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Clinical Examples Used in this Course

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are actual, redacted office visit and procedure notes donated by AAPC members.

To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Module 1

Evaluation and Management Coding

Introduction
Evaluation and management (E/M) services describe the time and work involved when a provider of service is evaluating a patient’s condition(s) and determining the management of the care required to treat the patient. Understandably, E/M services are among the most utilized codes in the CPT® codebook. E/M services can be provided in a variety of locations such as a provider’s office, urgent care clinic, or hospital, to name a few.

The determination of the correct E/M code is dependent upon many factors. Your CPT® codebook provides steps for determining the correct CPT® code. In addition, the Centers for Medicaid & Medicare Services (CMS) have outlined two sets of Documentation Guidelines for Evaluation and Management Services, 1995 and 1997. Taking all of the documentation readily available to you and applying it can be daunting. One objective for this curriculum is to break it down in small pieces to help you master evaluation and management coding.

During evaluation and management services, providers can address one symptom or diagnosis, or multiple symptoms and diagnoses. These condition(s) must be accurately coded using ICD-9-CM codes to support the medical necessity of the service provided. Minor (or simple) office procedures can also be provided during the E/M service, affecting what documentation is used for the procedure and what documentation is used for the E/M service.

There are CMS regulations on the use of E/M services in certain circumstances. Although the regulations are for CMS, they are often adopted by commercial insurance carriers. Regulations that will be discussed in this curriculum include “incident-to” guidelines, reporting of shared/split visits, and teaching physician guidelines.

The final piece of this curriculum will detail evaluation and management services specific to certain specialties. The specialties discussed will include Family Practice and Internal Medicine, Pediatrics, OB/Gyn, Emergency Department, Cardiovascular, and Orthopaedics.

Evaluation and Management Overview
E/M is not specific to one medical specialty, nor is it specific to one body system or an anatomical area. To code E/M services appropriately, you will need to understand terms and anatomy related to the entire body.

During each visit, a physician uses a variety of methods to evaluate a patient. The physician observes the patient during the encounter and documents mannerisms and behavior. The skin and symmetry of the body are inspected. After inspection and observation (or visual evaluation), a physician may explore a body system further using palpation, auscultation, and percussion. Palpation refers to examination of the body by touch. Body parts are palpated to look for organ size or condition (eg, abdominal masses), or for tenderness (eg, there is no tenderness to palpation). Auscultation is listening to body sounds usually with a stethoscope. Percussion is creating sounds by tapping on body areas to examine body organs and body cavities. The vibrations of the sounds help identify abnormalities. All of these methods are used to help a provider evaluate and manage the condition(s) of a patient. The actions and
thought processes of a provider are all taken into consideration for the level of an E/M service.

Using the documentation from the provider to determining the correct E/M procedure code is often referred to as “leveling” the E/M service. To assist providers in determining the level of services provided to a patient, CMS and AMA developed the 1995 Documentation Guidelines for Evaluation and Management Services. Soon after these guidelines were in place, it was determined the guidelines did not adequately address the system specific exams often performed by specialists. To address this problem, the 1997 Documentation Guidelines for Evaluation and Management Services were created. This set of guidelines did not always apply either, so it was determined either the 1995 or 1997 guidelines could be used to determine the level of an E/M Service. Some insurance carriers, internal company protocols, or company compliance plans may specify the use of 1995 or 1997 guidelines. It is important to know and understand what your insurance carrier contracts require as well as internal company regulations so the correct set of guidelines can be used. Because the national guidelines allow you to determine the level of visit based on either the 1995 or the 1997 guidelines, we will discuss both.

The Evaluation and Management Services Guidelines in your CPT® code book outline six steps to determining the level of an evaluation and management service:

1. Select the category or subcategory of service and review the guidelines;
2. Review the level of E/M service descriptors and examples;
3. Determine the level of history;
4. Determine the level of exam;
5. Determine the level of medical decision making; and
6. Select the appropriate level of E/M service.

The 1995 and 1997 documentation guidelines (discussed in Module 2) give detailed instructions on how to determine steps 3–6.

### Categories and Subcategories of Service

The first step in determining the correct evaluation and management code is to determine the category or subcategory of service and review the guidelines. E/M services codes are divided into different categories based on the location and type of service. For example, there are different sets of codes for services performed in an office as opposed to those performed in a hospital. Categories may be further divided into subcategories. For example, office visits are further divided into new patient and established patient office visits.

It is imperative for a coder to understand that the level of service from one category to the next may vary from one category to the next. Table 1 shows an example of the different requirements for the same level of service among different categories/subcategories of service.

<table>
<thead>
<tr>
<th>Category/Subcategory</th>
<th>New Patient OV (99203)</th>
<th>Established Patient OV (99213)</th>
<th>Emergency Department (99283)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Detailed</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Exam</td>
<td>Detailed</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Low Complexity</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
</tr>
</tbody>
</table>
Different categories and subcategories of service can be reviewed by looking through the CPT® Table of Contents for the Evaluation and Management (E/M) services.

**New vs. Established**

Many categories of E/M services are further subcategorized by determining if the patient is new or established.

Whether a patient is new or established is determined by the length of time it has been since that patient has seen that physician. If the patient has had a face-to-face encounter with the physician in the last three years, the patient is considered established. If that patient has not seen that provider in the last three years, the patient is considered a new patient. However, there are some exceptions to this rule:

- **The patient sees a physician in the same group practice:** If the patient sees a physician in the same group practice, you will need to determine if the two physicians are of the exact same specialty and subspecialty. If they are, and the patient has seen them in the last three years, the patient will be considered an established patient.

  **Example:**
  05/01/2011—Patient A sees Dr. Smith (Orthopedic Surgery; Hand Surgery).
  05/01/2012—Patient A sees Dr. Jones (Orthopedic Surgery; Foot and Ankle Surgery) in the same group practice.

  When the patient sees Dr. Jones, she would be considered a new patient because, although the provider is in the same group practice, he is from a different subspecialty.

- **The specialty and subspecialty of the providers is determined during the credentialing process with the insurance carriers.**

- **The patient sees a provider that is on-call for the patient’s normal physician.** This can be seen often in OB/Gyn practices. When two physicians have independent practices cover for each other, the service is coded as if the same physician is seen.

  **Example:**
  The patient sees Physician A who is covering for Physician B for a follow-up appointment. The patient has never seen Physician A before, but saw Physician B last week. Because Physician B is covering for Physician A, the patient is considered an established patient.

