Evaluation and Management— Additional Guidelines

Introduction to Evaluation and Management Coding

The AMA and the Centers for Medicare and Medicaid Services (CMS) developed the evaluation and management service codes in an effort to provide a more objective framework to represent services provided to patients and more clearly define work performed by the provider.

The Evaluation and Management section contains the codes applicable to all services commonly referred to as "visits." The following category titles are found in the *Current Procedural Coding Expert* and may be different from those found in the 2023 CPT® book. The code ranges are the same for both resources.

CPT Section	Code Range
Office and Other Visits	99202–99215
Hospital Inpatient or Observation Care, Initial and Subsequent	99221–99233, 99231–99233
Hospital Inpatient or Observation Care, Admitted/Discharged on Same Day	99234–99236
Hospital Inpatient or Observation Care, Discharge Services	99238–99239
Consultations: Office or Other Outpatient	99242–99245
Consultations: Inpatient or Observation	99252–99255
Emergency Department Visits	99281–99288
Critical Care Visits	99291–99292
Nursing Facility Visits, Initial and Subsequent	99304–99310
Nursing Facility Discharge	99315–99316
Home and Residence Visits	99341–99350
Prolonged Services on Date Other Than Face-to-Face Evaluation and Management Service Without Direct Patient Contact	99358–99359
Prolonged Clinical Staff Services Under Supervision	99415–99416
Prolonged Service with or Without Direct Patient Contact on Date of Evaluation and Management Service	99417–99418
Standby Services	99360
Interdisciplinary Conferences	99366–99368
Care Plan Oversight: Patient Under Care of HHA, Hospice, or Nursing Facility	99374–99380
Preventive Medicine Visits	99381–99397
Counseling Services: Risk Factor and Behavioral Change Modification	99401–99412
Telephone Calls for Patient Management	99441–99443
Digital Evaluation and Management Services	99421–99423
Online and Telephone Consultative Services	99446–99449, 99451–99452
Remote Monitoring/Collection Biological Data	99453–99454, 99091, 99473–99474
Remote Monitoring Management	99457–99458
Life/Disability Insurance Eligibility Visits	99450, 99455, 99456
Evaluation and Management Services for Age 28 Days or Less	99460–99463
Newborn Delivery Attendance/Resuscitation	99464–99465
Critical Care Transport Age 24 Months or Younger	99466–99467
Critical Care Transport Supervision Age 24 Months or Younger	99485–99486
Critical Care Age 5 Years and Younger	99468–99472, 99475–99476
Initial and Subsequent Inpatient Neonatal Intensive Care Services	99477–99480
Cognitive Impairment Services	99483
Chronic Care Management Services	99490–99491, 99437, 99439,
Complex Chronic Care Management Services	99487–99489
Principal Care Management Services	99424–99427
Psychiatric Collaborative Care	99492–99494
Management of Transitional Care Services	99495–99496
Advance Directive Guidance	99497–99498
Behavioral Health Integration	99484

General E/M guidelines precede the Evaluation and Management section of the *Current Procedural Coding Expert* and the CPT book. The information contained in the guidelines provides definitions, explanations of terms, time-based instruction as applicable, and any other information unique to that set of codes necessary for appropriate E/M code assignment.

E/M codes were designed to increase accuracy and consistency when reporting the various levels of patient encounters and were jointly developed by the AMA and CMS. The AMA and CMS have, over time, developed guidelines for the use of evaluation and management codes to supplement the information found in the CPT book. The level of visit is based on the extent of the clinical history taken, the level of physical examination performed, and the complexity of medical decision making. In 1995, CMS published guidelines on how to appropriately document and quantify the provider's evaluation and plan of care for patients. These guidelines were expanded in 1997 to recognize that certain specialists like ophthalmologists, would not need to perform a cardiovascular or gastrointestinal exam but instead would need to perform a focused, complex, single-system examination. Both sets of guidelines are valid for services prior to 2023, and providers may choose either set to assist them in their documentation.

Effective January 1, 2021, CMS and the AMA adopted changes to coding and guidelines for codes 99202–99215 to ease the administrative burden on providers and decrease unnecessary documentation not required to achieve appropriate patient care. Effective January 1, 2023, CMS and the AMA have adopted changes to code descriptions and guidelines for codes 99221–99223, 99231–99239, 99242–99245, 99252–99255, 99281–99285, 99304–99310, 99315–99316, 99341–99345, and 99347–99350 to ease the administrative burden on providers and decrease unnecessary documentation not required to achieve appropriate patient care. These codes no longer follow the 1995 or 1997 guidelines.

Although the number of E/M codes is a relatively small percentage of the total number of CPT codes, E/M codes represent some of the most frequently reported services by physicians of all specialties and other qualified healthcare providers.

E/M services represent such a significant percentage of all billed services that every year, the Office of Inspector General (OIG) includes some evaluation and management services in the agency's annual work plan as an area of continued investigative review.

The OIG continually reviews the accuracy of E/M coding with emphasis on documentation. Documentation has always been an area of concern for the OIG. The key to making the determination of accuracy will be the medical record documentation. Although these statements link correct coding of E/M and attendant documentation, there is enough separation of these two concepts, correct coding and documentation, to illustrate an important point that documentation should support the level of service assigned but does not always dictate the correct code in terms of work performed. Any federal review will likely focus on documentation as the determinant of correct coding, but in fact the level of documentation merely supports, or does not support, the correctly assigned level of work performed.

Reimbursement for E/M services, and passing an audit of these services, ultimately depends on supporting documentation in the patient's medical chart and upon a determination that the services rendered were medically necessary. The latter aspect of medical necessity is linked to both the diagnosis code assigned and a determination of whether the documented elements are consistent with the problems addressed.

