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Evaluation and Management Services Guide

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

Contents

What's Changed?

We made significant updates to the language, order, and formatting of this product to better meet provider needs and improve understanding.

- 2024 Medicare Physician Fee Schedule Final Rule updates and links
  - Updates to billing telehealth services (page 21)
- Change Request (CR 13473), Pub. 100-04 Medicare Claims Processing, R12461CP
  - Using add-on code G2211 for Office or Outpatient E/M Visits (page 4)
    - Use with CPT codes 99202-99205 and 99211-99215
- Change Request (CR 13592), Pub. 100-04 Medicare Claims Processing, R12604CP
  - Updates to definition of substantive portion of split (or shared) E/M Visits (page 13)

Substantive content updates are in dark red.

Office or Outpatient E/M Visits

For dates of service in 2023, use the revised CPT codes for Other E/M services (except for prolonged services). This includes:

- Hospital inpatient and observation visits merged into a single code set
- New descriptor times, where relevant
- Revised CPT E/M guidelines for levels of MDM

HCPCS Add-on Code G2211

Beginning January 1, 2024, you may use G2211 with office or outpatient (O/O) evaluation and management (E/M) CPT codes 99202-99205 and 99211-99215, the base service codes to account for the additional resources of visits when:

- You're the continuing focal point for all needed services, like a primary care practitioner
- You're giving ongoing care for a single, serious condition or a complex condition, like sickle cell disease or HIV

G2211 captures the complexity of the O/O E/M visit based on the ongoing relationship between the practitioner and patient. The complexity that code G2211 captures isn't in the clinical condition. The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. See MM13473 Revised.

You must document the reason for billing the O/O E/M visit. The visits themselves would need to be medically reasonable and necessary for the practitioner to report G2211. In addition, the documentation would need to illustrate medical necessity of the O/O E/M visit. Examples of supporting documentation for billing code G2211:

- Information included in the medical record or in the claim history for a patient/practitioner combination, such as diagnoses
- The practitioner's assessment and plan for the visit
- Other service codes billed

G2211 and Modifier 25

G2211 may not be reported without reporting one of its base service codes. G2211 isn't payable when its base service code (one of the nine O/O E/M visit codes listed above) is reported with modifier 25. See MM13272.

Prolonged Office/Outpatient E/M Visits

When you select office or outpatient E/M visit level using time, report prolonged office or outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office or outpatient E/M services). For more information see Prolonged Services.

Critical Care Services

CPT Codes 99291 & 99292

Beginning January 1, 2022, use the AMA CPT language for the definition of critical care visits (CPT codes 99291 and 99292):

- Your direct delivery of care to a critically ill or injured patient when 1 or more vital organ systems are acutely impaired,
- A probability of imminent or life-threatening deterioration of the patient's condition exists, and
- Your high complexity decision making to treat single or multiple vital organ system failure or to prevent further life-threatening deterioration of the patient's condition that requires your full attention

During time spent providing critical care services, you can't provide services to any other patient. Bundled services that are included by CPT in critical care services and therefore not separately payable include interpretation of cardiac output measurements, chest X rays, pulse oximetry, blood gases and collection and interpretation of physiologic data (for example, ECGs, blood pressures, hematologic data), gastric intubation, temporary transcutaneous pacing, ventilator management, and vascular access procedures. See CR 12543.

When you provide 30-74 minutes of critical care services to a patient on a given day, report CPT code 99291.

- Only use CPT code 99291 once per date even if the time you spend isn't continuous on that date
- Report CPT code 99292 for additional 30-minute time increments you provide to the same patient
- Don't report 99292 until you spend 104 minutes (74 + 30 = 104 minutes) with the patient
- You may add non-continuous time for medically necessary critical care services

Concurrent Critical Care Services: Different Specialties

Concurrent care is when more than 1 individual provides services that are more extensive than consultative services at the same time. We cover the reasonable and necessary services of each individual providing concurrent care when each plays an active role in the patient's treatment.

You may provide critical care services concurrently with more than 1 individual from more than 1 specialty to the same patient on the same day if the services meet the definition of critical care and aren't duplicative.

