IDSA

Evaluation and Management Services Reference Guide

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(For use 2025-2028)

Contents

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The **AMA CPT Professional 2025 Guide** includes detailed information adapted into the **Evaluation and Management Services Reference Guide** across multiple sections. For instance, the "Split or Shared Visits" section from pages 5–6 of the CPT Book is adapted on pages 41–42 of the EM Guide. The "Table 1: Levels of Medical Decision Making (MDM)" from pages 9–10 of the CPT Book is adapted on pages 19-28 and pages 29–39 of the EM Guide. Additionally, the "Number and Complexity of Problems Addressed at the Encounter" section from pages 8–9 and 12–13 of the CPT Book appears on pages 5–8 of the EM Guide, while "Risk of Complications and/or Morbidity or Mortality of Patient Management" from the same CPT pages is adapted on page 8 of the EM Guide. Guidelines for selecting levels of service based on time, located on pages 8–9 and 12–13 of the CPT Book, are also included under "Description of Total Time" on page 9 of the EM Guide. Further, "Telemedicine Services," found on pages 17–21 of the CPT Book, is adapted on pages 17–18 of the EM Guide, and "Prolonged Services With or Without Direct Patient Contact on the Date of an Evaluation and Management Service," located on pages 34–37 of the CPT Book, is adapted on pages 10–11 of the EM Guide.

About This Guide

This Evaluation and 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 evaluation and management (E/M) service 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. Since then, we have updated it to reflect changes made in 2023 and 2024. This updated version of the guide expands on the initial version by addressing new coding changes for 2025.

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. Clinical examples follow in a single patient's case, from a minor problem with a low level of medical decision making (MDM) as it progresses to the highest level of MDM, indicating the elements that led to the code that was chosen.

The updated guide was developed under the leadership of IDSA's Coding and Payment Subcommittee. IDSA wishes to thank the following IDSA members who contributed time and expertise to the development of this guide: Catherine M. Berjohn, CDR, MC, USN; Ronald Devine, MD; Amy Beth Kressel, MD, MS, FIDSA, FSHEA; Asher Schranz, MD; Timothy Sullivan, MD; Casi Wyatt, DO, FIDSA; John Fangman, MD; Nilesh H. Hingarh, MS, MD, MBA; Alice Kim, MD, MBA; Prashant Malhotra, MBBS, MD; and Matt Shoemaker, MD.

Section One: Introduction

Over the past years, the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) have made significant revisions to evaluation and management (E/M) services, allowing physicians to select the E/M visit level 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. In 2024 CMS created a new add-on complexity code G2211 and in 2025 CMS created add-on code G0545 specifically for infectious diseases providers. The 2025 E/M changes emphasize audio-only telemedicine services while removing non-face-to-face codes.

Summary of 2025 Revisions to E/M CPT Codes

New changes in 2025:

- Seventeen new codes have been added for telemedicine, expanding remote care options for both audio-video and audio-only telemedicine. These include codes specifically for new (98000–98003) and established patients (98004–98007) in audio-video visits, as well as audio-only codes (98008–98011 for new patients; 98012–98015 for

established patients). A new brief communication technology-based service code, 98016, replaces the previous G2012 code used for virtual check-ins.

- CMS has introduced an add-on code G0545 specifically aimed at compensating for the added complexity of treating infectious disease patients. This add-on code applies to hospital inpatients or observation of care when an infectious diseases specialist is evaluating a patient for a confirmed or suspected infectious disease. It covers the complexities of managing the case, including evaluating and mitigating transmission risks, supporting public health investigation and testing, and providing detailed counseling on complex antimicrobial therapies. This code is billed separately in addition to the primary inpatient or observation evaluation and management visit, whether it is the initial visit, a same-day discharge, or a follow-up visit.

Previous revisions to be aware of:

- **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.
- A s**plit or shared visit is** when an E/M service is performed by a physician and non-physician practitioner (i.e., nurse practitioner or physician assistant) from the same practice group. Billing is based on the provider who performed the substantive portion of the visit as determined by MDM or by which professional spent the majority of time performing services.
- 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 code (99418). The changes will provide continuity across all E/M coding and documentation.