Classification of E/M Services

The levels of evaluation and management (E/M) services define the wide variations in skill, effort, time, and medical knowledge required for preventing or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent provider work—mostly cognitive work. Because much of this work revolves around the thought process, and involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code appears to be complex, but the system of coding medical visits is actually fairly simple once the requirements for code selection are learned and used.

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

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified.

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

Categories of E/M Services

Codes for E/M services are categorized by the place of service (e.g., office or hospital) or type of service (e.g., critical care, preventive medicine services). Many of the categories are further divided by the status of the medical visit (e.g., new vs. established patient or initial vs. subsequent care).

New and Established Patients

A **new patient** is defined by the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) as one who has *not* received any professional services from a provider or other qualified healthcare professional (OQHP)of the exact same specialty and subspecialty from the same group practice within the last three years. An **established patient** is defined as one who *has* received a professional service from a provider or OQHP of the exact same specialty and subspecialty from the same group practice within the last three years. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient is considered the same as if seen by the physician or OQHP who is unavailable.

Initial and Subsequent Services

An **initial** service is defined by the AMA as one who has *not* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice during an inpatient, observation, or nursing facility admission. A **subsequent** service is defined as one who *has* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice, during an inpatient, observation, or nursing facility admission. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient is considered the same as if seen by the physician or OQHP who is unavailable.

Note: Per the CY 2023 physician fee schedule (PFS) final rule, CMS is adopting these definitions with one exception: CMS does not recognize subspecialties and has left "subspecialty" out of their definitions.

Services Reported Separately

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

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified healthcare professional reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.

Changes to E/M Coding by the CPT® Editorial Panel for 2023

CPT® Editorial Panel Actions

The following changes and revisions to evaluation and management (E/M) codes are effective January 1, 2023. The Centers for Medicare & Medicaid Services (CMS) has adopted the following changes, except where noted. For additional information or to review the CY2023 physician final rule regarding E/M services, refer to:
https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf

The CPT editorial panel had four goals when it outlined and finalized changes to E/M office visits. One of these, easing administrative burden, was a shared goal with CMS. The AMA and CMS have both taken further steps to ease administrative burden, as well as other goals, such as decreasing unnecessary documentation not needed for patient care and decreasing the need for audits through changes in guidelines.

2023 Changes to Hospital Care Services, Consultations, ED Visits, Nursing Facility Services, Domiciliary and Home Services, and Prolonged Coding and Guidelines

Effective January 1, 2023, and aligning with changes adopted by the CPT Editorial Panel, CMS finalized the following changes to coding and guidelines for the following E/M codes:

- For the E/M sections (Hospital Inpatient and Observation Care Services [99221–99239], Consultations [99242–99255], Emergency Department Services [99281–99285], Nursing Facility Services [99304–99310, 99315–99316], Home or Residence Services [99341–99350]), providers choose the level of visit based solely on total time or medical decision making (MDM). (Note: Emergency department visit codes are selected based on MDM only; time is not used for code selection.)

- History and physical examination are no longer scored and used to select the level of E/M visit for these services; however, a medically appropriate history and physical examination should still be performed and documented to demonstrate patient complexity and medical necessity.
- Code descriptors have been revised as they appear in the 2023 edition of the CPT book and *Current Procedural Coding Expert*.
- The required face-to-face element has been removed; time now includes face-to-face and non-face-to-face time (e.g., reviewing test results beforehand, documenting clinical information in the medical record).
- Times included in the code descriptors have been revised and state "total time on the date of the encounter."
- The MDM table adopted by the CPT Editorial Panel in 2021 is incorporated, including additional revisions for 2023.
- The concept of MDM does not apply to 99281.
- With guideline changes to these additional sections, prolonged service code 99417 may now be reported with 99205, 99215, 99245, 99345, 99350, or 99483 for each additional 15 minutes beyond the time of the primary service.
- CMS added new add-on code 99418 for prolonged inpatient or observation care visits when time is used for code level selection, including face-to-face and non-face-to-face time of at least 15 additional minutes, to be reported in addition to 99223, 99233, 99236, 99255, 99306, or 99310.

Summary of Changes for Each Section/Subsection Listed Above

Evaluation and Management (E/M) Services Guidelines

- Deleted the "Concurrent Care and Transfer of Care" subsection
- Revised the "Levels of Medical Decision Making" table to account for code changes listed below

Inpatient and Observations Care Services

- Deleted observation codes 99217–99226
- Revised hospital inpatient services 99221–99239 to include observation care
- Revised Hospital Inpatient Services subsection including heading and guidelines

Consultations

- Deleted level one consultation codes 99241 and 99251
- Revised consultation codes 99242–99245 and 99252–99255
- Revised Consultations section including heading and guidelines
  Note: CMS does not recognize or use consultation codes.

