AMA
AMERICAN MEDICAL ASSOCIATION

cpt® 2021

PROFESSIONAL EDITION

The only official CPT® codebook with rules and guidelines from the AMA's CPT Editorial Panel.

Symbols

- ▲ Revised code
- ● New code
- ▶◀ New or revised text
- ➲ Reference to *CPT Assistant, Clinical Examples in Radiology,* and *CPT Changes*
- + Add-on code
- ⊘ Exemptions to modifier 51
- ⚡ Product pending FDA approval
- # Out-of-numerical sequence code
- ★ Telemedicine
- ⚹ Duplicate PLA test
- ⇅ Category I PLA

Modifiers (See Appendix A for definitions)

- **22** Increased Procedural Services
- **23** Unusual Anesthesia
- **24** Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
- **25** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- **26** Professional Component
- **32** Mandated Services
- **33** Preventive Services
- **47** Anesthesia by Surgeon
- **50** Bilateral Procedure
- **51** Multiple Procedures
- **52** Reduced Services
- **53** Discontinued Procedure
- **54** Surgical Care Only
- **55** Postoperative Management Only
- **56** Preoperative Management Only
- **57** Decision for Surgery
- **58** Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **59** Distinct Procedural Service
- **62** Two Surgeons
- **63** Procedure Performed on Infants less than 4 kg
- **66** Surgical Team
- **76** Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- **77** Repeat Procedure by Another Physician or Other Qualified Health Care Professional
- **78** Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
- **79** Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **80** Assistant Surgeon
- **81** Minimum Assistant Surgeon
- **82** Assistant Surgeon (when qualified resident surgeon not available)
- **90** Reference (Outside) Laboratory
- **91** Repeat Clinical Diagnostic Laboratory Test
- **92** Alternative Laboratory Platform Testing
- **95** Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System
- **96** Habilitative Services
- **97** Rehabilitative Services
- **99** Multiple Modifiers

Category II Modifiers

- **1P** Performance Measure Exclusion Modifier due to Medical Reasons
- **2P** Performance Measure Exclusion Modifier due to Patient Reasons
- **3P** Performance Measure Exclusion Modifier due to System Reasons
- **8P** Performance measure reporting modifier–action not performed, reason not otherwise specified

Anesthesia Physical Status Modifiers

- **P1** A normal healthy patient
- **P2** A patient with mild systemic disease
- **P3** A patient with severe systemic disease
- **P4** A patient with severe systemic disease that is a constant threat to life
- **P5** A moribund patient who is not expected to survive without the operation
- **P6** A declared brain-dead patient whose organs are being removed for donor purposes

Modifiers Approved for Hospital Outpatient Use

Level I (CPT)

- **25** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- **27** Multiple Outpatient Hospital E/M Encounters on the Same Date
- **33** Preventive Services
- **50** Bilateral Procedure
- **52** Reduced Services
- **58** Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **59** Distinct Procedural Service
- **73** Discontinued Outpatient Procedure Prior to Anesthesia Administration
- **74** Discontinued Outpatient Procedure After Anesthesia Administration
- **76** Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- **77** Repeat Procedure by Another Physician or Other Qualified Health Care Professional
- **78** Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
- **79** Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **91** Repeat Clinical Diagnostic Laboratory Test

Level II (HCPCS/National)

- **LT** Left side (used to identify procedures performed on the left side of the body)
- **RT** Right side (used to identify procedures performed on the right side of the body)
- **E1** Upper left, eyelid
- **E2** Lower left, eyelid
- **E3** Upper right, eyelid
- **E4** Lower right, eyelid
- **FA** Left hand, thumb
- **F1** Left hand, second digit
- **F2** Left hand, third digit
- **F3** Left hand, fourth digit
- **F4** Left hand, fifth digit
- **F5** Right hand, thumb
- **F6** Right hand, second digit
- **F7** Right hand, third digit
- **F8** Right hand, fourth digit
- **F9** Right hand, fifth digit
- **GG** Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- **GH** Diagnostic mammogram converted from screening mammogram on same day
- **LC** Left circumflex coronary artery
- **LD** Left anterior descending coronary artery
- **LM** Left main coronary artery
- **QM** Ambulance service provided under arrangement by a provider of services
- **QN** Ambulance service furnished directly by a provider of services
- **RC** Right coronary artery
- **RI** Ramus intermedius coronary artery
- **TA** Left foot, great toe
- **T1** Left foot, second digit
- **T2** Left foot, third digit
- **T3** Left foot, fourth digit
- **T4** Left foot, fifth digit
- **T5** Right foot, great toe
- **T6** Right foot, second digit
- **T7** Right foot, third digit
- **T8** Right foot, fourth digit
- **T9** Right foot, fifth digit

Place-of-Service Codes for Professional Claims

Listed below are place-of-service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (eg, Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective 10/1/03)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective 1/1/17)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg, emergency shelters, individual or family shelters).
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective 10/1/03)
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration). (Effective 10/1/03)
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective 1/1/08)
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (Effective 5/1/10)
18	Place of Employment—Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013.)
19	Off Campus—Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective 1/1/03)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus—Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A

31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility—Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective 10/1/03)
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

current procedural terminology

cpt® 2021

Professional Edition

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AMERICAN MEDICAL ASSOCIATION

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About CPT

Current Procedural Terminology (CPT®), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians and other qualified health care professionals, patients, and third parties. CPT 2021 is the most recent revision of a work that first appeared in 1966.

CPT descriptive terms and identifying codes currently serve a wide variety of important functions in the field of medical nomenclature. The CPT code set is useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review. The uniform language is also applicable to medical education and outcomes, health services, and quality research by providing a useful basis for local, regional, and national utilization comparisons. The CPT code set is the most widely accepted nomenclature for the reporting of physician and other qualified health care professional procedures and services under government and private health insurance programs. In 2000, the CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA). This means that for all financial and administrative health care transactions sent electronically, the CPT code set will need to be used.

The changes that appear in this revision have been prepared by the CPT Editorial Panel with the assistance of physicians and representatives of other health care professions representing all specialties of medicine, and with important contributions from many third-party payers and governmental agencies.

The American Medical Association trusts that this revision will continue the usefulness of its predecessors in identifying, describing, and coding medical, surgical, and diagnostic services.

Maintenance and Authorship of the CPT Code Set

The CPT Editorial Panel (Panel) is tasked with ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients. In order to do this, the Panel maintains an open process and convenes meetings at a minimum three times per year.

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Also key to authorship of the code set and resulting *CPT Professional Edition* codebook is AMA CPT staff. This experienced team prepares agenda materials for each panel meeting, facilitates the application process, compiles and reviews advisor comments, reconciles differences in opinions, and ultimately compiles all resulting information into a codebook filled with informative guidelines, practical tips, and procedural illustrations.

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Contents

Introduction

Current Procedural Terminology (CPT®), Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services. In the CPT code set, the term "procedure" is used to describe services, including diagnostic tests.

Inclusion of a descriptor and its associated five-digit code number in the CPT Category I code set is based on whether the procedure or service is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT code set of a procedure or service, or proprietary name, does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure or service or proprietary test or manufacturer. Inclusion or exclusion of a procedure or service, or proprietary name, does not imply any health insurance coverage or reimbursement policy.

►The main body of the Category I section is listed in six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with one exception—the entire **Evaluation and Management** section (99202-99499) appears at the beginning of the listed procedures. These items are used by most physicians in reporting a significant portion of their services.◄

►Release of CPT Codes◄

►The CPT code set is published annually in late summer or early fall as both electronic data files and books. The release of CPT data files occurs annually on or around August 31. The release of the CPT Professional publication comes several weeks later. However, to meet the needs of a rapidly changing health care environment, the CPT code set is periodically updated throughout the year on a set schedule. Each update has both a release date and an effective date. The interval between the release of the update and the effective date is considered an implementation period and is intended to allow physicians and other providers, payers, and vendors to incorporate CPT changes into their systems. Changes to the CPT code set are meant to be applied prospectively from the effective date. The following table outlines the complete CPT code set update calendar.