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

Two of the three elements must be met or exceeded when selecting the code level. For example, for a new patient encounter involving moderate problem addressed, a limited review of data, and a low level of risk, then the medical decision making (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, then specifically state the date and author or clinical service of EACH note reviewed.
- If used, then 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 is 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 drug monitoring: aminoglycosides, amphotericin, IV acyclovir, IV 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.).
- Clearly document that the risk or morbidity and mortality is due to the condition or problem or from the management and treatment.

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
According to the *Current Procedural Terminology (*CPT®*) Professional Edition 2025*, published by the American Medical Association, a **"problem"** refers to any disease, condition, symptom, injury, finding, or other concern discussed during a patient visit. The issue does not need to have a confirmed diagnosis—if it is evaluated or treated during the encounter, then it counts as "addressed."

Even when a provider considers testing or treatment, but decides against it, the problem is still considered addressed. However, just listing a problem in the record without evaluating or managing it does not count.

For inpatient or observation settings, the status of the problem addressed is determined on that date of encounter and not with regards to presenting problem status such that a patient admitted with sepsis due to bacteremia which is a life threatening problem once improved and doing well may no longer have a life threatening problem and problem addressed no longer high level, but moderate or low.

Comorbidities or chronic conditions are only relevant to the level of service if they are actively managed and **increase the complexity of decision-making or risk**.

A final diagnosis alone does not determine complexity—signs and symptoms can require extensive workup even if they point to a condition that is not highly severe.
Also, multiple minor problems may collectively pose a higher risk when interacting with each other, which should be clearly documented.

These definitions are paraphrased from the AMA CPT® Professional 2025 edition.

Types of Problems That Affect MDM Level Selection

- **Minimal problem**: Does not typically require a provider, but the provider is still involved (e.g., answering questions during a routine injection or vaccine).

- **Self-limited or minor problem**: Temporary with a predictable course and no long-term health impact.
    - Example: Viral upper respiratory infection or a rash diagnosed as tinea corporis with simple over-the-counter treatment.
- **Stable, chronic illness**: Long-term condition lasting at least a year or until death. The term "stable" means the patient is at a treatment goal.
    - Example: Well-controlled HIV on ART.
- **Chronic illness with exacerbation, progression, or side effects**: The condition is worsening or only partially controlled, needing additional care or monitoring.
    - Example: HIV patient with declining CD4 cell count due to nonadherence to ART.
- **Chronic illness with severe exacerbation, progression, or side effects**: Poses a high risk of complications, requiring urgent or increased care.
    - Examples:
        - HIV patient with an opportunistic infection
        - Infections requiring ICU care
        - Worsening diabetic foot ulcer requiring possible surgery
        - Acute flare of a long-standing prosthetic joint infection
- **Acute, uncomplicated illness or injury**: New, short-term issue with low risk and expected full recovery without lasting impact.
    - Example: UTI was diagnosed and treated in a hospitalized patient.
- **Acute, uncomplicated illness requiring inpatient/observation care**: Low-risk condition, but hospitalization is needed due to factors like drug allergies or IV treatment needs.
    - Example: Cellulitis requiring IV vancomycin due to an allergy history.
- **Stable, acute illness**: A new problem being treated that is improving, but not yet resolved.
    - Example: Acute pyelonephritis improving with IV antibiotics.
- **Undiagnosed new problem with uncertain prognosis**: The exact issue is unknown, but could be serious without treatment.
    - Examples:
        - Fever of unknown origin in a healthy patient
        - Marked leukocytosis without clear cause
- **Acute illness with systemic symptoms**: An illness with body-wide effects or high risk if untreated. Systemic symptoms might be limited to one organ.
    - Examples:
        - Cellulitis with fever and rapid heart rate
        - Pyelonephritis with nausea and vomiting
        - Pneumonia with fever and elevated white count
        - Ventilator-associated pneumonia in ICU with fever

Acute, Complicated Injuries and Serious Illnesses

An **acute, complicated injury** is one that:

- Involves significant trauma,
- May require evaluation beyond just the injured area (involving other body systems),
- Involves extensive damage, or
- Presents multiple or high-risk treatment options.

Example: A trauma patient who develops an infection after surgery.

A **serious illness or injury** (acute or chronic) is one that could threaten life or bodily function if not treated quickly. These conditions often show systemic symptoms or complications and may require urgent or complex treatment.