Concurrent Critical Care Services: Individuals in the Same Specialty & Same Group (Follow-Up Care)

CPT Codes 99291 & 99292

When you provide the entire initial critical care service and report CPT code 99291, any provider in the same specialty and the same group providing care concurrently to the same patient on the same date should report their time using the code for additional time intervals (CPT code 99292).

- These providers shouldn't report CPT code 99291 more than once for the same patient on the same date
- When 1 provider begins the initial critical care service but doesn't meet the time needed to report CPT code 99291, another provider in the same specialty and group can continue to deliver critical care to the same patient on the same date

- Combine the total time providers spent to meet the required time to bill CPT code 99291
- Once you meet the cumulative time to report critical care service CPT code 99291, only an individual in the same specialty and group can report CPT code 99292 when they provide an additional 30 minutes of critical care services to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes)
- The time spent on critical care visits must be medically necessary, and each visit must meet the definition of critical care

Tip: There are different billing rules when the critical care services are split between a physician and NPP. See Split (or Shared) Services.

Critical Care & Other Same-Day E/M Visits

Starting February 15, 2022, you may bill hospital E/M visits the same day as critical care services in certain circumstances. See CR 12543.

For other E/M services billed for the same patient on the same date as a critical care service, document that the service is:

- Provided before the critical care service at a time when the patient didn't require critical care
- Medically necessary
- Separate and distinct, with no duplicative elements from the critical care service provided later in the day

Use modifier 25 (same-day significant, separately identifiable E/M service) on the claim when you report critical care services unrelated to the service or procedure that you perform on the same day. You must also document the medical record with the relevant criteria for the respective E/M service you're reporting.

Critical Care Services & Global Surgery

If you perform critical care unrelated to the surgical procedure during a global surgical period, you may get separate payment for the services. Medicare may pay for preoperative and postoperative critical care in addition to the procedure if:

- The patient is critically ill and requires your full attention
- The critical care is above and beyond, and unrelated to the specific anatomic injury or general surgical procedure performed (like, trauma or burn cases)

When a critical care service is unrelated to the surgical procedure, use modifier FT on your claim. Modifier FT describes an unrelated E/M visit:

- On the same day as another E/M service, or
- During a global procedure (preoperative period or postoperative period), or on the same day as the procedure
- Also report modifier FT if you provide 1 or more unrelated E/M visits on the same day as the critical care CPT code

If the surgeon fully transfers care to you and the critical care is unrelated, use the appropriate modifier to show the transfer of care. Surgeons will use modifiers 54 (surgical care only) or 55 (postoperative management only) on their claims. When you accept the transfer of care, add both modifier 55 and modifier FT to your claim. Medical record documentation must support the claims.

Initial Hospital Inpatient or Observation Care

Observation Care Following Initiation of Observation Services

CPT Codes 99221-99223, 99231-99236

Starting January 1, 2023, bill for hospital inpatient and observation care services using the revised Hospital Inpatient or Observation Care services code set (CPT codes 99221-99223, 99231-99239). For patients admitted and discharged on the same date of service, bill hospital inpatient or observation care (including admission or discharge) using CPT codes 99234-99236.

The time you count toward hospital inpatient or observation care codes is per day. Per day (also called the encounter date) means the calendar date. When you use MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service.

- Report the date the patient encounter begins
- If you provide a continuous service (before and through midnight), you may apply all of the time to the date of the service you report (the calendar date the encounter starts).
- You may only bill 1 of the hospital inpatient or observation care codes per calendar date for:
  - An initial visit
  - A subsequent visit
- Select a code that includes all of the services (including admission and discharge) you provide on that date

The treating provider bills for the observation care codes. Individuals who provide consultations, other evaluations, or services while the patient is getting hospital outpatient observation services must bill using the appropriate outpatient service codes.

When billing an initial hospital inpatient or observation care service, a transition from observation status to inpatient status isn't a new stay. Medicare Administrative Contractors (MACs) will only pay you for 1 hospital visit per day for the same patient, even if the problems you treat aren't related.

Tip: In some cases, you may bill a prolonged code in addition to the Hospital Inpatient or Observation Care services base code. You may count time you spend on the same day with the same patient in multiple settings or time you spend on a patient who transitions between outpatient and inpatient status toward the Hospital Inpatient or Observation Care services base code and a prolonged code (if it applies).

