CHAPTER 4 - E/M SERVICE CODE SETS

OFFICE/OUTPATIENT CODES

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215

All these codes are for sick visits, not for well child checks. 99211 is a non-MDM-based code for simple follow-ups, such as BP or weight checks. These can be done by a nurse and do not require a physician's time. When 99211 is excluded, both new and established patient codes have four levels that correspond to the four MDM levels: straightforward, low, medium, and high. These codes are used by all types of physicians practicing in the office, regardless of specialty. These codes are also visit based, so one code from this set is reported for each visit. If you see an unlucky child first at 9 am for URI and then again at 3 pm for an acute arm fracture, you should report 2 different codes: the first for the 9 am visit and the second for the 3 pm visit. Each visit gets one code. Modifier 25 needs to be added to the second reported CPT code to show it is a separate service.

Inpatient admission codes

Initial hospital inpatient or observation care	99221	99222	99223

This code set has 3 levels, all of which are MDM-based. These codes are used to report admissions to both inpatient and observation settings. Used only once per admission. Not used if admission and discharge is on the same date. Given that it is day-based code, the codes from this group are reported only once per day. This is why you do not need to write a separate note (from the billing perspective) if a patient is admitted after midnight and you are rounding in the morning. In this situation, you cannot report the admission codes which is already been reported, and you cannot report the subsequent day care code because it is not yet a subsequent day.

Subsequent day care

Subsequent hospital inpatient or observation care	99231	99232	99233

This code set has 3 levels, all of which are MDM-based. These codes are used to report subsequent care/follow-up on days other than the admission day and discharge day. Not used if admission and discharge is on the same date. Given that it is day-based code, the codes from this group are reported only once per day.

Same day admission and discharge care codes

Same day	99234	99235	99236

This code set has 3 levels, all of which are MDM-based. These codes are reported when both admission and discharge happen on the same date. These codes have nothing to do with 24 hours but only with the date. If a patient is admitted at 9pm and discharged at 11pm on the same day/date, then one code

from this set is used to report the 2 hours of admission. If the same patient is admitted at 11pm and discharged at 1am the next day, then the first code (99221-99223) is used for the admission at 11pm, and the second code (99238 or 99239) is used for the discharge at 1am the next day. Given that it is a day-based code set, the codes from this group are reported only once per day.

Discharge day care codes

99238	*Hospital discharge day management, 30 minutes or less*
99239	*Hospital discharge day management, more than 30 minutes*

Both are non-MDM-based codes. These codes are used to report all care provided on discharge day. These codes include, as appropriate, final examination, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, preparation of discharge records, prescriptions, and referrals. These codes are reported only once per day. These codes are to be utilized to report all the E/M services provided to a patient on the date of discharge.

CONSULTATION CODES

Outpatient	99242	99243	99244	99245
Inpatient	99252	99253	99254	99255

This code set has 4 levels and is all MDM-based, which aligns with MDM levels. ER is considered to be an outpatient setting. If you see a consult in the ER, use outpatient consultation codes for patients who are not admitted. If you are consulted and the patient is admitted to the hospital by another service, use inpatient consultation codes even if you saw the patient in the ER.

Consult codes are used only once for a specific referral question; subsequent codes are then used to follow up on the patient. In the office setting, use appropriate follow-up codes (99212-99215) for follow-up visits. In hospital settings, use appropriate subsequent-day care codes (99231-99233). In the hospital setting, the consult code is used only once during the entire hospitalization.

The consultant physician should consider selecting different ICD codes from the primary attending when reporting services. This clarifies that their care was distinct from that provided by the primary attending. If the same ICD codes are used, the payer may reject the consultant's services as duplicates.

The request and the reason for consultation should be documented in either the requester's note, the consultant's note, or in a written order. Consultation codes should not be used when a physician is called to transfer care, but may be used if the decision to accept patient care cannot be made without first evaluating the patient.

EMERGENCY DEPARTMENT SERVICE CODES

ER codes	99281	99282	99283	99284	99285

99281 is a non-MDM code for minor problems that do not require a physician's attention or time. The remaining 4 codes are all MDM-based and align with 4 MDM levels.

Although typically used by ER providers, this code set is not restricted to ER physicians; any physician who serves as the primary physician in the ED can use these codes. This applies to physicians who have ER privileges and see their patients in the ER without any involvement of ER doctors. Non-ER physicians are typically consulted on ER patients and use appropriate admission, consultation, or critical care codes.

