosterone injection, vaccine), and the patient is seen by the provider to answer questions about the injection being received.

A *self-limited or minor problem* has a definite and prescribed course, is transient in nature, and is likely not to permanently alter the patient's health status.

- A patient is evaluated for upper respiratory symptoms and diagnosed with a viral upper respiratory tract infection. No further evaluation, treatment or monitoring is indicated.
- A patient is hospitalized for a non-ID problem and is noted to have a rash. You see the patient and determine it is tinea corporis and recommend topical treatment.

A *stable, chronic illness* has an expected duration of at least one year or until the death of the patient (e.g., diabetes, hypertension, HIV). The term *"chronic"* does not relate to the stage or severity of the illness. The term *"stable"* means the patient has reached their treatment goal.

- A patient with well-controlled HIV on ART who is admitted for a non-ID problem. The physician will confirm the patient's ART regimen and assess for drug interactions.

A *chronic illness with exacerbation, progression or side effects of treatment* is a chronic illness that has acutely worsened, is partially controlled or is progressing

with the treatment intent of controlling progression through additional care and treatment of side effects.

- A patient with known HIV is hospitalized for a non-ID issue. They disclose that they have been nonadherent to ART and their CD4 count has declined. The physician is consulted to evaluate ART options with the patient and plan for treatment, monitoring and follow-up.

A *chronic illness with severe exacerbation, progression or side effects of treatment* has a significant risk of morbidity and may require escalation in the level of care.

- An HIV patient previously well controlled is now with falling CD4+ cell count and now has an opportunistic infection.
- A hospitalized patient with pneumonia, urinary tract infection or other infection with hypotension is now requiring ICU level of care.
- A diabetic foot infection not improved and worsening and may require surgical intervention for debridement.
- Chronic prosthetic joint infection on long-term oral suppression > 1 year presents with acute prosthetic joint infection.

An *acute, uncomplicated illness or injury* is a recent or new short-term problem with low risk of morbidity with considered treatment and little risk of mortality with treatment with expected full recovery without functional impairment. A problem that is normally self-limited or minor but is not resolving with the prescribed course can be considered an *acute, uncomplicated illness*.

- A patient is hospitalized with a non-ID problem and, while inpatient, complains of dysuria and is found to have a urinary tract infection. The physician evaluates the patient to recommend treatment for uncomplicated acute cystitis.

An *acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care* is a recent or short-term problem with low risk of morbidity with considered treatment and little risk of mortality with treatment with expected full recovery without functional impairment and requires hospital inpatient or observation level setting.

- A patient is hospitalized with an uncomplicated cellulitis. Due to a history of antibiotic allergies and intolerances, she is hospitalized for intravenous vancomycin. The physician is consulted to confirm the plan of care and assess antibiotic monitoring needs.

A *stable, acute illness* is a problem that is new or recent for which treatment has been initiated and the patient has improved even though it has not yet resolved.

- A patient is admitted with acute pyelonephritis and treated with intravenous antibiotics with good response. The consult is needed to provide comment on an oral antibiotic to complete the patient's course of therapy upon discharge.

An *undiagnosed new problem with uncertain prognosis* indicates there is a problem in the differential diagnosis that may represent in condition likely to result in a high risk of morbidity without treatment.

- An otherwise healthy patient is hospitalized with fever of unknown origin. Evaluation is needed by the ID physician.
- A patient hospitalized for a non-ID problem is found to have a marked leukocytosis. Evaluation is needed by the ID physician.

An *acute illness with systemic symptoms* is an illness that causes systemic symptoms and has a high risk of morbidity without treatment. Systemic symptoms may not be general and may affect only a single system.

- A patient is hospitalized with cellulitis, found to be febrile and tachycardic.
- A patient with acute pyelonephritis with fever and nausea and vomiting.
- A patient with community acquired bacterial pneumonia, with associated leukocytosis.
- An ICU patient develops a ventilator-associated pneumonia and has fever.

An *acute, complicated injury* is an injury that 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 or associated with risk of morbidity.

- A trauma patient who develops postoperative or other infection from their injuries.

An *acute or chronic illness or injury that poses a threat to life or bodily function* is an acute illness with systemic symptoms, an acute complicated injury or chronic illness or injury with exacerbation or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment. This can include some symptoms that may represent a condition that that is significantly probable and could pose a potential threat to life or bodily function.

- A patient is hospitalized with septic shock
- A patient with bacterial meningitis
- Necrotizing fasciitis
- Infective endocarditis with systemic symptoms
- COVID-19 pneumonia requiring invasive mechanical ventilation
- A foot infection that requires amputation for control/cure
- Multifocal *Staphylococcus aureus* infection until source control achieved

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

Data are considered *analyzed* when the practitioner reviews medical data in determining the level of MDM. Tests ordered are presumed to be analyzed when the results are reported and are counted toward level selection during the encounter in which the tests were ordered and are not counted during subsequent encounters. Results that are auto populated in the medical record can be considered as analyzed or as being reviewed if they are indeed analyzed or reviewed at that encounter and have not previously been reviewed. If a test is ordered outside of the encounter, then it may be counted during the visit in which it was analyzed and therefore used for MDM. Recurring orders that have previously been ordered may be counted during the encounter in which they were analyzed. If the data are a service for which a professional component is separately reported by the physician or other QHCP, such as an ECG performed in the office and the ECG with interpretation were separately billed, this cannot be used twice. Those data are not considered ordered, analyzed, reviewed or independently interpreted for the determination of level of MDM.

