

cpt 2023

Evaluation & Management

The following codes, medium descriptors, and abbreviated guidelines are a subset of the AMA's Current Procedural Terminology (CPT®) code set. For unabridged code descriptors and complete guidelines, please refer to the CPT 2023 codebook or data file.

EVALUATION AND MANAGEMENT (E/M)

Evaluation and Management (E/M) Services Guidelines
The E/M function 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. This classification is important because the nature of work varies by type of service, place of service, and the patient's status.

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 subspecialty as the physician.

Concurrent care is the provision of similar services (eg, hospital visit(s)) 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 consultation 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 where 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.

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.

- 99.001 Office outpatient new 10 minutes
- 99.002 Office outpatient new 20 minutes
- 99.003 Office outpatient new 30 minutes
- 99.004 Office outpatient new 45 minutes
- 99.005 Office outpatient new 60 minutes
- 99.011 Office outpatient visit 1-minute
- 99.012 Office outpatient visit 10 minutes
- 99.013 Office outpatient visit 15 minutes
- 99.014 Office outpatient visit 25 minutes
- 99.015 Office outpatient visit 40 minutes

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.

- 99.017 Observation care/discharge management
- 99.018 Initial observation care/day 10 minutes
- 99.019 Initial observation care/day 30 minutes
- 99.020 Initial observation care/day 70 minutes
- 99.024 Single observation care/day 10 minutes
- 99.025 Single observation care/day 25 minutes
- 99.026 Single observation care/day 65 minutes

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 their partial hospitalization services. See also psychiatry notes in the full text of the CPT code set.

- 99.021 Initial hospital care/day 30 minutes
- 99.022 Initial hospital care/day 50 minutes
- 99.023 Initial hospital care/day 70 minutes
- 99.024 Single hospital care/day 10 minutes
- 99.025 Single hospital care/day 25 minutes
- 99.026 Single hospital care/day 35 minutes
- 99.029 Observation/inpatient hospital care 40 minutes
- 99.030 Observation/inpatient hospital care 50 minutes
- 99.031 Observation/inpatient hospital care 55 minutes
- 99.032 Hospital discharge day management 30 min/c
- 99.033 Hospital discharge day management > 30 min

Consultations

- 99.041 Office consultation new/initial patient 15 min
- 99.042 Office consultation new/initial patient 30 min
- 99.043 Office consultation new/initial patient 45 min
- 99.044 Office consultation new/initial patient 60 min
- 99.045 Office consultation new/initial patient 80 min

- 99.051 Initial inpatient consult new/initial pt 20 min
- 99.052 Initial inpatient consult new/initial pt 40 min
- 99.053 Initial inpatient consult new/initial pt 55 min
- 99.054 Initial inpatient consult new/initial pt 80 min
- 99.055 Initial inpatient consult new/initial pt 110 min

Emergency Department Services

- 99.057 Emergency department visit limited/minor severity
- 99.058 Emergency department visit low/moderate severity
- 99.059 Emergency department visit moderate/severity
- 99.060 Emergency department visit high/severe severity
- 99.061 Emergency dept visit high severity/differential

Critical Care Services

- 99.062 Critical care (disrupt patient less 30-70 min)
- 99.063 Critical care (disrupt patient add 30 min)

Nursing Facility Services

The following codes are used to report evaluation and management services to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), or long-term care facilities (LTCFs).

- 99.064 Initial nursing facility care/day 23 minutes
- 99.065 Initial nursing facility care/day 33 minutes
- 99.066 Initial nursing facility care/day 43 minutes
- 99.067 Single nursing facility care/day w/min stable 10 min
- 99.068 Single nursing facility care/day minor comp 15 min
- 99.069 Single nursing facility care/day new problem 15 min
- 99.070 Single nursing facility care/day unstable/new prob 25 min
- 99.071 Nursing facility discharge management 30 minutes
- 99.072 Nursing facility discharge management 30 minutes
- 99.073 E/M annual nursing facility assessment stable 30 min

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

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. They also are used to report evaluation and management services in an assisted living facility.

- 99.074 Domicil/rest home new pt visit low sever 20 min
- 99.075 Domicil/rest home new pt visit mod/sever 30 min
- 99.076 Domicil/rest home new pt mod/sever 45 min
- 99.077 Domicil/rest home new pt visit hi sever 60 min
- 99.078 Domicil home w/min new pt signif new prob 75 min
- 99.079 Domicil home w/min new pt signif/minor 15 min
- 99.080 Domicil home w/min new pt mod/sever 25 min
- 99.081 Domicil home w/min new pt signif new prob 60 min
- 99.082 Domicil home w/min new pt signif new prob 60 min

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

- 99.083 Initial (phys rep) home/domicil home visit 15-20 min
- 99.084 Initial (phys rep) home/domicil home visit 30 min/c

Coding Guidelines For Cpt A4645

Gail I. Smith



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Massachusetts register ,2000 **OWCP Medical Fee Schedule 1999** ,1999 **Federal Register** ,2001-08 **Michigan Register** Michigan. Legislative Council,1999 Ohio Monthly Record ,1998 Rules of state administrative agencies In full text with tables and index including chart of proposed rules with time and location of public hearings **Basic CPT/HCPCS Coding** Gail I. Smith,2003 Coding with Modifiers Deborah J. Grider,2004 Don t forget about the modifier Missing or incorrect usage of modifiers is the most common reason that claims are rejected by payors Leave off a modifier or put in the wrong one and your claim may be denied or paid the wrong amount Coding with Modifiers A Guide to Correct CPT and HCPCS Level II Modifier Usage provides step by step guidance for the proper use of CPT and HCPCS modifiers Also included are specific requirements for modifier usage in both professional service and hospital reporting **Introduction to CPT Coding** American Medical Association,2014-05-14 CPTr coding education straight from the source The AMA the expert in CPT coding offers this new publication on the Introduction to CPTr Coding Basic principles to learning understanding and applying the CPT code set This entry level coding education resource can be used alone or in a classroom setting Students and self learners entering the coding and billing field will learn how to appropriately select the correct codes for the services and procedures performed It is crucial to understand and correctly apply the CPT coding guidelines for each section and subsection of the CPT codebook This valuable resource addresses the general guidelines for each at the beginner s level and facilitates comprehension and application of the CPT coding guidelines Each chapter contains valuable features to provide further educational guidance on appropriate coding such as Check your Knowledge questions and answers to test your comprehension of the material Key Terms defines fundamental terms used within the text for ease of use Coding Tips helpful information listed throughout each chapter Illustrations specific to the anatomy of the procedures and codes Real life coding examples teach you how to apply your new skills Chapter exercises hands on exercises challenge your knowledge of each chapter Whether you are a student or a self learner this book will teach you the essentials of CPT coding and help to launch you into the exciting career of coding **Cpt-4 Outpatient Coding Reference and Study Guide 2012** Rhit Kobayashi,2012-05

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