Examples include:

- A patient hospitalized with septic shock
- Bacterial meningitis
- Necrotizing fasciitis
- Infective endocarditis with widespread symptoms
- Severe COVID-19 pneumonia needing mechanical ventilation
- A serious foot infection requiring amputation
- Widespread Staphylococcus aureus infection before the infection source is controlled

Complexity and Review of Medical Data

Medical decision making (MDM) involves reviewing and analyzing data. Tests ordered during a visit are considered part of the MDM for that visit in which they were ordered and also include review or analysis of tests and not count for future visits. Data are counted as reviewed only if they are actively analyzed and have not been previously reviewed.
Auto-populated results in the record count only if they are actively reviewed and documented.

Tests ordered outside the visit count only when reviewed during the visit in which they are considered. Repeated or recurring tests can count in the encounter in which they are analyzed. If you place orders for a patient for outpatient parental antibiotics and order weekly labs for a complete blood count and comprehensive metabolic panel, then those tests can be counted towards data reviewed during the encounter in which they were considered.

If a physician or qualified health care provider (QHCP) performs a test that is billed separately, such as an ECG, then it cannot be counted again for data reviewed purposes to determine the level of MDM.

Examples of data types:

- Imaging, labs, psychometric, or physiologic tests
- *Note: Pulse oximetry is not considered a test*

A “unique test” is based on its CPT code. Even if it includes multiple lab values (e.g., a basic metabolic panel), it only counts once. Overlapping tests like BMP and CMP only count once because they share elements.

A “unique source” is a provider from a different group or specialty. All notes from one such provider count as one data point for MDM.

An external provider cannot be in the same group or same specialty or subspecialty.

“Discussion” must be a direct interaction between providers and cannot be through clinical staff. Interaction can be done through messaging and may occur within a short time (1-2 days) of the encounter for which it is considered. Sending notes or messages passively is not considered to be a discussion.

Independent Historian

An **independent historian** provides additional or confirmatory patient history when the patient is unable to give complete or reliable information (e.g., due to dementia or developmental delay). This could be a spouse, parent, guardian, or caregiver. Medical interpreters **do not** count as independent historians. The need for historians and their identity must be clearly documented.

Independent Interpretation

If the provider personally interprets a test (e.g., a chest radiograph or ECG) and does not bill separately for that report, then it can be counted towards MDM as **independent interpretation**. This applies only to tests with formal CPT codes and reports. Basic lab results (e.g., complete blood count, Gram stain interpretation, or blood cultures) do not count.

Appropriate Source

An **appropriate source** refers to someone involved in patient care management who is not a healthcare provider, such as a lawyer, case manager, or teacher. Conversations with family members or informal caregivers **do not** count.

Risk Assessment in Patient Management

Risk considers both the **likelihood** and the **severity** of possible outcomes. Even low-probability events may be considered high risk if their consequences (like death) are severe. Risk includes management options performed as well as management options considered, but not performed including diagnostic tests, referrals, medications, and hospitalizations.

Social Determinants of Health (SDOH)

SDOH are economic and social factors affecting health. Examples include food insecurity, unstable housing, lack of transportation, group home living, or drug use.

Drug Therapy Requiring Intensive Monitoring

Some medications carry a high risk of serious side effects or toxicity and need intensive monitoring for safety and not for effectiveness. This monitoring can be through lab tests, imaging, or physiologic testing on the date of encounter for which it was considered. Monitoring does not include history or examination. It must follow accepted clinical guidelines and occur at least quarterly if ongoing.

To count this in MDM, providers should document:

- The drug name,
- The risks or side effects being monitored,
- The tests used for monitoring,
- The monitoring schedule.

Risk from Patient Management Decisions and Associated Health Outcomes

- This refers to the potential for complications, illness, or death based on clinical decisions made during the visit, in connection with the patient's conditions and treatments.
- It includes both the management options that were chosen and those that were considered, but ultimately not used.
- It also takes into account any risks stemming from social determinants of health.