Tests reviewed may include imaging, laboratory, psychometric or physiologic data. Evaluating pulse oximetry using a pulse oximeter is not considered a test.

A *unique test* is defined by the CPT code set (e.g., basic metabolic panel [80047]) and is considered a single test despite possibly having multiple laboratory

values included. Reviewing multiple results of the same unique test when compared during an E/M service counts as one unique test. Tests that have overlapping elements are not considered unique even if those tests are identified by distinct CPT codes. Some examples include if both a CMP and BMP are reviewed, this only counts as a single test due to overlapping values of the BMP being encompassed in the CMP. Review of a molecular panel counts as a single test even though multiple targets are reported.

A *unique source* is a physician or other QHCP who is in a distinct group or different specialty or subspecialty or a unique entity. All medical record notes from a unique source count as one element toward MDM.

External physician or other QHCP is a physician or other QHCP who is not in the same group practice or is in a different specialty or subspecialty.

Discussion requires an interactive exchange that must be direct and not through intermediaries such as clinical staff or trainees, nor does it involve sending chart notes or written exchanges that are within progress notes. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in decision making of the encounter. It may be asynchronous, but follow-up must be initiated and completed within a short period of time such as within one to two days. Two-way virtual discussions using the electronic health record messaging and chat functions on the day of the encounter would meet the criteria for a discussion regarding a patient through an interactive exchange if that interaction is used in medical decision making on the day of encounter. Simply routing a chart note through the electronic health record would not meet the necessary criteria for "discussion."

An *independent historian* is an individual such as a parent, guardian, surrogate, spouse or witness who provides additional history to the history provided by the patient who is unable to provide a complete or reliable history or because a confirmatory history is judged to be necessary. The independent history does not need to be obtained in person but does need to be obtained directly from the historian who is providing the information. Some examples of independent historians include a spouse, parent or adult caregiver for a developmentally disabled patient or patient with a traumatic brain injury or dementia. Using a medical interpreter would not qualify as an "independent historian." If an independent historian is used, it is important to clearly document the historian and why they were specifically needed to provide history (i.e., why the patient is unable to provide his/her own history).

Independent interpretation involves the interpretation of a test for which there is a CPT code, and an interpretation or report is customary. When a review and interpretation of a test is performed and documented by the provider, but not separately reported (billed), then this would represent an independent interpretation. This report does not need to conform to the usual standards of a complete report of the test. This does not include interpretation of tests that do not have formal reports such as a complete blood count with differential and blood cultures. Examples would include reviewing a chest radiograph and documenting in the medical record an interpretation, but not separately reporting (billing) the interpretation of the chest radiograph.

An appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient, such as a lawyer, upper officer, case manager or teacher, and does not include discussion with family or informal caregivers.

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

Risk is the probability and/or consequence of an event to occur when the addressed problem is treated appropriately. The level of risk is determined by the

nature of the considered event, such that a low probability of death to occur with treatment may be a high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be a low risk. Risk is based on the problems addressed at the encounter and includes diagnostics and disposition considered during the encounter. Diagnostics, therapeutics and decisions regarding hospitalization, escalation of care or surgery considered during the encounter contribute to the *risk* and include those considered, but not done.

Social determinants of health are economic and social conditions that influence the health of people in communities. Common SDOHs include insecurity in realms such as food, housing, and transportation; patients living in group homes; and persons who use drugs. For information on how and when to use ICD-10 diagnosis codes to report SDOH, visit cms.gov/files/document/zcodes-infographic.pdf.

Drug therapy requiring intensive monitoring for toxicity involves monitoring of a therapeutic agent that has the potential to cause serious morbidity or death and requires intensive monitoring for potential adverse effects and not primarily for assessment of therapeutic efficacy. Per AMA's 2024 CPT guidelines, drug therapy monitoring should be done with generally accepted practice standards for the agent but may be patient specific. Monitoring may be long term or short term, and if long term, it must be performed no less than quarterly. Monitoring can include laboratory tests, physiologic tests or imaging, but it does not include history or examination. The drug therapy monitoring can be included in the MDM of the encounter if it is considered in the management of the patient during that encounter. Providers should explicitly document the need for intensive drug monitoring in the medical record. Documentation could be, "[medication name] requires intensive drug monitoring due to concerns for possible adverse effects of [medication name] including [list adverse effects] and will be monitored with [list tests or images] to be done [list frequency]." An example would be, "Telavancin requires intensive drug monitoring due to concerns for possible adverse effects of telavancin, including acute kidney injury, and will be monitored with basic metabolic panel to be done twice weekly while on therapy."