Emergency Department (ED) Services

- Revised ED codes 99281–99285
- Revised ED subsection guidelines

Nursing Facility Services

- Deleted other nursing facility service code 99318
- Revised nursing facility codes 99304–99310
- Revised Nursing Facility Services subsection guidelines

Home and Residence Services

- Deleted Home and Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324–99340 and 99343
- Revised home services codes 99341–99342 and 99344–99350
- Deleted Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services subsection including guidelines
- Deleted Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight services subsection including guidelines
- Revised Home Services section including heading and guidelines

Prolonged Services

- Added code 99418
- Deleted prolonged service codes 99354–99357
- Revised codes 99417 and 99483
- Revised Prolonged Services section headings and/or guidelines

E/M Code Deletions and What Codes to Report — Effective January 1, 2023

Codes Deleted for 2023		Codes to Report in 2023 (Effective 1/1/23)
Hospital Inpatient and Observation Care Services		
99217	Observation care discharge day management	99238, 99239
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.	99221
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.	99222
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.	99223
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity.	99231
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity.	99232
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity.	99233
Nursing Facility Services		
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity.	99307, 99308, 99309, 99310
Home or Residence Services		
99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making.	99341

Codes Deleted for 2023		Codes to Report in 2023 (Effective 1/1/23)
Home or Residence Services (continued)		
99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity.	99342
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.	99344
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.	99344
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.	99345
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.	99347
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	99348
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.	99349
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity.	99350
Prolonged Services		
99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services)	99417
Prolonged Services (continued)		
99355	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	99417
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)	99418
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	99418
Care Plan Oversight in Rest Home [eg, assisted living facility] or Home		
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) within a calendar month; 15-29 minutes	99437, 99491,99424, 99425
99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) within a calendar month; 30 minutes or more	99437, 99491, 99424, 99425

E/M Office/Other Outpatient and Prolonged Service Coding and Guidelines

For the 2023 edition of CPT there were no changes to the codes and descriptions for the Office/Other Outpatient section codes (99202–99205, 99211–99215). The office/outpatient prolonged services code (99417) was revised.

- Providers are allowed to choose the level of visit based solely on total time or level of medical decision making (MDM).
- History and physical examination are no longer scored and used to select the level of office/outpatient E/M visit; however, a medically appropriate history and physical examination should still be performed to demonstrate patient complexity and medical necessity.
- Time now includes face-to-face and non-face-to-face time (e.g., reviewing test results beforehand, documenting clinical information in the medical record).
- MDM criteria as revised by the CPT Editorial Panel are incorporated, including the revised table for determining the appropriate level of MDM. The table replaced the CMS Table of Risk. The Editorial Panel used elements from the Table of Risk when designing the new table, which includes three main topics: the number of problems addressed, amount of data reviewed, and risk of complications and/or morbidity or mortality.
- Concept of medical decision making and time do not apply to 99211.
- Use add-on code (99417) for prolonged office visits when time is used for code level selection, including face-to-face and non-face-to-face time, and exceeds level 5 office visits (99205, 99215) by at least 15 minutes.

Established Patient Office/ Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT Code
40-54 minutes	99215
55-69 minutes	99215x1 and 99417x1
70-84 minutes	99215x1 and 99417x2
85 or more minutes	99215x1and 99417x3 or more for each additional 15 minutes

New Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT Code
60-74 minutes	99205
75-89 minutes	99205x1 and 99417x1
90-104 minutes	99205x1 and 99417x2
105 or more minutes	99205x1 and 99417x3 or more for each additional 15 minutes

- CMS no longer reimburses separately for codes 99358–99359 in association with office E/M services.

Determining the Level of E/M Service for Office or Other Outpatient Services, Hospital Inpatient and Observation Care, Consultations, Emergency Department Services, Nursing Facility, and Home or Residence Services

Per CMS and CPT guidelines, the history and examination are no longer used to select the code level for these services. These services, including a medically appropriate history and/or physical examination and the number of body systems/areas examined or reviewed as part of the history and examination, are not used for code-level selection. The history and examination are still required and should be documented, but the nature and extent of the history and/or physical examination are determined by the treating clinician based on clinical judgment and what is deemed as reasonable, necessary, and clinically appropriate.

Selecting the level of service for these E/M categories should be based on the redefined levels of MDM or total time spent by the clinician on the day of the encounter, including face-to-face and non-face-to-face activities. Keep in mind that medical necessity is still the overarching criterion for selecting a level of service in addition to the individual requirements of the E/M code.

Medical Decision Making

MDM is used to establish diagnoses, assess the status of a condition, and select a management option(s). MDM for these services is defined by three elements detailed in the redefined MDM table published in the CPT E/M guidelines. Two noteworthy changes in the redefined table are that new and established patient levels are scored the same and new and established codes require two out of three elements for any given code.

The three elements of the table look familiar but do differ slightly from the existing MDM elements.

- Number and complexity of problems addressed during the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Number and Complexity of Problems Addressed During the Encounter

The first element used in selecting these levels of E/M services is the number and complexity of problems addressed during the encounter. Several new or established problems may be addressed at the same time and may affect MDM.

Symptoms may cluster around a specific diagnosis, and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M service unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Note: The AMA defines a problem as being addressed or managed once the problem has been evaluated and/or treated at the encounter by the physician or OQHP reporting the service. This service(s) includes consideration of additional testing and/or treatment that may not be provided due to risk vs. benefit analysis or patient/guardian/parent choice. Referring a patient without evaluation or consideration of treatment does not qualify as being addressed. For hospital inpatient or observation care services, the problem being addressed or managed may be different from the reason for the admission or extended stay.

The CPT coding system now includes definitions to help select the different levels of problems listed in the MDM table.

- **Minimal problem:** A problem that may not require the presence of the physician or other qualified healthcare professional, but the service is provided under the physician's or other qualified healthcare professional's supervision (see 99211, 99281).
- **Self-limited or minor problem:** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
- **Stable, chronic illness:** A problem with an expected duration of at least one year or until the death of the patient.
- **Acute, uncomplicated illness or injury:** Recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
- **Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care:** A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is provided in a hospital inpatient or observation setting.
- **Stable, acute illness:** A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.
- **Chronic illness with exacerbation, progression, or side effects of treatment:** A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.
- **Acute illness with systemic symptoms:** An illness that causes systemic symptoms and has a high risk of morbidity without treatment.
- **Acute, complicated injury:** An injury that requires treatment that includes evaluation of body systems that are not directly part of the injured organ, extensive injuries, or the treatment options are multiple and/or associated with risk of morbidity.
- **Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

- **Acute or chronic illness or injury that poses a threat to life or bodily function:** An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment.
- **Undiagnosed new problem with uncertain prognosis:** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Level Low: Number and Complexity of Problems Addressed

Level of MDM	Number and Complexity of Problems Addressed at the Encounter
Low	**Low** • Two or more self-limited or minor problems or • One stable, chronic illness or • One acute, uncomplicated illness or injury • One stable, acute illness • One acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

Note: Each level has the same requirements for new or established patients.