For critically ill patients, critical care codes 99291 and 99292 can be used by any physician to report critical care services. If pediatric or neonatal critical care codes are used at admission, then critical care in the ED is not reported separately by the same admitting provider/group. If a pediatric/neonatal patient received critical care services in the ED but was not admitted under the provider, and care was transferred to another physician/group or another facility, then critical care codes 99291 and 99292 should be used regardless of the age. The same provider cannot report both critical care and ED codes for the same patient on the same date.

CRITICAL CARE SERVICES ~ Time based

99291	*Critical care, evaluation and management of the critically ill or injured patient, 1st 30-74 minutes*
99292	*each additional 30 minutes.*

These codes, also known as adult critical care codes, are time-based. Although the code descriptor doesn't specify any requirements, the CPT code book allocates several pages on how and when these codes are used. The definition of terms used in critical care billing by CPT is given below.

A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability *of imminent or life-threatening deterioration in the patient's condition.*

Critical care involves high complexity medical decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

As long as the patient's condition meets the CPT definition of critical care, these codes can be used. By definition, critical care involves high-level MDM, so all critical care codes are MDM-based. Because all critical care codes have the same MDM level, MDM does not affect code selection; therefore, I group them with non-MDM-based codes for code selection purposes. By definition, there should be an acute vital organ impairment with a high probability of deterioration. If there is no acute vital organ impairment or high risk of deterioration, then there is no critical illness from the CPT perspective, and these codes cannot be used. Example: a 10-year-old in the PICU for q1 hour neurochecks for acute traumatic epidural bleed with a perfectly normal neurological examination. Can you bill critical care for this patient? Given that there is no acute impairment in the neurological system, it is hard to argue for

critical illness from CPT perspective. This patient perfectly meets the definition of critical illness when he develops an altered mental state, because then he would have an acute impairment of a vital organ, the brain.

This code set includes a bundle containing 19 procedural CPT codes that cannot be reported separately. Any procedure not included in the bundle, such as intubation or central line placement, can be reported separately.

These codes are not reserved for intensivists and can be reported by any physician. They can be considered universal critical care codes and are used in the following situations, **regardless of age**.

1-In the outpatient setting (office, ER).

2- By consulting physicians (consulting physicians cannot use neonatal/pediatric critical care codes).

3-By physicians physically transporting critically ill patients over the age of 2 years.

4- When a patient younger than 6 years of age is transferred to another physician group in a separate institution (*or another physician group in the same institution).* For the day of the transfer, the transferring physician uses time-based critical care codes, and the accepting physician uses initial neonatal/pediatric critical care codes.

5- Patients aged 6 years (72 months) and above.

Age-dependent selection is the most common use of these codes, but the first 4 situations are good examples of their universal application. Neonatal/Pediatric critical care codes are only reserved for admission under inpatient status, and are only reported once a day, as they are per-day codes and only reported by primary/admitting physicians. Once reported, neonatal/pediatric critical care encompasses all critical care provided that day, including critical care in the ED by the same provider/group.

Critical care (99291, 99292) and other E/M services may be provided to the same patient on the same date by the same individual. For example, 99233 can be reported in the morning, and if the patient worsens and requires intubation later, 99291 can be reported by the same physician in the afternoon.

As a rule, critical care (99291, 99292) requires undivided attention, and a physician can provide critical care to only one patient at a time, meaning an intensivist can report a maximum of 24 hours of critical care time in a calendar day. Another rule concerns 2 physicians providing critical care (99291, 99292) to a critically ill patient simultaneously. In this situation, only one physician can report critical care at a time. A patient can receive a maximum of 24 hours of critical care services in a day.

Because critical care codes 99291, 99292 are time-based, the total time of critical care should be documented in the patient's chart/note. Critical care of less than 30 minutes is reported with other appropriate E/M service codes, like subsequent hospital codes.