Prolonged Hospital Inpatient or Observation Care Services

HCPCS Code G0316

Starting January 1, 2023, report prolonged services for certain hospital inpatient or observation care visits using HCPCS code G0316. You can report prolonged services when you use time to select your visit level, and you exceed your total time for the highest-level visit by 15 or more minutes on medically necessary services. See Prolonged Services for detailed reporting instructions.

Initial Hospital Inpatient or Observation Care on Day Following Visit

CPT Codes 99221-99223, 99231-99236, 99238 & 99239

MACs pay both visits if you see a patient in the office on 1 day, and they're admitted to the hospital as an inpatient or get observation care on the next day. This applies even if fewer than 24 hours has elapsed between the visit and the admission for hospital inpatient or placement in observation care.

Initial Hospital Inpatient or Observation Care and Discharge on Same Day

CPT Codes 99221-99223, 99231-99236, 99238 & 99239

Bill both hospital inpatient and observation care coding as follows:

- When you admit a patient to inpatient hospital or observation care for less than 8 hours on the same day, report the Initial Hospital Inpatient or Observation Care from CPT code range 99221 - 99223
- Don't report Hospital Inpatient or Observation Discharge Day Management services, (CPT codes 99238 or 99239) if the patient is in observation care for less than 8 hours
- When you admit a patient to inpatient hospital or observation care and discharge them on a different date, report an Initial Hospital Inpatient or Observation Care from CPT code range 99221 - 99223 and a Hospital Inpatient or Observation Discharge Day Management service, CPT code 99238 or 99239
- When you admit a patient to inpatient hospital or observation care for 8 or more hours but less than 24 hours and discharge them on the same calendar date, report Hospital Inpatient or Observation Care services (including admission and discharge services), CPT code range 99234 - 99236

You must satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. You must also meet and document the guidelines for history, examination, and MDM in the medical record.

Tip: Per the CPT code descriptors, Initial Hospital Inpatient or Observation Care services requires a medically appropriate history and examination but won't be used to select your visit level. If you're working in hospitals, be aware of the documentation you need to bill under the Physician Fee Schedule (PFS), other payment systems, or Conditions of Participation.

Table 1 shows billing based on hospital length of stay and discharge date.

Table 1. Billing Hospital Length of Stay and Discharge Date

Discharged On	Hospital Length of Stay	Codes to Bill
Same calendar date as admission or start of observation	Less than 8 hours	Initial hospital services only*
	8 or more hours	Same-day admission/discharge*
Different calendar date than admission or start of observation	Less than 8 hours	Initial hospital services only*
	8 or more hours	Initial hospital services* + discharge day management

*Plus prolonged inpatient/observation services, if applicable.

Home or Residence Services

CPT Codes 99341-99350

Starting January 1, 2023, the 2 E/M visit families called Domiciliary, Rest Home (Boarding Home), or Custodial Care services and Home services are now 1 E/M code family, Home or Residence services. Use the codes in this family to report E/M services you provide to a patient in:

- Their home or residence
- An assisted living facility
- Group home (not licensed as an intermediate care facility for people with intellectual disabilities)
- Custodial care facility
- Residential substance abuse treatment facility

There are no changes to the care settings for the current families. They're in the new merged family. This change removes CPT codes 99324-99337. Therefore, multiple Place of Service (POS) codes can be billed with the new merged family of CPT codes 99341-99350 for Home or Residence Services:

- Home (POS 12)
- Assisted Living Facility (POS 13)
- Group Home (POS 14)
- Custodial Care Facility (POS 33)
- Residential Substance Abuse Treatment Facility (POS 55)

Prolonged Home or Residence E/M Visits

You may report reasonable and medically necessary prolonged services with the appropriate E/M codes when you provide a prolonged Home or Residence Service that's beyond the usual E/M visit. When you select a Home or Residence E/M visit level using time, report prolonged Home or Residence E/M visit time using HCPCS add-on code G0318 (Prolonged home or residence E/M services). You must meet all of the requirements for prolonged services. For more information see Prolonged Services.