**Category and Subcategory Guidelines**

Once the category and subcategory of service has been determined, the guidelines for that category/subcategory should be reviewed to verify you are in the correct place. Many of the categories and subcategories will have instructions stating what is included in that category as well as references to other categories that might be more specific to the service you are coding.

**Office or Other Outpatient Services**

Office or Other Outpatient Services are divided into subcategories of new and established patients, as described above. This category represents visits performed in the physician’s office, outpatient hospital, or other ambulatory facility such as an urgent care center.

**Hospital Observation Services**

When a patient has a condition needing to be monitored to determine a course of action, he may be admitted to “observation status.” For example, if a patient presents to the Emergency Department (ED) with acute abdominal cramping, the provider can admit the patient to observation status. After a period of monitoring, the patient may be discharged, or—if the condition worsens—may be admitted to the hospital as an inpatient for additional treatment.

According to the Medicare Benefit Policy Manual (Section 20.6.A.), observation services are defined as “a well-defined set of specific, clinically
appropriate services, which include ongoing short
term treatment, assessment, and re-assessment
before a decision can be made regarding whether
patients will require further treatment as hospital
inpatients or if they are able to be discharged from
the hospital.”

The patient is not required to be in a specific
area of the hospital to be deemed in “observation
status.” There is no distinction between a new
or established patient for observation services.
When the patient is seen at another site of service
(eg, Emergency Department), and observation
status is initiated at the site of service, all E/M
services provided by the admitting physician are
considered to be part of the initial observation
care and not reported separately.

Example

A patient presents to the emergency department
with chest pain. After evaluation of the patient,
the provider determines the patient has a pending
infarction and admits the patient to observation
status.

In this case, the provider would only report the
admission to the observation status and not the
emergency department visit.

Hospital Observation includes three types of
service: Observation Care Discharge Services,
Initial Observation Care, and Subsequent
Observation Care. Typically, observation stays
are between 24 and 48 hours. Occasionally, an
observation stay might last 72 hours.

The initial observation care should be reported
only by the physician admitting the patient
to observation status. Commonly, additional
providers of specific specialties will be asked to
consult on the patient’s condition. These providers
would report the outpatient consult codes or
subsequent observation codes as appropriate.

Subsequent Observation Care is reported for
subsequent visits for the date of services after the
initial observation status admission visit to the
patient during that observation stay. This E/M
subcategory can be reported by more than one
physician on the same date of service, but each
physician can only report the code once per day.
When reported by the admitting physician, the
subsequent observation codes are used when the
patient is seen on a day other than the date of
admission or discharge.

Observation Care Discharge Services are used to
report the final exam and discharge of the patient.
This code is not to be reported on the same date
as an inpatient admission. Should the provider
decide to admit the patient to the hospital from
observation, the observation discharge services are
considered part of the inpatient admission and are
not reported separately.

The Initial Observation Care and the Observation
Care Discharge should be reported separately only
if they occur on separate dates of service. If they
occur on the same date of service, a code from the
Observation or Inpatient Care Services (Including
Admission and Discharge Services), range 99234–
99236, is reported.

Hospital Inpatient Services

Hospital Inpatient Services are subcategorized into
Initial Hospital Care, Subsequent Hospital Care,
Observation or Inpatient Care Services (Including
Admission and Discharge Services), and Hospital
Discharge Services. These services do not
distinguish between new and established patients.

Initial Hospital Care should be reported only
by the admitting physician, according to CPT®
guidelines. CMS, by contrast, allows the use of
the initial hospital care codes in place of inpatient
consultation codes (we will discuss this in detail
when reviewing consultation services, below).

Any services performed on the same date, when
related to the admission, should be included in
the initial hospital care code and not reported
separately. This includes office visits, observation
visits, and nursing facility visits if provided by the
same provider on the same date of service.
Example

2.12.2012—Office Visit Note—Dr. Shoe

CC: Foul discharge, pain down there

S: An estab. pt., a 37 yo G3P1 seen for a yellow-green discharge and severe cramps. She reports visiting her former partner a week ago in an attempt to reconcile. They had sexual relations both Friday and Saturday. Three days later she noted a foul discharge with an odor. In the last 2 days this discharge has increased requiring use of a pad. She has also noted bilateral lower abdominal cramping, more severe than a normal menstrual period. The pain is episodic, radiates into her lower back, not improved with heating pad. She has missed work the last 2 days due to the pain. She has not taken her temperature, but has felt uncomfortably warm, occasional chill. She denies any change in her bowel or bladder; no diarrhea, no frequency or urgency. Denies N/V. She took Ibuprofen yesterday and this morning with mild improvement. No other meds currently for symptoms; previous BTL for contraception; no hx chronic illness; no previous similar event.

O: VS—T 100.1, BP 122/78, RR 20, P 88 & regular. U/A neg dipstick
   Neuro : intact
   Cardiac : NSR, -murmur or gallop
   Resp : lungs clear bilat.
   Abd : + BS, decreased; no masses.
   Generalized tenderness in lower quad, R>L
   Adnexa—no masses, 3+/4+ tenderness
   Cultures obtained; wet prep, - trichomonas, + clue cells
   Ext: legs negative

A: PID; pelvic pain; r/o ectopic, r/o appendicitis

P: Admit for IV antibiotics, pain control & lab w/u.
   NPO, possible surgery
   Send by wheel chair to hospital.

Signed: J. Shoe, MD

2.12.2012—Admission History & Physical examination, 19:45,
Attending Physician: J. Shoe, MD

Admission diagnosis: Pelvic pain, probable pelvic inflammatory disease; rule out ectopic; rule out appendicitis.

History: This established patient is a 37 y.o. G3P1012 white female seen in the office this afternoon for recent onset of a foul discharge and pelvic pain. LMP was 5 weeks ago, she is often irregular. She reports 7 days ago having relations with her former partner on consecutive days. 3 to 4 days following the weekend, she noted the gradual onset of a foul smelling yellow-green discharge and cramping. Over the subsequent 3 days this discharge has increased requiring a Peri-Pad. She has had to change the pad q hour. She has also noted the increase in pelvic and lower abdominal pain and cramping. The pain is worse than her normal menstrual cramps, not helped with the application of heat. There was initially a small improvement with oral Ibuprofen; it has not helped today. Upon questioning her partner, he reports some mild burning with urination for 5 days, otherwise no symptoms. She does not have a thermometer, has not taken her temperature. She has felt uncomfortably warm the last 2 days and today has had occasional chills.