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

The second element listed for determining the level of service is no longer based on counting points for each test category or specific task. Each level has the same requirements for new or established patients. The four levels for this category are consistent with the current guidelines: minimal, limited, moderate, and extensive.

This MDM element includes medical records, tests, and other information that must be obtained, reviewed, ordered, and/or analyzed for the visit, including information obtained from multiple sources or interprofessional correspondence and interpretation of tests that are not reported separately. Ordering and subsequently reviewing test results are considered part of the current encounter, not a subsequent encounter.

The CPT coding system now includes definitions of certain elements used within the data category of the MDM table to help with the interpretation of these elements.

- **Analyzed:** Each specific data element may not be subject to analysis (e.g., glucose), but it is instead included in the thought process for diagnosis, evaluation, or treatment. Tests ordered are typically analyzed when the results are reported. Consequently, when ordered during a specific encounter, tests are counted in that encounter. Tests ordered outside of an encounter may be counted in the encounter in which they are analyzed. For recurring orders, each new result may be counted in the encounter in which it is analyzed. Services for which the professional component is separately reported by the provider reporting the E/M service should not count as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.
- **Unique:** A unique test is defined by the CPT code, not section/category (e.g., laboratory, 80000 series). When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an encounter, this counts as one unique test. Test elements that overlap are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a separate group or different specialty or subspecialty, or a unique entity. Review of materials from any unique source counts as one data element toward MDM.
- **Combination of data elements:** A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed/analyzed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, a note reviewed, and an independent historian counts as three data elements.
- **Test:** Imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. Pulse oximetry is not counted toward data reviewed and analyzed.
- **External:** Records, communications, and/or test results from an external physician, other qualified healthcare professional, facility, or healthcare organization.
- **External physician or other qualified healthcare professional:** An external physician or other qualified healthcare professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home healthcare agency.
- **Discussion:** Discussion requires a direct interactive exchange. The exchange cannot be through intermediaries (e.g., clinical staff or trainees) to be counted. Sending chart notes or written exchanges that are in the medical record does not qualify as an interactive exchange. The discussion does not have to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time (e.g., within a day or two).
- **Independent historian(s):** Individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.
- **Independent interpretation:** Interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified healthcare professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.
- **Appropriate source:** Professionals who are not healthcare professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

Low Level: Amount and/or Complexity of Data Reviewed and Analyzed

Level of MDM	Amount and/or Complexity of Data to be Reviewed and Analyzed*
Low	**Limited** (Must meet the requirements of at least one of the two categories.) **Category 1: Tests and documents** • Any combination of two from the following: — review of prior external note(s) from each unique source* — review of the result(s) of each unique test* — ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

* Each unique test, order, or document contributes to the combination of two or combination of three in Category 1 below.

Note: Each level has the same requirements for new or established patients.

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

The third element listed for determining the level of service includes decisions made during the encounter associated with the patient's problems, diagnostic procedures, and treatments. This includes potential management options selected, and those considered but not selected, after shared MDM with the patient and/or family. Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

The four levels for this category are consistent with the current guidelines: minimal, low, moderate, and high. The minimal and low categories no longer include examples, and the examples for moderate and high risk have been revised.

The CPT system now includes definitions of certain elements used within the data category of the MDM table to help interpret these elements.

- **Risk:** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified healthcare professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.
- **Morbidity:** A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- **Social determinants of health:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- **Drug therapy requiring intensive monitoring for toxicity:** A drug that requires intensive monitoring and is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.
- **Surgery:** *Minor or major*—These are not defined by a surgical package classification. The classification is based on the common meaning of such terms when used by trained clinicians.
  - *Elective or emergency*—These describe the timing of a procedure when the timing is directly related to a patient's condition. Elective procedures are usually planned in advance. Emergent procedures are usually performed immediately or with minimal delay. Both types of procedures may be considered minor or major.
  - *Risk factors*—Evidence based risk calculators may be used but are not required when assessing patient/procedure risk. Risk factors are those that are relevant to the patient and procedure.

Low Level to Moderate: Risk of Complications and/or Morbidity or Mortality of Patient Management

Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
Low	**Low risk of morbidity from additional diagnostic testing or treatment**
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

Note: Each level has the same requirements for new or established patients.

2023 Medical Decision Making Table

CPT E/M Services Revisions to Level of Medical Decision Making (MDM) (Revisions effective January 1, 2023)

	Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
N/A	N/A	N/A	N/A
Straight-forward	**Minimal** • **One** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • **Two** or more self-limited or minor problems; **or** • **One** stable, chronic illness; **or** • **One** acute, uncomplicated illness or injury **or** • **One** stable, acute illness **or** • **One** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least one of the two categories)* **Category 1: Tests and documents** • Any combination of two from the following: — Review of prior external note(s) from each unique source*; — Review of the result(s) of each unique test*; — Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate	**Moderate** • **One** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **Two** or more stable, chronic illnesses; **or** • **One** undiagnosed new problem with uncertain prognosis; **or** • **One** acute illness with systemic symptoms; **or** • **One** acute, complicated injury	**Moderate** **(Must meet the requirements of at least one out of three 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 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
High	**High** • **One** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **One** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least two out of three categories)* **Category 1: Tests, documents, or independent historian(s)** • Any combination of three 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 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

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

Time as the Basis for Code Selection

Certain categories of time-based E/M codes do not have levels of services based on MDM (e.g., Critical Care Services). It is important to review the instructions for each category.

