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Figure 1B
Body Aspects — Side View

Figure 1C
Body Planes — Front View

Coronal (frontal) plane
Sagittal plane (at the body’s median)
Horizontal or transverse plane

Superior (cranial) aspect
Posterior aspect
Anterior aspect

Dorsal surface of hand
Palmar surface of hand
Dorsal surface of foot
Plantar surface of foot

Proximal end of upper limb
Distal end of upper limb
Ulnar side of hand
Medial border upper limb
Radial (thumb) side of hand
Lateral border upper limb
### Evaluation and Management Tables

#### Office or Other Outpatient Services

**Patient:** New  
**Required Components:** 3/3

<table>
<thead>
<tr>
<th>Code</th>
<th>12286</th>
<th>22286</th>
<th>12288</th>
<th>22288</th>
<th>12289</th>
<th>22289</th>
</tr>
</thead>
</table>

**Required Key Components**

**History and Exam (#1 and #2)**
- Problem-Focused  
- Expanded Problem-Focused  
- Detailed  
- Comprehensive

**Medical Decision Making (Complexity) (#3)**
- Straightforward  
- Moderate  
- High

**Contributory Factors**

**Presenting Problem (Severity) (#1)**
- Self-limited or Minor  
- Low to Moderate  
- Moderate to High

**Counseling (#2)**
- See E/M Guidelines

**Coordination of Care (#3)**
- See E/M Guidelines

**Typical Face-to-Face Time (#4)**
- Minutes 10, 20, 30, 45, 60

---

#### Initial Observation Care

**Patient:** New or Established  
**Required Components:** 3/3

<table>
<thead>
<tr>
<th>Code</th>
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<th>12288</th>
<th>22288</th>
<th>12289</th>
<th>22289</th>
</tr>
</thead>
</table>

**Required Key Components**

**History and Exam (#1 and #2)**
- Detailed or Comprehensive  
- Comprehensive

**Medical Decision Making (Complexity) (#3)**
- Straightforward or Low  
- Moderate  
- High

**Contributory Factors**

**Presenting Problem (Severity) (#1)**
- Low  
- Moderate  
- High

**Counseling (#2)**
- See E/M Guidelines

**Coordination of Care (#3)**
- See E/M Guidelines

**Bedside/Unit/Floor Time (#4)**
- Minutes 30, 50, 70

---

#### Subsequent Observation Care

**Patient:** New or Established  
**Required Components:** 2/3

<table>
<thead>
<tr>
<th>Code</th>
<th>12286</th>
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<th>12288</th>
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<th>12289</th>
<th>22289</th>
</tr>
</thead>
</table>

**Required Key Components**

**Interval History and Exam (#1 and #2)**
- Problem-Focused  
- Expanded Problem-Focused  
- Detailed

**Medical Decision Making (Complexity) (#3)**
- Straightforward or Low  
- Moderate  
- High

**Contributory Factors**

**Presenting Problem (Severity) (#1)**
- Stable/Recovering/Improving  
- Responding Inadequately/Moderate Complication Development  
- Unstable/Significant Complication/New Problem

**Counseling (#2)**
- See E/M Guidelines

**Coordination of Care (#3)**
- See E/M Guidelines

**Bedside/Unit/Floor Time (#4)**
- Minutes 15, 25, 35

---

#### Initial Hospital Care

**Patient:** New or Established  
**Required Components:** 3/3

<table>
<thead>
<tr>
<th>Code</th>
<th>12286</th>
<th>22286</th>
<th>12288</th>
<th>22288</th>
<th>12289</th>
<th>22289</th>
</tr>
</thead>
</table>

**Required Key Components**

**History and Exam (#1 and #2)**
- Detailed or Comprehensive  
- Comprehensive

**Medical Decision Making (Complexity) (#3)**
- Straightforward or Low  
- Moderate  
- High

**Contributory Factors**

**Presenting Problem (Severity) (#1)**
- Low  
- Moderate  
- High

**Counseling (#2)**
- See E/M Guidelines

**Coordination of Care (#3)**
- See E/M Guidelines

**Bedside/Unit/Floor Time (#4)**
- Minutes 30, 50, 70

---

#### Subsequent Hospital Care

**Patient:** New or Established  
**Required Components:** 2/3

<table>
<thead>
<tr>
<th>Code</th>
<th>12286</th>
<th>22286</th>
<th>12288</th>
<th>22288</th>
<th>12289</th>
<th>22289</th>
</tr>
</thead>
</table>