New CPT codes have been created to streamline services related to the novel coronavirus. It is imperative to check the AMA CPT public website at https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance throughout the year to obtain the necessary frequent updates to the CPT code set.◄

►CPT Code Set Update Calendar◄

►CPT Category/Section	Release Timeline	Effective Timeline
Category I Category II	August 31	January 1
Category III	January 1	July 1
Immune Globulins, Serum, or Recombinant Products Vaccines, Toxoids	July 1	January 1
Molecular Pathology Tier 2	April 1	July 1
Administrative MAAA	July 1	October 1
	October 1*	January 1
PLA	January 1	April 1
	April 1	July 1
	July 1	October 1
	October 1	January 1

*Note that the release date may be delayed by several days due to the timing of the CPT Panel fall meeting.◄

►It is imperative to check the AMA CPT public website throughout the year to obtain the necessary updates to the CPT code set. The following are several links on the AMA CPT website where these updates can be found:

- Category III codes: ama-assn.org/cpt-cat-iii-codes
- Immune globulins, serum, or recombinant products and vaccines, toxoids: ama-assn.org/cpt-cat-i-vaccine-codes
- Proprietrary Laboratory Analyses (PLA) codes: ama-assn.org/cpt-pla-codes
- Administrative MAAA codes: ama-assn.org/maaa-code
- Molecular pathology tier 2 codes: ama-assn.org/mo-path-tier-2-codes
- General errata and technical correction updates: ama-assn.org/practice-management/cpt/errata-technical-corrections◄

Section Numbers and Their Sequences

Evaluation and Management. 99202-99499

Anesthesiology. 00100-01999, 99100-99140

Surgery. 10004-69990

Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) 70010-79999

Pathology and Laboratory. 80047-89398, 0001U-0222U

Medicine (except Anesthesiology) 90281-99199, 99500-99607

The first and last code numbers and the subsection name of the items appear at the top margin of most pages (eg,

"10140-11006 Surgery/Integumentary System"). The continuous pagination of the CPT codebook is found on the lower margin of each page along with explanation of any code symbols that are found on that page.

Instructions for Use of the CPT Codebook

Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph. Other additional procedures performed or pertinent special services are also listed. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs Medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as "surgery" or "not surgery" for insurance or other purposes. The placement of a given service in a specific section of the book may reflect historical or other considerations (eg, placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).

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

Throughout the CPT code set the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

Instructions, typically included as parenthetical notes with selected codes, indicate that a code should not be reported with another code or codes. These instructions are intended to prevent errors of significant probability and are not all inclusive. For example, the code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed. These instructions are not intended as a listing of all possible code combinations that should not be reported, nor do they indicate all possible code combinations that are appropriately reported. When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (ie, *Clinical Examples in Radiology*).

Format of the Terminology

The CPT code set has been developed as stand-alone descriptions of medical procedures. However, some of the procedures in the CPT codebook are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry. This is evident when an entry is followed by one or more indentations. This is done in an effort to conserve space.

Example

25100 Arthrotomy, wrist joint; with biopsy

25105 with synovectomy

Note that the common part of code 25100 (the part before the semicolon) should also be considered part of code 25105. Therefore, the full procedure represented by code 25105 should read:

25105 Arthrotomy, wrist joint; with synovectomy

Requests to Update the CPT Nomenclature

The effectiveness of the CPT nomenclature depends on constant updating to reflect changes in medical practice. This can only be accomplished through the interest and timely suggestions of practicing physicians and other qualified health care professionals, specialty/professional societies, state medical associations, organizations, agencies, individual users of the CPT code set, and other stakeholders. Accordingly, the AMA welcomes correspondence, inquiries, and suggestions concerning CPT coding and nomenclature for old and new procedures and services, as well as any matters relating to the CPT code set.

For information on submission of an application to add, delete, or revise codes contained in the CPT code set, please see www.ama-assn.org/go/cpt-processfaq or contact:

CPT Editorial Research & Development
American Medical Association
330 North Wabash Avenue
Suite 39300
Chicago IL 60611-5885

Code change applications are available at the AMA's CPT website at https://www.ama-assn.org/practice-management/cpt/cpt-code-change-applications.

All proposed changes to the CPT code set will be considered by the CPT Editorial Panel, in consultation with medical specialty societies as represented by the CPT Advisory Committee, other health care professional societies as represented by the Health Care Professionals Advisory Committee (HCPAC), and other interested parties.

Application Submission Requirements

All complete CPT code change applications are reviewed and evaluated by the CPT staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Strict conformance with the following is required for review of a code change application:

- Submission of a complete application, including all necessary supporting documents;
- Adherence to all posted deadlines;
- Cooperation with requests from the CPT staff and/or Editorial Panel members for clarification and information; ***and***
- Compliance with CPT Lobbying Policy.

General Criteria for Category I, II, and III Codes

All Category I, II, and III code change applications must satisfy each of the following criteria:

- The proposed descriptor is unique, well-defined, and describes a procedure or service that is clearly identified and distinguished from existing procedures and services already in the CPT code set;
- The descriptor structure, guidelines, and instructions are consistent with the current CPT Editorial Panel standards for maintenance of the code set;
- The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes;
- The structure and content of the proposed code descriptor accurately reflects the procedure or service as typically performed. If always or frequently performed with one or more other procedures or services, the descriptor structure and content will reflect the typical combination or complete procedure or service;
- The descriptor for the procedure or service is not proposed as a means to report extraordinary circumstances related to the performance of a procedure or service already described in the CPT code set; ***and***
- The procedure or service satisfies the category-specific criteria set forth below.

Category-Specific Requirements

Category I Criteria

A proposal for a new or revised Category I code must satisfy all of the following criteria:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service;
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States;
- The procedure or service is performed with frequency consistent with the intended clinical use (ie, a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume);
- The procedure or service is consistent with current medical practice; and
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

Category II Criteria

The following criteria are used by the CPT/HCPAC and the CPT Editorial Panel for evaluating Category II code applications:

- Measurements that were developed and tested by a national organization;
- Evidence-based measurements with established ties to health outcomes;
- Measurements that address clinical conditions of high prevalence, high risk, or high cost; and
- Well-established measurements that are currently being used by large segments of the health care industry across the country.

In addition, all of the following are required:

- Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement)
- Aspect of care measured is substantially influenced by the physician (or other qualified health care professional or entity for which the code may be relevant)
- Reduces data collection burden on physicians (or other qualified health care professionals or entities)
- Significant
  - o Affects a large segment of health care community
  - o Tied to health outcomes
  - o Addresses clinical conditions of high prevalence, high costs, high risks
- Evidence-based
  - o Agreed upon
  - o Definable
  - o Measurable
- Risk-adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant
- Sufficiently detailed to make it useful for multiple purposes
- Facilitates reporting of performance measure(s)
- Inclusion of select patient history, testing (eg, glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (eg, blood pressure) to support performance measurements
- Performance measure–development process that includes
  - o Nationally recognized expert panel

- o Multidisciplinary
- o Vetting process

Category III Criteria

The following **criteria** are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Category III code **applications**:

- The procedure or service is currently or recently performed in humans; ***and***

At least one of the following additional criteria has been met:

- The application is supported by at least one CPT or HCPAC advisor representing practitioners who would use this procedure or service; ***or***
- The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature, which is available in English for examination by the CPT Editorial Panel; ***or***
- There is (a) at least one Institutional Review Board–approved protocol of a study of the procedure or service being performed; (b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service; or (c) other evidence of evolving clinical utilization.

Guidelines

Specific guidelines are presented at the beginning of each of the sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the **Medicine** section, specific instructions are provided for handling unlisted services or procedures, special reports, and supplies and materials provided. Guidelines also provide explanations regarding terms that apply only to a particular section. For instance, **Radiology Guidelines** provide a definition of the unique term, "radiological supervision and interpretation." While in **Anesthesia**, a discussion of reporting time is included.

A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. Please see the guidelines regarding Imaging Guidance in each individual section.

Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the **+** symbol and they are listed in **Appendix D** of the CPT codebook. Add-on codes in CPT 2021 can be readily identified by specific descriptor nomenclature that includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

The add-on code concept in CPT 2021 applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, eg, additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. When the add-on procedure can be reported bilaterally and is performed bilaterally, the appropriate add-on code is reported twice, unless the code descriptor, guidelines, or parenthetical instructions for that particular add-on code instructs otherwise. Do not report modifier 50, *Bilateral procedures,* in conjunction with add-on codes. All add-on codes in the CPT code set are exempt from the multiple procedure concept. See the definitions of modifier 50 and 51 in **Appendix A**.

