Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

►In the **Evaluation and Management** section (98000-98016, 99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Telemedicine Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◄

Rationale

In accordance with the establishment of codes 98000-98016, the E/M Guidelines Overview subsection has been revised to reflect these changes.

Refer to the codebook and the Rationale for codes 98000-98016 for a full discussion of these changes.

Evaluation and Management

Office or Other Outpatient Services

New Patient

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

(For services 75 minutes or longer, use prolonged services code 99417)

Established Patient

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

(For services 55 minutes or longer, use prolonged services code 99417)

Rationale

In accordance with the establishment of codes 98000-98016 for reporting telemedicine office visits, the telemedicine symbol (★) has been removed from codes 99202-99205 and 99212-99215 because they will no longer be reported for telemedicine office visits.

Refer to the codebook and the Rationale for codes 98000-98016 for a full discussion of these changes.

►Telemedicine Services◄

►Telemedicine services are synchronous, real-time, interactive encounters between a physician or other qualified health care professional (QHP) and a patient utilizing either combined audio-video or audio-only telecommunication. Unless specifically stated in the code descriptor, level selection for telemedicine services is based on either the level of medical decision making (MDM) or the total time for E/M services performed on the date of the encounter, as defined for each service. Telemedicine services are used in lieu of an in-person service when medically appropriate to address the care of the patient and when the patient and/or family/caregiver agree to this format of care. Telemedicine services are not used to report routine telecommunications related to a previous encounter (eg, to communicate laboratory results). They may be used for follow-up of a previous encounter, when a follow-up E/M service is required, in the same manner as in-person E/M services are used. For example, telemedicine services may be used for a patient requiring re-assessment for response or complications related to the treatment plan of a previous visit. Except for 98016, these services do not require a specific time interval from the last in-person or telemedicine visit and may be initiated by a physician or other QHP as well as

by a patient and/or family/caregiver. However, the telemedicine services must be performed on a separate calendar date from another E/M service. When performed on the same date as another E/M service, the elements and time of these services are summed and reported in aggregate, ensuring that any overlapping time is only counted once. If the minimum time for reporting a telemedicine service has not been achieved, time spent with the patient may still count toward the total time on the date of the encounter of an in-person E/M service.

For audio-only telemedicine services for established patients with 5 to 10 minutes of medical discussion, report brief communication technology service (eg, virtual check-in) code 98016. Code 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [99212, 99213, 99214, 99215]). Video technology is not required for audio-only visits. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for the total time on the date of the encounter.

For services that are asynchronous (ie, not live in real-time), see **Online Digital Evaluation and Management Services** (99421, 99422, 99423). Do not report telemedicine services for oversight of clinical staff (eg, chronic care management [CCM]). Do not count the time performing telemedicine services toward time performing CCM (99437, 99491) or principal care management services (99424, 99425). See Table 2, Telemedicine and Non-Face-to-Face Services.

For 98000-98015, the level of service is selected based on MDM or total time on the date of the encounter. For

►**Table 2: Telemedicine and Non-Face-to-Face Services**

Service	New/Established	Synchronous	Level/Unit Reported	Service Reported	Other E/M Notations
Synchronous audio-video (98000-98007)	Both	Yes	MDM or total time on the date of the service. No minimum required time, unless level selected by time.	Per single calendar date	Do not report with same-day in-person E/M
Synchronous audio-only (98008-98015)	Both	Yes	MDM or total time on the date of the service. Must be more than 10 minutes of medical discussion.	Per single calendar date	Do not report with same-day in-person E/M
Brief synchronous communication technology service (98016)	Established	Yes	A single 5- to 10-minute medical discussion	Per single calendar date	Not related to E/M in prior 7 days or leading to E/M in next 24 hours
Online digital E/M (99421-99423)	Established	No	Minutes during 7-day period	Per 7 days	Not related to E/M in prior 7 days or leading to E/M in next 24 hours
Interprofessional telephone/Internet/EHR consultations (99446-99451)	Both	Not required	Minutes during 7-day period	Per 7 days	No in-person encounter within 14 days
Interprofessional telephone/Internet/EHR consultations (99452)	Both	Not required	Minutes during a single day	Per 14 days	No in-person encounter within 14 days
Care management and remote treatment management (99424, 99425, 99437, 99484, 99491)	Established	Not required	Minutes	Per calendar month	Physician or QHP time excluded on date of other E/M
All services (98000-98016, 99421-99425, 99437, 99446-99452, 99484, 99491)			Same time is not counted twice◄		