**Required Key Components**

**Interval History and Exam (#1 and #2)**
- Problem-Focused  
- Expanded Problem-Focused  
- Detailed

**Medical Decision Making (Complexity) (#3)**
- Straightforward or Low  
- Moderate  
- High

**Contributory Factors**

**Presenting Problem (Severity) (#1)**
- Stable/Recovering/Improving  
- Responding Inadequately/Moderate Complication Development  
- Unstable/Significant Complication/New Problem

**Counseling (#2)**
- See E/M Guidelines

**Coordination of Care (#3)**
- See E/M Guidelines

**Bedside/Unit/Floor Time (#4)**
- Minutes 15, 25, 35
Evaluation and Management (E/M) Services Guidelines

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

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of work varies by type of service, place of service, and the patient’s status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See “Levels of E/M Services,” page 6, for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on page 7.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

New and Established Patient

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

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

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

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

The decision tree on page 5 is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.
Evaluation and Management

Office or Other Outpatient Services

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

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 15) or initial nursing facility care (page 25).

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

For observation care, see 99217-99226.

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

Coding Tip

Determination of Patient Status as New or Established Patient

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

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

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

CPT Coding Guidelines, Evaluation and Management, Definitions of Commonly Used Terms, New and Established Patient

New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

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

Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Straightforward medical decision making.

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

Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of low complexity.
Evaluation and Management

Office or Other Outpatient Services

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

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 15) or initial nursing facility care (page 25).

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

For observation care, see 99217-99226.

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

Coding Tip

Determination of Patient Status as New or Established Patient

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

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

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

CPT Coding Guidelines, Evaluation and Management, Definitions of Commonly Used Terms, New and Established Patient

New Patient

99201  Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

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

Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

99202  Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Straightforward medical decision making.

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

Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

99203  Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of low complexity.
Adjacent Tissue Transfer or Rearrangement

For full thickness repair of lip or eyelid, see respective anatomical subsections.

Codes 14000-14302 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (e.g., Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap). When applied in repairing lacerations, the procedures listed must be performed by the surgeon to accomplish the repair. They do not apply to direct closure or rearrangement of traumatic wounds incidentally resulting in these configurations. Undermining alone of adjacent tissues to achieve closure, without additional incisions, does not constitute adjacent tissue transfer, see complex repair codes 13100-13160. The excision of a benign lesion (11400-11446) or a malignant lesion (11600-11646) is not separately reportable with codes 14000-14302.

Skin graft necessary to close secondary defect is considered an additional procedure. For purposes of code selection, the term “defect” includes the primary and secondary defects. The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine the code.

14000 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less

14001 defect 10.1 sq cm to 30.0 sq cm

14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less

14021 defect 10.1 sq cm to 30.0 sq cm

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

14041 defect 10.1 sq cm to 30.0 sq cm

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
Skin Replacement Surgery

Skin replacement surgery consists of surgical preparation and topical placement of an autograft (including tissue cultured autograft) or skin substitute graft (ie, homograft, allograft, xenograft). The graft is anchored using the individual’s choice of fixation. When services are performed in the office, routine dressing supplies are not reported separately.

The following definition should be applied to those codes that reference “100 sq cm or 1% of body area of infants and children” when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children 10 years of age and older; and percentages of body surface area apply to infants and children younger than 10 years of age. The measurements apply to the size of the recipient area.

Procedures involving wrist and/or ankle are reported with codes that include arm or leg in the descriptor.

When a primary procedure requires a skin substitute or skin autograft for definitive skin closure (eg, oribectomy, radical mastectomy, deep tumor removal), use 15100-15278 in conjunction with primary procedure.

For biological implant for soft tissue reinforcement, use 15777 in conjunction with primary procedure.

The supply of skin substitute graft(s) should be reported separately in conjunction with 15271-15278.

Definitions

Surgical preparation codes 15002-15005 for skin replacement surgery describe the initial services related to preparing a clean and viable wound surface for placement of an autograft, flap, skin substitute graft or for negative pressure wound therapy. In some cases, closure may be possible using adjacent tissue transfer (14000-14061) or complex repair (13100-13153). In all cases, appreciable nonviable tissue is removed to treat a burn, traumatic wound or a necrotizing infection. The clean wound bed may also be created by incisional release of a scar contracture resulting in a surface defect from separation of tissues. The intent is to heal the wound by primary intention, or by the use of negative pressure wound therapy. Patient conditions may require the closure or application of graft, flap, or skin substitute to be delayed, but in all cases the intent is to include these treatments or negative pressure wound therapy to heal the wound. Do not report 15002-15005 for removal of nonviable tissue/debris in a chronic wound (eg, venous or diabetic) when the wound is left to heal by secondary intention. See active wound management codes (97597, 97598) and debridement codes (11042, 11047) for this service. For necrotizing soft tissue infections in specific anatomic locations, see 11004-11008.