Modifiers

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure had both a professional and technical component.
- A service or procedure was performed by more than one physician or other health care professional and/or in more than one location.
- A service or procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

Example

A physician providing diagnostic or therapeutic radiology services, ultrasound, or nuclear medicine services in a hospital would add modifier 26 to report the professional component.

73090 with modifier 26 = Professional component only for an X ray of the forearm

Example

Two surgeons may be required to manage a specific surgical problem. When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. Modifier 62 would be applicable. For instance, a neurological surgeon and an otolaryngologist are working as co-surgeons in performing transphenoidal excision of a pituitary neoplasm.

The first surgeon would report:

61548 62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

and the second surgeon would report:

61548 62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. It should be noted that if a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate. A complete listing of modifiers is found in **Appendix A**.

Place of Service and Facility Reporting

Some codes have specified places of service (eg, evaluation and management codes are specific to a setting). Other services and procedures may have instructions specific to the place of service (eg, therapeutic, prophylactic, and diagnostic injections and infusions). The CPT code set is designated for reporting physician and other qualified health care professional services. It is also the designated code set for reporting services provided by organizations or facilities (eg, hospitals) in specific circumstances. Throughout the CPT code set, the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency). The CPT code set uses the term "facility" to describe such providers and the term "nonfacility" to describe services settings or circumstances in which no facility reporting may occur. Services provided in the home by an agency are facility services. Services provided in the home by a physician or other qualified health care professional who is not a representative of the agency are nonfacility services.

Unlisted Procedure or Service

It is recognized that there may be services or procedures performed by physicians or other qualified health care professionals that are not found in the CPT code set. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure number is used, the service or procedure should be described (see specific section guidelines). Each of these unlisted procedural code numbers (with the appropriate accompanying topical entry) relates to a specific section of the book and is presented in the guidelines of that section.

In some cases, alternative coding and procedural nomenclature as contained in other code sets may allow appropriate reporting of a more specific code. CPT references to use an unlisted procedure code do not preclude the reporting of an appropriate code that may be found in other code sets.

Results, Testing, Interpretation, and Report

Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in CPT involve a technical component (eg, tests), which produces "results" (eg, data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting in order to report that code.

Special Report

A service that is rarely provided, unusual, variable, or new may require a special report. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.

Time

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. Phrases such as "interpretation and report" in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes has elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. See also the **Evaluation and Management (E/M) Services Guidelines**. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM, 96360 would be reported once and 96361 twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.

Code Symbols

A summary listing of additions, deletions, and revisions applicable to the CPT codebook is found in **Appendix B**. New procedure numbers added to the CPT codebook are identified throughout the text with the ● symbol placed before the code number. In instances where a code revision has resulted in a substantially altered procedure descriptor, the ▲ symbol is placed before the code number. The ► ◄ symbols are used to indicate new and revised text other than the procedure descriptors. These symbols indicate CPT

Editorial Panel actions. The AMA reserves the right to correct typographical errors and make stylistic improvements.

CPT add-on codes are annotated by the + symbol and are listed in **Appendix D**. The symbol ⊘ is used to identify codes that are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures or services. A list of codes exempt from modifier 51 usage is included in **Appendix E**. The ✓ symbol is used to identify codes for vaccines that are pending FDA approval (see **Appendix K**). The # symbol is used to identify codes that are listed out of numerical sequence (see **Appendix N**). The ★ symbol is used to identify codes that may be used to report telemedicine services when appended by modifier 95 (see **Appendix P**).

Resequenced codes that are not placed numerically are identified with the # symbol, and a reference placed numerically (ie, Code is out of numerical sequence. See…) as a navigational alert to direct the user to the location of the out-of-sequence code (see **Appendix N**). Resequencing is utilized to allow placement of related concepts in appropriate locations within the families of codes regardless of the availability of numbers for sequential numerical placement.

Duplicate proprietary laboratory analyses (PLA) tests are annotated by the ⌘ symbol. PLA codes describe proprietary clinical laboratory analyses and can be either provided by a single ("sole-source") laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the Food and Drug Administration [FDA]). All codes that are included in the PLA section are also included in Appendix O, with the procedure's proprietary name. In some instances, the descriptor language of PLA codes may be identical and the code may only be differentiated by the listed proprietary name in Appendix O. When more than one PLA test has an identical descriptor, the codes will be denoted by the symbol ⌘.

Unless specifically noted, even though the Proprietary Laboratory Analyses section of the code set is located at the end of the Pathology and Laboratory section of the code set, a PLA code does not fulfill Category I code criteria. A PLA code(s) that has Category I status is annotated by the ⇅ symbol.

Alphabetical Reference Index

This codebook features an expanded alphabetical index that includes listings by procedure and anatomic site. Procedures and services commonly known by their eponyms or other designations are also included.

Use of Anti-Piracy Technology in *CPT Professional 2021* Codebook

The AMA takes the act of and/or the prospect of piracy of its books and copyrighted content very seriously, and is committed to providing the most effective anti-piracy service to its authors and readers. To help combat print piracy and protect our intellectual properties and customers' right to AMA-certified content, the AMA has adopted anti-piracy technology in the *CPT Professional 2021* codebook.

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CPT 2021 in Electronic Formats

CPT 2021 procedure codes and descriptions are available as downloadable data files. The CPT data files are available in ASCII and EBCDIC formats and provide a convenient way to import the 2021 CPT codes and descriptions into existing documentation or into any billing and claims reporting software that accepts a text (.TXT) file format. The data files contain the complete official AMA CPT guidelines, descriptor package, and new descriptors for consumers and clinicians.

The *CPT Professional* codebook is also available as an e-book. For more information about CPT electronic formats, call 800 621-8335 or visit **amastore.com**.

References to AMA Resources

The symbols ➔ ➔ and ➔ appear after many codes throughout this codebook, which indicate that the AMA has published reference material regarding that particular code.

The symbol ➔ refers to the *CPT Changes: An Insider's View*, an annual book with all of the coding changes for the current year, the ➔ refers to the *CPT Assistant* monthly newsletter. The symbol ➔ refers to the quarterly newsletter *Clinical Examples in Radiology*.

Example

36598 Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report

➔ *CPT Changes: An Insider's View* 2006

➔ *Clinical Examples in Radiology* Winter 2006:15

In this example, the blue reference symbol indicates that in the 2006 edition of *CPT Changes: An Insider's View* information is available that may assist in understanding the application of the code. The red reference symbol indicates that the 2006 Winter issue of *Clinical Examples in Radiology* (page 15) should be consulted.

CPT Assistant and *Clinical Examples in Radiology* are available online. Benefits exclusive to the online versions include:

- Monthly (*CPT Assistant*) and quarterly (*Clinical Examples in Radiology*) updates! The home screen notifies you when a new issue is available, and you can review the latest issue in its entirety.
- Unlimited access to every archived issue and article dating back to when the newsletters first published.
- A historical CPT code list that references when a code was added, deleted, and/or revised since 1990.
- Simple search capabilities, including intuitive menus and a cumulative index of article titles.
- Anatomical illustrations, charts, and graphs for quick reference.
- A full archive of *CPT Assistant* articles (1990-2019) is also available in the *CPT Professional Print and Digital* app bundle (see the following information about the *CPT QuickRef* app).

The *CPT QuickRef* app is available for iOS (Apple) and Android devices (smart phones and tablets). The *QuickRef* app contains important coding and billing tools, including:

- The entire CPT 2021 code set (full codes, descriptions, icons, illustrations, and parenthetical notes), plus the entire 2020 code set to facilitate the year-end code set transition.
- Facility and non-facility RVUs and Global Days.
- Medicare Physician Fee Schedule calculator that can be set to a specific geographic region (GPCI)
- E/M Code Selection Wizard with the option to apply CPT, CMS '95, or CMS '97 guidelines.
- *CPT Assistant* Archive: all content and every issue of *CPT Assistant* from 1990 through 2018, linked to the pertinent CPT codes and available for browsing.
- Official AMA CPT coding guidelines linked to each CPT code.
- Up to 4,200 clinical examples/vignettes.
- More than 200 AMA-created colorized procedural and anatomical illustrations
- Modifiers
- Keyword and code number search
- Favorites capability, to store most-frequently used codes or modifiers for easy access.