ROS: She denies any N/V, diarrhea, or changes in her bowel or bladder function. She denies any SOB or palpitations. She denies headache or visual disturbance.

PMH: Prozac for depression x 3 years; 3 pregnancies, 1 spontaneous Ab, 2 SVDs, 1 at term, 1 at 35 weeks, living male age 8 years, female age 5 years. Postpartum BTL for contraception 5 years ago. No chronic illnesses.

SH & FH: single parent, lives with children age 5 and 8 years. Currently works as a medical record auditor. Parents are living and healthy. Mother has type II diabetes. Is the oldest with 3 living siblings in good health.
Physical examination:
Patient is a healthy white female in mild distress, crying quietly, sitting slumped over in bed.

VS: 19:00 – T: 102.1; BP : 118/70; p: 92; RR: 24
Skin: face is flushed, moist with hair damp.
HEENT: nose & throat clear
Neck: supple, no masses
Lungs: clear bilaterally
Cardiac: normal S1, S2, no murmur or gallop; RRR
Abdomen: +BS, soft, no masses; bilateral tenderness in lower quadrants. Negative rebound, 1+/4 guarding. - CVAT
Pelvic: per office, foul discharge, no masses. 3+/4+ tenderness bilaterally.
Extremities: normal gait

Assessment/ Differential Diagnosis: 1) pelvic pain; 2) pelvic inflammatory disease; 3) rule out ectopic; 4) rule out appendicitis

Plan: 1) Admit for observation, begin IV antibiotics; 2) IV fluids & NPO, bed rest; 3) pain control; 4) labs ordered: CBC with diff tonight and in am, pregnancy test STAT; 3) ultrasound in am; 4) cultures from office pending; blood cultures tonight before IV antibiotics begun; 5) Prozac qd with sip

J. Shoe, MD, attending OB/GYN physician

In this case, the patient was seen by Dr. Shoe in his office, sent to the hospital, and admitted on the same day by Dr. Shoe. Because Dr. Shoe provided both the office visit and admission to the hospital, and both were on the same date of service, the work from the office visit would be included in the admission to the hospital. Only one code would be reported, the hospital admission code.

Subsequent Hospital Care is used to report the visit(s) after the date of the initial hospital admission visit to the patient during that hospital stay. This E/M subcategory can be reported by more than one physician on the same date of service, but each physician can only report the code once per day. These codes include the provider reviewing the medical record, diagnostic test results, and changes in the patient’s status since the last physician assessment.

Example

2.13.2012—Progress note—Hospital Day 2, 5:48am Dr. Shoe; I.M. Smart, Med.3
S: Pt asleep. When awakened, “I have been up all night” with pain and cramping. No real improvement in S&S. Would like pain meds more often. Hungry, has been NPO. IV in place in left arm, patent.

Objective:
VS – (5am) T 102.2, BP 118/74, P 90 & regular. Temp to 103.0 during the night.
Pt anxious and somewhat agitated when awakened. Otherwise alert and oriented
Skin – warm and moist to touch; pt flushed
Abd: +BS, normal; 3+/4+ tender in lower quads bilaterally. Rebound --; guarding –

Exam unchanged from yesterday on admission
Admission labs:
WBC: 14.8, + left shift. Hct 31
HCG (urine) negative
Urinalysis—negative
Cultures—pending
A: Moderate PID. Has received 2 doses of IV antibiotics.
P: Continue IV antibiotics
Check cultures & gram stain
Continue NPO and modified bed rest
Ultrasound at 9:30am
Increase Demerol to q3h

J. Shoe, MD with I.M. Smart, Med. 3

Observation or Inpatient Care Services (Including Admission and Discharge Services) codes should be used to report an admit and discharge on the same date of service for patients in observation status or as an inpatient.
Hospital Discharge Services report the total time spent by the physician on the date of discharge. Discharge services include the final examination, discussion of the stay, continuing care instructions, discharge paperwork, prescriptions, and referral forms. This service is reported by the amount of time spent by the physician on the date of discharge, even if the time is not continuous. Discharge services are time-based; the time must be documented in the patient’s record to qualify for a discharge time of over 30 minutes. Visits to the patient on the date of discharge by physicians who are not the attending physician should be reported using Subsequent Hospital Care codes (99231–99223).

Consultations

Consultation codes are divided into two subcategories based on the location of the consult: Office or Other Outpatient Consultations, and Inpatient Consultations.

According to CPT®, a consultation has the following components:

A physician (or other appropriate source) requests another physician (or appropriate source) to evaluate a patient’s specific problem or condition and render an opinion. The request can be written or verbal; if verbal, the request must be documented in the patient’s medical record. According to the AMA CPT® codebook, an other appropriate source can be a physician’s assistant, nurse practitioner, chiropractor, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company.

The consultant either will recommend care for the patient’s condition, or will determine whether to accept care of the patient.

The consultant must submit a written report back to the requesting physician (or other appropriate source).

If another physician requests an opinion or advice on the same condition, or a new condition, for the same patient, the consulting provider can again report a consultation code.

Consultations requested by a patient or family member should be reported using the appropriate codes from categories other than consultation; Office or Other Outpatient Visits, Home Service, or Domiciliary or Rest Home. When a consultation is mandated by a third party payer, or by government, legislative, or regulatory requirement, append modifier 32 Mandated services to the consultation code.

Example

**Consultation**

**REASON FOR CONSULT:** Atrial flutter

**HISTORY OF PRESENT ILLNESS:** The patient is a 60-year-old male who comes today at the request of Dr. Y for a consultation of his atrial flutter. He was originally diagnosed with this in January of 2011. At that time he developed extensive palpitations as well as chest tightness. He was subsequently found to be in atrial flutter and was admitted to St. Francis Hospital. He spontaneously converted to sinus rhythm. He underwent echo showing normal LV function and left heart catheterization showing no significant CAD. Since that time the patient has been taking aspirin and Multaq. His Multaq was stopped December 2011 secondary to patient preference. He subsequently had an episode when he was working out in which he had a fast irregular heartbeat. He also felt short of breath, fatigue, and dizzy during this episode. He restarted his Multaq and the symptoms improved. Since that time he does not feel that he has had further episodes of palpitations.

The patient reports that he is quite active. He exercises 4 days a week and is able to perform cardio workout up to 30 minutes. He denies chest pain, chest tightness, or syncope.