audio-only codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, the service must exceed 10 minutes of medical discussion. Code 98016 describes services for established patients with 5 to 10 minutes of medical discussion and is based only on the time of medical discussion and not MDM. Do not count time for establishing the connection or arranging the appointment, even when performed by the physician or other QHP. Services of less than five minutes are not reported.

For audio-only codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, medical discussion is synchronous (real-time) interactive verbal communication and does not include online digital communication (except when via a telecommunication technology device for the deaf). The meaning of MDM has the meaning used in the E/M Guidelines and is a cognitive process by the physician or other QHP.

If during the encounter, audio-video connections are lost and only audio is restored, report the service that accounted for the majority of the time of the interactive portion of the service. Ten minutes of medical discussion or patient observation must be exceeded in order to report the audio-only service.◄

►Synchronous Audio-Video Evaluation and Management Services◄

►Codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007 may be reported for new or established patients. Synchronous audio and video telecommunication is required. These services may be reported based on total time on the date of the encounter or MDM.◄

►New Patient◄

#● **98000** **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

#● **98001** **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

#● **98002** **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

#● **98003** **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

►(For services 75 minutes or longer, use prolonged services code 99417)◄

Clinical Example (98000)

Synchronous audio-video visit for a new patient with a self-limited problem.

Description of Procedure (98000)

Prior to Visit: Review any medical records and data. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate visual examination. Synthesize the relevant history and visual examination to formulate a differential diagnosis and treatment plan (requiring straightforward medical decision making). Discuss the treatment plan with the patient and the patient's family. Provide patient education, and respond to questions from the patient and/or the patient's family. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with the quality payment program and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures that may occur after the visit. Coordinate follow-up or orders with office staff.

Clinical Example (98001)

Synchronous audio-video visit for a new patient with a stable chronic illness or acute uncomplicated injury.

Description of Procedure (98001)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to formulate a differential diagnosis, diagnostic strategy, and treatment plan (requiring low level of medical decision making). Discuss the treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying the preferred pharmacy, making changes as needed based on the payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98002)

Synchronous audio-video visit for a new patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Description of Procedure (98002)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to formulate a differential diagnosis, diagnostic strategy, and treatment plan (requiring moderate level of medical decision making). Discuss the treatment options with the patient and that patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying the preferred pharmacy, making changes as needed based on the payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98003)

Synchronous audio-video visit for a new patient with a chronic illness with severe exacerbation, or an acute illness/injury, that poses an acute threat to life or bodily function.

Description of Procedure (98003)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to formulate a differential diagnosis, diagnostic strategy, and treatment plan (requiring high level of medical decision making). Discuss the treatment options with the patient and the patient's family, incorporating their values in creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying preferred pharmacy, making changes as needed based on payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In

concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

►Established Patient◄

#● **98004** **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

#● **98005** **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

#● **98006** **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

#● **98007** **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

►(For services 55 minutes or longer, use prolonged services code 99417)◄

Clinical Example (98004)

Synchronous audio-video visit for an established patient with a self-limited problem.

Description of Procedure (98004)

Prior to Visit: If necessary, review interval correspondence, referral notes, and medical records generated since the last visit. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history. Update pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate visual examination. Synthesize the relevant history and visual examination to formulate a differential diagnosis and treatment plan (requiring straightforward medical decision making). Discuss the treatment plan with the patient and the patient's family. Provide patient education, and respond to questions from the patient and/or the patient's family. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures that may occur after the visit. Coordinate follow-up or orders with office staff.

Clinical Example (98005)

Synchronous audio-video visit for an established patient with a stable chronic illness or acute uncomplicated illness or injury.