99291 is actually the 1st hour of critical care (it was defined that way prior to 2000). New description: 30-74 minutes is still consistent with 1 hour because nothing less than 30 minutes is critical care, and to report the first block of 30 minutes with 99292, the midpoint of 30 minutes should be reached. The midpoint of 30 minutes is 15 minutes, and when 15 minutes is added to 60 minutes, 75 minutes is reached. Because the first 14 minutes of the additional 30 minutes may not be separately reportable, 99291 includes services up to 74 minutes. Clock for the first unit of 99292 starts ticking at 61 minutes

and reaches a reportable level at 75 minutes. For the second unit of 99292, the clock starts ticking at 91 minutes and reaches a reportable level at 105 minutes. When these considerations are combined, the first hour of critical care is practically 30-74 minutes. Although some intensivists document *"I provided 30-74 minutes of critical care……"* in their note, it is better to document instead *"I provided 1 hour of critical care…..".* There are several reasons not to use this range of minutes. There is a big difference between 30 and 74 minutes, and it indicates a clinician who doesn't have a good sense of how much time is spent on patient care. Time for 99292 only starts after 60 minutes and is reported when it reaches 75 minutes. If you document 30-74 minutes, then it is not clear when the time for 99292 starts, and reporting 99292 becomes problematic.

The complexity of our healthcare industry's billing practices is best exemplified by Medicare's different rules for reporting 99292. Although CPT allows 99292 to be billed at 75 minutes as explained above, Medicare mandates that the clock starts ticking at 74 minutes and 99292 is reported when its full 30 minutes are spent, which practically means that the first 99292 block can be reported only at 105 minutes (74+30).

CRITICAL CARE SERVICES-NEONATAL/PEDIATRIC: ~ Day based

Neonatal	99468	*Initial inpatient neonatal critical care, per day, for the evaluation and management of critically ill neonate, 28 days of age or younger*
	99469	*Subsequent inpatient neonatal critical care, per day, for the evaluation and management of critically ill neonate, 28 days of age or younger*

Pediatric	99471	*Initial inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 29 days through 24 months of age*
	99472	*Subsequent inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 29 days through 24 months of age*
	99475	*Initial inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 2 through 5 years of age*
	99476	*Subsequent inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 2 through 5 years of age*

Similar to time-based critical care codes, there are no specific requirements beyond the requirement for critical illness. The same definition of critical care applies to adults, children, and neonates. As it's clear in the description, these codes are based on day rather than time. Similar to time-based critical care codes, these code sets are also based on MDM because critical care involves high level of MDM.

These codes may be reported only by a single physician/primary attending and only once per day/date, per patient. Use of these code sets is not limited to pediatric and neonatal intensivists and can be used by other ICU physicians. Initial care codes (99468, 99471, 99475) may only be reported once per hospital admission. If a patient is readmitted to the ICU during the same hospitalization, then subsequent codes are used. Consultants may report 99291 or 99292 for critical care services, while the primary attending reports neonatal/pediatric critical care codes.

These codes are not used

1-In the outpatient setting (office/clinic, ED), regardless of age. Only reserved for inpatient use.
2-By consultants. Use is restricted to the primary/admitting attending group.
3-For transport or critically ill patients of any age.
4- When a patient is transferred to another physician group in a separate institution (*or another physician group in the same institution).* For the day of the transfer, the transferring physician uses time-based critical care codes, and the accepting physician uses initial-day-based critical care codes.
5- Patients aged 6 years (72 months) and above.

The popular name given to these codes, bundled codes, is a misnomer, as time-based critical care codes also have a bundle. The bundle of neonatal/pediatric critical care codes contains 39 procedures, 20 more than the time-based critical care codes. Procedures in the bundle are not reported separately, and any procedure that is not in the bundle is reported separately. Intubation is in the bundle of this code set and is not reported separately.
When a neonate or infant becomes critically ill and require critical care services who already received care (hospital services, neonatal intensive care services or normal newborn services) and transferred to another provider then first provider either report time based critical care (99291-99292), hospital based services (99221-233), neonatal intensive care (99477-99480) or normal newborn services (99460-99463) but only one of these groups. Accepting provider reports neonatal/pediatric critical care codes.
When a neonate, infant, or child becomes critically ill on the same day they have received normal newborn care, hospital care, intensive care, and the same individual assumes critical care to report neonatal/pediatric critical care codes, then only normal newborn care is reported separately. Hospital care services, intensive care services, and care in the ED are included in the pediatric/neonatal critical care codes.