1 Documentation of the request for consult.
PAST MEDICAL HISTORY:
1. Atrial flutter, diagnosed 1/2011 - EKG appears consistent with right atrial flutter, negative in inferior leads and slightly positive in VI; perhaps clockwise atrial flutter
2. Hypertension
3. Hyperlipidemia
4. Minimal CAD-1/2011 left heart catheterization only demonstrating luminal irregularities

PAST SURGICAL HISTORY:
1. Tonsillectomy
2. Right inguinal hernia repair
3. Left knee arthroscopic surgery

PREVIOUS CARDIAC EVALUATION:
1/2011 LHC: Minimal CAD, normal LV systolic function
1/2011 TTE: EF greater than 55%, moderate LVH, left atrium mildly dilated, mild TR

ALLERGIES: No history of contrast or iodine allergy
CURRENT ALLERGY LIST: NKDA

CURRENT MEDICATION LIST:
DAILY VITAMIN FORMULA ORAL TABLET, daily
ASPIRIN BUFFERED ORAL TABLET 325 MG, daily
SIMVASTATIN ORAL TABLET 40 MG, daily
LISINOPRIL ORAL TABLET 10 MG, 1/2 daily
MULTAQ ORAL TABLET 400 MG, 1 Every Day

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient’s memory.

SOCIAL HISTORY: The patient is married. He works as a principal at a local school. No tobacco use ever, he drinks 8-10 alcoholic beverages per week, no history of illicit drug use.

FAMILY HISTORY: The patient has no family history of sudden death or significant arrhythmias. No family history of premature coronary artery disease.

REVIEW OF SYSTEMS: Please see HPI above for relevant cardiac ROS. Otherwise, a full review of systems including constitutional, neurologic, ENT, pulmonary, gastrointestinal, genitourinary, musculoskeletal, endocrine, and psychiatric systems was reviewed. These were all negative except as noted in the HPI above and urinary frequency at night.

PHYSICAL EXAM:
VITAL SIGNS: PULSE: 40 Right Radial, Regular, BP: 150/90 Left Arm Sitting, HEIGHT: 6 ft 5 in, VS-WEIGHT: 234 lbs 8 oz, BMI: 27.8
General: alert and oriented x3. No acute distress
HEENT: normocephalic, clear oropharynx, mucus membranes moist
Neck: supple; no carotid bruits; no thyromegaly; JVD normal
Chest: normal respiratory effort; lungs clear to auscultation
CV: normal SI, S2; no audible murmurs, rubs, or gallops
Abdomen: soft, non-tender, non-distended, NABS; no hepatosplenomegaly
EXT: warm, well perfused, no cyanosis, no LE edema
Neuro: CN II-XII intact, no major motor or sensory deficits

LABS: 3/2011 TSH3.6, Cr 1.1

ECG: A 12-lead electrocardiogram obtained today in clinic reveals sinus rhythm with a rate of 40. There is normal P wave morphology with a PR interval of 190. There are no pathologic Q waves or evidence of ventricular preexcitation noted. There are no significant ST-T wave changes. The adjusted QT interval is 439 msec.

IMPRESSION/RECOMMENDATION:
1. Paroxysmal atrial flutter: The patient has documented atrial flutter from 1/2011. I suspect that he had an additional episode very recently after stopping his Multaq. His previous EKG is suggestive to me of a right atrial flutter. P waves are negative in the inferior leads and positive in VI. There is a somewhat atypical appearance of this which may suggest that it is a clockwise atrial flutter. Furthermore, we’ve discussed stroke prevention. He has a CHADS risk score of one considering his hypertension. After discussion of the risks and
benefits, he is interested in anticoagulation with Pradaxa. I do think this is reasonable for the most optimal stroke prevention in him. At this point therapeutic options include continuing current medical therapy versus considering an ablation procedure. The advantage of him having an ablation procedure would be that in the long term he might not need antiarrhythmic medication and might not need anticoagulation. Regardless, prior to consideration of an ablation procedure, I would like to make sure that he is not having any atrial fibrillation,

- check a one month CardioNet monitor
- hold Multaq in anticipation of diagnosis of atrial flutter versus atrial fibrillation
- with another episode he will try to immediately come to our office for an EKG
- re-start Multaq vs. start flecainide at the time of recurrent atrial flutter or a fib
- start Pradaxa 150mg bid and stop ASA

2. Hypertension: He will continue his current lisinopril.

3. Hyperlipidemia: He is currently taking simvastatin. If his Multaq is restarted then we will need to decrease his simvastatin dose to 10 mg p.o. q.h.s.

4. Sinus bradycardia: The patient reports that he chronically has a heart rate in the 40s. He does not appear to have any significant symptoms from this.

RETURN VISIT: 6 weeks.

Thank you very much for the opportunity to participate in the care of this patient. Please feel free to contact me with any questions or concerns.

Tim Smith, M.D.
Electrophysiology/Cardiology

Referrals and Transfer of Care

A consultation differs from a referral. A referral occurs when a patient is sent to another physician for care of a specific problem or condition. The requesting physician is not expecting to receive recommendations back from the referring physician, and does not expect to continue treating the patient for the condition.

A transfer of care occurs when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patient's complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

CPT® defines a transfer of care similarly as, “the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.”

When transfer of care has been established, the provider accepting care bills subsequent visits with the appropriate established patient visit codes based on the location of the service; Office or Other Outpatient Established Patient Visit (99211–99213), Domiciliary or Rest Home (99334–99337), Home Visit (99347–99350), Subsequent Hospital Care Services (99231–99233), or Subsequent Nursing Facility (99307–99310).

Reporting Consultations for Medicare

Medicare no longer pays for consultation codes (except telehealth consultations), and requires that consultations services be billed with the most appropriate (non-consultation) E/M code for the service.

Outpatient consultations should be reported by selecting the appropriate level code from the Office or Other Outpatient Services (99201–99215).

Inpatient consultations should be reported using the Initial Hospital Care code (99221–99223) for the initial evaluation and a Subsequent Hospital Care code (99231–99233) for subsequent visits.
The physician who admitted the patient as a hospital inpatient (whether that physician is the “consultant” or another physician), should append modifier AI Principal physician of record to indicate that he or she is the admitting physician, and to distinguish the physician from others who may provide inpatient services.

Other non-Medicare payers may allow you to continue to report Consultation codes. Check with individual payers for guidelines.