Description of Procedure (98005)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to update differential diagnosis, diagnostic strategy, and treatment plan (requiring low level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family.

Electronically prescribe medications, making changes as needed based on payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98006)

Synchronous audio-video visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Description of Procedure (98006)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and the prior clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to update differential diagnosis, diagnostic strategy, and treatment plan (requiring moderate level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe medications, making changes as needed based on the payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98007)

Synchronous audio-video visit for an established patient with a chronic illness with severe exacerbation, or an acute illness/injury, that poses an acute threat to life or bodily function.

Description of Procedure (98007)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Perform a medically appropriate visual examination. Synthesize the relevant history, visual examination, and data elements to update differential diagnosis, diagnostic strategy, and treatment plan (requiring high level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe medications, making changes as needed based on the payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

►Synchronous Audio-Only Evaluation and Management Services◄

►Codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015 may be reported for new or established patients. They require more than 10 minutes of medical discussion. For services of 5 to 10 minutes of medical discussion, report 98016, if appropriate. If 10 minutes of medical discussion is exceeded, total time on the date of the encounter or MDM may be used for code level selection.◄

►New Patient◄

#● **98008** **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

#● **98009** **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

#● **98010** **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

#● **98011** **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

►(For services 75 minutes or longer, use prolonged services code 99417)◄

Clinical Example (98008)

Synchronous audio-only visit for a new patient with a self-limited problem.

Description of Procedure (98008)

Prior to Visit: Review any medical records and data. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring straightforward medical decision making). Discuss the treatment plan with the patient and the patient's family. Provide patient education, and respond to questions from the patient and/or the patient's family. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures that may occur after the visit. Coordinate follow-up or orders with office staff.

Clinical Example (98009)

Synchronous audio-only visit for a new patient with a stable chronic illness or acute uncomplicated illness or injury.

Description of Procedure (98009)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring low level of medical decision making). Discuss the treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying the preferred pharmacy, making changes as needed based on the payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other

orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98010)

Synchronous audio-only visit for a new patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Description of Procedure (98010)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring moderate level of medical decision making). Discuss the treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying the preferred pharmacy, making changes as needed based on the payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98011)

Synchronous audio-only visit for a new patient with a chronic illness with severe exacerbation, or an acute illness/injury, that poses an acute threat to life or bodily function.

Description of Procedure (98011)

Prior to Visit: Review any medical records and data. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring high level of medical decision making). Discuss the treatment options with the patient and the patient's family, incorporating their values in creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe all chronic and new medications after verifying preferred pharmacy, making changes as needed based on payer formulary. Arrange for diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications, or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

►Established Patient◄

#● **98012** **Synchronous audio-only visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.

►(Do not report 98012 for home and outpatient INR monitoring when reporting 93792, 93793)◄

►(Do not report 98012 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄

►(Do not report 98012 during the same month with 99487, 99489)◄

►(Do not report 98012 when performed during the service time of 99495, 99496)◄

#● **98013** **Synchronous audio-only visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

►(Do not report 98013 for home and outpatient INR monitoring when reporting 93792, 93793)◄

►(Do not report 98013 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄

►(Do not report 98013 during the same month with 99487, 99489)◄

►(Do not report 98013 when performed during the service time of 99495, 99496)◄

#● **98014** **Synchronous audio-only visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

►(Do not report 98014 for home and outpatient INR monitoring when reporting 93792, 93793)◄

►(Do not report 98014 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄

►(Do not report 98014 during the same month with 99487, 99489)◄

►(Do not report 98014 when performed during the service time of 99495, 99496)◄

#● **98015** **Synchronous audio-only visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

►(Do not report 98015 for home and outpatient INR monitoring when reporting 93792, 93793)◄

►(Do not report 98015 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄

►(Do not report 98015 during the same month with 99487, 99489)◄

►(Do not report 98015 when performed during the service time of 99495, 99496)◄

►(For services 55 minutes or longer, use prolonged services code 99417)◄

Clinical Example (98012)

Synchronous audio-only visit for an established patient with a self-limited problem.