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

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services.

Effective January 1, 2023, time alone may be used to select the appropriate code level for 99202–99205, 99212–99215, 99221–99239, 99242–99255, 99304–99316, 99341–99350, 99358–99359, and 99415–99418. Time alone may be used to report these services regardless of whether counseling and/or coordination of care was provided or dominated greater than 50 percent of the encounter. These services do require a face-to-face encounter, but face-to-face and non-face-to-face time personally spent by the provider or OQHP on the date of the encounter count toward the total reported time.

The time defined in the code descriptor is used for selecting the appropriate level of service. Applicable time spent on the date of the encounter should be documented in the medical record when it is used as the basis for code selection.

Time includes time spent in activities that require the physician or OQHP and does not include time in activities normally performed by clinical staff. It includes time regardless of the location of the physician or OQHP (e.g., whether on or off the inpatient unit or in or out of the outpatient office).

The following activities may be counted toward total time on the date of the encounter:

- Preparing to see the patient
- Obtaining/reviewing a separately obtained history
- Performing a medically appropriate physical examination
- Counseling and education (patient, family, caregiver)
- Ordering tests, procedures and/or medications
- Referring and communicating with other clinicians (not reported separately)
- Documenting in the electronic or other medical record
- Independently interpreting results (not reported separately) and communicating results with the patient, family and/or caregiver
- Care coordination (not reported separately)

The following should not be counted when using time as the basis for code selection:

- Performance of services that are reported separately
- Travel
- Teaching that is general and not limited to discussion required for management of the patient

A shared or split visit occurs when a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the encounter. When time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified healthcare professional(s) evaluating and managing the patient on the date of the encounter is added together to determine total time. If two or more providers meet with or discuss the patient, only one provider should count this time toward the total time of the split/shared visit.

Quick Comparison of E/M Services

General Guidelines

- Code selection is based on MDM or total time, including face-to-face and non-face-to-face time spent on the date of the encounter.
- History and physical examination elements are not required for code level selection for office and other outpatient services. However, a medically appropriate history and/or physical examination should still be documented. The nature and degree of the history and/or physical examination is determined by the treating physician or other qualified healthcare professional reporting the service.
- Clinical staff may collect information pertaining to the history and exam and the patient and/or caregiver may provide information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting provider.
- Total time for these services includes total face-to-face and non-face-to-face time personally spent by the physician or other qualified healthcare professional on the day of the encounter.
- Physician or other qualified healthcare professional time may include the following activities:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other healthcare professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)
- Comorbidities or other underlying conditions should not be considered when selecting the level of service unless they are addressed during the encounter and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality.
- Do not include the time spent by any other staff (e.g.,nurse, nurse practitioner or physician assistant) toward the time thresholds. Face-to-face and non-face-to-face time is the time the treating provider spent on the date of the encounter.

Office and Other Outpatient Services—New Patient 99202–99205

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99202	Straightforward	Medically appropriate	Medically appropriate	15–29 min.
99203	Low	Medically appropriate	Medically appropriate	30–44 min.
99204	Moderate	Medically appropriate	Medically appropriate	45–59 min.
99205	High	Medically appropriate	Medically appropriate	60–74 min.

Office and Other Outpatient Services—Established Patient (99211–99215)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99211	Does not apply	N/A	N/A	N/A
99212	Straightforward	Medically appropriate	Medically appropriate	10–19 min.
99213	Low	Medically appropriate	Medically appropriate	20–29 min.
99214	Moderate	Medically appropriate	Medically appropriate	30–39 min.
99215	High	Medically appropriate	Medically appropriate	40–54 min.

Initial Hospital Inpatient or Observation Care (99221–99223)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99221	Straightforward or low	Medically appropriate	Medically appropriate	40 min.
99222	Moderate	Medically appropriate	Medically appropriate	55 min.
99223	High	Medically appropriate	Medically appropriate	75 min.

Subsequent Hospital Inpatient or Observation Care and Hospital Discharge Services (99231–99239)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99231	Straightforward or low complexity	Medically appropriate	Medically appropriate	25 min.
99232	Moderate complexity	Medically appropriate	Medically appropriate	35 min.
99233	High complexity	Medically appropriate	Medically appropriate	50 min.
99234	Straightforward or low complexity	Medically appropriate	Medically appropriate	45 min.
99235	Moderate complexity	Medically appropriate	Medically appropriate	70 min.
99236	High complexity	Medically appropriate	Medically appropriate	85 min.
99238[2]	Hospital inpatient or observation discharge day management			30 minutes or less [2]
99239[2]	Hospital inpatient or observation discharge day management			more than 30 minutes [2]

1 All subsequent levels of service include reviewing the medical record, diagnostic studies and changes in patient's status, such as history, physical condition and response to treatment since last assessment.

2 These codes are not based on the three key elements of patient history, physical examination, and level of medical decision making. These codes are correctly assigned based on time, as the CPT code description indicates.

Consultations: Office or Other Outpatient (99242–99245)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99242	Straightforward	Medically appropriate	Medically appropriate	20 min.
99243	Low complexity	Medically appropriate	Medically appropriate	30 min.
99244	Moderate complexity	Medically appropriate	Medically appropriate	40 min.
99245	High complexity	Medically appropriate	Medically appropriate	55 min.