**Emergency Department Services**

An Emergency Department (ED) is a department of a hospital organized and designated to treat unscheduled patient visits for immediate medical attention. Emergency departments must be open 24 hours a day, seven days a week. A patient may receive critical care treatment in an emergency department. In this event, critical care codes (discussed below) will be reported, rather than ED services. Due to the nature of ED services, there is no distinction made between new and established patients. Any physician may report ED services when the patient is seen by that physician in the ED, it is not exclusive to emergency department physicians. For example, a patient is sent to the ED and evaluated by the ED physician. The ED physician calls the patient’s personal physician and asks him to come to the ED to evaluate whether the patient should be admitted or sent home. If the patient is sent home, both the ED physician and the personal physician can report the ED visit codes. If either the personal physician or ED physician admits the patient, the services of the admitting physician are included in the admit.

**Example**

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**Emergency Department**

**CHIEF COMPLAINT:** Left elbow injury.

**HISTORY OF PRESENT ILLNESS:** This is a 19-year-old female who presents with pain in her left elbow. She states that this morning, around 8 o’clock in the morning, she tripped over a vacuum, fell, landing on an outstretched arm. It felt like her left arm was stuck in place straightened, so she bent it and now worse than before like she cannot bend or straighten her elbow. Went to an urgent care around 5 o’clock. X-rays were done which were normal. She was told that she might need an MRI to look for a ligamentous injury. She was referred to the ED. She presents at midnight tonight complaining of elbow pain and is requesting an MRI of her elbow. No numbness or tingling in the fingers. No pain into the wrist or into the shoulder joint. Never injured this elbow before. She is wearing a sling upon presentation. She took ibuprofen earlier in the day.

**REVIEW OF SYSTEMS:** All systems reviewed and negative except for those stated in HPI.

**PAST MEDICAL HISTORY:** She denies.

**PAST SURGICAL HISTORY:** She denies.

**SOCIAL HISTORY:** She is a smoker.

**ALLERGIES:** Allergic to erythromycin.

**MEDICATIONS:** She is on Zyrtec.

**PHYSICAL EXAMINATION**

This is a 19-year-old female who appears in no acute distress. Temperature 97.1, heart rate is 89, blood pressure 116/64, respirations are 20, she is 99% on room air. She is awake, alert and oriented x3. Her head is atraumatic, normocephalic. Pupils are equally reactive to light. Extraocular motions are intact. Her neck is supple. Chest wall is nontender. Heart is a regular rate and rhythm. Lungs: Clear to auscultation bilaterally. Abdomen is soft, nontended, nontender, no guarding, mass or rebound.

Skin is warm and dry, without any rashes. She has full range of motion of the wrists to bilateral upper extremities. She is mildly tender along the left radius, into the radial head and ulna. However, she can supinate, pronate, flex and extend her arm with assistance. No pain into the left shoulder with full range of motion of that shoulder.

In the emergency room, X-rays were done of the elbow showing no acute abnormalities, no fractures noted. She already has a sling. She is going to be discharged.

**IMPRESSION:** Elbow sprain.

**PLAN:** Given a prescription for Naprosyn, Vicodin, two weeks off work. Told to wear the sling for the next 5–7 days as needed for comfort. Return to the ED with any new concerns. Follow up with her doctor this week.
Another service found in this category is the physician direction of emergency medical services (EMS) emergency care, advanced life support (99288). This code reports the services of a physician, located in a facility’s emergency department or critical care department, who is in two-way communication with emergency services personnel. The physician directs the personnel in performing life-saving procedures.

**Critical Care Services**

Critical care service codes report the direct delivery of medical care to a critically injured or critically ill patient. According to CPT®, “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 is a condition, not a location. A patient does not have to be in an intensive care unit (ICU) or other designated area to meet the requirements of critical care. Nor do all patients in an ICU or other designated unit qualify automatically for critical care. Any patient meeting the definition of critically ill or critically injured may qualify for critical care.

Critical care bundles a number of services, such as cardiac output measurements (93561, 93562), that typically may be required for critically ill or critically injured patients. A complete list of services bundled with critical care may be found in the critical care portion of the CPT® codebook. Any procedures performed by the physician that are not included in the procedures that are bundled in critical care can be reported separately (eg, 31500 Endotracheal intubation). The time spent on performing separately reportable procedures is not included in the critical care time documented. If the physician does not indicate this time, then time is deducted from critical care time in order to report the services separately.

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**Example**

**EMERGENCY DEPARTMENT**

**CHIEF COMPLAINT:** Unresponsiveness.

**HISTORY OF PRESENT ILLNESS**

The patient is a 77-year-old female with a seizure disorder. She has also had a stroke with persistent left hemiparesis and right gaze preference. She was found unresponsive in her bed today. She has snoring respirations. She does not respond to painful stimulus. Family also arrived with the patient; however, from the nursing home no other information is available. Patient’s family had nothing else to add.

**REVIEW OF SYSTEMS:** No review of systems is available due to patient unresponsive.

**PAST MEDICAL HISTORY:** Seizure disorder, stroke, left hemiparesis.

**MEDICATIONS:** List reviewed.

**ALLERGIES:** Reviewed.

**SOCIAL HISTORY:** Nursing home resident. Multiple family members are here, but no other history is available.

**FAMILY HISTORY:** Not known.

**PHYSICAL EXAMINATION**

The patient is unresponsive, snoring respirations and no response to painful stimulus. She has a right gaze preference and does not respond to any verbal stimulus. Head and neck exam: No evidence of trauma, no ecchymosis. Skin: Pale, but warm and dry. No rashes or edema. Oral mucosa well hydrated. Pupils: Equal, round and reactive to light, stay deviated to the right. No nystagmus identified. Ears: Clear. Neck: Stays predominantly turned towards the right. She resists movement back to the left. Lungs: Clear. No wheezes. Heart: Regular. There is no murmur. There are loud referred upper airway noises. Abdomen: Soft, not grossly distended. No mass or pulsations. Back: No ecchymosis or skin breakdown. Pelvis is stable. Hips are mobile passively.

The left lower extremity is flaccid; the right lower extremity is held in extension and somewhat stiffly. Upper extremities are both flaccid; however, the right upper extremity does somewhat resist passive range of motion. There is no response to painful stimulus on either side. There is an upgoing Babinski on the right. The lower extremities have good peripheral
pulses. There is no edema, no ecchymosis. Neuro exam: As noted, no response to painful stimulus, snoring respirations with gurgling and upper airway noises. There is a right gaze preference, flaccid left upper extremity and left lower extremity. The right upper extremity: No withdrawal to pain. Right lower extremity: Upward-going Babinski.