Description of Procedure (98012)

Prior to Visit: If necessary, review interval correspondence, referral notes, and medical records generated since the last visit. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history. Update pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring straightforward medical decision making). Discuss the treatment plan with the patient and the patient's family. Provide patient education, and respond to questions from the patient and/or the patient's family. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures that may occur after the visit. Coordinate follow-up or orders with office staff.

Clinical Example (98013)

Synchronous audio-only visit for an established patient with a stable chronic illness or acute uncomplicated illness or injury.

Description of Procedure (98013)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior

clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring low level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe medications, making changes as needed based on the payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98014)

Synchronous audio-only visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Description of Procedure (98014)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring moderate level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe medications, making changes as needed based on payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Clinical Example (98015)

Synchronous audio-only visit for an established patient with a chronic illness with severe exacerbation, or an acute illness/injury, that poses an acute threat to life or bodily function.

Description of Procedure (98015)

Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the prescription monitoring program, health information exchange, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history form completed by the patient and prior clinical note. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring high level of medical decision making). Discuss treatment options with the patient and the patient's family, incorporating their values in the creation of the plan. Provide patient education, and respond to questions from the patient and/or the patient's family. Electronically prescribe medications, making changes as needed based on the payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Perform

electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After Visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures or complications or adverse reactions to medications that may occur after the visit. Review and analyze interval testing results. Communicate results to and plan modifications with the patient and/or the patient's family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

►Brief Synchronous Communication Technology Service (eg, Virtual Check-In)◄

►Code 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [99212, 99213, 99214, 99215]). Video technology is not required. Code 98016 describes a service of shorter duration than the audio-only services and has other restrictions that are related to the intended use as a "virtual check-in" or triage to determine if another E/M service is necessary. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for total time on the date of the encounter.◄

#● **98016** **Brief communication technology-based service** (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

►(Do not report 98016 in conjunction with 98000-98015)◄

►(Do not report services of less than 5 minutes of medical discussion)◄

Rationale

A new subsection, "Telemedicine Services," has been added to the Evaluation and Management section with new guidelines and 17 new codes for reporting synchronous (ie, real-time) evaluation and management (E/M) services.

Prior to 2025, audio-video telemedicine office or other outpatient E/M services were reported using codes 99202-99205 (new patient) and 99211-99215 (established patient) with modifier 95, *Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System,* appended. The new codes better reflect the resources needed to provide these services.

The Relative Value Scale Update Committee (RUC)/Current Procedural Terminology (CPT) (RUC/CPT) E/M Workgroup (Workgroup) performed an assessment of available data for audio-video and audio-only office visits and surveyed medical specialty societies. The Workgroup's findings indicated that PE for clinical staff time is applicable to both audio-video and audio-only office visits; therefore, a coding solution was needed to accurately reflect the clinical staff time associated with these services. For 2025, codes 98000-98007 have been established for synchronous **(real-time) audio-video** E/M office services. Codes 98008-98015 have been established for synchronous **(real-time) audio-only** E/M services. With the establishment of these codes, codes 99441-99443 for telephone services have been deleted and a cross-reference parenthetical note added directing users to new codes 98008-98016. These telemedicine service codes describe real-time, interactive encounters between the physician or other qualified health care professional and the patient. Both the audio-video and the audio-only codes have the same categories (new and established patients) and structure as the office or other outpatient codes 99202-99205 and 99211-99215.

Code 98016 has been established for a brief synchronous communication technology service (eg, a virtual check-in). Note that this service is reported for an established patient and is initiated by the patient to determine if a more extensive E/M service is necessary. Code 98016 is similar to Healthcare Common Procedure Coding System (HCPCS) Level II code G2252.

New guidelines have been added to define the services described in these new codes and explain the appropriate reporting of these services. It is important to note that when a telemedicine office visit is performed on the same date as another E/M service, the elements and time of these services are summed together to avoid duplicate reporting. The new guidelines include a Telemedicine and Non-Face-to-Face Services table, which provides additional guidance for reporting codes 98000-98016 and other online and non-face-to-face E/M services codes. Parenthetical notes have been added throughout the new subsection to provide instructions on the appropriate reporting of these new codes, too.