Description of Total Time

Coding based on time includes the entire duration of all activities related to a patient's care on the date of the encounter. This includes both face-to-face interactions with the patient and/or family or caregiver, as well as non-face-to-face activities performed by the physician and/or qualified health care professional (QHCP) personally for that encounter. Activities may include, but are not limited to:

- Reviewing tests and medical records before seeing the patient
- Gathering the patient's history
- Conducting a medically appropriate physical exam
- Providing counseling and education to the patient, family, or caregiver
- Ordering medications, labs, or procedures
- Communicating with or referring to other health care professionals
- Documenting the visit
- Independently interpreting tests (if not billed separately)
- Coordinating care (if not billed separately)

Total time includes all these activities, no matter where they take place, whether in the office, hospital unit, or remotely. However, it does not include:

- Activities that are separately billable
- Travel time
- Any time spent outside of the encounter date

To bill based on time, providers must accurately document the total time spent on patient care on the date of the encounter. This documentation should reflect the activities performed, such as reviewing records, discussing care plans, ordering medications, providing education, and documentation. Total time should be documented for all activities performed, but times for each performed activity do not need to be documented. Time should be accurate and not estimated or rounded.

Routine tasks performed by clinical support staff (e.g., checking vital signs, dressing changes, arranging home care, or retrieving records) do not count toward the total time.

For shared or split visits involving a physician and a QHCP (such as a nurse practitioner or physician assistant), only separate, distinct time spent individually by each provider on the date of encounter can be added together. If both providers are working together on the same activity at the same time, then that time can only be counted once toward total time.

Table 2 provides information on which code should be selected based on the 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	No time component
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, G2212 and G0316, 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 be 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.

Example

A physician has a follow-up appointment with an established patient to manage complex chronic conditions, including HIV and hepatitis B. The provider spends an extended amount of time with 70 minutes total time reviewing medical history, adjusting the treatment plan, coordinating care, and counseling the patient on medication adherence.

Time Breakdown:

1. **99215** is an E/M code for established patients that requires **40 minutes** of total time on the date of the encounter.
2. In this example, the physician spends **70** minutes total time on the encounter date with the patient. This time includes direct interaction with the patient, reviewing labs, coordinating care, counseling, and documentation.

Using CPT Code 99417:

- Since the physician has spent **15 minutes beyond the minimum 40-minute** threshold for 99215, the physician can now bill for prolonged services.
- **99417** can be added for each **15-minute increment** beyond the minimum threshold time for the highest-level E/M code.

Here is how it breaks down:

- **E/M Code 99215**: Covers up to **54 minutes** of time with the patient.
- **99417**: Covers the additional **15-minute increment** beyond the 40-minute minimum time threshold and can be added once 55 minutes is reached.

Since the provider spent **70 minutes** in total, they can bill:

- **99215** for time to **54 minutes** and
- **99417** for time from 55 minutes to 70 minutes

Final Billing:

- **99215** (E/M service for established patient, 40 minutes)
- **99417 x 2** (Prolonged service for two 15-minute increment beyond the highest-level E/M time)

*Tables 3 was adapted from the American Medical Association CPT® Professional 2025 edition.

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	99215 x1 AND 99417 x2
85 minutes or more	99215 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)	**Code(s) Reported**
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)	**Code(s) Reported**
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 2025 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 the medical record.
    - Time is the total time spent in one day and does not need to be continuous.

Add-On Complexity Code G2211

What is the G2211 code?

G2211 is an add-on code introduced by CMS to address the additional time, effort, and resources that primary care and certain specialty care providers invest in patient care management. The code is intended to capture the complexity, comprehensiveness, and ongoing nature of the provider-patient relationship over time, especially when multiple conditions or preventive care are addressed in a single visit.

The G2211 add-on code is intended for visits that involve extensive, ongoing management, and coordination of patient care, especially when dealing with multiple chronic conditions, a single chronic condition, or engaging in preventive care. It is used as an add-on code to E/M codes for outpatient visits when a long-standing provider-patient relationship adds complexity.

There is no specific documentation requirements when using the G2211 add-on code, but documentation should reflect the medical necessity of the visit and the ongoing patient care relationship as appropriate to justify the additional complexity and ongoing patient relationship. This ensures that the billing reflects the high-value care that providers deliver in managing complex patient needs.