Consultations: Inpatient or Observation (99252–99255)

E/M Code[1]	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99252	Straightforward	Medically appropriate	Medically appropriate	35 min.
99253	Low complexity	Medically appropriate	Medically appropriate	45 min.
99254	Moderate complexity	Medically appropriate	Medically appropriate	60 min.
99255	High complexity	Medically appropriate	Medically appropriate	80 min.

1 These codes are used for hospital inpatients, observation-level services, residents of nursing facilities or patients in a partial hospital setting.

Emergency Department Visits (99281–99288)

E/M Code	Medical Decision Making	History	Exam	Time Spent Face to Face (avg.)[1]
99281	May not require the presence of a physician	Medically appropriate	Medically appropriate	N/A
99282	Straightforward complexity	Medically appropriate	Medically appropriate	N/A
99283	Low complexity	Medically appropriate	Medically appropriate	N/A
99284	Moderate complexity	Medically appropriate	Medically appropriate	N/A
99285	High complexity			N/A
99288[2]	Physician direction of EMS			N/A

1 Time is not a component for selecting emergency department levels.
2 Code 99288 is used to report two-way communication with emergency medical services personnel in the field.

Critical Care Visits (99291–99292)

E/M Code	Patient Status	Physician Attendance	Time
99291[1]	Critically ill or critically injured	Constant	First 30–74 min.
99292[2]	Critically ill or critically injured	Constant	Each additional 30 minutes beyond the first 74 minutes

1 Under outpatient prospective payment rules, only 99291 is submitted for critical care services in a hospital setting.
2 Under outpatient prospective payment rules, 99292 is not an appropriate code for hospital outpatient use.

Nursing Facility Visits, Initial (99304–99306)

E/M Code	Medical Decision Makin	History	Exam	Time Spent on Date of Encounter
99304	Straightforward or low complexity	Medically appropriate	Medically appropriate	25 min.
99305	Moderate complexity	Medically appropriate	Medically appropriate	35 min.
99306	High complexity	Medically appropriate	Medically appropriate	45 min.

Nursing Facility Visits, Subsequent and Discharge (99307–99316)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99307	Straightforward	Medically appropriate	Medically appropriate	10 min.
99308	Low complexity	Medically appropriate	Medically appropriate	15 min.
99309	Moderate complexity	Medically appropriate	Medically appropriate	30 min.
99310	High complexity	Medically appropriate	Medically appropriate	45 min.
99315	Nursing facility discharge day management			30 minutes or less
99316	Nursing facility discharge day management			More than 30 minutes

Home or Residence Visits, New Patient (99341–99345)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99341	Straightforward complexity	Medically appropriate	Medically appropriate	15 min.
99342	Low complexity	Medically appropriate	Medically appropriate	30 min.
99344	Moderate complexity	Medically appropriate	Medically appropriate	60 min.
99345	High complexity	Medically appropriate	Medically appropriate	75 min.

Home or Residence Visits, Established Patient (99347–99350)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99347	Straightforward complexity	Medically appropriate	Medically appropriate	20 min.
99348	Low complexity	Medically appropriate	Medically appropriate	30 min.
99349	Moderate complexity	Medically appropriate	Medically appropriate	40 min.
99350	High complexity	Medically appropriate	Medically appropriate	60 min.

Prolonged Service on Date Other Than Face-to-Face Evaluation and Management Service Without Direct Patient Contact (99358–99359)

E/M Code	Office or Outpatient Facility	Inpatient Facility	Time Spent Before/After Direct Patient Care
99358	Yes	Yes	First 30–74 min.
99359	Yes	Yes	Each additional 30 min.

Prolonged Clinical Staff Services Under Supervision (99415–99416)

E/M Code	Office or Outpatient Facility	Inpatient Facility	Time Spent Face to Face (avg.)
99415	Yes	No	First 45–74 min.
99416	Yes	No	Each additional 30 min.

Prolonged Service With or Without Direct Patient Contact on Date of Evaluation and Management Service (99417, 99418)

E/M Code	Office or Other Outpatient Facility	Inpatient or Observation Setting	Time Spent With and/or Without Patient Contact (Avg.)
99417	Yes	No	Each additional 15 min.
99418	No	Yes	Each additional 15 min.

Standby Services (99360)

E/M Code	Intent of Service	Face-to-Face Visits	Time Spent on Standby
99360	Standby services are provided by a clinician at the request of another clinician and include prolonged attendance without face-to-face contact with the patient (i.e., operative high-risk delivery standby, EEG monitoring)	No	Each 30 min.

Interdisciplinary Conferences (99366–99368)

E/M Code	Intent of Service	Provider	Presence of Patient	Time
99366	To plan and coordinate	Nonphysician member of interdisciplinary team	Patient and/or family present	30 min.
99367	To plan and coordinate	Physician member of interdisciplinary team	Patient and/or family not present	30 min.
99368	To plan and coordinate	Nonphysician member of interdisciplinary team	Patient and/or family not present	30 min.

