



Evaluation and Management

Evaluation and Management (E/M) codes, also known as E&M codes or E and M codes, represent a standardized coding system within the CPT (Current Procedural Terminology) code set—specifically within the range 99202–99499. These evaluation and management CPT codes are used to describe services provided by physicians and other qualified healthcare professionals who evaluate or manage a patient’s health.

First Section of CPT®

- Numerically, it should fall last
- Brought to the front because this is where most services begin with a patient
- Most highly utilized codes

Evaluation ->

- Inspection and observation
- Palpation- examination by touch
- Auscultation-listening to body sounds
- Percussion-Creating sounds from tapping on body areas

Management -> treatment options

ICD-10-CM Coding

Principal diagnosis

- reason for the visit

Signs and Symptoms

- Report all if no definitive diagnosis is stated
- Report any symptom not routinely associated with the definitive diagnosis
- Not reported if symptom is associated with definitive diagnosis

7 components in medical records

- ➔ History
- ➔ Exam
- ➔ MDM
- ➔ Time
- ➔ Counselling
- ➔ Coordination of care
- ➔ Nature of presenting problem

Key components or contributing factors

- ➔ History
- ➔ Exam
- ➔ MDM

Non – contributing factors or non – key components

- ➔ Time
How many minutes or hrs. Spent with the patient per encounters
- ➔ Counselling
Counseling is a discussion with a patient and/or family concerning one or more of the following areas:
Diagnostic results, impressions, and/or recommended diagnostic studies
Prognosis
Risks and benefits of management (treatment) options
Instructions for management (treatment) and/or follow-up
Importance of compliance with chosen management (treatment) options
Risk factor reduction
Patient and family education
- ➔ Coordination of care
Coordination of care is communication with other clinicians or agencies regarding the nature of the patient's condition and the needs of the patient and family
- ➔ Nature of presenting problem
Minimal, low, moderate, High

History

- ➔ Chief complaint (CC) (1 is enough)
- ➔ HPI (History of present illness) (8 elements)

- ➔ ROS (Review of system) (14 elements)
- ➔ PFSH (past, family, social, history) (3)

History:

CC: (chief complaint)

Reason for the encounter

- A CC is a medically necessary reason for the patient to meet with the physician.
- The CC is part of history components
- Every E/M visit need.

HPI (8 Elements) – 1995 Based

- Location
- Context
- Duration
- Timing
- Quality
- Severity
- Modifying Factors
- Associated Signs & Symptoms

• **Review of Systems**

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. **The following systems are recognized for ROS purposes:**

- ❖ Constitutional Symptoms (e.g., fever, weight loss);
- ❖ Eyes;
- ❖ Ears, Nose, Mouth, Throat;
- ❖ Cardiovascular;
- ❖ Respiratory;
- ❖ Gastrointestinal;
- ❖ Genitourinary;
- ❖ Musculoskeletal;
- ❖ Integumentary (skin and/or breast);
- ❖ Neurological;
- ❖ Psychiatric;
- ❖ Endocrine;
- ❖ Hematologic/Lymphatic; and
- ❖ Allergic/Immunologic.

PFSH (past, family, social, history) (3)

Past medical history

- Prior major illness & injuries
- Prior operations
- Prior hospitalization
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/Dietary status

Family History

- ➔ List of disease or hereditary conditions that may place the patient at risk (e.g) family history of hypertension, diabetes, cancer
- ➔ Living status of immediate family
- ➔ Disease of parents, grand parents & siblings

Social History

- ➔ Marital status
- ➔ Employment status
- ➔ Living status
- ➔ Occupational History
- ➔ Educational level
- ➔ Sexual history
- ➔ Any social event / occurrence / impacting patients conditions
- ➔ Use of drug, tobacco & Alcohol use
- ➔ Recent travels

PE (physical examination)

- Provider examining the patient
- 2 systems it won't come in PE that are allergy & Endocrine
 1. constitutional
 2. Eyes
 3. ENT (Ear, Nose, throat)
 4. Respiratory
 5. Cardiovascular

6. Gastro intestinal (GI)
7. Genitourinary
8. Musculoskeletal
9. Skin
10. Nervous system
11. Psychiatric
12. Hematology / lymphatic

Medical Decision Making (MDM)

Medical Decision Making:

The process by which a diagnosis or treatment plan is formulated from available medical information, often incorporating known patient preferences.