PEDIATRIC CRITICAL CARE TRANSPORT SERVICES

There is a special code set for pediatric critical care transport for patients less than 2 years of age. Codes 99466 and 99467 are used when the physician actually attends the transport and physically manages the transfer of the critically ill child. Codes 99485 and 99486 are used when a physician supervises a transport team on the phone. The same physician can't report both code groups simultaneously. If a transport is already physically carried out by a physician, then another physician cannot report supervising codes of 99485/99486. Pediatric critical care transport codes 99466 and 99467 include a bundle very similar to the time-based bundle.

99466	*Critical care face to face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger;* ***first 30-74 minutes of hands on care during transport***
994477	***; each additional 30 minutes***

99485	*Supervision by a control physician of interfacility transport care of critically ill or critically injured pediatric patient, 24 months of age or younger, includes 2-way communication with transport team before transport, at the referring facility, and during the transport, including data interpretation and report****; first 30 minutes***
99486	***; each additional 30 minutes***

Face-to-face critical care transport services provided by physicians to patients aged 2 years or older can be reported using time-based critical care codes 99291 and 99292. There are no specific E/M codes for the transfer of non-critically ill patients, but code 99082 can be reported. 99082: Unusual travel (eg, transportation and escort of patient).

NEONATAL INTENSIVE CARE SERVICES-IN PATIENT

Initial	99477	*Initial hospital care, per day, for the evaluation and management of the neonate, 28 days or younger, who requires intensive observation, frequent interventions and other intensive care services.*
Subsequent	99478	*Subsequent intensive care, per day, for the evaluation and management of the recovering VLBW infant (present body weight less than 1500 grams)*
	99479	*Subsequent intensive care, per day, for the evaluation and management of the recovering LBW infant (present body weight of 1500-2500 grams)*
	99480	*Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)*

Intensive care is defined as ***services for infants or neonates who are not critically ill but continue to require intensive cardiac and respiratory monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct supervision of the physician***. These codes are based on day rather than time.

This code set is not MDM based. There are no specific documentation requirements beyond ensuring that the provided services meet the CPT definition of intensive care. Intensive care is defined as services for infants or neonates who are not critically ill but continue to require

1- Intensive cardiac and respiratory monitoring.

2- Heat maintenance support.

3- Enteral and/or parenteral nutritional adjustments.

4- Laboratory and oxygen monitoring.

5- Constant observation by the health care team under the direct supervision of a physician.

Note for 99477 should include the patient's age, as this code applies only to infants 28 days or younger. Note for 99478, 99479, and 99480 should document the infant's current daily weight, as these codes are weight-based codes.

These codes may also be used for infants in the PICU instead of 99231-99233 if the infant requires and meets the definition of intensive care services.

The initial intensive care code 99477 may only be reported for neonates (less than 28 days old), regardless of weight. Subsequent neonatal intensive care codes 99478, 99479, and 99480 can be reported for any infant (up to 12 months) as long as the patient weighs less than 5kg. If an infant is older than 28 days or more than 5 kg, then none of these intensive care codes may be reported. For example, a 1-day-old 32 weeks 32-week-old premature baby (birth weight 2 kg) was admitted to the NICU. The

baby was not critically ill but required intensive care. First day 99477 is reported. Baby stayed in the NICU for 6 months for feeding issues and continued to require intensive care. For the remainder of the stay, subsequent neonatal intensive care codes were used until the patient reached 5 kg, at which point subsequent hospital care codes (99231-99233) were used to report daily E/M services. Another example is a 1-day-old baby who is 5.2 kg (infant of diabetic mother), who was admitted to NICU and required neonatal intensive care services. For this baby, 99476 may be reported for the first day, but even if the baby continued to require intensive care, subsequent-day intensive care codes may not be used because the baby is more than 5kg.

Neonatal intensive care codes also include a bundle, which contains the same 39 CPT codes as neonatal/pediatric critical care codes.

Code 99477 can be reported once per hospitalization and is not reported if an initial neonatal critical care code has already been reported. If an initial neonatal critical care code is already reported and the patient improves and does not meet the definition of critical care but still requires intensive care, then subsequent neonatal intensive care codes are used.