Clinical Example (98016)

An established patient contacts the office to request an evaluation regarding the necessity of being seen for symptoms of concern to the patient.

Description of Procedure (98016)

Prior to Visit: Review any medical records and data. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm the patient's identity. Review the medical history forms completed by the patient. Obtain a medically appropriate history, including pertinent components of history of present illness, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Assess the patient's condition with available information to formulate a differential diagnosis and treatment plan (requiring straightforward medical decision making). Discuss the treatment plan with the patient and the patient's family. Provide patient education, and respond to questions from the patient and/or the patient's family. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment programs and other electronic mandates.

After visit: Answer follow-up questions from the patient and/or the patient's family, and respond to treatment failures that may occur after the visit. Coordinate follow-up or orders with office staff.

Hospital Observation Services

Observation Care Discharge Services

(99217 has been deleted. To report observation care discharge services, see 99238, 99239)

Prolonged Services

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

#★✚ **99417** **Prolonged outpatient evaluation and management service(s)** time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient **Evaluation and Management** service)

►(Use 99417 in conjunction with 98003, 98007, 98011, 98015, 99205, 99215, 99245, 99345, 99350, 99483)◄

(Use 99417 in conjunction with 99483, when the total time on the date of the encounter exceeds the typical time of 99483 by 15 minutes or more)

(Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)

(Do not report 99417 for any time unit less than 15 minutes)

Rationale

In accordance with the establishment of telemedicine codes 98003, 98007, 98011, and 98015, the inclusionary parenthetical note for add-on code 99417 has been revised with the addition of these codes.

Refer to the codebook and the Rationale for codes 98000-98016 for a full discussion of these changes.

Case Management Services

Medical Team Conferences

Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (eg, legal guardian), and/or caregiver(s). The participants are actively involved in the development, revision, coordination, and implementation of health care services needed by the patient. Reporting participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days.

Physicians or other qualified health care professionals who may report evaluation and management services should report their time spent in a team conference with the patient and/or family/caregiver present using evaluation and management (E/M) codes. These introductory guidelines do not apply to services reported using E/M codes (see E/M Services Guidelines). However, the individual must be directly involved with the patient, providing face-to-face services outside of the conference visit with other physicians, and qualified health care professionals, or agencies.

Reporting participants shall document their participation in the team conference as well as their contributed information and subsequent treatment recommendations.

No more than one individual from the same specialty may report 99366-99368 at the same encounter.

Individuals should not report 99366-99368 when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organization or facility.

►The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communicating to the other team members or patient and/or family/caregiver. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight (99374-99380), prolonged services (99358, 99359), psychotherapy, or any E/M service. For team conferences where the patient is present for any part of the duration of the conference, nonphysician qualified health care professionals report the team conference face-to-face code 99366.◄

Rationale

The terms "physician" and "other qualified health care professional (QHP)" appear in many places in the CPT code set. In 2012, the CPT code set was updated to provide a definition of "physician or other QHP" in the introductory guidelines. The CPT 2013 code set was extensively revised to standardize the terminology and ensure neutral reporting across the code set. A small section of codes focuses on services provided by QHPs who are considered "nonphysicians" within the coding nomenclature. In some cases, the reference to "nonphysician QHP" is stated inconsistently across the code set. Revisions have been made to the CPT 2025 code set to standardize the use of "nonphysician qualified health care professional" in those areas that were misaligned.

It is important to note that the CPT code set will continue to adhere to the definition provided in the **Instructions for Use of the CPT Codebook** subsection, which defines *physician or other qualified health care professional* as follows:

A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other QHP and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service. Other policies may also affect who may report specific services.