Description of Total Time

The element of coding by time includes the *total time* of all activities related to the patient visit on the date of the encounter including 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 QHCP on date of encounter,* including but not limited to:

- Preparing to see patient (e.g., review tests, medical records)
- Obtaining history
- Performing a medically appropriate physical examination
- Counseling and education (patient, family member, caregiver)
- Ordering medications, tests and procedures
- Referring and communicating to other health care professionals
- Documenting the encounter
- Independent interpretation of tests (when not separately reported)
- Care coordination (when not separately reported)

Total time involves the above activities regardless of location such as on or off an inpatient unit or in the office. Total time does not include time involved with any activities that are separately reported nor travel time. Total time does not include any activities or time spent other than on the *date of the encounter*. To bill by time, the total time spent on patient care activities on the date of the encounter should be documented correctly and not guessed or rounded, and activities performed should be documented for that time (e.g., reviewing medical records, reviewing labs or tests, obtaining history, discussion of plan of care with patient), but it is not necessary to document time for each activity individually – rather, just the total time with all activities. Time spent with normal activities by ancillary clinical staff (such as check-ins, obtaining vital signs, wound dressing changes, arranging home health care, obtaining medical records, etc.) should not be used to calculate total time.

For shared or split visits between a physician and other QHCP, such as advanced practice providers, only distinct time spent separately on the date of the encounter may be summed to equal total time. If a physician and QHCP perform the same activity together, then time can only be counted for one of the providers in the sum of the total time.

Table 2 provides information on which code should be selected based on total time spent on the date of the encounter for new and established patients.

Table 2: Total Time Spent on the Date of the Encounter for E/M Codes

New Outpatient E/M CPT® Code	Total Time*
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes
Established Outpatient E/M CPT® Code	**Total Time***
99211	Time component removed
99212	10 minutes
99213	20 minutes
99214	30 minutes

99215	40 minutes
Initial Hospital Inpatient E/M CPT® Code	**Total Time***
99221	40 minutes
99222	55 minutes
99223	75 minutes
Subsequent Hospital Inpatient E/M CPT® Code	**Total Time***
99231	25 minutes
99232	35 minutes
99233	50 minutes
Office or Outpatient Consultations E/M CPT® Code	**Total Time***
99242	20 minutes
99243	30 minutes
99244	40 minutes
99245	55 minutes
Inpatient Consultations E/M CPT® Code	**Total Time***
99252	35 minutes
99253	45 minutes
99254	60 minutes
99255	80 minutes

*Total Time is time that must be met or exceeded to report the code.

Prolonged Service Time

Prolonged services CPT codes have been changed to include total time on date of encounter, regardless of time spent face-to-face/on the unit or non-face-to-face/off the unit.

CPT code 99417 is used to report prolonged services when the total time on the date of encounter of an outpatient service (99205, 99215, 99245) exceeds 15 minutes beyond the time required to report the highest-level service. CPT code 99418 is used to report prolonged services when the total time on the date of encounter during an inpatient or observation service (99223, 99233, 99255) exceeds 15 minutes beyond the time required to report the highest-level service. CPT codes 99417 and 99418 are to be reported only when the primary E/M service has been selected based on time and the highest level of E/M service has been achieved and the total time has exceeded 15 minutes beyond the time requirement for that selected E/M code. CPT codes 99417 and 99418 can be billed in subsequent 15-minute increments to account for all total time spent in patient care activities on the date of encounter. **Do not report a unit of 99417 or 99418 of less than 15 minutes (i.e., all 15 minutes must be achieved to be able to report 99417 or 99418).** Total time for prolonged services includes the same activities able to be used to select the initial E/M code based on time. Medicare does not recognize CPT codes 99417 and 99418 and has developed two G codes to report prolonged services on the date of encounter. **Code G2212 is used in association with an office or other outpatient E/M visit (99202-99215**) and requires that the highest E/M level be selected by time. More than 15 minutes beyond the maximum time for that level must be exceeded before the G code may billed. G2212 should be billed in 15-minute increments. **Code G0316 may be used to report prolonged services in association with an initial hospital or subsequent hospital**

E/M visit of the highest level only (99223 and 99233) and is also billed in 15-minute increments, with time thresholds to report G0316 being 90 minutes for 99223 and 65 minutes for 99233.

Examples

A provider spends a total time of 83 minutes with a new patient. The time limit for a new outpatient visit, E/M visit 99205, is 60-74 minutes. The 83-minute visit is 23 minutes beyond the minimal time limit of 99205 of 60 minutes, and therefore the provider may bill CPT code 99417. For each additional 15 minutes, code 99417 may be reported. Tables 3 through 10 illustrate reporting prolonged service codes on date of encounter (99417 and 993X0). Tables 3, 4 and 5 were adapted from the American Medical Association CPT® Professional 2024 edition.