For more information, call 800 621-8335.

Illustrated Anatomical and Procedural Review

It is essential that coders have a thorough understanding of medical terminology and anatomy to code accurately. The following section reviewing the basics of vocabulary and anatomy can be used as a quick reference to help you with your coding. It is not intended as a replacement for up-to-date medical dictionaries and anatomy texts, which are essential tools for accurate coding.

Prefixes, Suffixes, and Roots

Although medical terminology may seem complex, many medical terms can be broken into component parts, which makes them easier to understand. Many of these terms are derived from Latin or Greek words, but some include the names of physicians.

Prefixes are word parts that appear at the beginning of a word and modify its meaning; suffixes are found at the end of words. By learning what various prefixes and suffixes mean, it is possible to decipher the meaning of a word quickly. The following lists are a quick reference for some common prefixes and suffixes.

Numbers

Prefix	Meaning	Example
mono-, uni-	one	monocyte, unilateral
bi-	two	bilateral
tri-	three	triad
quadr-	four	quadriplegia
hex-, sex-	six	hexose
diplo-	double	diplopia

Surgical Procedures

Suffix	Meaning	Example
-centesis	puncture a cavity to remove fluid	amniocentesis
-ectomy	surgical removal (excision)	appendectomy
-ostomy	a new permanent opening	colostomy
-otomy	cutting into (incision)	tracheotomy
-orrhaphy	surgical repair/suture	herniorrhaphy
-opexy	surgical fixation	nephropexy
-oplasty	surgical repair	rhinoplasty
-otripsy	crushing, destroying	lithotripsy

Conditions

Prefix	Meaning	Example
ambi-	both	ambidextrous
aniso-	unequal	anisocoria
dys-	bad, painful, difficult	dysphoria
eu-	good, normal	euthanasia
hetero-	different	heterogeneous
homo-	same	homogeneous
hyper-	excessive, above	hypergastric
hypo-	deficient, below	hypogastric
iso-	equal, same	isotonic
mal-	bad, poor	malaise
megalo-	large	megalocardia

Suffix	Meaning	Example
-algia	pain	neuralgia
-asthenia	weakness	myasthenia
-emia	blood	anemia
-iasis	condition of	amebiasis
-itis	inflammation	appendicitis
-lysis	destruction, break down	hemolysis
-lytic	destroy, break down	hemolytic
-oid	like	lipoid
-oma	tumor	carcinoma
-opathy	disease of	arthropathy
-orrhagia	hemorrhage	menorrhagia
-orrhea	flow or discharge	amenorrhea
-osis	abnormal condition of	tuberculosis
-paresis	weakness	hemiparesis
-plasia	growth	hyperplasia
-plegia	paralysis	paraplegia
-pnea	breathing	apnea

Directions and Positions

Prefix	Meaning	Example
ab-	away from	abduction
ad-	toward	adduction
ecto, exo-	outside	ectopic, exocrine
endo-	within	endoscope
epi-	upon	epigastric
infra-	below, under	infrastructure
ipsi-	same	ipsilateral
meso-	middle	mesopexy
meta-	after, beyond, transformation	metastasis
peri-	surrounding	pericardium
retro-	behind, back	retroversion
trans-	across, through	transvaginal

Word	Meaning
anterior or ventral	at or near the front surface of the body
posterior or dorsal	at or near the back surface of the body
superior	above
inferior	below
lateral	side
distal	farthest from center
proximal	nearest to center
medial	middle
supine	face up or palm up
prone	face down or palm down
sagittal	vertical body plane, divides the body into equal right and left sides
transverse	horizontal body plane, divides the body into top and bottom sections
coronal	vertical body plane, divides the body into front and back sections

Additional References

For best coding results, you will need to use other reference materials in addition to your CPT® coding books. These references include medical dictionaries and anatomy books.

Medical Dictionaries

Dorland's Illustrated Medical Dictionary, 32nd ed.
Philadelphia, PA: Elsevier; 2011.

Stedman's CPT® Dictionary, 2nd ed.
Chicago, IL: American Medical Association; 2009.
OP:300609

Stedman's Medical Dictionary. 28th ed.
Philadelphia, PA: Lippencott; 2005.

Anatomy References

Bernard, SP. *Netter's Atlas of Human Anatomy for CPT® Surgery.*
Chicago, IL: American Medical Association; 2015.
OP495015

Kirschner, CG. *Netter's Atlas of Human Anatomy for CPT® Coding*, 3rd ed.
Chicago, IL: American Medical Association; 2019.
OP490619

Netter, FH. *Atlas of Human Anatomy*, 6th ed.
Philadelphia, PA; Elsevier; 2014.
OP936714

Lists of Illustrations

To further aid coders in properly assigning CPT codes, the codebook contains a number of anatomical and procedural illustrations.

Anatomical Illustrations

Thirty-two anatomical illustrations are located on the following pages:

Procedural Illustrations

Procedural illustrations are placed throughout the codebook and are associated with the following specific CPT codes.