Nursing Facility Services

CPT Codes 99304–99310, 99315-99316, & 99318

You can't bill an initial Nursing Facility (NF) service and another E/M service (like an office or other outpatient visit or ED visit) on the same date of service for the same patient. You can count the time you spend providing services in another setting toward reporting prolonged NF services if you meet the requirements for reporting prolonged NF services.

Starting January 1, 2023, you can't use CPT code 99318 (Other NF Service) to report an annual NF assessment visit. You must use the regular Medicare Part B NF Services code set for dates of service on and after January 1, 2023.

Prolonged Services

You may report prolonged E/M services for certain E/M visit families when the total visit time you spend with a patient exceeds a certain time threshold. Report prolonged E/M services using Medicare-specific coding. When reporting prolonged visits, you would report the codes for the primary service and the prolonged services.

Starting in 2024, for prolonged visits, the substantive portion is more than 50% of the practitioners' total time. See MM13592.

Prolonged Office or Outpatient E/M Visits

HCPCS Add-on Code G2212

When you select a visit level using time, you may report a prolonged office or outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services).table provides reporting examples.

Table 2 gives reporting examples for prolonged office or outpatient E/M visits.

Table 2. Codes for Billing Prolonged Office or Outpatient E/M Visits

Codes	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

Codes	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

* Total time is all of the reportable time, including prolonged time, you spend with the patient on the date of service of the visit.

You may also report prolonged cognitive impairment assessment and care management services (primary service CPT code 99483) using G2212, the Medicare-specific code for prolonged office and outpatient services.

HCPCS Code G2212: Prolonged Office or Other Outpatient E/M Services
The following criteria apply:

- Use for services beyond the maximum time of the primary service you select using total time on the date of the primary service
- Use for each additional 15 minutes beyond the maximum time you provide, with or without direct patient contact
- List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient E/M services
- Don't report G2212 on the same date of service as codes 99358, 99359, 99415, or 99416
- Don't report G2212 for less than 15 additional minutes

The AMA's E/M Services Guidelines (Guidelines for Selecting Level of Service Based on Time) lists qualifying activities.

You may count these activities when:

- You use time to select your visit level
- Your services are medically reasonable and necessary

You'll find 3 new Medicare-specific HCPCS codes (1 per E/M family) for billing prolonged Other E/M services, listed below in Table 3.

Prolonged Other E/M Visits

HCPCS Codes G0316, G0317, & G0318

Starting January 1, 2023, report prolonged Other E/M services using HCPCS codes G0316, G0317, and G0318. Other E/M services include:

- Inpatient visits
- Observation visits

- NF visits
- Home or residence visits
- Cognitive impairment assessment and care planning

For timed visits, you may report prolonged Other E/M services with the highest visit level when your total visit time exceeds a certain threshold.

- Don't report prolonged services with ED visits or critical care services
- Prolonged services give you payment for additional practitioner time that isn't already accounted for in your primary service
- You can count your time spent providing qualifying activities when you perform them, and the total time spent is at least 15 minutes beyond the total time shown below.

Table 3 summarizes billing prolonged Other E/M Services.

Table 3. Billing Prolonged Other E/M Visits

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	65 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	110 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	N/A	N/A	N/A
Emergency Department Visits	N/A	N/A	N/A
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	N/A	N/A	N/A
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	N/A	N/A	N/A

* You must use time to select your visit level.
NPP= non-physician practitioner
IP/Obs. = inpatient/observation

Prolonged NF Services

HCPCS Code G0317

Starting January 1, 2023, report prolonged NF services using Medicare-specific coding (HCPCS code G0317). You can report prolonged services when you use time to select your visit level, and you exceed the total time for the highest-level visit by 15 or more minutes providing reasonable and medically necessary services. You can't bill prolonged services with codes for NF discharge-day management.

Split (or Shared) E/M Services

A split (or shared) service is an E/M visit in the facility setting that is performed in part by both a physician and a NPP who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if only one of them furnished it independently. We pay the practitioner who performs the substantive portion of the visit, which can be more than half of the total time spent by the physician and NPP, or a substantive part of the medical decision making (defined by the AMA CPT) for visits involving medical decision making (MDM). See the AMA's E/M Guidelines and MM13592.