Throughout the CPT code set, the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

To address misaligned and inconsistent use of terminology, numerous revisions and deletions have been made throughout the CPT code set to incorporate the consistent use of "nonphysician qualified health care professional," wherever applicable:

- Revisions to guidelines in various sections, including E/M, Radiology, and Medicine, to support standardization and consistency throughout the guidelines.
- Revisions to codes 98960-98962, 98966-98968, and 98970-98972.
- Revisions to section headers in the Medicine subsection. In conjunction with these revisions, other updates to various parenthetical notes to support standardization and consistency were made as well.

In conjunction with these changes, editorial changes have been made throughout guidelines in the Medicine subsection and the guidelines for non-face-to-face nonphysician services by replacing "E/M" with "assessment and management."

Care Plan Oversight Services

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home or residence (including assisted living facility, group home, custodial care facility, residential substance abuse treatment facility, rest home), nursing facility, or non-face-to-face services. The complexity and approximate time of the care plan oversight services provided within a 30-day period determine code selection. Only one individual may report services for a given period of time to reflect the sole or predominant supervisory role with a particular patient. These codes should not be reported for supervision of patients in nursing facilities or under the care of home health agencies, unless they require recurrent supervision of therapy.

The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes.

(For care plan oversight services provided in rest home [eg, assisted living facility] or home, see care management services codes 99437, 99491, or principal care management codes 99424, 99425, and for hospice agency, see 99377, 99378)

►(Do not report 99374-99380 for time reported with 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 99421, 99422, 99423)◄

(Do not report 99374-99378 during the same month with 99487, 99489)

99374 **Supervision** of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99375 30 minutes or more

Rationale

In accordance with the deletion of codes 99441-99443 and the establishment of codes 98012-98016, the exclusionary parenthetical note preceding code 99374 has been revised to reflect these changes.

Refer to the codebook and the Rationale for codes 98012-98016 for a full discussion of these changes.

Preventive Medicine Services

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents, and adults.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management service, then the appropriate office/outpatient code 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215 should also be reported. Modifier 25 should be added to the office/outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

The "comprehensive" nature of the preventive medicine services codes 99381-99397 reflects an age- and gender-appropriate history/exam and is **not** synonymous with the "comprehensive" examination required in evaluation and management codes 99202-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. (Refer to 99401, 99402, 99403, 99404, 99411, and 99412 for reporting those counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

(For behavior change intervention, see 99406, 99407, 99408, 99409)

►Immunization/vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and immunization risk/benefit counseling, see 90460, 90461, 90471-90474, 90480, 96380, 96381. For immunization/vaccine/toxoid products, see 90380, 90381, 90476-90759, 91304, 91318, 91319, 91320, 91321, 91322.◄

Rationale

The guidelines within the Preventive Medicine Services subsection have been revised to: (1) include the addition of existing codes for immune globulin products for respiratory syncytial virus (RSV) (90380, 90381); (2) accommodate the addition of new codes for reporting immune globulin administration for RSV (96380, 96381); (3) reflect the removal of previously deleted COVID-19 product codes (91300-91317) and administration codes (0001A-0174A); (4) add a reference to a new code for COVID-19 vaccine administration (90480); (5) add new codes for reporting COVID-19 vaccine products (91318-91322); and (6) retain the use of code 91304 for Novavax vaccine product.

In addition, the term "immunization" has been included within these guidelines to be congruent with the new terminology added to the code set that clarifies the use of immune globulins in addition to vaccines/toxoids for immunizations.

Refer to the codebook and the Rationale for codes 90380, 90381, 90480, 96380, and 96381 for a full discussion of these changes.

Counseling Risk Factor Reduction and Behavior Change Intervention

Other Preventive Medicine Services

99421 Code is out of numerical sequence. See 99412-99447

99422 Code is out of numerical sequence. See 99412-99447

99423 Code is out of numerical sequence. See 99412-99447

Non-Face-to-Face Services

Telephone Services

►(99441, 99442, 99443 have been deleted. To report, see 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016)◄

Rationale

In accordance with the establishment of codes 98008-98016, telephone service codes 99441-99443 and their associated guidelines and parenthetical notes have been deleted. A deletion parenthetical note has been added that directs users to the new codes.