Figure 1A

Body Planes — 3/4 View

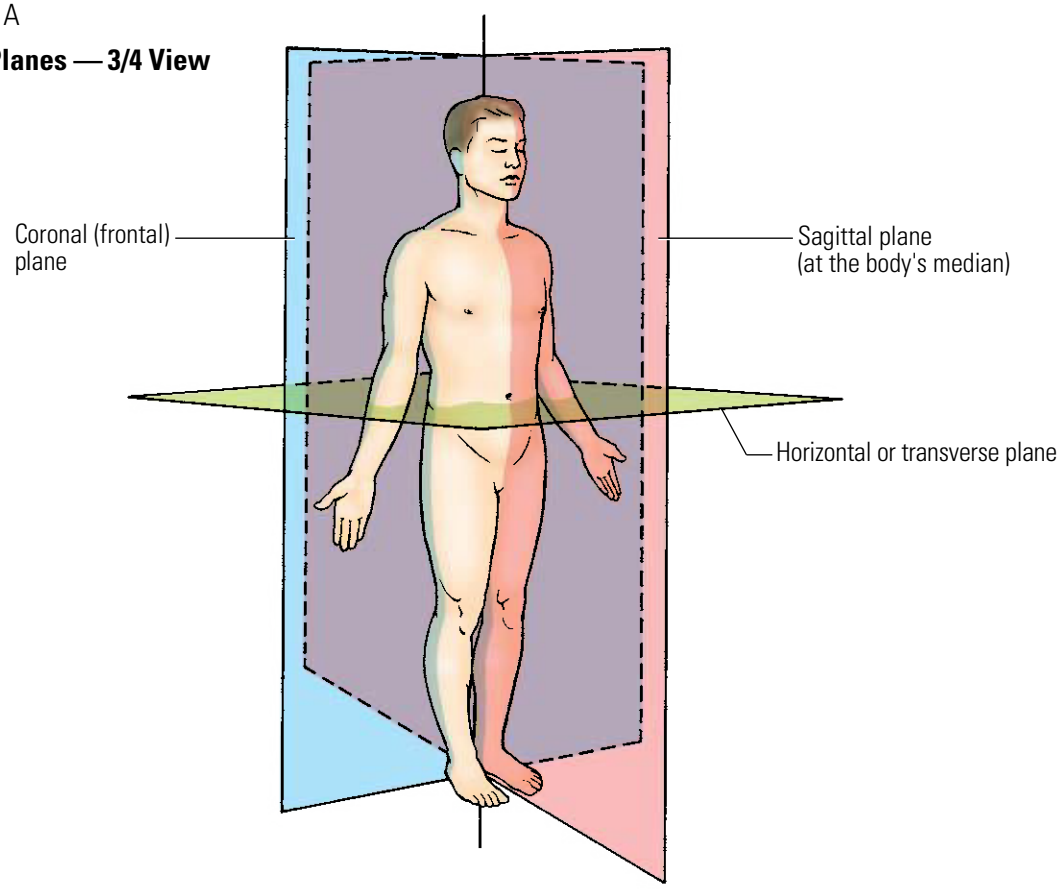


Figure 1B

Body Aspects — Side View

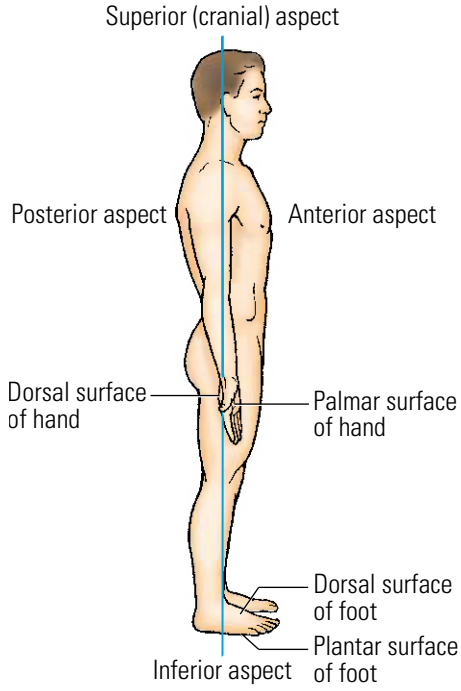
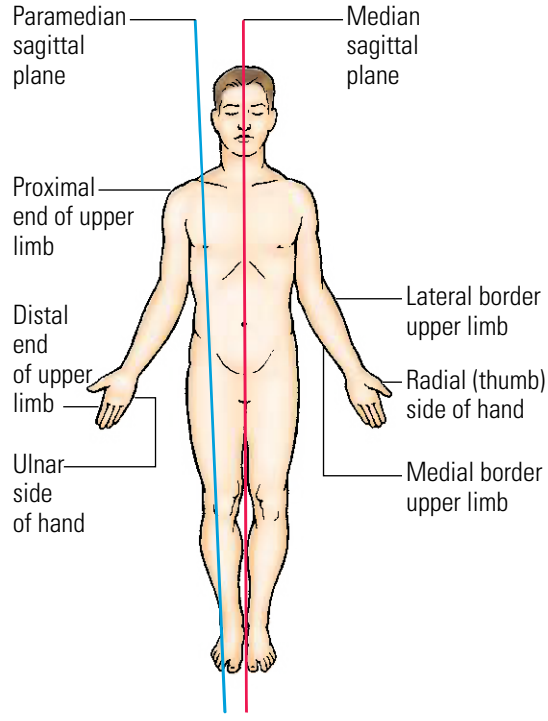


Figure 1C

Body Planes — Front View



Evaluation and Management Tables

Office or Other Outpatient Services

Patient: New

Code	99202	99203	99204	99205
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes (Range)	15-29	30-44	45-59	60-74

Initial Observation Care

Patient: New or Established

Required Components: 3/3

Code	99218	99219	99220
REQUIRED KEY COMPONENTS			
History and Examination (#1 and #2)			
Detailed or Comprehensive	X		
Comprehensive		X	X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Low	X		
Moderate		X	
High			X
Counseling (#2) See E/M Guidelines			
Coordination of Care (#3) See E/M Guidelines			
Bedside/Unit/Floor Time (#4)			
Minutes	30	50	70

Subsequent Observation Care

Patient: New or Established

Required Components: 2/3

Code	99224	99225	99226
REQUIRED KEY COMPONENTS			
Interval History and Examination (#1 and #2)			
Problem-Focused	X		
Expanded Problem-Focused		X	
Detailed			X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Stable/Recovering/ Improving	X		
Inadequate Response to Therapy/ Minor Complication Development		X	
Unstable/Significant Complication/ Significant New Problem			X
Counseling (#2) See E/M Guidelines			
Coordination of Care (#3) See E/M Guidelines			
Bedside/Unit/Floor Time (#4)			
Minutes	15	25	35

Office or Other Outpatient Services

Patient: Established

Code	99211	99212	99213	99214	99215
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	N/A	X	X	X	X
Medical Decision Making Level					
Straightforward	N/A	X			
Low			X		
Moderate				X	
High					X
OR					
Total Time (On Date of the Encounter)					
Minutes (Range)	N/A	10-19	20-29	30-39	40-54

Initial Hospital Care

Patient: New or Established

Required Components: 3/3

Code	99221	99222	99223
REQUIRED KEY COMPONENTS			
History and Examination (#1 and #2)			
Detailed or Comprehensive	X		
Comprehensive		X	X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Low	X		
Moderate		X	
High			X
Counseling (#2) See E/M Guidelines			
Coordination of Care (#3) See E/M Guidelines			
Bedside/Unit/Floor Time (#4)			
Minutes	30	50	70

Subsequent Hospital Care

Patient: New or Established

Required Components: 2/3

Code	99231	99232	99233
REQUIRED KEY COMPONENTS			
Interval History and Examination (#1 and #2)			
Problem-Focused	X		
Expanded Problem-Focused		X	
Detailed			X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Stable/Recovering/Improving	X		
Responding Inadequately/ Minor Complication		X	
Unstable/Significant Complication/ New Problem			X
Counseling (#2) See E/M Guidelines			
Coordination of Care (#3) See E/M Guidelines			
Bedside/Unit/Floor Time (#4)			
Minutes	15	25	35

Office or Other Outpatient Consultations

Patient: New or Established

Required Components: 3/3

Code	99241	99242	99243	99244	99245
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X	X			
Low			X		
Moderate				X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Self-limited or Minor	X				
Low		X			
Moderate			X		
Moderate to High				X	X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	15	30	40	60	80

Inpatient Consultations

Patient: New or Established

Required Components: 3/3

Code	99251	99252	99253	99254	99255
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X	X			
Low			X		
Moderate				X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Self-limited or Minor	X				
Low		X			
Moderate			X		
Moderate to High				X	X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Bedside/Unit/Floor Time (#4)					
Minutes	20	40	55	80	110

Subsequent Nursing Facility Care

Patient: New or Established

Required Components: 2/3

Code	99307	99308	99309	99310
REQUIRED KEY COMPONENTS				
History and Examination (#1 and #2)				
Problem-Focused	X			
Expanded Problem-Focused		X		
Detailed			X	
Comprehensive				X
Medical Decision Making (Complexity) (#3)				
Straightforward	X			
Low		X		
Moderate			X	
High				X
CONTRIBUTORY FACTORS				
Presenting Problem (Severity) (#1)				
Stable/Recovering/Improving	X			
Responding Inadequately to Therapy/Minor Complication		X		
Significant Complication/ Significant New Problem			X	
Unstable/Significant New Problem Requiring Immediate Physician Attention				X
Counseling and Coordination of Care (#2 and #3) Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.				
Bedside/Unit/Floor Time (#4)				
Minutes	10	15	25	35

Observation or Inpatient Care Services (Including Admission and Discharge Services)

Patient: New or Established

Required Components: 3/3

Code	99234	99235	99236
REQUIRED KEY COMPONENTS			
History and Examination (#1 and #2)			
Detailed or Comprehensive	X		
Comprehensive		X	X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Low	X		
Moderate		X	
High			X
Counseling (#2) See E/M Guidelines			
Coordination of Care (#3) See E/M Guidelines			
Bedside/Unit/Floor Time (#4)			
Minutes	40	50	55

Initial Nursing Facility Care

Patient: New or Established

Required Components: 3/3

Code	99304	99305	99306
REQUIRED KEY COMPONENTS			
History and Examination (#1 and #2)			
Detailed or Comprehensive	X		
Comprehensive		X	X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Low	X		
Moderate		X	
High			X
Counseling and Coordination of Care (#2 and #3) Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.			
Bedside/Unit/Floor Time (#4)			
Minutes	25	35	45

Emergency Department Services

Patient: New or Established

Required Components: 3/3

Code	99281	99282	99283	99284	99285
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X	X		
Detailed				X	
Comprehensive					X
Medical Decision Making (Complexity) (#3)					
Straightforward	X				
Low		X			
Moderate			X	X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Self-limited or Minor	X				
Low to Moderate		X			
Moderate			X		
High				X	
High Severity/ Immediate Significant Threat to Life or Physiological Function					X
Counseling and Coordination of Care (#2 and #3) Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.					
Typical Time (#4)					
N/A					

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

Patient: New

Required Components: 3/3

Code	99324	99325	99326	99327	99328
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X				
Low		X			
Moderate			X	X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Low	X				
Moderate		X			
Moderate to High			X		
High				X	
Unstable/Significant New Problem Requiring Immediate Physician Attention					X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Time (#4)					
Minutes	20	30	45	60	75

Home Services

Patient: New

Required Components: 3/3

Code	99341	99342	99343	99344	99345
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X				
Low		X			
Moderate			X	X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Low	X				
Moderate		X			
Moderate to High			X		
High				X	
Unstable/Significant New Problem					X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	20	30	45	60	75