Care Plan Oversight: Patient Under Care of HHA, Hospice, or Nursing Facility (99374–99380)

E/M Code	Intent of Service	Place of Service	Under Care of	Presence of Patient	Time
99374	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	In home, a domiciliary or equivalent environment (e.g., Alzheimer's facility)	Home health agency	Patient not present	15–29 min.
99375	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	In home, a domiciliary or equivalent environment (e.g., Alzheimer's facility)	Home health agency	Patient not present	30 min. or more
99377	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	Hospice	Hospice	Patient not present	15–29 min.
99378	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	Hospice	Hospice	Patient not present	30 min. or more
99379	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	Nursing facility	Nursing facility	Patient not present	15–29 min.
99380	Supervision of a patient requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professionals, family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	Nursing facility	Nursing facility	Patient not present	30 min. or more

Preventive Medicine Visits: New Patient (99381–99387)

E/M Code	Patient Status	Age	History	Exam	Medical Decision Making[1]
99381	No complaints	Under 1 year	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99382	No complaints	1–4 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99383	No complaints	5–11 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99384	No complaints	12–17 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99385	No complaints	18–39 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99386	No complaints	40–64 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99387	No complaints	65 and over	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures

1 Includes age appropriate immunizations, laboratory/diagnostic procedures and age appropriate counseling/anticipatory guidance and risk factor reduction intervention(s).

Preventive Medicine Visits: Established Patient (99391–99397)

E/M Code	Patient Status	Age	History	Exam	Medical Decision Making[1]
99391	No complaints	Under 1 year	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99392	No complaints	1–4 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99393	No complaints	5–11 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99394	No complaints	12–17 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99395	No complaints	18–39 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/di agnostic procedures
99396	No complaints	40–64 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99397	No complaints	65 and over	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures

1 Includes age appropriate immunizations, laboratory/diagnostic procedures, and age appropriate counseling/anticipatory guidance and risk factor reduction intervention(s).

Preventive Medicine Visits: Counseling and/or Risk Factor Reduction Intervention (99401–99429)

E/M Code	Patient Status	Intent of Service	Time
Individual Counseling			
99401	No complaints	Promote health, prevent illness or injury	15 min.
99402	No complaints	Promote health, prevent illness or injury	30 min.
99403	No complaints	Promote health, prevent illness or injury	45 min.
99404	No complaints	Promote health, prevent illness or injury	60 min.
Behavior Change Interventions, Individual			
99406	Smoking or tobacco history	Promote health, smoking or tobacco cessation counseling	3–10 min.
99407	Smoking or tobacco history	Promote health, smoking or tobacco cessation counseling	> 10 min.
99408	Alcohol or substance screening	Promote health, alcohol or substance abuse screening with brief intervention	15–30 min.
99409	Alcohol or substance screening	Promote health, alcohol or substance abuse screening with brief intervention	> 30 min.
Group Counseling			
99411	No complaints	Promote health	30 min.
99412	No complaints	Promote health	60 min.
Other Preventive Medicine Services			
99429		Unlisted preventive medicine service	

Telephone Calls for Patient Management (99441–99443)

E/M Code	Intent of Service	Type of Communication	Time
99441	E/M service at the request of established patient or care giver	Telephone	5–10 min
99442	E/M service at the request of established patient or care giver	Telephone	11–20 min.
99443	E/M service at the request of established patient or care giver	Telephone	21–30 min.

Digital Evaluation and Management Services (99421–99423)

E/M Code	Intent of Service	Type of Communication	Time
99421	Online E/M service at the request of established patient	Online digital	5–10 min.
99422	Online E/M service at the request of established patient	Online digital	11–20 min.
99423	Online E/M service at the request of established patient	Online digital	At least 21 min.

Online and Telephone Consultative Services (99446–99452)

E/M Code	Intent of Service	Time Spent
99446	Consultation, including verbal and written report, at the request of another provider via the telephone, internet, or EHR	5–10 min
99447	Consultation, including verbal and written report, at the request of another provider via the telephone, internet, or EHR	11–20 min.
99448	Consultation, including verbal and written report, at the request of another provider via the telephone, internet, or EHR	21–30 min.
99449	Consultation, including verbal and written report, at the request of another provider via the telephone, internet, or EHR	31 min. or more
99451	Consultation, including written report, at the request of another provider via the telephone, internet, or EHR	5 min. or more
99452	Interprofessional telephone, internet, or electronic health record referral services provided by a requesting or treating provider	30 min.

Remote Monitoring/Collection Biological Data (99453–99454, 99091, 99473–99474, 99457–99458)

E/M Code	Intent of Service	Face-to-Face Visit	Time Spent
99453	Setup and patient education on the use of remote monitoring equipment used by the patient that collects, monitors, and reports health-related data (e.g., weight, blood pressure, pulse oximetry) to the provider	No	N/A
99454	Daily recordings or program alert transmissions via the remote monitoring device, for each 30-day period	No	N/A
99091	Collection and interpretation of health-related data gathered via a remote patient monitoring system used to manage physiologic data (e.g., blood pressure, glucose), including education and training	No	At least 30 min.
99473	Patient education/training and device calibration for the patient to self-measure their blood pressure	Yes	N/A
99474	Collection of data reported to the provider of average systolic and diastolic pressures over a 30-day period (minimum of 12 readings) with subsequent treatment plan provided to the patient	No	N/A
99457	Remote patient monitoring by the provider/clinical staff utilizing data from an FDA-defined remote monitoring system to oversee the patient's treatment plan	No. Does require interactive communication with the patient	At least 20 min.
99458	Remote patient monitoring by the provider/clinical staff utilizing data from an FDA-defined remote monitoring system to oversee the patient's treatment plan	No. Does require interactive communication with the patient	Each additional 20 min.