Select the appropriate code from 15002-15005 based upon location and size of the resultant defect. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (eg, face and arms). Use 15002 or 15004, as appropriate, for excisions and incisional releases resulting in wounds up to and including 100 sq cm of surface area. Use 15003 or 15005 for each additional 100 sq cm or part thereof. For example: Surgical preparation of a 20 sq cm wound on the right hand and a 15 sq cm wound on the left hand would be reported with a single code, 15004. Surgical preparation of a 75 sq cm wound on the right thigh and a 75 sq cm wound on the left thigh would be reported with 15002 for the first 100 sq cm and 15003 for the second 50 sq cm. If all four wounds required surgical preparation on the same day, use modifier 59 with 15002, and 15004.

Autografts/tissue cultured autografts include the harvest and/or application of an autologous skin graft. Repair of donor site requiring skin graft or local flaps is reported separately. Removal of current graft and/or simple cleansing of the wound is included, when performed. Do not report 97602. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.

Select the appropriate code from 15040-15261 based upon type of autograft and location and size of the defect. The measurements apply to the size of the recipient area. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (eg, face and arms).
Appendix L

Vascular Families

Assignment of branches to first, second, and third order in this table makes the assumption that the starting point is catheterization of the aorta. This categorization would not be accurate, for instance, if a femoral or carotid artery were catheterized directly in an antegrade direction. Arteries highlighted in bold are those more commonly reported during arteriographic procedures.

<table>
<thead>
<tr>
<th>First Order</th>
<th>Second Order Branch</th>
<th>Third Order Branch</th>
<th>Beyond Third Order Branches</th>
</tr>
</thead>
<tbody>
<tr>
<td>R. ophthalmic</td>
<td>R. internal carotid</td>
<td>R. vertebral</td>
<td>R. superior thyroid</td>
</tr>
<tr>
<td>L. ophthalmic</td>
<td>R. internal carotid</td>
<td>R. inferior thyroid</td>
<td>R. ascending pharyngeal</td>
</tr>
<tr>
<td>R. internal carotid</td>
<td>R. p. communicating</td>
<td>R. vertebrobasilar</td>
<td>R. suprascapular</td>
</tr>
<tr>
<td>L. internal carotid</td>
<td>R. middle cerebral</td>
<td>R. transverse cervical</td>
<td>R. transverse cervical</td>
</tr>
<tr>
<td>R. a. cerebral</td>
<td>R. middle cerebral</td>
<td>R. high intercostal</td>
<td>R. internal maxillary</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. a. cerebral</td>
<td>R. deep cervical</td>
<td>R. external carotid</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. vertebral</td>
<td>R. circumflex scapular</td>
<td>R. subclavian &amp; axillary</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>R. ulnar</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. thoracic (internal mammary)</td>
<td>R. radial</td>
<td>R. radial</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. thyrocervical trunk</td>
<td>R. interosseous</td>
<td>R. interosseous</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. costocervical trunk</td>
<td>R. deep palmar arch</td>
<td>R. deep palmar arch</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. lateral thoracic</td>
<td>R. superficial palmar arch</td>
<td>R. superficial palmar arch</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. thoracocervical trunk</td>
<td>R. metacarpals and digits</td>
<td>R. metacarpals and digits</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. humeral circumflex (A/P)</td>
<td>R. brachial</td>
<td>L. ophthalmic</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. superior thyroid</td>
</tr>
<tr>
<td>R. common carotid</td>
<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. ascending pharyngeal</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. facial</td>
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<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. lingual</td>
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<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. occipital</td>
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<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. p. auricular</td>
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<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. superficial temporal</td>
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<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. internal maxillary</td>
</tr>
<tr>
<td>R. external carotid</td>
<td>R. subclavian &amp; axillary</td>
<td>R. brachial</td>
<td>L. middle meningeal</td>
</tr>
</tbody>
</table>

R = right, L = left, A = anterior, P = posterior