Add-On Complexity Code

- CMS proposes a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211. The add-on code is designed to capture resource costs associated with E/M visits for primary care and longitudinal care of complex patients

- G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.
    - Billed with office/outpatient evaluation and management (E/M) services.
    - Cannot be billed when modifier 25 is appended to the E/M code.
    - Code is used to report services for longitudinal care
    - CMS clarified that the provider/patient relationship is the focal point of when deciding whether to bill the complex care code.
    - "The most important information used to determine whether the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS G2211 add-on code could be billed. Or, if the practitioner is part of ongoing care for a single, serious and complex condition, e.g., sickle cell disease, then the add-on code could be billed. The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship."[1]

- For ID physicians, use of this code may be appropriate for HIV primary care visits, and for the longitudinal care of some chronic infections, for example mycobacterial infections or osteomyelitis. It should not be used for a one-time consultation or the short-term management of an acute infection.

[1] CRD Associates via *CMS Manual System, Pub 100-04 Medicare Claims Processing Manual*, Transmittal 12372; https://www.cms.gov/files/document/r12372cp.pdf Accessed by CRD Associates on December 14, 2023.

Table 3: Using Code 99417 With New Patient Office or Other Outpatient Services E/M

Use With 99205 (New Patient)	Code(s) Reported
Less than 75 minutes	Use appropriate E/M code
75-89 minutes	99205 x1 AND 99417 x1
90-104 minutes	99205 x1 AND 99417 x2
105 minutes or more	99205 x1 AND 99417 x3 or more for each additional 15 minutes

Table 4: Using Code 99417 With Established Patient Office or Other Outpatient Services E/M

Use With 99215 (Established Patient)	**Code(s) Reported**
Less than 55 minutes	Use appropriate E/M code
55-69 minutes	99215 x1 AND 99417 x1
70-84 minutes	992015 x1 AND 99417 x2
85 minutes or more	992015 x1 AND 99417 x3 or more for each additional 15 minutes

Table 5: Using Code 99417 With Office or Other Outpatient Consultation Services E/M

Use With 99245 (Outpatient Consult)	**Code(s) Reported**
Less than 70 minutes	Use appropriate E/M code
70-84 minutes	99245 x1 AND 99417 x1
80-99 minutes	99245 x1 AND 99417 x2
100 minutes or more	99245 x1 AND 99417 x3 or more for each additional 15 minutes

Table 6: Using Code 99418 With Initial Hospital Care Services E/M

Use With 99223 (Outpatient Consult)	**Code(s) Reported**
Less than 75 minutes	Use appropriate E/M code
90-104 minutes	99223 x1 AND 99418 x1
105-119 minutes	99223 x1 AND 99418 x2
120 minutes or more	99223 x1 AND 99418 x3 or more for each additional 15 minutes

Table 7: Using Code 99418 With Subsequent Hospital Inpatient or Observation Care Services E/M

Use With 99233 (Outpatient Consult)	**Code(s) Reported**
Less than 50 minutes	Use appropriate E/M code
65-79 minutes	99233 x1 AND 99418 x1
80-94 minutes	99233 x1 AND 99418 x2
95 minutes or more	99233 x1 AND 99418 x3 or more for each additional 15 minutes

Table 8: Using Code 99418 With Inpatient or Observation Consultations E/M

Use With 99255 (Outpatient Consult)	**Code(s) Reported**
Less than 80 minutes	Use appropriate E/M code
95-109 minutes	99255 x1 AND 99418 x1

110-124 minutes	99255 x1 AND 99418 x2
125 minutes or more	99255 x1 AND 99418 x3 or more for each additional 15 minutes

Table 9: Using Code G2212 With Office or Other Outpatient Consultation Services E/M

Use With 99205 (New Patient)	**Code(s) Reported**
60-74 minutes	99205
89-103 minutes	99205 x1 AND G2212 x1
104-118 minutes	99205 x1 AND G2212 x2
119 minutes or more	99205 x1 AND G2212 x3 or more for each additional 15 minutes
Use **With 99215 (Established Patient)**	
40-54 minutes	99215
69-83 minutes	99215 x1 AND G2212 x1
84-98 minutes	99215 x1 AND G2212 x2
99 minutes or more	99215 x1 AND G2212 x3 or more for each additional 15 minutes

Table 10: Using Code G0316 With Hospital Inpatient or Observation Care Services E/M

Use With 99223 (New Patient)	**Code(s) Reported**
Less than 89 minutes	Use appropriate E/M code
90-104	99223 x1 AND G0316 x1
105-119 minutes	99223 x1 AND G0316 x2
120 minutes or more	99223 x1 AND G0316 x3 or more for each additional 15 minutes
Use **With 99233 (Established Patient)**	
Less than 64 minutes	Use appropriate E/M code
65-79 minutes	99233 x1 AND G0316 x1
80-94 minutes	99233 x1 AND G0316 x2
95 minutes or more	99233 x1 AND G0316 x3 or more for each additional 15 minutes

Critical Care Service Codes

99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Each additional 30 minutes of critical care provided beyond the first 74 minutes (billed in addition to 99291)

Critical care codes are reimbursed at a higher rate than traditional E/M codes and may be used by physicians in **any specialty,** including infectious diseases. Many ID physicians already use these codes. Critical care codes are typically used for care provided in an intensive care unit, but they may be used for the care of critically ill patients outside of an ICU as long as the visit meets the time requirements and definition of critical care.