Key Points of G2211

1. **Purpose of G2211:**
    - G2211 is aimed at compensating providers for the cognitive work involved in maintaining a long-term, continuous relationship with patients. This often includes addressing chronic conditions, coordinating multiple aspects of care, or conducting preventive care activities.
    - It reflects the provider's efforts to manage and plan patients' long-term health, requiring careful analysis, planning, and coordination of complex medical conditions.
2. **When to Use G2211:**

- **Establishing or maintaining a long-term relationship:** If you are providing ongoing management or engaging in preventive care, G2211 can be added to account for the additional time and resources you invest in the patient.
- **Multiple or complex health issues:** Use this code if you are managing chronic or multiple health conditions that require a higher level of decision making and coordination.
- **Primary care focus:** G2211 is designed for primary care and certain specialties that focus on comprehensive, whole-person care (e.g., family medicine, internal medicine).
- **Same day use with E/M codes:** G2211 is an add-on code that should be billed along with an E/M code for outpatient visits (99202-99215).

3. **Documentation Requirements:**
   - No specific documentation is required, but documentation should include:
     1. Document the nature of the provider-patient relationship, indicating any long-standing or complex conditions.
     2. Highlight the scope of issues addressed in the visit and any preventive or health maintenance strategies discussed.
     3. Show that the care provided goes beyond basic care and involves complexity that merits additional compensation.

How to Use G2211

1. **Billing With E/M Codes:**
   - G2211 should be billed in addition to the primary E/M code used for the visit (e.g., 99203 for a moderately complex office visit).
   - It can be added when the provider-patient relationship is a significant aspect of care and when the provider needs to address multiple aspects of health management.
2. **Specific Situations to Use G2211:**
   - **Patients with multiple chronic conditions:** For example, if you are managing diabetes, hypertension, and chronic kidney disease in one visit, then this code can reflect the complexity.
   - **Preventive care combined with chronic care:** If you are doing an annual preventive visit but also have to manage chronic issues, then this code captures the added work.
   - **Patient coordination and continuity of care:** If you are coordinating with other specialists or adjusting treatment plans based on recent evaluations or tests, then G2211 can apply.
3. **Use With Telehealth:**
   - As of the recent 2025 CMS updates, G2211 can also be used for virtual visits if they involve the same level of ongoing relationship and complexity as in-person visits, and E/M code used is 99202-99215.
4. **Example:**

   - A 65-year-old patient presents for a follow-up visit with their infectious diseases' physician. The patient has a long-standing history of HIV. During the visit, the physician reviews the patient's most recent HIV labs, including CD4 count and viral load. The physician refills antiretroviral therapy (ART) reinforces the importance of medication adherence and discusses necessary lifestyle modifications to support overall health.

5. **Why G2211 Fits:**

   - The provider is managing a single, serious condition and providing longitudinal care for this condition.

When Not to Use G2211

1. **Not for Short-Term or Limited Relationships:**
    - This code is inappropriate for encounters with patients whom you are seeing temporarily, or if it is a one-time or limited engagement without a long-term relationship or coordination of multiple health issues.
2. **Avoid With Procedures:**
    - If the visit is mainly focused on a procedure (like a biopsy, injection, etc.) rather than on comprehensive care and management, then G2211 would not apply.
3. **Example:**
    - A patient visits a primary care provider for a one-time evaluation of a minor rash, with no prior relationship or ongoing care planned. The visit is straightforward, and there is no longitudinal care relationship.

Add-On Complexity Code G0545

CMS has introduced an add-on code that recognizes the increased work and complexity for the diagnosis, management, and treatment of infectious diseases which are not accounted for with current inpatient E/M codes. This add-on code applies to hospital inpatient or observation of care when an infectious diseases specialist manages a confirmed or suspected infectious disease. It covers the complexities of managing the case, including evaluating and mitigating transmission risks, supporting public health investigation and testing, and providing detailed counseling on complex antimicrobial therapies. This code is billed separately in addition to the primary inpatient or observation evaluation and management visit, whether it is the initial visit, a same-day discharge, or a subsequent visit.