**DIAGNOSTIC STUDIES**
Cardiogram: Atrial fibrillation, rate of 167, narrow complexes, left axis deviation. Study reviewed by me. Chest X-ray shows worsened interstitial prominence consistent with mild congestive heart failure. CT scan of the brain showed no acute findings. CBC: White count 17, hemoglobin 14.5, BNP 400. Electrolytes: BUN and creatinine normal, glucose 136. Liver functions are normal. Cardiac enzymes are negative. INR 2.2.

**EMERGENCY DEPARTMENT COURSE**
The patient developed generalized seizure activity. This carried on for a couple of minutes, and after Ativan intravenously, the seizure activity stopped. The patient had IV Dilantin following that. She had no further seizure activity, was much more calm. Her stiff right lower extremity resolved and was now mobile. She still does not respond to any verbal or painful stimulus. She was given IV Cardizem, both bolus and infusion. Her heart rate promptly dropped to 80, remained in atrial fibrillation. Her blood pressure stabilized. Initially, blood pressure was 190 systolic and subsequently was 120 systolic. She does seem to be more stable. She required 90 minutes of critical care time in the emergency room, excluding time for procedures. Nasopharyngeal airway was placed, and her snoring respirations improved. She is maintained on supplemental oxygen with good oxygen saturations.

**IMPRESSION**
1. Status epilepticus.
2. Atrial fibrillation with rapid ventricular response.

**DISPOSITION**
The patient is from Whetstone Nursing Home, and the patient will be admitted to the COPC service to the intensive care unit.

Critical Care services are reported based on the time the physician spent dedicated, and directly available, to the patient. The physician cannot work on any other patient during this time; however, the time is not required to be continuous, and the physician is not required to be in the same room as the patient. The physician can report only time spent on the same unit or floor as the patient.

All time spent on the management of the patient’s condition on the same floor or unit as the patient is totaled throughout the day and reported with 99291 and 99292. When the time is less than 30 minutes, critical care codes are not reported. Code 99291 is used to report when the total time is between 30 and 74 minutes. Each additional 30 minutes, or part thereof, is reported with a unit of 99292.

For younger patients, specific code ranges may apply when reporting critical care:

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<th>Service</th>
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<td>Infants (29 days through 24 months)</td>
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<td>Neonates and infants up through 71 months (up through 5 years, 11 months)</td>
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<tr>
<td>Pediatric patients (6 years of age or older)</td>
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Nursing Facility Services

Nursing facility services are subcategorized into Initial Nursing Facility Visit, Subsequent Nursing Facility Visits, Nursing Facility Discharge, and Other Nursing Facility Services. E/M services provided to patients in a nursing facility or a psychiatric residential treatment service are reported with these codes.

An initial nursing facility visit should include:

- Thorough assessment of the patient
- Plan of care
- Writing or verifying admitting orders for the resident

This initial visit is a federally mandated visit that must occur within 30 days of admission to the nursing home. Other EM visits can occur at the nursing home prior to and after this federally mandated visit for all residents in a Medicare or Medicaid certified nursing home.

For Medicare, the initial visit may be reported by more than one physician, but the physician of record for an admission to the nursing home should append a modifier AI to indicate primary physician of record.

Initial and subsequent nursing home visits are reported based on a “per day” basis. If the patient is seen by the same provider more than once in the same day, the services are combined and only one nursing facility E/M code is reported.

Nursing facility discharge codes report the services provided by a physician to discharge the patient. The codes are reported by time, which includes all time spent on the patient for the date of discharge.

The final code in this section is for an Annual Nursing Facility Assessment by the provider. Government regulations required Nursing Facilities to perform Minimum Data Set/Resident Assessment Instrument (MDS/RAI) annually. When a physician completes this information and performs the annual nursing facility assessment, report 99318.

Domiciliary, Rest Home, or Custodial Care Services

This category includes E/M services provided to patients residing in Domiciliary, Rest Home, or in Custodial Care. Domiciliary care refers to care provided in a supervised home setting. Assisted living facilities would be considered domiciliary care.

Domiciliary, Rest Home, or Home Care Plan Oversight (CPO) Services

Care plan oversight indicates oversight of the services provided to patients in their own home or a facility which provides room, board, and other personal assistance, generally on a long-term basis. These facilities include assisted living facilities, adult living facilities, group homes, custodial care facilities and residential substance abuse facilities. The oversight of these services is reported with codes from this category, based on the physician time.

Home Services

E/M services provided to a patient in a private residence (e.g., private home, apartment, town home) are reported from this category. The physician must be present in the home to provide a home service and medical necessity for the home visit must be established.

Prolonged Services

Codes in this category are subcategorized based on whether the physician has direct (face-to-face) contact with the patient, and are reported based on location and time.

Prolonged services with direct patient contact are add-on codes reported in addition to one of the designated E/M codes listed in the parenthetical instructions after each code.
Prolonged services without direct patient contact are used to report services for time spent managing the patient’s care without direct face-to-face patient contact. Prolonged services without direct patient contact may be reported on a different date than the E/M services to which it is related.

Prolonged services are reported in addition to a primary E/M service. Prolonged service codes should be reported only in addition to other E/M codes which have time stated in the description. As an example, the descriptor for an established patient outpatient service, 99215 specifies, “Physicians typically spend 40 minutes face-to-face with the patient and/or family.” Below each prolonged service add-on code are parenthetical instructions indicating with which E/M codes the add-on code can be reported. Prolonged services may be appended to any level of service unless the service is coded based on time for counseling and/or coordination of care. When the E/M service is coded based on time, the add-on code for prolonged services can only be appended to the highest level code (eg, 99215, 99245, etc). Prolonged services may not be reported for services of fewer than 30 minutes.

Example

At the end of seven pages of documentation for an inpatient consultation, a neurologist documents, “I had an extremely extensive 180+ minutes interview, examination, and series of discussion, with the patient and her family members, this evening, in her hospital room. This is more than 50% of the total time for the service.”

The CPT® codebook states the highest level of inpatient consultations (99255) typically takes 110 minutes. In this case, the additional 70 minutes can be billed as prolonged services.