Tip: Facility setting is an institutional setting in which payment for services and supplies provided incident to a physician or NPP's professional services is prohibited under our regulations.

Rules for reporting split (or shared) E/M services between a physician and NPP:

Hospital Inpatient, Hospital Outpatient, & ED Visits

Beginning January 1, 2024, the physician or NPP who provides more than 50% of the total time or the substantive part of MDM should bill for the visit. See MM13592.

Critical Care Services

- Since critical care visits don't use MDM to define the service, the substantive portion is not determined using MDM. The substantive portion means more than 50% of the total time spent by the practitioners

- Unlike other E/M services, critical care services can include additional activities that are bundled into the critical care visit codes 99291 and 99292. There's a unique list of qualifying activities for split (or shared) critical care. See the CPT Codebook for preferred descriptions.
- The same documentation rules apply for split (or shared) critical care visits as for other types of split (or shared) E/M visits

SNF E/M Visits

- You may bill SNF E/M visits that only use time as split (or shared) visits if they meet the rules for split (or shared) visit billing, except for SNF E/M visits that a physician must perform in their entirety
- NF visits don't meet the definition of split (or shared) services, because "incident to" payment is available in the NF setting (see Split__or_shared__services_and_critical_care_FAQs_07Apr2022.pdf (cms.gov))

Billing & Documentation

- Use modifier FS (Split or Shared E/M Visit) on claims to report these services. This tells us that even though you're submitting the claim under 1 practitioner's NPI, 2 practitioners performed the visit.
- To bill split (or shared) critical care services, report CPT code 99291. If you spend 104 or more cumulative total minutes providing critical care, report 1 or more units of CPT code 99292. Add modifier FS to the critical care CPT codes on the claim.
- No matter where the split (or shared) visit took place, document the medical record to include:
  - The identity of both practitioners who perform the visit
  - Who performed the substantive portion of the visit

Submit the claim using the NPI for the practitioner who performed the substantive portion of the visit. That practitioner must also sign and date the medical record.

Table 4 shows the definition of the substantive portion for E/M visit code families.

Table 4. Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2024 Definition of Substantive Portion
Hospital Outpatient*	More than 50% of total time or a substantive part of the MDM
Inpatient, Observation, Hospital, and SNF*	More than 50% of total time or a substantive part of the MDM
Emergency Department	More than 50% of total time or a substantive part of the MDM
Critical Care	More than 50% of total time

* You can't bill office visits or nursing facility visits as split (or shared) services, because "incident to" payment is available in those settings..

Distinct Time

You can only count distinct time for split (or shared) E/M services. When providers jointly meet with or discuss the patient, you can only count the time of 1 provider.

Qualifying Time

You can count the following list of activities toward total time to decide the substantive portion (except for critical care visits), regardless of whether the activities involve direct patient contact:

- Preparing to see the patient (like review of tests)
- Getting or reviewing separately obtained history
- Performing a medically appropriate exam 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, or caregiver
- Coordinating care (not separately reported)

You can't count time spent on these activities:

- Travel
- The performance of other services that you reported separately
- Teaching that's general and isn't limited to discussion of the management of a specific patient

For all split (or shared) visits, 1 of the providers must have face-to-face (in-person) contact with the patient, but it doesn't necessarily have to be the provider who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

You can report split (or shared) visits for:

- New and established patients
- Initial and subsequent visits
- Prolonged services

For 2022-2023 transitional years, when you use a key part as the substantive portion, use different approaches for hospital outpatient E/M visits than other kinds of E/M visits:

- For shared hospital outpatient visits where you use a key part as the substantive portion, the provider who reports the primary services may report prolonged services if the combined time of both providers meets the threshold for reporting prolonged hospital outpatient services
- For all other kinds of E/M visits (except ED and critical care visits), the provider who reports the primary service may report prolonged services when the combined time of both providers meets the threshold for reporting prolonged E/M services other than office or outpatient E/M services

Both providers will add their time, and the provider with more than 50% of the total time (the substantive portion), including prolonged time, will report both the primary service code and the prolonged services add-on code, if they meet the time threshold for prolonged services. See CR 13064.