Key Components of HCPCS Code G0545

HCPCS code G0545 enables infectious diseases specialists to report additional complexities beyond the standard inpatient or observation E/M codes. This add-on code covers three core areas:

1. **Disease Transmission Risk Assessment and Mitigation:** Includes infection control procedures, counseling for patients and caregivers, and coordinated efforts to minimize transmission risks.
2. **Public Health Investigation, Analysis and Testing:** Involves detailed patient history assessments, advanced diagnostic evaluations, and collaboration with public health agencies for contact tracing and diagnostic testing.
3. **Complex Antimicrobial Therapy Counseling and Treatment:** Focuses on educating patients and families on antimicrobial stewardship, addressing resistance issues, and tailoring therapy options based on public health data.

When to Use:

- If the patient is an inpatient or inpatient observation.
- If the patient has confirmed or suspected infectious disease.
- If the billing provider is “an infectious disease consultant.” This includes infectious diseases specialty physicians, but also other qualified healthcare professionals, e.g., a nurse practitioner or physician assistant with infectious diseases specialization.
- At least one of the three above core areas are addressed during the visit.

Section Three: Telemedicine Services

In accordance with the establishment of new codes 98000-98015 for reporting telemedicine office visits, the telemedicine symbol (*) has been removed from codes 99202-99205 and 99211-99215, as they will no longer be reported for telemedicine office visits.

Telemedicine Services Overview

Telemedicine involves live, real-time communication between a physician or qualified healthcare professional (QHCP) and a patient through audio-video or audio-only means. Unless a specific code indicates otherwise, the service level for telemedicine is determined by either the medical decision making (MDM) or the total time spent on evaluation and management (E/M) on the encounter date, according to guidelines for that service.
Telemedicine is an alternative to in-person visits when clinically appropriate, provided the patient (or their family/caregiver) agrees to this method of care.

Important Billing Notes:

- Routine follow-up calls, such as simply giving lab results, should not be billed as telemedicine services.
- However, telemedicine can be used for E/M follow-up visits when additional evaluation is needed (e.g., checking treatment response or monitoring complications), similar to in-person follow-up visits.

With the exception of code 98016, there are no required time intervals between previous in-person or telemedicine visits. These services can be initiated by the provider, patient, or family/caregiver, but must be on a different calendar date from other E/M services.

If a telemedicine and in-person E/M service happen on the same date, then the activities and time are combined into a single service report. Overlapping time is only counted once.

If the time threshold to bill a separate telemedicine service is not met, the time spent can still contribute toward the total time of an in-person E/M service on that date.

For services that are asynchronous (e.g., not live in real-time), see **Online Digital Evaluation and Management Services** (99421-99423). Telemedicine services should not be used for supervision of clinical staff, such as in chronic care management. Time spent on telemedicine services should not be counted toward the time for performing chronic care management (99490-99491 and 99437 and 99439) or principal care management services (codes 99424-99427).

For 98000-98015, the level of service is selected based on MDM or total time on the date of the encounter. For audio-only codes 98008-98015, the service must exceed 10 minutes of *medical discussion*. Code 98016 describes services for established patients with 5 to 10 minutes of medical discussion and is based only on the time of medical discussion and not MDM. Time spent on setting up the connection or scheduling the appointment should not be included, even if done by the physician or other QHCP. Services lasting less than 5 minutes are not billable.

For audio-only codes 98008-98015, medical discussion is synchronous (real-time) interactive verbal communications and does not involve online digital communication, unless using a telecommunications device specifically for individuals who are deaf. In this context, “MDM” aligns with the definition in the E/M guidelines and represents a cognitive process by the physician or QHCP.

If an audio-video connection is lost during the encounter, but audio-only communication is restored, report on the service

based on whichever mode was used for the majority of the interactive session. To bill for an audio-only service, the interaction must exceed 10 minutes of medical discussion or patient observation.

Synchronous Audio-Video Evaluation and Management Services

Codes 98000-98007 may be reported for new or established patients. Synchronous audio and video telecommunication is required. These services may be reported based on total time on the date of the encounter or MDM.

Synchronous Audio-Only Evaluation and Management Services

Codes 98008-98015 may be reported for new or established patients. They require more than 10 minutes of medical discussion. For services of 5 to 10 minutes of medical discussion, report 98016, if appropriate. If 10 minutes of medical discussion is exceeded, then total time on the date of the encounter or MDM may be used for code level selection.