NORMAL NEWBORN CARE SERVICES

99460	*Initial hospital or birthing center care, per day, for E/M of normal newborn infant*
99461	*Initial care, per day, for E/M of normal newborn infant seen in other than hospital or birthing center*
99462	*Subsequent hospital care, per day, for E/M of normal newborn infant*
99463	*Initial hospital or birthing center care, per day, for E/M of normal newborn infant admitted and discharged on the same date*

Use of normal newborn codes is limited to initial care of the normal newborn in the first days of life after delivery. E/M services for the normal newborn include maternal, fetal, and birth history; physical examination(s); ordering diagnostic tests and treatments; meeting with family; and documentation in the medical record. This code set is neither MDM nor time-based. These are day-based codes and reported once per date/day. In the hospital setting, 99460 is reported on the first day and 99462 on subsequent days. 99463 is for admission and discharge on the same date.

These codes are not used if the newborn is anything other than normal. Use appropriate E/M codes for not-normal babies, including hospital, intensive, and critical care codes. The same physician or members of the same group cannot bill a newborn care service with a hospital admission code on the same day. For example, a newborn was seen in the morning, and 99460 was billed. Baby got sick and was admitted to the floor in the afternoon for IV antibiotics. Although a different physician group may use the hospital admission code 99223, the same physician may not bill both the normal newborn code and the hospital admission code on the same day; either should bill the normal newborn code or the hospital admission code for that day.

DELIVERY ROOM ASTTANDANCE AND RESUSCITATION SERVICES

99464	*Attendance to delivery (when requested by physician) and **initial stabilization of newborn***
99465	*Delivery room **resuscitation, provision of positive pressure ventilation and/or chest compressions** in the presence of acute inadequate ventilation and/or cardiac output.*

99464 is reported only when the provider's presence is requested by a delivering physician or other qualified health care worker, indicating a high-risk patient. 99464 includes initial drying, stimulation, suctioning, blow-by oxygen and CPAP administration. These codes are not included in normal newborn care and are reported separately. Procedures that are done in the delivery room, like these 2 codes and other procedures like intubation and central line placement, can be reported separately in addition to the neonatal critical/intensive care codes by the same provider as long as these procedures are performed as part of resuscitative efforts and not as a convenience prior to admission. Code 99465 includes the same services as code 99464, so these 2 codes are not reported together. CPAP administration is covered under 99464, but if the patient requires positive-pressure ventilation, 99465 is reported.

STAND BY SERVICES

99360	*Standby service, requiring prolonged attendance, each 30 minutes, (standby for cesarean/high risk delivery, operative standby, stand for frozen section)*

This code can be used by physicians/pediatricians attending deliveries. This service should be requested by another physician. This code is reported with normal newborn examination (99460) or neonatal resuscitation (99465), but not with initial neonatal stabilization (99464). If the time is less than 30 minutes, 99360 is not reported.

PROLONGED SERVICES

There are 2 different types of prolonged service code sets for physicians. The first is for prolonged services on the same day/date as the encounter, and the second is for prolonged services on any day/date other than the encounter day.

1-Prolonged service with or without direct patient contact on the date of an E/M service

Outpatient	99417	*Prolonged outpatient E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time.*
Inpatient	99418	*Prolonged inpatient or observation E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time*

Basically, these codes exist so you can request additional revenue when you spend too much time with a patient on the day/date of the encounter (the day you physically saw the patient). These codes support the concept that almost everything you do for the patient counts toward the total time, and when in excess, you can bill for that extra time, irrespective of the setting in which it is spent.

As is clear from the above definitions, this code set originates from an existing E/M service and is reported only when the time associated with that E/M service code is exceeded by more than 15 minutes. For example, the level 5 office code of 99215 has a time requirement of 40 minutes when the

total time is used for code selection. What happens if you spend 55 minutes? Then you can report 99215 plus 1 unit of 99417 (40 + 15 = 55). If you spend 70 minutes, then you can report 99215 plus 2 units of 99217 (40+15+15).

You cannot report these codes without reporting a relevant E/M service code first for the same date. 99217 is typically used with one of the following: 99205, 99215, 99245. 99418 is typically used with one of the following: 99223, 99233, 99236, 99255.

To report these codes, the related E/M service code should have an upper time limit, such as 50 minutes for 99233, so that the clock starts ticking for prolonged care when this upper limit is passed and reported when it reaches 15 minutes. If there is no upper limit time, the clock cannot start ticking. Because of this, these codes cannot be used with any E/M service codes that have no upper time limit, such as normal newborn codes, ER codes, critical care codes, intensive care codes, well-child check codes, or hospital discharge day care codes.