Table 5 summarizes reporting prolonged services for split (or shared) visits.

Table 5. Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	2024
	Substantive Portion Must Be Time
Other Outpatient* Inpatient Observation Hospital SNF*	More than 50% of the practitioners total time
ED Critical Care	N/A

* You can't bill office visits as split (or shared) services.

General Principles of E/M Documentation

Clear and concise medical record documentation is critical to giving patients quality care and getting correct and prompt payment for services. Medical records chronologically report a patient's care and records related facts, findings, and observations about the patient's health history.

Medical record documentation helps you evaluate and plan the patient's immediate treatment and watch their health care over time.

Your MAC may ask for documentation to make sure a service is consistent with the patient's insurance coverage and to confirm:

- The site of service
- The medical necessity and appropriateness of the diagnostic or therapeutic services
- That you report services correctly

General principles of medical record documentation apply to all medical and surgical services and settings.

While E/M services vary, like the nature and amount of physician work needed, these general principles help make sure medical record documentation is correct for all E/M services:

- The medical record should be complete and legible
- Your documentation of each patient encounter should include:

  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
- If you don't document the date, legible name of the observer and your rationale for ordering diagnostic and other services, it should be easily inferred
- Past and present diagnoses should be accessible to you or the consulting physician
- You should identify appropriate health risk factors
- You should document the patient's progress, response to and changes in treatment, and revision of diagnosis
- Documentation in the medical record should report the diagnosis and treatment codes you report on the health insurance claim form or billing statement

Document services during the encounter or as soon as possible after the encounter to keep the medical record accurate.

Common Sets of Codes Used to Bill for E/M Services

When billing for a patient's visit, choose codes that best characterize the services you give during the visit. A billing specialist or alternate source may review your documentation before you send the claim. Reviewer may help you choose codes that show the services you give to the patient. You must make sure:

- Your claim correctly shows your services
- The medical record documentation supports the level of service you report to a payer
- Don't use the volume of documentation to decide the specific level of service to bill

Your services must meet the medical necessity guidelines in the statute, regulations, manuals, and the medical necessity criteria in the National Coverage Determinations (NCDs) and Local Coverage Determinations(LCDs), if any exist for the service reported on the claim. For every service billed, you must show the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

HCPCS

HCPCS is the code set you use to report procedures, services, drugs, and devices you provide in the office, hospital outpatient facility, ambulatory surgical center, or other outpatient facility. This system includes CPT codes the AMA develops and supports.

ICD-10-CM

ICD-10-CM is a code set you use to report medical diagnoses on all claims for services you provide in the U.S.

ICD-10-PCS

ICD-10-PCS is a code set facilities use to report inpatient procedures and services they give patients in U.S. hospital inpatient health care settings.

E/M Services Providers

To get payment from Medicare for E/M services, your state must allow you to bill for E/M services within your scope of practice.

Choosing the Code That Characterizes Your Services

To bill Medicare for an E/M services, you must choose a CPT code that best represents the:

- Patient type
- Setting of service
- Level of E/M service you provide the patient

Patient Type

For purposes of billing office and outpatient E/M services, we identify patients as either new or established, depending on previous encounters with the provider. When billing certain other visit types (e.g., inpatient, NF), the patient type is initial or subsequent.

New Patient: A person who didn't receive any professional services from the physician. NPP, or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Established Patient: A person who receives professional services from the physician, NPP, or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Setting of Service

CMS categorizes E/M services into different settings depending on where you furnish the service. Examples of settings include:

- Office or other outpatient setting
- Hospital inpatient
- ED
- NF

Level of E/M Service You Provide the Patient

The code sets to bill for E/M services are organized into categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category.

To bill any code, the:

- Services you provide must meet the definition of the code
- Codes must reflect the services you provide

Medical necessity is the primary reason we pay for a service. It wouldn't be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is more appropriate.

- As of January 1, 2023, for most E/M visit families, choose visit level based on the level of MDM or the amount of time you spend with the patient

- For some types of visits (like ED visits and critical care), use only MDM or only time to bill

The CPT E/M Guidelines for MDM apply. For all E/M visits, your history and physical exam must meet the descriptions in the code descriptors, but they don't affect visit level selection. When you use time to select the visit level, you must provide services for the full time.