Brief Synchronous Communication Technology Service (e.g., Virtual Check-In)

Code 98016 is reported for established patients only when it is initiated by the patient to determine if a more extensive visit is required. Video is not required for this service. Involves 5-10 minutes of medical discussion. Service is not related to a previous visit within 7 days nor does it lead to an E/M visit within the next 24 hours or the next available appointment. If this virtual check-in leads to an E/M service on the same date and that service is billed based on time, then the time from virtual check-in can be added to the total time for the encounter for the visit and code 98016 is not billed.

Medicare Telemedicine Services

Medicare does not recognize the CPT telemedicine codes 98000-98015 but will cover telemedicine when billed with routine E/M codes for outpatient visits with modifier -95. When the patient cannot use video but has access to audio and the provider has access to audio-video compatibilities, then use modifier -93 with the appropriate outpatient E/M code (99202-99205; 99212-99215).

Table 11: Telemedicine and Non-Face-to-Face Services*

Service Type	Patient Type	Video/Audio	Time Requirement	Billing Period	Important Notes
Audio + Video (98000–98007)	New or Established	Yes (audio + video)	MDM or any time (no minimum)	Per day	Don’t bill with same-day in-person visit
Audio Only (98008–98015)	New or Established	Yes (audio only)	More than 10 mins	Per day	Don’t bill with same-day in-person visit
Brief Audio/Video (98016)	Established	Yes	5–10 mins	Per day	Not related to E/M 7 days before or 24 hrs after
Online Digital E/M (99421–99423)	Established	No	Over 7 days	Per 7 days	Same restriction as above
Interprofessional Consults (99446–99451)	Both	Not required	Over 7 days	Per 7 days	No in-person visit within 14 days
Interprofessional Consults (99452)	Both	Not required	Same-day minutes	Per 14 days	No in-person visit within 14 days
Care/Remote Treatment Mgmt (99424, etc.)	Established	Not required	Per month	Per month	Can’t include time on day of another E/M

Section Four: 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 injury
		• 1 stable acute illness
			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
				Low
				Low risk of morbidity from additional diagnostic testing or treatment

		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	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/ 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
				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

			•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)	• 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 non-purulent 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
			• 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
				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

			• 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)	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	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:	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	• 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)	
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	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	High High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective

		function	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)	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

Inpatient Visits

Inpatient Clinical Example #1

The 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	Level of Risk
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
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)	Low Low risk of morbidity from additional diagnostic testing or treatment

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)	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
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	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

			professional/appropriate source (not separately reported)	to de-escalate care because of poor prognosis • Parenteral controlled substances

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	Level of Risk
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
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	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

		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care		

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)
				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

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)
				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

			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 regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

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	Level of Risk
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal
99221 99231 99253	Low	Low • 2 or more self-limited/minor problems • 1 stable chronic illness	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	Low Low risk of morbidity from additional diagnostic testing or treatment

		• 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	• 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)	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
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	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

			•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)	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

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	Level of Risk
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal

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)
				Low
				Low risk of morbidity from additional diagnostic testing or treatment

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
			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

		complicated injury		health
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)	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

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	Level of Risk
99221 99231 99252	Straightforward	Minimal • 1 self-limited problem or minor problem	Minimal or none	Minimal

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)
				Low
				Low risk of morbidity from additional diagnostic testing or treatment

99222
99232
99254
	Moderate	Moderate
		• 1 or more chronic problem with progression/exacerbation/ adverse effects of treatment
		• 2 or more stable chronic illnesses
			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
				Moderate
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor

		• 1 undiagnosed new problem with uncertain prognosis • 1 new problem or acute illness with systemic symptoms • 1 acute complicated injury	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)	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
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)	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

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)

Telemedicine Examples

Telemedicine Example #1

A 42-year-old patient with long well controlled HIV has a ***synchronous audio-video visit*** as a new patient to establish HIV care. The patient gives consent for the audio-video visit which is documented in the chart. During the real-time audio-video visit, the provider asks questions about the patient's medical history, including the patient's HIV history and HIV treatment regimens. The provider notes that the patient is well controlled on current HIV medications and reviewed previous records from another infectious diseases' provider noted the patient's well controlled HIV. The provider orders labs including complete blood count, comprehensive metabolic panel, CD4+ cell count, and HIV PCR to be done at a laboratory facility near the patient's home. The provider also refills the patient's HIV medications. MDM would meet criteria for **98002** with moderate medical decision making.