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

Patient: Established

Required Components: 2/3

Code	99334	99335	99336	99337
REQUIRED KEY COMPONENTS				
History and Examination (#1 and #2)				
Problem-Focused	X			
Expanded Problem-Focused		X		
Detailed			X	
Comprehensive				X
Medical Decision Making (Complexity) (#3)				
Straightforward	X			
Low		X		
Moderate			X	
Moderate to High				X
CONTRIBUTORY FACTORS				
Presenting Problem (Severity) (#1)				
Self-limited or Minor	X			
Low to Moderate		X		
Moderate to High			X	
Moderate to High/Unstable/ Significant New Problem				X
Counseling (#2) See E/M Guidelines				
Coordination of Care (#3) See E/M Guidelines				
Typical Time (#4)				
Minutes	15	25	40	60

Home Services

Patient: Established

Required Components: 2/3

Code	99347	99348	99349	99350
REQUIRED KEY COMPONENTS				
History and Examination (#1 and #2)				
Problem-Focused	X			
Expanded Problem-Focused		X		
Detailed			X	
Comprehensive				X
Medical Decision Making (Complexity) (#3)				
Straightforward	X			
Low		X		
Moderate			X	
Moderate to High				X
CONTRIBUTORY FACTORS				
Presenting Problem (Severity) (#1)				
Self-limited or Minor	X			
Low to Moderate		X		
Moderate to High			X	
Moderate to High/Unstable/ Significant New Problem				X
Counseling (#2) See E/M Guidelines				
Coordination of Care (#3) See E/M Guidelines				
Typical Time (#4)				
Minutes	15	25	40	60

Neonatal and Pediatric Critical/Intensive Care

Initial Inpatient Neonatal and Pediatric Critical Care

Code	99468	99471	99475	99291–99292
Age	28 days or less	29 days to 24 mos	2–5 yrs	6 yrs +

Subsequent Inpatient Neonatal and Pediatric Critical Care

Code	99469	99472	99476	99291–99292
Age	28 days or less	29 days to 24 mos	2–5 yrs	6 yrs +

Initial Neonatal Intensive Care

Code	99477
Age	28 days of age or younger
Presenting Problem	Requires intensive observation, frequent interventions/other intensive care services

Continuing Neonatal and Infant Inpatient Low Birth-Weight Intensive Care

Code	99478	99479	99480	99231–99233
Weight	1500 gms or less	1500–2500 gms	2501–5000 gms	+5000 gms
Presenting Problem	Recovering			

Reporting Critical Care Time

Total Duration of Critical Care	CPT Codes
Less than 30 minutes	Appropriate E/M codes
30–74 minutes (1/2 hour–1 hour 14 minutes)	**99291 X 1**
75–104 minutes (1 hour 15 minutes–1 hour 44 minutes)	**99291 X 1** and **99292 X 1**
105–134 minutes (1 hour 45 minutes–2 hours 14 minutes)	**99291 X 1** and **99292 X 2**
135–164 minutes (2 hours 15 minutes–2 hours 44 minutes)	**99291 X 1** and **99292 X 3**
165–194 minutes (2 hours 45 minutes–3 hours 14 minutes)	**99291 X 1** and **99292 X 4**
195 minutes or longer (3 hours 15 minutes–etc.)	**99291** and **99292** as appropriate

Notes

Evaluation and Management (E/M) Services Guidelines

The following is a listing of headings and subheadings that appear within the Evaluation and Management section of the CPT codebook. The subheadings or subsections denoted with asterisks (*) below have special instructions unique to that subsection. Where these are indicated, special notes or guidelines will be presented preceding those procedural terminology listings, referring to that subsection specifically.

Evaluation and Management

Evaluation and Management (E/M) Services Guidelines

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

►E/M Guidelines Overview◄

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

There are two sets of guidelines: one for office or other outpatient services and another for the remaining E/M services. There are sections that are common to both (ie, Guidelines in Common). These guidelines are presented as Guidelines Common to all E/M Services, Guidelines for E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home) and Guidelines for Office or Other Outpatient Services.

The main differences between the two sets of guidelines is that the office or other outpatient services use medical decision making (MDM) ***or*** time as the basis for selecting a code level, whereas the other E/M codes use history, examination, ***and*** MDM and only use time when counseling and/or coordination of care dominates the service. The definitions of time are different for different categories of services.◄

►Summary of Guideline Differences◄

►Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use key components (history, examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use key components (history, examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service. *Time is **not** a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at 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 of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality◄

Classification of Evaluation and Management (E/M) Services

►The E/M section is divided into broad categories such as office visits, hospital 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 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 the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)◄

Definitions of Commonly Used Terms

►Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services and others are specific to one or more categories only.◄

►Guidelines Common to All E/M Services◄

►Levels of E/M Services◄

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

New and Established Patient

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

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

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

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

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

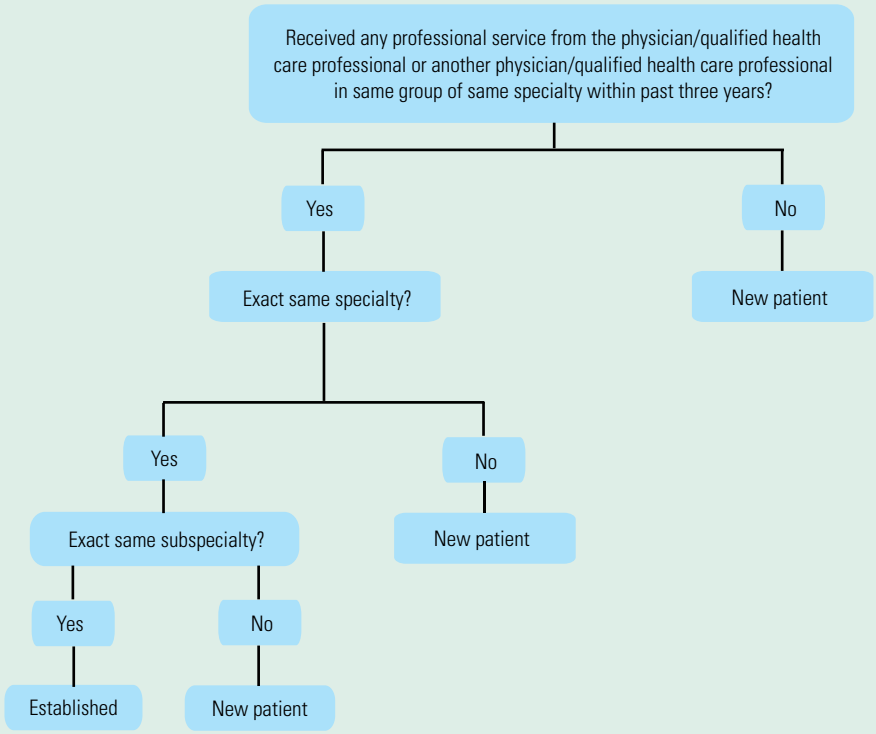
Coding Tip

Instructions for Use of the CPT Codebook

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

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

Decision Tree for New vs Established Patients



Time

►The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.◄

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

►Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the ***other*** E/M services when counseling and/or coordination of care dominates the service.

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

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]): For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

Total time on the date of the encounter (office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]): For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

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

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

Concurrent Care and Transfer of Care

Concurrent care is the provision of similar services (eg, hospital visits) to the same patient by more than one physician or other qualified health care professional on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician or other qualified health care professional who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified health care professional transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician or other qualified health care professional who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

(For psychotherapy, see 90832-90834, 90836-90840)

►Services Reported Separately◄

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

The 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 reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed

written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM.

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

►Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, and Home E/M Services◄

Levels of E/M Services

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained.")

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.

►The final component, time, is discussed in detail following the Decision Tree for New vs Established Patients.◄

Chief Complaint

A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

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

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

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies (eg, drug, food)
- Age appropriate immunization status
- Age appropriate feeding/dietary status

Family History

A review of medical events in the patient's family that includes significant information about:

- The health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review
- Diseases of family members that may be hereditary or place the patient at risk

Social History

An age appropriate review of past and current activities that includes significant information about:

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Military history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of the CPT codebook the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

▸Instructions for Selecting a Level of E/M Service for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, and Home E/M Services◂

Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

▸The first three of these components (ie, history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits that consist predominantly of counseling or coordination of care.◂

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

Determine the Extent of History Obtained

The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: Chief complaint; brief history of present illness or problem.

Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent system review.

Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; **pertinent** past, family, and/or social history **directly related to the patient's problems.**

Comprehensive: Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; **complete** past, family, and social history.

The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: A limited examination of the affected body area or organ system.

Expanded problem focused: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: A general multisystem examination or a complete examination of a single organ system. **Note:** The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT definitions, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

For the purposes of these CPT definitions, the following organ systems are recognized:

- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in Table 1 must be met or exceeded.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision making.

Select the Appropriate Level of E/M Services Based on the Following

►1. For the following categories/subcategories, **all of the key components,** ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: initial observation care; initial hospital care; observation or inpatient hospital care (including admission and discharge services); office or other outpatient consultations; inpatient consultations;

Table 1
Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
minimal	minimal or none	minimal	**straightforward**
limited	limited	low	**low complexity**
multiple	moderate	moderate	**moderate complexity**
extensive	extensive	high	**high complexity**

emergency department services; initial nursing facility care; other nursing facility services; domiciliary care, new patient; and home services, new patient.

2. For the following categories/subcategories, **two of the three key components** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: subsequent observation care; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home services, established patient.◀

3. When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

▸Guidelines for Office or Other Outpatient E/M Services◂

▸History and/or Examination◂

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

▸Number and Complexity of Problems Addressed at the Encounter◂

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

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:

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

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic

study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

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

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

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

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

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 but that does not require consideration of hospital level of care.

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. An example may be a lump in the breast.

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

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

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 hospital 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. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

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

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

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met.

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

Appropriate source: For the purpose of the **discussion of management** data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high, medium, low*, or *minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the 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 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. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.◀

▶Instructions for Selecting a Level of Office or Other Outpatient E/M Services◀

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

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

▶Medical Decision Making◀

▶MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the office or other outpatient services codes is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data are divided into three categories:
  - Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
  - Independent interpretation of tests.
  - Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source.
- The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care.

Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

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

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

MDM may be impacted by role and management responsibility.

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

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an office or other outpatient E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. See Table 2: Levels of Medical Decision Making (MDM) on the following page. ◄

▶Table 2: Levels of Medical Decision Making (MDM)◀

▶Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable, chronic illness; **or** • **1** acute, uncomplicated illness or injury	**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)** *(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**
99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable, chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute, complicated injury	**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 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

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 **99215**	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily 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 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 • Decision not to resuscitate or to de-escalate care because of poor prognosis◄

►Time◄

►For instructions on using time to select the level of office or other outpatient E/M services code, see the ***Time*** subsection in the ***Guidelines Common to All E/M Services.***◄

Unlisted Service

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

99429 **Unlisted preventive** medicine service

99499 **Unlisted evaluation and management** service

Special Report

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

Clinical Examples

Clinical examples of the codes for E/M services are provided to assist in understanding the meaning of the descriptors and selecting the correct code. The clinical examples are listed in Appendix C. Each example was developed by the specialties shown.

The same problem, when seen by different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

Evaluation and Management

Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 23) or initial nursing facility care (page 33).

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226.

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

Coding Tip

Determination of Patient Status as New or Established Patient

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

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

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

CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, New and Established Patient

New Patient

►(99201 has been deleted. To report, use 99202)◄

★▲ **99202** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:13, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jul 98:9, Sep 98:5, Feb 00:11, Aug 01:2, Apr 02:14, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, Oct 06:15, Apr 07:11, Sep 07:1, Mar 09:3, Aug 09:5, Dec 09:9, Jan 11:3, Mar 12:4, 8, Jan 13:9, Jun 13:3, Aug 13:13, 14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

Clinical Examples in Radiology Winter 12:9

★▲ **99203** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jul 98:9, Sep 98:5, Feb 00:11, Aug 01:2, Apr 02:14, Oct 04:10, Feb 05:9, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, Oct 06:15, Apr 07:11, Sep 07:1, Mar 09:3, Aug 09:5, Dec 09:9, Jan 11:3, Mar 12:4, 8, Jan 13:9, Jun 13:3, Aug 13:13, 14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

Clinical Examples in Radiology Winter 12:9

★▲ **99204** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jul 98:9, Sep 98:5, Feb 00:11, Aug 01:2, Apr 02:14, May 02:1, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, Oct 06:15, Apr 07:11, Sep 07:1, Mar 09:3, Aug 09:5, Dec 09:9, Jan 11:3, Mar 12:4, 8, Jan 13:9, Jun 13:3, Aug 13:13, 14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

Clinical Examples in Radiology Winter 12:9

★▲ **99205** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jul 98:9, Sep 98:5, Feb 00:11, Aug 01:2, Apr 02:2, May 02:1, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, Oct 06:15, Apr 07:11, Sep 07:1, Mar 09:3, Aug 09:5, Dec 09:9, Jul 10:4, Jan 11:3, Jan 12:3, Mar 12:4, 8, Jan 13:9, Jun 13:3, Aug 13:13, 14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

Clinical Examples in Radiology Winter 12:9

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

Established Patient

▲ **99211** **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

CPT Changes: An Insider's View 2013, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Oct 96:10, Feb 97:9, May 97:4, Jul 98:9, Sep 98:5, Oct 99:9, Feb 00:11, Aug 01:2, Jan 02:2, Oct 04:10, Feb 05:15, Mar 05:11, Apr 05:1, 3, May 05:1, Jun 05:11, Nov 05:1, Dec 05:10, Feb 06:14, May 06:1, Jun 06:1, Jul 06:19, Oct 06:15, Nov 06:21, Apr 07:11, Jul 07:1, Sep 07:1, Dec 07:9, Mar 08:3, Aug 08:13, Mar 09:3, Aug 09:5, Apr 10:10, Jan 11:3, Jan 12:3, Mar 12:4, 8, Apr 12:10, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Nov 13:3, Mar 14:14, Jan 15:12, Mar 16:11, Sep 16:6, Mar 17:10, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

★▲ **99212** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jul 98:9, Sep 98:5, Feb 00:11, Jun 00:11, Aug 01:2, Jan 02:2, May 02:3, Apr 04:14, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Feb 10:13, Jul 10:4, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Apr 12:17, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Feb 14:11, Jan 15:12, Mar 16:11, Sep 16:6, Dec 16:12, Oct 17:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

★▲ **99213** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jan 97:10, Jul 98:9, Sep 98:5, Aug 01:2, May 02:3, Oct 03:5, Apr 04:14, Oct 04:10, Mar 05:11, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

★▲ **99214** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:15, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, May 97:4, Jul 98:9, Sep 98:5, Aug 01:2, Jan 02:2, May 02:1-2, Oct 03:5, Apr 04:14, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Jan 15:12, Oct 15:3, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3

★▲ **99215** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

CPT Changes: An Insider's View 2013, 2017, 2021

CPT Assistant Winter 91:11, Spring 92:15, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jan 97:10, Jul 98:9, Sep 98:5, Aug 01:2, Jan 02:2, May 02:1, 3, Apr 04:14, Oct 04:10, Mar 05:11, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Jul 10:4, Sep 10:4, Jan 11:3, Jun 11:3, Jan 12:3, Mar 12:4, 8, Apr 12:10, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Nov 13:3, Aug 14:3, Oct 14:3, Nov 14:14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Oct 19:10, Jan 20:3, Feb 20:3, Mar 20:3

►(For services 55 minutes or longer, use prolonged services code 99417)◄

Hospital Observation Services

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.

If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.

For definitions of key components and commonly used terms, please see **Evaluation and Management Services Guidelines.**

Coding Tip

The Significance of Time as a Factor in Selection of an Evaluation and Management Code from This Section

The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):

For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time

Observation Care Discharge Services

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.

99217 **Observation care discharge** day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])

CPT Changes: An Insider's View 2013, 2018

CPT Assistant Nov 97:2, Mar 98:1, May 98:3, Sep 98:5, Sep 00:3, May 05:1, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Jun 11:3, Jul 12:10, 11, 14, Jan 13:9, Jun 13:3, Nov 14:14, Jul 19:10

Initial Observation Care

New or Established Patient

The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.