MDM is defined by three elements:

- The number and complexity of **problem(s) that are addressed** during the encounter
- The amount and/or complexity of **data** to be reviewed and analyzed
- The **risk** of complications and/or morbidity or mortality of patient management

MDM Level Determination

To qualify for a particular level of MDM, **two of the three elements** for that level must be met or exceeded.

Types of MDM Levels

- Straightforward
- Low
- Moderate
- High

Note:

The concept of the level of MDM **does not apply to 99211, 99281**

2/3

- Need to select middle one in MDM hierarchy
- Which is having two times

Ex: 1

A: LOW

B: HIGH

C: MOD

FINAL MDM:

Ex: 2

A: SF

B: HIGH

C: MOD

FINAL MDM:

Ex: 3

A: LOW

B: HIGH

C: LOW

FINAL MDM:

E/M Visit Code Criteria (2023–2025 Guidelines)

To qualify for a particular level of Medical Decision Making (MDM), two of the three MDM elements for that level must be met or exceeded.

Level of MDM	Number & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal <ul style="list-style-type: none"> • 1 self-limited or minor problem 	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low <ul style="list-style-type: none"> • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury; OR • 1 stable acute illness; OR • 1 acute, uncomplicated illness or injury requiring inpatient or observation care 	Limited – must meet 1 of the 2 categories: Category 1: Tests and documents <ul style="list-style-type: none"> • Any combination of 2 from: <ul style="list-style-type: none"> – Review of prior external note(s) from each unique source – Review of result(s) of each unique test – Ordering of each unique test OR	Low risk of morbidity from additional diagnostic testing or treatment Examples: OTC drugs, minor surgery no risk factors, physical/occupational therapy, IV fluids without additives

		Category 2: Assessment requiring an independent historian	
Moderate	<p>Moderate</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR • 2 or more stable chronic illnesses; OR • 1 undiagnosed new problem with uncertain prognosis; OR • 1 acute illness with systemic symptoms; OR • 1 acute complicated injury 	<p>Moderate – must meet 1 of the 3 categories:</p> <p>Category 1: Any combination of 3 from:</p> <ul style="list-style-type: none"> – Review of prior external note(s) from each unique source – Review of result(s) of each unique test – Ordering of each unique test – Assessment requiring an independent historian <p>OR</p> <p>Category 2: Independent interpretation of tests performed by another provider (not separately reported)</p> <p>OR</p> <p>Category 3: Discussion of management or test interpretation with external physician/qualified professional (not separately reported)</p>	<p>Moderate risk of morbidity from testing or treatment</p> <p>Examples: Prescription drug management, IV fluids with additives, therapeutic nuclear medicine, decision for minor surgery with risk factors, elective major surgery without risk factors, closed treatment of fracture/dislocation, social determinants limiting care</p>
High	<p>High</p> <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	<p>Extensive – must meet 2 of the 3 categories:</p> <p>Category 1: Any combination of 3 from:</p> <ul style="list-style-type: none"> – Review of prior external note(s) from each unique source – Review of result(s) of each unique test – Ordering of each unique test – Assessment requiring an independent historian <p>OR</p> <p>Category 2: Independent interpretation of tests performed by another provider (not separately reported)</p> <p>OR</p> <p>Category 3: Discussion of management or test interpretation with external physician/qualified professional (not separately reported)</p>	<p>High risk of morbidity or mortality from testing or treatment</p> <p>Examples: Drug therapy requiring intensive monitoring, elective major surgery with risk factors, emergency major surgery, hospitalization or escalation of care, decision not to resuscitate or de-escalate, parenteral controlled substances</p>

Definitions of Number & Complexity of Problems Addressed

- Self Limited Problem:

A problem that runs a definite and Prescribed course, is transient in nature, and is not likely to permanently alter health status. Ex: Fever, Common Cold etc.

- Stable chronic illness:

A problem with an expected duration of at least one year

Or Until the death of the patient. For Example: Uncontrolled Diabetes, HTN.

- 1 acute uncomplicated illness or injury:

Recent or new short term problem with low risk of morbidity for which treatment is considered. For Ex: Sprain, Strain.

- Stable acute illness:

A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete , is stable with respect to this condition

Ex: Influenza, treatment previously started & condition improving, no fever or lung involvement.

- Acute, Uncomplicated illness or injury requiring hospital inpatient or observation level care:

A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of Mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or Observation level setting.

Ex: Head Injury with LOC required further observation and admitted to observation care

- 1 or More chronic illness with Exacerbation, Progression, or side effects of treatment:

A chronic illness that is acutely worsening, Poorly controlled or progression and requiring additional supportive care or requiring intention to treatment for side effects.