Another requirement is that the initial E/M service code selection should be based on time, and the highest level in the code set should be reported. So you cannot use 99417 with 99214. You need to report the highest-level code, like 99215, in the code set first. You can't use 99418 with 99232; you should report the highest-level code, like 99233, first. You also cannot use 99417 or 99418 if the initial code selection is based on MDM. Example: you billed 99215 or 99233 based on MDM, which means you did not document how much time you spent with the patient. In this situation, you cannot report 99417 or 99418 because there is no initial time to start from for each additional 15 minutes.

Each code represents an additional 15 minutes. Any duration less than 15 minutes is not reported. Clock starts ticking when the time in the initial E/M service is exceeded, but not reported until a full 15 extra minutes is reached. So, if you spend 64 minutes on the floor, you cannot report 99418 because 99233 has 50 50-minute requirement and 50+14=64 (you need a full 15 minutes). For the same patient, if you spend 79 minutes, then you can only report 1 unit of 99418 (50+15+14).

With direct patient contact means that prolonged service was provided face-to-face while in the patient's room. Example: spending too much time taking a history and performing a physical examination, and counseling while in the patient's room.

Without direct patient contact means that prolonged service is provided without direct face-to-face patient contact (not in the patient's room), such as reviving labs or imaging, talking with a consultant on the phone, or coordination of care, all carried out while not in the patient's room. Examples: in the office, you saw a patient at 9 am, the patient left at 10 am, and you discussed this patient's management with a consultant on the phone at 5pm. Similar example in the hospital: after seeing a patient on the floor, you went to the radiologist's room, spent an hour reviewing the MRI images, and discussed the findings.

Lastly, these codes can only be reported on the day of the original E/M service. If you saw the patient on Monday, then you cannot use these codes for an hour-long discussion with a consultant on Tuesday.

2-Prolonged service without direct patient contact on the date other than the face to face E/M service

99358	*Prolonged evaluation and management service before and/or after direct patient care; first hour*
99359	*Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes*

These codes exist so you can request additional revenue for time spent for a patient on any day you have not seen the patient face-to-face. Example: if you see a patient on Monday morning, you can report the prolonged services for a prolonged conversation with a consultant you had on Monday night using 99417 or 99418, but what if the consultant doesn't answer and calls you back the next day and has an hour-long discussion? What now? You can't use 99417 or 99418, it's not the same day anymore. This is exactly the situation to use this code set.

To use these codes, there must be an E/M service of reference, either in the past or in the future. Example: reviewing a NICU discharge, 3 months' worth of files on Monday, and seeing the actual patient on Wednesday. You probably need a separate note, or at least an addendum, to your reference E/M service note regarding this prolonged service. Documenting what you did and the total extra time.

The big difference between this code set and 99417/99418 is that you can use these codes (99358, 99359) with any other E/M service codes, and the referenced E/M service does not need to be time-based. Remember, you could not use 99417 with 99214 because you need to go to the highest level in the code set first, but you can use 99358 with 99214 or any relevant code in the code set, and it doesn't matter whether 99214 is time or MDM-based.

99358 is used for the first hour of prolonged service and is not reported if the prolonged service is less than 30 minutes. 99359 is an add-on code and is reported only after 99358. 99359 is used to report each additional 30 minutes and is not reported if additional time is less than 15 minutes. Example: you saw a patient on Monday, reported 99213, and then spent 130 minutes on Tuesday reviewing the chart and talking with multiple consultants. Then appropriate billing would be 99213 for Monday and 99358 plus 2 units of 99359 (60+30+30+10 =130, the last 10 minutes do not qualify for an additional unit of 99359).

This code set is typically for outpatient physicians, because it would be unusual for an inpatient physician not to see their patient on the day they are providing care. This code set can be reported by inpatient physicians when they are on call and do not physically see the patient face-to-face. For example, a hospitalist on call at home gets a call from a resident at night, discusses patient management for 40 minutes, and sees the patient the next day. The hospitalist can report 99358 for the night discussion and the relevant E/M service the next day. In a rare situation, let's say you were the hospitalist on Monday and were off service Tuesday, but were somehow called about a patient you took care of on Monday and spent 1 hour coordinating care; then you can bill 99359. Consultants may also use these codes when they discuss the patient care, but do not see the patient on the same day of initial discussion, but see the patient on another day.