- The general CPT rule about the midpoint for certain timed services doesn't apply
- If you use time to support billing the E/M visit, document the medical record with the time spent with patient using a start and stop time or the total time

Chief Complaint

A **CC** is a short statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words, like patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly show the CC.

For more information, review the CY 2024 Physician Fee Schedule Final Rule (CMS-1784-F) and the CPT® Evaluation and Management webpage.

History and Examination

When you perform E/M codes that have levels of services they include a medically appropriate history or physical examination. The treating physician or other qualified health care professional reporting the service determine the nature and extent of the history or physical examination. The care team may collect information, and the patient or caregiver may supply information directly (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 these E/M service codes.

Medical Decision Making

MDM is included in the CPT codes and services you submit on your claims. When selecting a level of MDM for these services, review the 2023 Evaluation and Management (E/M) Services Guidelines for a detailed breakdown the elements of MDM.

Other Considerations

Chronic Pain Management

HCPCS Codes G3002-G3003

Chronic pain is persistent or recurrent pain lasting longer than 3 months. When billing monthly chronic pain management (CPM) services in 2023, use the 2 HCPCS codes below.

HCPCS G3002: Chronic Pain Management Services
Code G3002 describes a monthly bundle for chronic pain management and treatment services, including:

- Diagnosis, assessment, and monitoring
- Administering a validated pain rating scale or tool

- Developing, implementing, revising, and maintaining a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes
- Overall treatment management
- Facilitating and coordinating any necessary behavioral health treatment
- Medication management
- Pain and health literacy counseling
- Any necessary chronic pain related crisis care
- Ongoing communication and coordinating care between providers furnishing care (like physical therapy and occupational therapy, complementary and integrative approaches, and community-based care), as appropriate

These criteria apply:

- Requires an initial face-to-face visit of at least 30 minutes provided by a physician or other qualified health professional
- First 30 minutes personally provided by physician or other qualified health care professional per calendar month
- You must meet or exceed 30 minutes
- You must develop and maintain a person-centered plan
- Billable per calendar month
- You must provide the appropriate elements of the code bundle specific to each patient
- You don't have to provide all of the bundled elements listed above every month

HCPCS G3003: Add-on Code for Chronic Pain Management Services

- Use code G3003 to bill for each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional per calendar month
- List separately in addition to code G3002
- You must meet or exceed 15 minutes per calendar month

Consultation Services

CPT Codes 99251–99255 & 99241–99245

Medicare doesn't recognize these codes for Part B payment purposes:

- Inpatient consultation codes (CPT codes 99251–99255)
- Office and other outpatient consultation codes (CPT codes 99241–99245)

Medicare recognizes telehealth consultation codes (HCPCS G0406–G0408 and G0425–G0427) for payment.

If you provide services using CPT consultation codes, you should report the correct E/M visit code to bill for these services.

Teaching Physician Services

The AMA CPT office or outpatient E/M visit coding framework allows you to choose the office or outpatient E/M visit level to bill, based on the total time you personally spent with the patient or MDM (with or without direct patient contact on the date of the service), including the time you're present when the resident is performing qualifying activities.

Starting January 1, 2022, you may include the time a teaching physician is present with the patient when determining E/M visit level. Under the primary care exception, you can only use MDM to choose the visit level. This limits the possibility of inappropriate coding based on residents' inefficiencies instead of a measure of the time for the services. See CR 12543.

As referenced in CR 12543, Section 100.1.1(A), for purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

As referenced in CR 12543, Section 100.1.1(B), any contribution and participation of students to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed but may verify any student documentation of them in the medical record, rather than re-documenting this work.

As referenced in CR 12543, Section 100.1.4, for procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary.