Critical care codes may be used when all of the following criteria are met:

1. The patient has a critical illness.
    - A critical illness is a life-threatening condition that impairs one or more organ systems.
2. Care provided meets the definition of “critical care.”
    - Critical care is defined in AMA’s CPT Book 2024 as “high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failures and/or to prevent further life-threatening deterioration of the patient’s condition.”
3. Care does not duplicate care provided by another billing physician.
    - Physicians from more than one specialty may use critical care codes when billing for the care of the same patient on the same day, if care is not provided concurrently (i.e., at the exact same time) and the care is not duplicative.
4. Time requirements are met.
    - Critical care time is defined as time spent either at the bedside or in the patient’s hospital unit directly engaged in care for that patient.
    - It may include time spent reviewing records, discussing management and documenting in the medical record.
    - Time is the total time spent in one day and does not need to be continuous.

Section Three: Clinical Examples of Code Level Selection

The following clinical examples build on a base level patient; with each subsequent example, the severity of the patient's problem progresses, therefore indicating a higher level of MDM. MDM includes an increase in the number or complexity of problems to be assessed, along with review of increasing amounts of complex data and risk.

The notes of the case are presented first, followed by the MDM table highlighting (in red) the elements that were considered when choosing the code level. As noted previously, E/M code level selection is now based on medical decision making or time. In the clinical examples that follow, there are examples that include medical decision making or time used to justify code selection.

Outpatient Visits

Outpatient Clinical Example #1: CPT Code Level 99202 (New Patient)/99212 (Established Patient)

Patient is 65-year-old with congestive heart failure, diabetes mellitus type 2 and hypertension who presents with leg swelling and erythema, and no tenderness. Exam indicates signs of venous stasis, but no cellulitis. Advised leg elevation and follow-up visit with primary care physician for management of congestive heart failure medication. No antimicrobials were prescribed. Follow-up as needed.

Medical decision making for this case is a straightforward review of a single self-limiting problem with review of minimal data and a minimal level of risk; therefore, code level 99202 or 99212 is indicated, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed	Level of Risk
99202 99212	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
99203 99213	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique	Low Low risk of morbidity from additional diagnostic testing or treatment

		injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	source • Review of the result(s) of each unique test • Ordering of each unique test or Category 2: Assessment requiring an independent historian(s)	
99204 99214	Moderate	Moderate • 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 new problem or acute illness with systemic symptoms • 1 acute complicated injury	Moderate (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 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)	Moderate Moderate risk of morbidity from 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 determinants of health
99205 99215	High	High • 1 or more chronic illness with severe progression/exacerbation/adve rse effects or treatment • 1 acute or chronic illness or injury that poses threat to life or body function	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: • 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)	High High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive 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

			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)	• Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Outpatient Clinical Example #2: CPT Code Level 99203 (New Patient)/99213 (Established Patient)

Patient is 65-year-old with congestive heart failure, diabetes mellitus type 2 and hypertension who presents with leg swelling and erythema that began four days ago. Patient indicates there is some pain in the leg and is feeling warm; however, vital signs show no systemic fever. Exam suggestive of nonpurulent cellulitis. Review of prior PCP patient medical records show no history of methicillin-resistant *Staphylococcus aureus.* Cultures not available for review. Patient indicates no allergies. Prescribed five-day course of cephalexin with follow-up with ID physician in seven days.

Medical decision making for this case is low level for a single, acute, uncomplicated problem that involved the review of a prior external note. Even though moderate risk level could be met, since two of the three elements of MDM are needed, code level 99203 or 99213 is indicated, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed	Level of Risk
99202 99212	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
99203 99213	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) 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)	Low Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic problem with progression/exacerbation/adverse effects of treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 new problem or acute illness with systemic symptoms • 1 acute complicated injury	Moderate (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	Moderate Moderate risk of morbidity from 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

			• Independent interpretation of a test 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)	• Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illness with severe progression/exacerbation/adverse effects or treatment • 1 acute or chronic illness or injury that poses threat to life or body function	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: • 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 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)	High High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive 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 • Parenteral controlled substances

Outpatient Clinical Example #3: CPT Code Level 99204 (New Patient)/99214 (Established Patient)

Patient is 65-year-old with congestive heart failure, diabetes mellitus type 2 and hypertension who presents with leg swelling and erythema that began four days ago. Patient indicates some pain in leg and is feeling warm with temperature reading of 101.2°F. Exam is suggestive of purulent cellulitis. Discussion with

patient's primary care provider notes history of soft tissue infection with methicillin-resistant *Staphylococcus aureus*. Patient indicates no allergies. Complete blood count, comprehensive metabolic panel and wound culture ordered. Five days of oral doxycycline prescribed with discussion of adverse effects. Patient is instructed to follow up in one week, or sooner if the problem worsens.