Life/Disability Insurance Eligibility Visits (99450–99456)

E/M Code	Intent of Service	Specific Data Provided
99450	Evaluation of patient prior to or after issuance of basic life policy or for determination of disability	Vital statistics, including blood pressure, height, weight Medical history completed as identified on life insurance pro forma Urine and blood samples collected and "chain of custody" protocols Complete documentation and certificates according to requester
99455	Evaluation of patient by treating physician for work related or medical disability examination	Medical history, including record review, completed as appropriate with patient condition. Examination appropriate to the patient condition and disability(ies) Identification of the diagnosis Assessment of patient stability, capabilities, and impairment calculation according to accepted guidelines (state or AMA impairment guidelines) Future treatment identified or developed Complete documentation, certificates and reports according to requester specifics
99456	Evaluation of patient by non treating physician for work-related or medical disability examination	Medical history, including record, review, completed as appropriate with patient condition Examination appropriate to the patient condition and disability(ies) Identification of the diagnosis Assessment of patient stability, capabilities, and impairment calculation according to accepted guidelines (state or AMA impairment guidelines) Future treatment identified or developed Complete documentation, certificates, and reports according to requester specifics

Evaluation and Management Services for Age 28 Days or Less and Newborn Delivery Attendance/Resuscitation (99460–99465)

E/M Code	Patient Status	Site of Care	Intent of Service
99460	Normal newborn	Hospital or birthing room	Perform history and physical exam; initiate diagnostic and treatment programs; prepare records
99461	Normal newborn	Other than hospital or birthing room	Perform physical examination; confer with parents
99462	Normal newborn	Hospital	Provide E/M subsequent care service per day
99463	Normal newborn	Hospital or birthing room	Perform history and exam; prepare medical records. Use this code for newborns assessed and discharged on the same date
99464	Unstable newborn	Hospital or birthing room	Initial stabilization of newborn when requested by delivering physician
99465	High-risk newborn at delivery	Hospital or birthing room	Provide inhalation therapy, aspirate, administer medication for stabilization

Critical Care Transport Age 24 Months or Younger (99466–99467 and 99485–99486)

E/M Code	Patient Status	Site of Care	Intent of Service
99466	Critically ill or critically injured, under 24 months	Constant during transport	First 30–74 min.
99467	Critically ill or critically injured, under 24 months	Constant during transport	Each additional 30 minutes beyond the first 74 min.
99485	Critically ill or critically injured, under 24 months	Two-way communication	First 16–45 min.
99486	Critically ill or critically injured, under 24 months	Two-way communication	Each additional 30 min.

Critical Care Age 5 Years and Younger (99468–99476)

E/M Code	Patient Status	Type of Visit
99468	Critically ill neonate, aged 28 days or less	Initial inpatient
99469	Critically ill neonate, aged 28 days or less	Subsequent inpatient
99471	Critically ill infant or young child, aged 29 days to 24 months	Initial inpatient
99472	Critically ill infant or young child, aged 29 days to 24 months	Subsequent inpatient
99475	Critically ill infant or young child, two to five years	Initial inpatient
99476	Critically ill infant or young child, two to five years	Subsequent inpatient

Initial and Subsequent Inpatient Neonatal intensive Care Services (99477–99480)

E/M Code	Patient Status	Type of Visit
99477	Neonate, aged 28 days or less	Initial inpatient care for the neonate requiring intensive observation, frequent interventions, and other intensive care services who is not critically ill
99478	Infant with present body weight of less than 1500 grams, no longer critically ill	Subsequent inpatient
99479	Infant with present body weight of 1500-2500 grams, no longer critically ill	Subsequent inpatient
99480	Infant with present body weight of 2501-5000 grams, no longer critically ill	Subsequent inpatient

Cognitive Impairment Services (99483)

E/M Code	Intent of Service	Face-to-Face Visit	Time Spent
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with several required elements	Patient and/or family/caregiver	60 min. on average

Chronic/Complex Chronic/Principal Care Management Services (99490, 99439, 99491, 99437, 99487, 99489, 99424–99427)

E/M Code	Intent of Service	Face-to-Face Visit	Time Spent
99490	Chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month	No	20 min.
99439	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month	No	Each additional 20 min.
99491	Chronic care management services, first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	No	30 min.
99437	Chronic care management services, each additional 30 minutes by a physician or other qualified health care professional, per calendar month	No	Each additional 30 min.
99487	Complex chronic care management services directed by a physician or other qualified healthcare professional, per calendar month	No	60–89 min.
99489	Complex chronic care management services directed by a physician or other qualified healthcare professional, per calendar month	n/a	Each additional 30 min.
99424	Principal care management services, for a single high-risk disease, first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	No	30 min.
99425	Principal care management services, for a single high-risk disease, each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	No	Each additional 30 min.
99426	Principal care management services, for a single high-risk disease, first 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	No	30 min.
99427	Principal care management services, for a single high-risk disease, each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	No	Each additional 30 min.

Psychiatric Collaborative Care/Behavioral Health Integration (99492–99494, 99484)

E/M Code	Intent of Service	Face-to-Face Visit	Time Spent
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating provider	No	36–85 min.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating provider	No	31–75 min.
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating provider	N/A	Each additional 30 min.
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified healthcare professional, per calendar month	Face-to-face or non-face-to-face	A minimum of 20 min.

Management of Transitional Care Services (99495–99496)

E/M Code	Medical Decision Making	Intent of Service	Patient Presence	Medical Decision Making	Face-to-Face Visit Within 7 Days	Face-to-Face Visit Within 8 to 14 Days
99495	Moderate complexity	Transitional care management services with these required elements: communication (direct contact, telephone, electronic), within 2 business days of discharge	Patient or caregiver present	Moderate complexity	99495	99495
99496	High complexity	Transitional care management services with these required elements: communication (direct contact, telephone, electronic), within 2 business days of discharge	Patient or caregiver present	High complexity	99496	99495

Advance Directive Guidance (99497–99498)

E/M Code	Intent of Service	Face-to-Face Visit	Time Spent
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional	Yes	Initial 30 min.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional	Yes	Each additional 30 min.