Telehealth Services

Beginning January 1, 2024, we're adding new codes to the list of Medicare telehealth services, including:

- CPT codes 0591T - 0593T for health and well-being coaching services (on a provisional basis)
- HCPCS code G0136 for Social Determinants of Health Risk Assessment (on a permanent basis)

Based on several telehealth-related provisions of the Consolidated Appropriations Act (CAA), 2023 and the CY 2024 PFS final rule, we're:

- Temporarily expanding the scope of telehealth originating sites for services you provide via telehealth to include any site in the U.S. where the patient is at the time of the telehealth service, including a person's home
- Temporarily expanding the definition of telehealth practitioners to include:
  - Qualified occupational therapists (OTs)
  - Physical therapists (PTs)
  - Speech-language pathologists (SLPs)
  - Audiologists
- Adding mental health counselors and marriage and family therapists as distant site practitioners when providing telehealth services
- Continuing payment for telehealth services rural health clinics (RHCs) and federally qualified health centers (FQHCs) you provide using the methodology established for those telehealth services during the PHE
- Temporarily delaying the requirement for an in-person visit with the physician or practitioner within 6 months before initiating mental health telehealth services, and, again, at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs, FQHCs, and hospital outpatient departments (HOPDs)
- Allowing teaching physicians to use audio or video real-time communications technology when the resident provides Medicare telehealth services in all residency training locations through December 31, 2024
- Temporarily removing frequency limitations in 2024 for:
  - Subsequent inpatient visits
  - Subsequent nursing facility visits
  - Critical care consultation
- Allowing hospitals providing PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) on the Medicare Telehealth Services List to continue to bill for these services when provided remotely in the same way they've been during the PHE except:
  - Patients' homes no longer need to be registered as provider-based entities to allow outpatient hospitals to bill for these services
  - Modifier 95 modifier is required on claims from all institutional providers (except for Critical Access Hospitals (CAHs) electing Method II) as soon as hospitals needing to do so update their system

HCPCS Codes G0316-G0318, G3002-G3003

Starting January 1 2023, we're adding these new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis: HCPCS codes G0316, G0317, G0318, G3002, and G3003.

We pay for specific Medicare Part B services that a physician or practitioner provides via 2-way, interactive technology (or telehealth). Telehealth substitutes for an in-person visit, and generally involves 2-way, interactive technology that permits communication between the practitioner and patient.

During the COVID-19 public health emergency (PHE), we used emergency waiver and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the Consolidated Appropriations Act, 2023 extended many of these flexibilities through December 31, 2024, and made some of them permanent.

For dates of service in 2024, continue billing telehealth services with the POS you would bill for an in-person visit. You must use modifier 95 to show they're telehealth services until December 31, 2024. See list of codes added to the telehealth services list.

> The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

See the MLN® Telehealth Services fact sheet for information on:

- Originating and distant sites
- Telehealth requirements
  - Section 4113 of the Consolidated Appropriations Act, 2023
- Currently covered telehealth
  - List of Telehealth Services ZIP file
  - Provider Billing Medicare FFS Telehealth
- Billing & payment
- New HCPCS G codes for home health telehealth
  - See MLN Matters Article MM12805
- Consent for care management & virtual communication services

Visit the HHS Telehealth Policy webpage or review the AMA's Telehealth Quick Guide. It's intended to help physicians, practices and health systems navigate changes to flexibilities. It includes information on:

- Practice Implementation
- Policy, Coding & Payment

Resources

- 2023 CPT E/M descriptors and guidelines (ama.org)
- 2025 ICD-10-CM
- 2025 ICD-10-PCS
- Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet
- Change Request CR 13064, Pub. 100-04 Medicare Claims Processing, R11842CP
- CPT® Books
- CPT® Evaluation and Management
- Evaluation and Management (E/M) Visits
- Evaluation and Management (E/M) Visit FAQs Physician Fee Schedule (PFS)
- HCPCS
- HHS Telehealth Policy
- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual
- Medicare Information for Patients
- Medicare Learning Network® (MLN) Products
- MLN Matters® Article MM 12982 - Medicare Physician Fee Schedule Final Rule Summary: (CY) 2023
- MLN Matters® Article MM 13452 - Medicare Physician Fee Schedule Final Rule Summary: (CY) 2024
- Reporting CPT Modifier 25
- Telehealth Quick Guide (ama.org)
- Telehealth Policy Changes after the COVID-19 PHE
- Tuesday, November 8, 2022-Transcript, Q&A and Audio File-Physicians Open Door Forum (ZIP) file