Medical decision making for this case has now progressed to a moderate level since the problem is now a single new problem with systemic symptoms, and data reviewed involves ordering three unique tests, discussion with another provider and review of external records, and the patient was given a prescription; therefore, code level 99204 or 99214 is indicated, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed	Level of Risk
99202 99212	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal

99203
99213
	Low	Low
		• 2 or more self-limited/minor problems
		• 1 stable chronic illness
		• 1 acute, uncomplicated illness or injury
		• 1 stable acute illness
		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			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)
				Low
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 performed by another physician/other qualified health care professional
				Moderate
				Moderate risk of morbidity from 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

			(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)	significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illness with severe progression/exacerbation/adverse effects or treatment • 1 acute or chronic illness or injury that poses threat to life or body function	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: • 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 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)	High High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive 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 • Parenteral controlled substances

Outpatient Clinical Example #4: CPT Code Level 99205 (New Patient)/99215 (Established Patient)

Patient is 65-year-old with congestive heart failure, diabetes mellitus type 2 and hypertension who presents with leg swelling and erythema that began four days ago. Patient is ill with some confusion and unable to provide history. Patient's daughter is called to obtain history, and patient's daughter mentions patient has had fever, malaise and severe leg pain. Exam indicates patient is very sick with leg erythema and severe tenderness. Patient has no allergies. Vital signs reveal hypotension and tachycardia. Decision is made to send patient to emergency room for hospitalization and emergent surgical evaluation for possible necrotizing fasciitis. Complete blood count, comprehensive metabolic panel and blood cultures are ordered. Recommendation that patient be started on IV vancomycin with therapeutic drug monitoring and IV piperacillin-tazobactam, and daily labs are ordered to monitor creatinine while on IV vancomycin and piperacillin-tazobactam. Case discussed with ER and surgical attending physicians. Patient transported to ED for admission.

Medical decision making for this case is at the highest level, given that the patient has an acute illness that poses threat to life or body function. The data reviewed are now more complicated in nature and involve speaking with an independent historian (the patient's daughter), ordering tests (more than three) and discussions with other providers. The risk has now increased to the high level, given the patient needs to be hospitalized and started on IV antibiotics, with consideration for emergency surgery. Therefore, code level 99205 or 99215 is indicated, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed	Level of Risk
99202 99212	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
99203 99213	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) 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)	Low Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 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)
				Moderate
				Moderate risk of morbidity from 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 determinants of health

99205
99215
	High	High
		• 1 or more chronic illness with severe progression/exacerbation/ adverse effects or treatment
		• 1 acute or chronic illness or injury that poses threat to life or body function
			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:
			  • 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
			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)
				High
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive 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
				• Parenteral controlled substances

Outpatient Clinical Example #5: Using Time to Select Code Level

58-year-old male established patient with venous insufficiency and chronic edema of both legs presents with complaint of redness and pain in the right lower leg. Examination notes cellulitis of right lower leg with no open wounds, ulcers, abscesses or purulence. Patient prescribed cephalexin. Discussion with patient on facilitating resolution of cellulitis through elevating leg to decrease edema. Instructions on use, wear and care of compression stockings. Total time for patient care on date of encounter was 34 minutes.

As total time of visit on date of encounter is 34 minutes, this meets the time requirement of CPT 99214, which ranges from 30 to 39 minutes. **The code to report is 99214**. In this case, while the MDM was low and would have met criteria for 99213, the actual time devoted to the patient exceeded time for 99213; therefore, using time to select the code level is a more accurate description and more appropriate way to value the physician's services.

Inpatient Visits

Inpatient Clinical Example #1
Patient is 65-year-old with congestive heart failure and diabetes mellitus type 2 with right foot plantar diabetic ulcer and has been admitted to hospital for exacerbation of congestive heart failure. Patient is seen regarding right foot diabetic ulcer present for four months without healing. On examination, there is a Wagner grade 1 ulcer on plantar aspect of right foot over first metatarsophalangeal joint and no presentation of purulent drainage or surrounding erythema. Recommendations for offloading and wound care are given. No antibiotics or further evaluation is needed.

Medical decision making for this case does not involve any data review or ordering of tests or prescription medications. There is minimal risk of morbidity regarding recommendations for offloading and wound care. This is not a chronic problem as it has not been present for at least one year and therefore would be an acute problem. This would be a straightforward level MDM, as shown in red below. Note: "Chronic" or "acute" may have different meanings in the clinical realm than in the coding/billing realm.