Telemedicine Example #2

A health care provider conducts a ***synchronous audio-only visit*** with an established patient diagnosed with chronic hepatitis C. The patient gives consent for the audio-only visit which is documented in the chart. The purpose of the call is to discuss recent lab results, address medication adherence, and provide guidance on managing symptoms and preventing further complications.

The provider spends **23 minutes** on the call. During this time, they review the patient's lab results in detail, explaining the significance of viral load changes and liver enzyme levels. The provider emphasizes the importance of consistent medication use to suppress the virus and discusses potential side effects. The provider also answers the patient's questions about dietary recommendations and addresses concerns about fatigue and joint pain which are common in chronic hepatitis C.

The provider ends the session by scheduling a follow-up call in a month to reassess symptoms and discuss any new lab work. This encounter is documented with **CPT code 98013** (*Synchronous audio-only visit, established patient*) because 20 minutes was met and exceeded.

Telemedicine Example #3

A 59 year old patient has an audio-video visit for follow up regarding treatment for urinary tract infection. The patient agrees to an audio-video visit which is documented in the chart. During the audio-video visit and after the audio-video connection lasting for **12 minutes** the patient loses connection and cannot re-establish the audio-video connection so the provider calls that patient on the phone to complete the visit. The provider reviews the urine culture results from the urine culture ordered at the previous visit and changes the antibiotic. The provider orders a complete blood count and basic metabolic panel to be done at a laboratory near the patient's home. The provider asks the patient to schedule a follow up visit via audio-video connection in three days. The total time of audio-video and audio-only connection was 18 minutes. Because the provider spent more than 10 minutes with patient observation during the audio-video portion before losing connection and that time spent with the audio-video visit was greater than the audio-only portion, then audio-visit E/M codes would be used and this would be a low level medical decision making and would be **98005.**

Section Five: 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 practice group. Determination of the billing provider for the split/shared E/M service is based on the provider who spent either more than half of the total time performing the service or provided a substantive portion of the MDM as defined by CPT.

What is the qualifying time?

- Preparing to see the patient
- Obtaining/reviewing separately obtained history
- Performing a medically appropriate exam and/or evaluation
- Counseling and educating the patient/family
- Ordering medications, tests or procedures
- Referring and communicating with other members of the health care team
- Documenting clinical information in the EMR
- Independently interpreting results and communicating them to the patient/family
- Care coordination

The physician billing the service must document the MDM elements required to support the level of service.
Documentation must support engagement in the overall MDM and that the billing provider made or approved the plan, addressing:

1. The number and complexity of problems/diagnoses addressed

2. The amount/complexity of data reviewed (e.g., records, tests, interdisciplinary conversations)

- It is key to understand and develop a potential strategy to bill the highest level based on MDM under physician or the highest level based on time under NPP at a reduced rate. There may be a difference in payment to a nonphysician practitioner compared to a physician, such as with Medicare.
- For shared or split visits between a physician and other NPP, such as an advanced practice provider or physician assistant, only distinct time spent separately on the date of the encounter can be summed to equal total time. If a physician and NPP perform the same activity together, then time can only be counted for one of the providers in the sum of the total time.
- CMS' Level II Modifier FS should be used for split or shared E/M visits when billing Medicare. This modifier can be used for E/M services split or shared between a physician and an 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 a hospital or skilled nursing facility.
- A substantive portion of the MDM requires that the physician or NPP make or approve the management plan for the number of complexity or problems addressed at the encounter and takes responsibility for the plan, including the risk of patient management. This results in the physician or NPP performing two of three elements of MDM used to select the code level.
- CMS does expect that the billing provider to appropriately document MDM elements themselves, including tests ordered and/or reviewed. CMS requires that for a discussion to be used as part of the MDM, then the provider billing for the split or shared visit must be the one having that discussion with another provider.

Section Six: Additional Resources

E/M Coding and Documentation Resources

American Medical Association. (2024). *CPT 2024 Professional Edition*. *Kindle (amazon.com)*

American Medical Association. (2025). *CPT 2025 Professional Edition*. American Medical Association

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.