Refer to the codebook and the Rationale for codes 98008-98016 for a full discussion of these changes.

Online Digital Evaluation and Management Services

Online digital evaluation and management (E/M) services (99421, 99422, 99423) are patient-initiated services with physicians or other qualified health care professionals (QHPs). Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the physician or other QHP, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications, which allow digital communication with the physician or other QHP.

Online digital E/M services are reported once for the physician's or other QHP's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry. Physician's or other QHP's cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including physician- or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M service. All professional decision making, assessment, and subsequent management by physicians or other QHPs in the same group practice contribute to the cumulative service time of the patient's online digital E/M service. Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.

►If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit. This includes E/M services that are provided through synchronous telemedicine visits using interactive audio and video telecommunication equipment. To report synchronous audio-video E/M services, see 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007. To report synchronous audio-only E/M services, see 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016.◄

If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported. If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, then the online digital E/M service is not reported separately.

If the patient generates the initial online digital inquiry for a new problem within seven days of a previous E/M visit that addressed a different problem, then the online digital E/M service may be reported separately.

If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the physician's or other QHP's time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the online digital E/M service for that seven-day period.

►(For online digital assessment and management services provided by a nonphysician qualified health care professional who may not report E/M services, see 98970, 98971, 98972)◄

 # 99421 **Online digital evaluation and management service,** for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

Rationale

In support of the establishment of codes 98000-98016, the Online Digital Evaluation and Management Services subsection guidelines have been revised to reflect these changes. Refer to the codebook and the Rationale for codes 98000-98016 for a full discussion of these changes.

In addition, in accordance with efforts to standardize the phrase "nonphysician qualified health care professional" throughout the CPT 2025 code set, the guidelines preceding code 99421 have been revised. Refer to the codebook and the Rationale for the Medical Team Conferences subsection guidelines in the E/M section for a full discussion of these changes.

Interprofessional Telephone/ Internet/Electronic Health Record Consultations

The consultant should use codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/ Internet/electronic health record consultations. An interprofessional telephone/Internet/electronic health record consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician or other qualified health care professional with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.

The patient for whom the interprofessional telephone/ Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet/ electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.

Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc is included in the telephone/Internet/electronic health record consultation service and should not be reported separately when reporting 99446, 99447, 99448, 99449, 99451. The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion. If greater than 50% of the time for the service is devoted to data review and/or analysis, 99446, 99447, 99448, 99449 should not be reported. However, the service time for 99451 is based on total review and interprofessional-communication time.

If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code. Codes 99446, 99447, 99448, 99449, 99451 should not be reported more than once within a seven-day interval.

The written or verbal request for telephone/Internet/ electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request. Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other qualified health care professional. Code 99451 concludes with only a written report.

►Telephone/Internet/electronic health record consultations of less than five minutes should not be reported. Consultant communications with the patient and/or family may be reported using 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 99421, 99422, 99423, and the time related to these services is not used in reporting 99446, 99447, 99448, 99449. Do not report 99358, 99359 for any time within the service period, if reporting 99446, 99447, 99448, 99449, 99451.◄

When the sole purpose of the telephone/Internet/electronic health record communication is to arrange a transfer of care or other face-to-face service, these codes are not reported.

The treating/requesting physician or other qualified health care professional may report 99452, if spending 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant. Do not report 99452 more than once in a 14-day period. If the telephone/Internet/electronic health record referral service(s) and an E/M service are performed on the same day by the treating/requesting physician or other qualified health care professional and total time is used to select the level of E/M service, the time spent providing the referral service is added to the time spent on the day of the encounter performing the E/M service. If MDM is used to select the level of E/M service, the work of performing the referral service is considered part of the MDM. Do not report 99452 separately on the same date an E/M service is reported.

►(For telephone services provided by a physician or other qualified health care professional to a patient, see 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016)◄

►(For telephone services provided by a nonphysician qualified health care professional who may not report evaluation and management services, see 98966, 98967, 98968)◄

(For online digital E/M services provided by a physician or other qualified health care professional to a patient, see 99421, 99422, 99423)

Rationale

In accordance with the deletion of codes 99441-99443 and the establishment of codes 98008-98016, the Interprofessional Telephone/Internet/Electronic Health Record Consultations subsection guidelines and the cross-reference parenthetical note for telephone services provided by a physician or other QHP to a patient have been revised to reflect these changes.