Prolonged staff services: *99415-99416.* This is yet another prolonged service codes for nursing staff in the outpatient clinic. Physicians can use these codes to report prolonged services delivered by nurses under their supervision in the office.

PREVENTIVE MEDICINE SERVICES

This code set is used in the outpatient setting and is commonly referred to as well-child checks. These codes are only for preventive medicine/well-child checks, including sports participation examinations. If any significant problem is identified and addressed during the encounter, it should be reported with appropriate E/M service codes using modifier 25. Modifier 25 lets the payer know that management of the problem was a separate service from the well-child check. An insignificant or trivial problem identified during a well check is included in the well check and not separately reported. If you see a patient for a well-child check and address his acute sinusitis, then you should bill both the preventative medicine service code and the appropriate E/M service code.

New Patient	99381	***Initial comprehensive preventative medicine*** *evaluation of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, new patient;* ***infant (age younger than 1 year)***
	99382	***; Early childhood (age 1 through 4 years)***
	99383	***; Late childhood (age 5 through 11 years)***
	99384	***; Adolescent (Age 12 through 18 years***
Established Patient	99391	*Periodic comprehensive preventative medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, established patient;* ***infant (age younger than 1 year)***
	99392	***; Early childhood (age 1 through 4 years)***
	99393	***; Late childhood (age 5 through 11 years)***
	99394	***; Adolescent (Age 12 through 18 years***

Separately reportable services, such as immunizations, office labs, and screening tests (e.g., vision and hearing), are not included in preventive care services and should be reported separately.

Preventive medicine, individual counseling, new or established patients

Preventive medicine counseling and risk-factor reduction interventions will vary with age and should address issues such as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

99401	*Preventative medicine counseling, and or risk factor reduction intervention(s) provided to an individual (separate procedure);* ***approximately 15 minutes***
99402	*;* ***approximately 30 minutes***

There are also several other preventive medicine CPT codes that are used for individual counseling (99401, 99402, 99403, 99404), behavior change interventions (99406, 99407, 99408, 99409), group counseling (99411, 99412).

Medical Team Conference ~ Team Meeting (Case Management Service)

The medical team conference requires face-to-face participation of a minimum of 3 qualified health care professionals from different specialties or disciplines. There are 2 different types. The first type of medical team conference involves direct face-to-face contact with the patient and/or the patient's caregiver or guardian. The second type is a medical team conference with only providers and no direct contact with the patient or caregiver. The distinction is important because how you bill the time you spend in the team meeting depends on whether the patient/caregiver is in the meeting. If the patient or caregiver giver present in the meeting, then the physician will report the time using appropriate E/M service codes, including prolonged service. If the patient/caregiver is not present at the meeting, physicians will report time using 99367.

Medical team conference, direct (face to face) contact with patient and/or caregiver.
Physicians: use appropriate E/M service codes including prolonged service codes

Medical team conference without direct (face to face) contact with patient and/or family
Physicians: use code 99367. Less than 30 minutes is not reported separately.

99367	*Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more, participation by physician*

TELEMEDICINE CODES

Telemedicine services are synchronous, real-time, and interactive encounters between a provider and a patient. There are 2 types of telemedicine services. The first one is a combined audio-video, and the second one is audio-only. Telemedicine services are not used to report routine communications related to a previous encounter, such as discussing lab results with the patient. They are intended for evaluation and management services, similar to in-person office codes. Telemedicine services may be used for follow-up of previous face-to-face E/M services, such as evaluation of treatment response or complications from therapy initiated at the previous visit. Telemedicine services are not reported on the same day/date of another E/M service. If they are done on the same day, then MDM elements and time are summed up and reported as an aggregate so that they are counted only once. When telemedicine and in-person services are provided on the same day, the time for telemedicine services can still be counted toward the total time of the in-person service, regardless of how long the telemedicine service lasted.

In 2025, AMA added 17 new telemedicine codes, 98000-98016. These are the only E/M codes that do not start with 99 thousand. Except for 98016, the rest (16 codes) are MDM-based codes that can also be based on time. The wording and usage of these 16 codes are very similar to those of in-person office visit codes.