To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care (page 23). For observation care services on other than the initial or discharge date, see subsequent observation services codes (99224-99226). For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate initial hospital care code (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with a hospital admission (99221-99223).

When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician or other qualified health care professional should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting.

►Evaluation and management services including new or established patient office or other outpatient services (99202-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99429) on the same date related to the admission to "observation status" should not be reported separately.◄

These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical "package." These codes apply to all evaluation and management services that are provided on the same date of initiating "observation status."

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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2012, 2013, 2018

CPT Assistant Spring 93:34, Fall 95:9, Nov 97:2, Mar 98:1, Sep 98:5, Sep 00:3, Jan 03:10, Aug 04:11, May 05:1, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Oct 10:6, Jun 11:3, Jul 12:11, 14, Jan 13:9, Jun 13:3, Aug 13:13, Mar 15:3, Jul 15:3, Dec 18:8, Jul 19:10

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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2012, 2013, 2018

CPT Assistant Spring 93:34, Fall 95:16, Nov 97:2, Mar 98:1, Sep 98:5, Sep 00:3, Jan 03:10, Aug 04:11, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Oct 10:6, Jun 11:3, Jul 12:11, 14, Jan 13:9, Jun 13:3, Aug 13:13, Dec 18:8, Jul 19:10

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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2012, 2013, 2018

CPT Assistant Spring 93:34, Fall 95:16, Nov 97:2, Mar 98:1, Sep 98:5, Sep 00:3, Jan 03:10, Aug 04:11, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Oct 10:6, Jun 11:3, Jul 12:11, Jan 13:9, Jun 13:3, Aug 13:13, Nov 14:14, Dec 18:8, Jul 19:10

Subsequent Observation Care

All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment.

 # 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2011, 2013

CPT Assistant Jun 11:3, Aug 11:11, Jul 12:10, 11, Jun 13:3, Aug 13:13, Nov 14:14, Jul 19:10

 # 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2011, 2013

CPT Assistant Jun 11:3, Aug 11:11, Jul 12:10, 11, Jan 13:9, Jun 13:3, Aug 13:13, Jul 19:10

 # 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2011, 2013

CPT Assistant Jun 11:3, Aug 11:11, Jul 12:10, 11, Jan 13:9, Jun 13:3, Aug 13:13, Nov 14:14, Jul 19:10

Hospital Inpatient Services

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a "partial hospital" setting. These codes are to be used to report these partial hospitalization services. See also psychiatry notes in the full text of the CPT code set.

For definitions of key components and commonly used terms, see **Evaluation and Management Services Guidelines.** For Hospital Observation Services, see 99218-99220, 99224-99226. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

Coding Tip

The Significance of Time as a Factor in Selection of an Evaluation and Management Code from This Section

The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):

For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time

Initial Hospital Care

New or Established Patient

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician.

For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

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

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in a hospital, office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.

►Evaluation and management services including new or established patient office or other outpatient services (99202-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99397) on the same date related to the admission to "observation status" should **not** be reported separately. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.◄

99221 **Initial hospital 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:9, Jul 96:11, Sep 96:10, Nov 97:2, Mar 98:1, Sep 98:5, Jan 02:2-3, Apr 03:26, Apr 04:14, Aug 04:11, May 05:1, Sep 06:8, Jul 07:12, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:13, Feb 14:11, May 14:4, Nov 14:14, Dec 15:16, Mar 16:11, Dec 18:8

99222 **Initial hospital 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:9, Jul 96:11, Sep 96:10, Nov 97:2, Mar 98:1, Sep 98:5, Jan 02:2-3, Apr 03:26, Apr 04:14, Aug 04:11, Sep 06:8, Jul 07:12, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:13, Mar 15:3, Dec 15:16, Mar 16:11, Dec 18:8

99223 **Initial hospital 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:9, Jul 96:11, Sep 96:10, Nov 97:2, Mar 98:1, Sep 98:5, Jan 02:2-3, Apr 03:26, Apr 04:14, Aug 04:11, Sep 06:8, Jul 07:12, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:13, May 14:4, Nov 14:14, Dec 15:16, Mar 16:11, Dec 18:8

99224 Code is out of numerical sequence. See 99219-99222

99225 Code is out of numerical sequence. See 99219-99222

99226 Code is out of numerical sequence. See 99219-99222

Subsequent Hospital Care

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition and response to management) since the last assessment.

★ **99231** **Subsequent hospital care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A problem focused interval history;**
- **A problem focused examination;**
- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013, 2017

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:16, Nov 97:2, Sep 98:5, Jan 99:10, Nov 99:5, Aug 01:2, Jan 02:2-3, Apr 04:14, Aug 04:11, Mar 05:11, May 05:1, May 06:1, 16, Jul 06:4, Mar 07:9, Jul 07:1, Mar 09:3, Dec 09:9, Jun 11:3, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:14, Sep 13:18, May 14:4, Nov 14:14, Dec 18:8

★ **99232** **Subsequent hospital 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013, 2017

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:16, Nov 97:2, Sep 98:5, Jan 99:10, Nov 99:5, Jan 00:11, Aug 01:2, Apr 04:14, Aug 04:11, May 06:1, 16, Jul 06:4, Mar 07:9, Jul 07:1, Mar 09:3, Dec 09:9, Jun 11:3, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:14, Oct 16:8, Dec 18:8

★ **99233** **Subsequent hospital 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013, 2017

CPT Assistant Winter 91:11, Spring 92:14, 24, Summer 92:10, 24, Fall 92:1, Spring 93:34, Spring 95:1, Fall 95:16, Nov 97:2, Sep 98:5, Jan 99:10, Nov 99:5, Aug 01:2, Apr 04:14, Aug 04:11, May 06:1, 16, Jul 06:4, Mar 07:9, Jul 07:1, Mar 09:3, Dec 09:9, Jun 11:3, Jul 12:12, Jan 13:9, Jun 13:3, Aug 13:13, 14, May 14:4, Nov 14:14, Oct 16:8, Dec 18:8

Observation or Inpatient Care Services (Including Admission and Discharge Services)

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

When a patient is admitted to the hospital from observation status on the same date, only the initial hospital care code should be reported. The initial hospital care code reported by the admitting physician or other qualified health care professional should include the services related to the observation status services he/she provided on the same date of inpatient admission.

When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same individual.

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99217, 99218-99220, 99224-99226, or 99221-99223, 99238 and 99239.

99234 **Observation or inpatient hospital care,** for the evaluation and management of a patient including admission and discharge on the same date, 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.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Nov 97:2, Mar 98:2, May 98:1, Sep 98:5, Jan 00:11, Sep 00:3, Jan 02:2, Jun 02:10, Jan 03:10, May 05:1, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Jun 11:3, Jul 12:14, Jun 13:3, Apr 18:10, Dec 18:8

99235 **Observation or inpatient hospital care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Nov 97:2, Mar 98:2, May 98:1, Sep 98:5, Jan 00:11, Sep 00:3, Jan 02:2, Jun 02:10, Jan 03:10, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Jun 11:3, Jul 12:14, Jun 13:3, Apr 18:10, Dec 18:8

99236 **Observation or inpatient hospital care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Changes: An Insider's View 2013

CPT Assistant Nov 97:2, Mar 98:2, May 98:1, Sep 98:5, Jan 00:11, Sep 00:3, Jan 02:2, Jun 02:10, Jan 03:10, Nov 05:10, Sep 06:8, Dec 06:14, Sep 10:4, Jun 11:3, Jul 12:14, Jun 13:3, Apr 18:10, Dec 18:8

Hospital Discharge Services

The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

99238 **Hospital discharge day management**; 30 minutes or less

CPT Assistant Fall 92:1, Spring 93:4, Nov 97:4, Mar 98:3, 11, May 98:2, Jan 99:10, Jan 02:2, Aug 04:11, May 05:1, Sep 06:8, Nov 09:10, Dec 09:9, Jul 11:16, Jul 12:10, 12, Jun 13:3, Aug 13:13, Dec 18:8

99239 more than 30 minutes

CPT Assistant Nov 97:4, Mar 98:3, 11, May 98:2, Jan 99:10, Jan 02:2, Aug 04:11, Sep 06:8, Nov 09:10, Dec 09:9, Jul 11:16, Jul 12:12, Jun 13:3, Aug 13:13, Dec 18:8