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none

99221
99231
99253
	Low	Low
		• 2 or more self-limited/minor problems
		• 1 stable chronic illness
		• 1 acute, uncomplicated illness or injury
		• 1 stable acute illness
		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			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)

99222
99232
99254
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 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 (no separately reported)

99223
99233
99255
	High	High
		• 1 or more chronic illness with severe progression/exacerbation/ adverse effects or treatment
		• 1 acute or chronic illness or injury that poses threat to life or body function
			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:
			  • 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
			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)

Inpatient Clinical Example #2

Patient is 65-year-old with congestive heart failure and diabetes mellitus type 2 with a right foot plantar diabetic ulcer admitted to hospital for exacerbation of congestive heart failure. Patient seen regarding right diabetic foot ulcer, which has been present for four months without healing. On examination, ulcer located on the plantar aspect of right foot over the first metatarsophalangeal joint. There appears to be bone exposed, no purulence or surrounding erythema. Order placed for c-reactive protein and MRI of right foot performed with recommendations to follow up in outpatient office.

Medical decision making for this case involves ordering of two unique tests. No treatment was recommended and risk of ordered tests is low. This would be a low level MDM, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none

99221
99231
99253
	Low	Low
		• 2 or more self-limited/minor problems
		• 1 stable chronic illness
		• 1 acute, uncomplicated illness or injury
		• 1 stable acute illness
		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			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)

99222
99232
99254
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 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)

99223
99233
99255
	High	High
		• 1 or more chronic illness with severe progression/exacerbation/ adverse effects or treatment
		• 1 acute or chronic illness or injury that poses threat to life or body function
			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:
			  • 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
			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)

Inpatient Clinical Example #3

65-year-old patient with congestive heart failure and diabetes mellitus type 2 with right foot plantar diabetic ulcer, which has been present for four months, has been admitted to hospital for right diabetic foot infection. Patient notes right foot ulcer redness and drainage over past two days.

Patient is afebrile with normal heart rate and blood pressure. Patient is experiencing malaise. Exam significant for ulcer on plantar aspect of right foot over first metatarsophalangeal joint with purulent drainage, but no frank bone exposed. Redness of right forefoot is present. Review of podiatrist notes documented from that same day note possible plans for debridement of infected ulcer. Laboratory review shows that nasal swab PCR was positive for methicillin-resistant *Staphylococcus aureus*. C-reactive protein and CT of right foot is ordered. Treatment is started with piperacillin-tazobactam and vancomycin IV.

Medical decision making for this case involves review of one unique test, ordering of two unique tests and review of one external note. Risk is moderate, as a prescription medication was ordered. This is an acute problem with systemic symptoms. Systemic symptoms do not have to be general and may affect only a single system. This would be a moderate level MDM, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none
99221 99231 99253	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) 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)
99222 99232 99254	Moderate	Moderate • 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 new problem or acute illness with systemic symptoms • 1 acute complicated injury	Moderate (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 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 (no separately reported)
99223 99233 99255	High	High • 1 or more chronic illness with severe progression/exacerbation/ adverse effects or treatment • 1 acute or chronic illness or injury that poses threat to life or body function	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: • 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

			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)

Inpatient Clinical Example #4

65-year-old with congestive heart failure and diabetes mellitus type 2 with right foot plantar diabetic ulcer admitted to hospital concerning a right-sided diabetic foot infection. Patient seen one day ago for initial consultation with recommendations and start of treatment with piperacillin-tazobactam and vancomycin IV. The c-reactive protein that was ordered on initial consultation was noted to be elevated. Right foot CT scan, which was also previously ordered on initial consultation, was noted to show an abscess in right forefoot area with possible osteomyelitis present. Patient is now hypotensive and tachycardic. The right foot erythema has progressed to involve entire right foot with blackened discoloration of some right toes. Two sets of blood cultures and a complete blood count are ordered. Communication with patient's attending physician regarding worsening clinical status and infection, with recommendation to transfer to ICU with podiatry re-evaluation for surgical intervention, including possible need for amputation with documentation, in medical record. Escalation of antibiotics to provide broader spectrum coverage, including MDROs, is ordered

Medical decision making for this case involves an acute illness that poses threat to life or body function and a need to escalate level of care in the hospital. Data reviewed only meet moderate level because the two sets of blood cultures ordered only count as one test since they are not unique tests, and the complete blood count will add to a combination of two data elements ordered. Although the previously ordered c-reactive protein and CT of the right foot were reviewed during this encounter, they cannot be used in the MDM for the current encounter since they are from a previous order from a previous encounter and therefore would not be used to determine the MDM for this encounter. The ordering of the test includes the review of that test result. The only new tests that could count for this encounter would be blood cultures and complete blood count that were ordered. Although the data reviewed MDM element is only moderate since there was discussion with a physician affecting the MDM, the problem and risk MDM elements are used in the MDM level decision since they are higher than the data reviewed MDM element. This would be a high-level MDM as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none
99221 99231 99253	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) 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)

99222
99232
99254
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 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 (no separately reported)

99223
99233
99255
	High	High
		• 1 or more chronic illness with severe progression/exacerbation/
		• adverse effects or treatment
		• 1 acute or chronic illness or injury that poses threat to life or body function
			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:
			  • 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
			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)

Inpatient Clinical Example #5

65-year-old with congestive heart failure and diabetes mellitus type 2 with right foot plantar diabetic ulcer admitted to hospital for right-sided diabetic foot infection. Patient seen for recommendations regarding further evaluation and treatment. Review of medical record is conducted since admission. Patient provides reliable history. Patient's spouse is in room and adds to history. (Note that history obtained from patient's spouse may be included in total time but would not qualify as independent historian because patient is able to provide reliable history so no need for additional or confirmatory history.)