Physician Standby Services

Occasionally, a request is made for a physician to be available to perform a possible procedure. For example, when there is a delivery involving risk to a neonate, the OB/Gyn delivering the neonate may request a pediatrician to “stand by” in case a surgical procedure is needed on the neonate. Standby services must be at least 30 minutes to be reported, and cannot be reported if the physician standing by performs a procedure with a global package. Code 99360 reports Physician Standby Services. This code is reported for each 30 minutes of standby time.

Case Management Services

The Case Management Services Category includes Anticoagulant Management and Medical Team Conferences.

Warfarin is an anticoagulant (blood thinner) used to prevent blood clots. Common brand names for warfarin include Coumadin®, Jantoven®, and Marevan®. The use of Coumadin® can also be referred to as “Coumadin therapy.” Due to the critical nature of thinning blood or reducing its clotting factor, patients on warfarin require constant oversight, along with International Normalized Ration (INR) testing. The medication is adjusted, as needed, to provide the best level of anticoagulation in the blood. The patient is reminded of the specific dietary needs, and observed for possible bruising. Anticoagulation management codes are used to report this oversight, which includes ordering, review, and interpretation of the INR testing, communication with the patient, and dosage adjustments, as necessary. The initial management must include at least 60 days of therapy and include a minimum of eight reported INR measurements. Each subsequent 90 days of therapy, including at least three INR measurements, may be reported using 99364.

Medical Team Conferences

Medical Team Conference codes report meeting or conference time (face-to-face) of at least three qualified health care professionals, with or without the presence of the patient or patient’s family member. The health care professionals should be of different specialties, and all should be involved
directly in the patient’s care. The code is selected based on whether the patient or patient’s family is present. If the patient or patient’s family is not present, the code is selected based on the type of provider; physician or nonphysician qualified health care professional.

**Care Plan Oversight Services**

When the care of a patient involves complex and multidisciplinary care modalities, physician supervision is required to monitor the patient’s progress and adjust the care plan as necessary. These services are reported with the codes from the Care Plan Oversight Services Category. The codes are selected based on the location of the patient, and the amount of time spent within a 30-day period to oversee the patient’s care.

**Preventive Medicine Services**

Preventive Medicine, Individual Services, also referred to as “well visits,” describe E/M services provided to a patient without a sign, symptom, condition, or illness. The comprehensive exam as described here is an age-appropriate examination of the patient, and not the same as the comprehensive exam referred to in other E/M code categories. The preventive medicine codes are determined based on the age of the patient, and whether the patient is new or established. Preventive medicine visits are often reported in family practice, pediatrics and gynecology; although, these codes are not limited to these specialties.

**Example**

Preventive Medicine

Reason for Appointment: 1. Complete Physical, age 76

History of Present Illness: pt f/u with CPE with labs, Pt doesn’t have any complaints.

Hypertension: Compared to last visit the hypertension is improved. The severity of the hypertension is classified as controlled < 120/80. The patient’s cardiovascular risk factors include dyslipidemia. Lifestyle modifications that the patient has adopted include increasing physical activity. Pharmacologic treatment includes ACE inhibitors. The patient adheres to the treatment regimen with a good response and no adverse effects.

Hypercholesterolemia: Compared to last visit the cholesterol is stable. The lipid profile goals for the patient are Total cholesterol < 200, LDL goal is <100, HDL goal for >40. Treatment has included prescription medications with good response and no side effects.

Current Medications:
Lisinopril 20 MG Tablet 1 tablet Once a day
Lipitor 10 MO Tablet I tablet Once a day
Medication List reviewed and reconciled with the patient
Past Medical History: Hyperlipidemia, Right ear hearing loss secondary from military
Surgical History: Right knee patella tendon repair 9/2003
Family History: Father: irregular heart, Mother: asthma, diabetes, Siblings: HTN
Social History: Tobacco Use: no Smoking, Allergies: N.K.D.A.
Review of Systems
General/Constitutional: Appetite normal, denies chills, fatigue, fever, night sweats, weight changes.
Allergy/Immunology: Denies angioedema, hives, itchy eyes, sneezing.
Ophthalmology: Denies blurring of vision, double vision, eye pain, vision loss, watery eyes.
HEENT/Neck: Denies ear pain, loss of hearing, epistaxis, loss of smell, sinus pain, change in voice, difficulty swallowing, dry mouth, sore throat.
Respiratory: Denies cough, dyspnea on exertion, hemoptysis, orthopnea, wheezing.
Cardiovascular: Denies, syncope, chest pain, fatigue, orthopnea, palpitations.
Gastrointestinal: Denies abdominal pain, black stools, blood in stool, change in stool, constipation, diarrhea, dysphagia, being gassy, heartburn, hemorrhoids, nausea, vomiting.
Hematology: Denies easy bleeding, easy bruising, enlarged lymph nodes, swollen glands.

Genitourinary: Denies blood in urine, burning on urination, dysuria, nocturia, urinary frequency.

Musculoskeletal: Denies shoulder pain, wrist pain, foot pain, arthritis, back pain, bone pain, hip pain, knee pain, neck pain, tingling/numbness.

Skin: Denies skin changes, rash, change in moles, change in nails.

Neurologic: Denies balance difficulty, confusion, headache, memory loss, migraines, paresthesias, tingling/numbness, vertigo, weakness.

Psychiatric: Denies anxiety, confusion, depression, hallucinations, irritability, mood swings, paranoia, suicidal ideation.

Examination:

Vital Signs: BP 130/80, RR 18, HR 104, Ht 72, Wt 228.4, BMI 30.97

General Examination:

GENERAL APPEARANCE: in no acute distress, pleasant.

HEENT: HEAD: normocephalic, atraumatic; EARS: tympanic membranes normal; EYES: PERRL, no conjunctival erythema; NOSE: no sinus tenderness, turbinates normal; THROAT: pharynx and tonsils normal.

NECK/THYROID: no lymphadenopathy, supple.

CARDIOVASCULAR: normal S1S2, regular rate and rhythm, normal S1S2, regular rate and rhythm, no murmurs.

RESPIRATORY: clear to auscultation bilaterally, no wheezes, rhonchi, rales.

GASTROINTESTINAL: no hepatosplenomegaly, no masses palpated.

NEUROLOGIC EXAM: alert and oriented x 3, gait normal.

SKIN: normal, no rash.

RECTAL: sphincter tone good, normal prostate, heme negative.

PSYCH: affect normal.