98016 is a non-MDM-based code and differs significantly from the rest of the telemedicine codes. It is simply used for triaging patients. It is an audio-only telemedicine service that involves 5 to 10-minute-long medical discussions. It is only for established patients. This service is patient-initiated and intended to determine whether a more extensive visit type is required, such as a face-to-face office visit. It can be considered as patient triage through an audio connection. It should not originate from an E/M service

within the prior 7 days and should not lead to a new visit within the next 24 hours or the soonest available.

The 16 telemedicine codes can be divided into 2 groups.

1) Synchronous audio-video evaluation and management services: 4 codes for new patients and 4 codes for established patients. No minimum time is required to report these codes.

2) Synchronous audio-only evaluation and management services: 4 codes for new patients and 4 codes for established patients. A minimum time of 10 minutes is required for these codes, even if the code selection is based on MDM.

4 code subgroups follow the 4 levels of MDM and are worded very similarly to office codes.

These codes are all reported once per day. Do not report these codes with same-day in-person E/M service. Prolonged service care codes can be used with these codes.

Tables below show the new and established patients' telemedicine codes and how they relate to office codes. It is clear that the codes in the same column are identical in terms of MDM level and total time. For example, codes 99205, 98003, and 98007 all have high MDM and 60 minutes of total time. The only minor difference is that audio-only codes have a minimum 10-minute time requirement.

MDM		Straightforward	Low	Moderate	High
Time		15 minutes	30 minutes	45 minutes	60 minutes
New Patient	Office – in person	99202	99203	99204	99205
	Audio-Video	98000	98001	98002	98003
	Audio only	98004	98005	98006	98007

MDM		Straightforward	Low	Moderate	High
Time		10 minutes	20 minutes	30 minutes	40 minutes
Established Patient	Office – in person	99212	99213	99214	99215
	Audio-Video	98008	98009	98010	98011
	Audio only	98012	98013	98014	98015

The use of this new code set is another example of the complexity of our billing regulations. Just because a CPT code exists does not mean it is accepted by payers. This code set was introduced in 2025, and CMS has not yet accepted these codes. Instead, CMS asks the providers to report regular office codes with modifier 93 for audio-only visits and modifier 95 for audio-visual visits. Given that these codes align perfectly with office codes, there would be no significant difference.

ONLINE DIGITAL E/M SERVICES

Codes 99421, 99422, 99423 involve patient-initiated services. The patient reaches the physician online via an app, email, etc., about a problem, and the physician addresses it using evaluation and management. If the encounter or interaction does not include evaluation and management, these codes may not be reported, such as when discussing a lab result on the internet app. The patient should be an established patient, though the problem can be new. These services require permanent storage of online encounters. These service codes cover the total care minutes over 7 days (one week). 99421: 5-

10minutes. 99422: 11-20 minutes and 99423: 21 minutes or more of total care time, in one week from the time of initial contact. These codes cannot be used if the patient is seen within 7 days before or after the initial online contact. This code set is not a universally reimbursed service, nor is it covered by MediCal. Further information can be found in the CPT book E/M section.

Interprofessional telephone/internet/electronic health record consultation

The 99446, 99447, 99448, and 99449 codes are used by consulting doctors to report their time for both verbal opinion and written report. Code 99451 is used when only a written report is given. Code 99452 is for the referring doctor. There are many rules about when and how this code set can be used. Only 9999451 and 99452 are covered by MediCal. Consultants can't use these codes if they saw the patient in the last 14 days or will see the patient in the next 14 days. 99452 can't be used separately by the physicians who are requesting the consult if they have seen the patient on the same day. Further information can be found in the CPT book E/M section.

Digitally stored data services/Remote physiologic monitoring.

These codes are used to report services when a physician monitors various physiologic parameters online, transmitted from the patient's device to the physician. Parameters monitored include weight, blood pressure, pulse oximetry, respiratory rate, and ECG. This code set includes 99453, 99454, 99091, 99473, 99474, 99457, and 99458, and is used by only a few physicians/specialties. Further information can be found in the CPT book E/M section.

ADVANCE CARE PLANNING

These codes are time-based and used to report face-to-face service between a physician or other QHCP and a patient, family member, or surrogate in counseling and discussing advance directives with or without completing relevant legal forms. These codes are not used with critical care codes but can be used with other E/M codes.

99-497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms when performed) by the physician; first 30 minutes, face to face time with the patient, family members and/or surrogate

+99498: each additional 30 minutes