Laboratory results reviewed include blood cultures without growth at day 2, complete blood count with leukocytosis and normal creatinine on chemistry. Examination of patient shows right foot diabetic ulcer present with surrounding cellulitis. Discussion with patient regarding recommendations of right foot MRI and antibiotic treatment. Patient's

hospital attending is called regarding recommendations from the outpatient office. Patient's hospital case manager is also notified regarding need to arrange outpatient IV antibiotics from the outpatient office.

Documentation of notes are completed, spending a total time of 78 minutes on the day of encounter for an initial hospital E/M visit. Documentation shows that 78 minutes were spent on date of encounter with review of medical records, obtaining history, performing a physical examination, reviewing laboratory studies, discussing with the patient's attending physician and case manager and completing documentation. (Travel time between the hospital and office cannot be included.)

This would be a moderate MDM (99223) based on the MDM elements but because the total time was 78 minutes, which exceeds the time threshold of 75 minutes for 99223, then the appropriate code would be 99223 based on total time, as shown in red below:

CPT Code	MDM Level	Problems (Number and Complexity)	Data Reviewed
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none

99221
99231
99253
	Low	Low
		• 2 or more self-limited/minor problems
		• 1 stable chronic illness
		• 1 acute, uncomplicated illness or injury
		• 1 stable acute illness
		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			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)

99222
99232
99254
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 new problem or acute illness with systemic symptoms
		• 1 acute complicated injury
			Moderate
			(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 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 (no separately reported)

99223 99233 99255	High	High • 1 or more chronic illness with severe progression/exacerbation/	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:

		adverse effects or treatment • 1 acute or chronic illness or injury that poses threat to life or body 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 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)

Inpatient Clinical Example #6

45-year-old man with history of heart transplantation seven months ago presents with fever, confusion, hemoptysis and hypotension. Initiation of intubation in emergency room, with vasopressors and admission to ICU. Chest imaging reveals large cavitary lung lesion suspicious for invasive pulmonary aspergillosis. Initiation of empiric voriconazole and antibiotics. Total time spent on evaluating patient, reviewing lab results, imaging, coordinating management with patient's other physicians and documenting visit in electronic medical record resulted in 40 minutes.

While this visit meets criteria for a high level of MDM and could be billed as 99233, it also meets the definition of a critical care service. If time spent, presence of a life-threatening illness and critical care services provided are appropriately documented in the medical record, then this visit should be billed as 99291.

99291	**Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes**
99292	Each additional 30 minutes of critical care provided beyond the first 74 minutes (billed in addition to 99291)

Section Four: Split or Shared Visits:

- A split/shared visit is an E/M service performed by a physician and a nonphysician practitioner belonging to the same group practice. Determination of the billing provider for the split/shared E/M service is based on the provider that spent **either** more than half of the total time performing the service or provided a substantive portion of the medical decision making as defined by CPT®.

- It's key to understand and develop a potential strategy to bill the highest level based on MDM under physician or highest level based on time under NPP at a reduced rate. There may be difference in payment to a NPP than to a physician such as with Medicare.

- For shared or split visits between a physician and other NPP, such as advanced practice providers, only distinct time spent separately on the date of the encounter may be summed to equal total time. If a physician and QHCP perform the same activity together, then time can only be counted for one of the providers in the sum of the total time.

- CMS's Level II Modifier FS can be used for split or shared evaluation and management visits. For E/M services split or shared between a physician and a non-physician practitioner (NPP) in a facility setting where both physician and NPP are in the same group. This modifier may not be used in an office or other setting outside of a facility setting defined as hospital or skilled nursing facility.

- Substantive portion of the MDM requires that the physician or non-physician practitioner make or approve the management plan for the number of complexity or problems addressed at the encounter and takes responsibility of plan including the risk of patient management. This results in the physician or non-physician practitioner performing two of three elements of MDM used to select the code level based.

Section Five: Additional Resources

E/M Coding and Documentation Resources

AMA E/M CPT® Code Resources
AMA is the official source of CPT® code information and guidelines. This website provides information on the revised E/M codes and provides a learning module to assist physicians and their staff in navigating those changes.

CMS Evaluation and Management Services Guide
This guide from the Centers for Medicare & Medicaid Services is a comprehensive guide issued by CMS to educate providers on the appropriate use of E/M codes and the associated documentation. The guide has been updated to include the revisions to the office visit E/M codes.

CMS Evaluation & Management Visits
CMS has provided several resources for documentation and payment for E/M visits under the Medicare Physician Fee Schedule.

To assist with questions regarding CPT® coding or other reimbursement issues, IDSA offers Ask the Coder. This service is available to IDSA members to aid in understanding and resolving medical coding issues. For more information and general inquiries, contact IDSA staff via clinicalaffairs@idsociety.org.