Assessments

Routine general medical examination at health care facility: The patient counseled regarding screening procedures and recommended schedules for regular prostate exam and PSA, GI hemoccult testing, and colonoscopy.

Hyperlipidemia: Refill Lipitor Tablet, 10 MG, 1 tablet, Orally, Once a day, 90 day(s), 90, Refills 3

Hypertension, benign: Refill Lisinopril Tablet, 20 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 3.

Diabetes mellitus without mention of complication, type II, uncontrolled: Start Glucophage XR Tablet Extended Release 24 Hour, 500 MG, 1 tablet with evening meal, Orally, Once a day, 30 day(s), 30, Refills 3.

LAB: Hemoglobin a1c (Ordered for 04/18/2012) Comp. Metabolic Panel (14) (Ordered for 04/18/2012) 6.3 a1c needs better life style, discussed all options and advised what will help, will start meds today and f/u after 3 month.

Follow up: 3 months for DM labs and OV

During preventive medicine exams, a provider may discover an abnormality or address a condition already in existence. If the abnormality or condition requires the provider to perform a significant amount of work, above what normally would be performed for a preventive service, the additional work can be reported with a separate E/M service code. The additional E/M code would be reported with modifier 25 appended. When determining whether a problem required a significant amount of work, it would be appropriate to see if you could separate the documentation into two distinct separate notes, one to support each service.

The reporting and payment of preventive services and additional E/M codes will depend largely on payer policy. Effective January 1, 2011, Medicare pays for preventive medicine visits. Many commercial policies do not include preventive visits as a benefit.

Other Preventive Medicine Services include Counseling Risk Factor Reduction and Behavior Change Intervention services.
Preventive Medicine Counseling is a service provided to patients to prevent a risky behavior from developing or to prevent injury from happening. The counseling occurs to address issues such as drug abuse, family problems, diet and exercise, etc. These services may not be reported in addition to preventive medicine visits (99381–99397). Code selection is based on the face-to-face time spent with the patient and according to whether the counseling is provided to an individual or in a group setting.

Behavior Changes, Individual Intervention services are provided to patients who have already developed the risky behavior. Smoking cessation (quitting smoking) counseling, and alcohol and substance abuse counseling, are found in the behavior change intervention codes. The codes are selected based on the substance and the amount of time spent with the patient.

**Non Face-to-Face Physician Services**

Non Face-to-Face Physician services are becoming increasingly popular with the advancement of technology. Services include Telephone Services and Online Medical Evaluations. Not all telephone encounters or online correspondence may be reported using these codes. Telephone services resulting in a visit to the physician within the next 24 hours, or next available urgent appointment, would be considered part of the service and would not be reported separately. To bill for a telephone service not resulting in a visit, the call must be initiated by an established patient, or established patient’s guardian. If the physician calls the patient within seven days of an E/M for something related to that E/M visit, the call would not be reported separately.

Online Medical Evaluations have similar guidelines. Online evaluations must be permanently stored. Online communications with the patient involving E/M services provided by the physician within seven days prior to the communication would not be reported separately.

**Special Evaluation and Management Services**

Obtaining Basic Life or Disability Insurance requires a medical evaluation, and a physician completes some forms on the patient’s behalf. In this category, codes exist to report these services. The code is selected based on the type of benefit being sought (basic life or disability).

**Newborn Care Services**

After the delivery of a newborn, the newborn is evaluated by a pediatrician or other qualified practitioner. Codes in this category are reported based on the location of the delivery and episode of care (initial or subsequent).

Additional critical services may be provided to the newborn immediately after delivery. These services include attendance at the delivery and stabilization of the newborn (99464) and the resuscitation, provision of positive pressure ventilation, and/or chest compressions (99465). Resuscitation does not include intubation (31500).

A newborn’s age is defined on the day of birth to the first 28 days.

**Inpatient Neonatal Intensive Care Services and Pediatric Neonatal Critical Care Services**

This category of E/M codes includes codes for Pediatric Critical Care Transport; Neonatal Critical Care, Pediatric Critical Care; and Initial and Continuing Intensive Care Services.

Sometimes, a critically ill pediatric patient needs to be transported from one facility to another for care. When a physician is in attendance for direct care to the patient during transport, the service can be reported using 99466 and 99467. The codes are reported based on time, beginning when the physician assumes primary responsibility of the patient and ending when the receiving facility has assumed responsibility for the patient. Only direct, face-to-face time during the transport may be reported.
Inpatient Neonatal and Pediatric Critical Care
visits are reported using 99468–99476. The code
is selected based on the age of the patient, and
whether a visit is initial or subsequent.

This category of codes is only intended for use
for inpatient neonatal and pediatric critically
ill patients (patients 5 years of age and under). Outpatient critical care services provided to
patients 5 years of age and under should be
reported with critical care codes 99291 and 99292. Critical care services provided to patients over 5
years of age are reported with 99291 and 99292,
whether they are inpatient or outpatient services.

Critical care includes many related services, such
as X-rays, gastric intubation, and more. CPT® lists
all included services in the Critical Care services
guidelines preceding adult critical care codes
99291–99292. Pediatric critical care codes 99471–
99476 include all the same services as adult critical
care, plus additional services (such as ventilator
management and lumbar puncture) as listed in
the Inpatient Neonatal and Pediatric Critical Care
services guidelines. Always check your CPT®
codebook prior to coding for additional services
with critical care to be sure those additional
services are separately reportable.

If a neonate is intubated or resuscitated in the
delivery room by the provider admitting the
neonate to critical care, the intubation and/or
resuscitation are reported separately. Modifier
59 is required to show the services were provided
prior to admission to neonatal critical care.

Codes 99477–99480 describe initial (99477) and
subsequent (99478–99480) intensive care for a
child. Intensive care is not the same as critical
care. CPT® clarifies children requiring intensive
care are not critically ill, but require “intensive
observation, frequent interventions, and other
intensive care services.”

The initial care code applies only to neonates,
age 28 days or less. CPT® provides parenthetical
notes to direct coding for services provided to
children who do not meet the requirements of
99477. Subsequent care is reported per day, and
depends on the infant’s body weight: less than
1500 grams or (99478), 1500–2500 grams (99479),
or 2501–5000 grams (99480).

Other Evaluation and Management Services
The only code in this section is unlisted E/M
service code 99499. This code is reported only if
no other available E/M code describes the service
provided. When reporting an unlisted service or
procedure code, documentation must substantiate
the nature of the service. Whenever possible, avoid
reporting an unlisted code.