In addition, in accordance with efforts to standardize the term "nonphysician qualified health care professional" throughout the CPT 2025 code set, a parenthetical note within the Interprofessional Telephone/Internet/Electronic Health Record Consultations subsection has also been revised.

Refer to the codebook and the Rationale for the Medical Team Conferences subsection guidelines in the E/M section and the Rationale for codes 98008-98016 for a full discussion of these changes.

Care Management Services

Chronic Care Management Services

 # 99490 **Chronic care management services** with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored;

first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

#+ 99439 each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Use 99439 in conjunction with 99490)

(Chronic care management services of less than 20 minutes duration in a calendar month are not reported separately)

(Chronic care management services of 60 minutes or more and requiring moderate or high complexity medical decision making may be reported using 99487, 99489)

(Do not report 99439 more than twice per calendar month)

(Do not report 99439, 99490 in the same calendar month with 90951-90970, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99487, 99489, 99491, 99605, 99606, 99607)

►(Do not report 99439, 99490 for service time reported with 93792, 93793, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99605, 99606, 99607)◄

 # 99491 **Chronic care management services** with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored;

first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.

#✚ 99437 each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Use 99437 in conjunction with 99491)

(Do not report 99437 for less than 30 minutes)

(Do not report 99437, 99491 in the same calendar month with 90951-90970, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99439, 99487, 99489, 99490, 99605, 99606, 99607)

►(Do not report 99437, 99491 for service time reported with 93792, 93793, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99495, 99496, 99605, 99606, 99607)◄

Rationale

In accordance with the deletion of codes 99441-99443 and the establishment of codes 98012-98016, the exclusionary parenthetical notes following codes 99437 and 99439 have been revised to reflect these changes.

Refer to the codebook and the Rationale for codes 98012-98016 for a full discussion of these changes.

Complex Chronic Care Management Services

99487 **Complex chronic care management services** with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored,
- moderate or high complexity medical decision making;

first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

(Complex chronic care management services of less than 60 minutes duration in a calendar month are not reported separately)

✚ 99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Report 99489 in conjunction with 99487)

(Do not report 99489 for care management service of less than 30 minutes)

(Do not report 99487, 99489 during the same calendar month with 90951-90970, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99439, 99490, 99491)

►(Do not report 99487, 99489 for service time reported with 93792, 93793, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99605, 99606, 99607)◄

Rationale

In accordance with the deletion of codes 99441-99443 and the establishment of codes 98012-98016, the exclusionary parenthetical note following code 99489 has been revised to reflect these changes.

Refer to the codebook and the Rationale for codes 98012-98016 for a full discussion of these changes.

Principal Care Management Services

99424 **Principal care management services,** for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.

#✚ 99425 each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Use 99425 in conjunction with 99424)

(Principal care management services of less than 30 minutes duration in a calendar month are not reported separately)

(Do not report 99424, 99425 in the same calendar month with 90951-90970, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99473, 99474, 99487, 99489, 99490, 99491)

►(Do not report 99424, 99425 for service time reported with 93792, 93793, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99605, 99606, 99607)◄

 # 99426 **Principal care management services,** for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

#+ 99427 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Use 99427 in conjunction with 99426)

(Do not report 99427 more than twice per calendar month)

(Do not report 99426, 99427 in the same calendar month with 90951-90970, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99437, 99439, 99473, 99474, 99487, 99489, 99490, 99491)

►(Do not report 99426, 99427 for service time reported with 93792, 93793, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99605, 99606, 99607)◄

Rationale

In accordance with the deletion of codes 99441-99443 and the establishment of codes 98012-98016, the exclusionary parenthetical notes following codes 99425 and 99427 have been revised to reflect these changes.

Refer to the codebook and the Rationale for codes 98012-98016 for a full discussion of these changes.