Ex: COPD with Exacerbation

- 1 Undiagnosed new problem with uncertain prognosis:

A problem in the differential diagnosis that represents a condition likely to results in a high risk of Morbidity without treatment.

Ex: Breast Lump – Ordered Mammogram.

- 1 acute illness with systemic symptoms:



A illness that causes a systemic symptoms and has high risk of morbidity without treatment. Systemic symptoms are General such as Fever, body aches, or Fatigue.

Ex: Colitis, Pneumonitis etc.

*1 acute complicated injury:

An injury which requires treatment that includes evaluation of body system that are not directly part of injured organs, the injury is extensive.

Ex: Head injury

- 1 or More chronic illness with severe Exacerbation, Progression, or side effects of treatment:

The severe Exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity.

For Ex: Severe Asthma with Epilepticus

- Acute on chronic illness or injury that poses a threat to life or bodily function:

An acute illness with systemic symptoms, an acute complicated injury or chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses threat to life or bodily function in the near term without treatment

For Ex: Sepsis, Acute respiratory Failure, Acute Kidney Injury, AMS etc.

Definitions of Amount and/or Complexity of Data to be Reviewed & Analyzed

- Test:

Tests are imaging , laboratory, psychometric, Or Physiological Data.

- Unique:

A unique test is defined by the CPT code set.

Ex: CBC, Hb, CMP, etc

* External Records:

Records are obtained from External physician.

- Discussion Test Results:

Discussed about test results with patient.

- Independent Historian:

An individual (Ex: Parent, Guardian, Surrogate, Spouse) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history(Ex: Dementia, AMS).

- Independent interpretation:

A interpretation of test performed by another physician /another qualified health care professional (not separately reported).

Definitions for Risk of Complications and/or Morbidity or Mortality of Patient Management

- Risk of Complications:

* Morbidity – A state of illness or functional impairment that function is limited Quality of life is impaired, or organ damage.

- * Prescription Drug Management:

A provider Prescribed for Medicine for Particular Conditions.

- Decision regarding Minor Surgery with identified risk factors:

0 to 10 days global Periods surgery with identified any Risk factors.

- Decision regarding elective Major surgery without identified Risk factors:

- Elective Major surgery is the provider scheduled for weeks later Ex: Right Hip arthroplasty.

- SDH – Social Determinants of health:

Economic and Social conditions that influence the health of people and communities. Ex: include Food and Money.

- * Decision regarding elective Major surgery with identified Risk factors:

Elective Major surgery is the provider scheduled for weeks later Ex: Right total Hip arthroplasty with identified any risk factors.

- Decision regarding Emergent Procedure:

Ex: Appendectomy

- Decision regarding hospitalization or escalation of hospital-level of care:

Admit, transfer, ICU) the decision to hospitalize applies to the outpatient or nursing facility encounters. Transfer to another facility also constitutes hospitalization or escalation of care. Observation, SNF, rehab, and to send patient to the ER for office/outpatients, etc. Also includes the decision not to hospitalize after initial consideration of hospitalization. The decision to escalate hospital level of care (e.g., Transfer to ICU) applies to the hospitalized or observation care patient

- E.g. - Patient with chest pain diagnosed with heart attack and admitted to ICU
- DNR: Decision not to resuscitate or to de-Escalate care because of poor prognosis
- Parenteral Controlled substances:



Narcotic and psychotropic is generally a drug or chemical whose manufacture, possession and use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. E.g.- Morphine, Phenobarbital, Diazepam and Estazolam.

1. Minor problem with minor risk
2. HTN stable with low risk
3. DM, HTN both stable with prescription
4. Patient is having Acute respiratory failure visited to the physician office first time. MDM given examination and workup after that admitted patient into the hospital.

Emergency Department: 3/3

- An **emergency department (ED)**, also known as an **accident & emergency department (A&E)**, **emergency room (ER)**, **emergency ward (EW)** or **casualty department**,
- ED is a section of hospital organized and designated to treat **Unscheduled** patient visits for immediate medical attention
- The **acute** care of patients who present without prior appointment; either by their own means or by that of an **ambulance**. The emergency department is usually found in a **hospital** or other **primary care** centre
- ED must be open 24/7
- **CPT code range:** 99281-99285 Critical care code: 99291, 99292

Example: 1 ED Patients

History: Comprehensive

Exam: Detailed

MDM: Moderate

Example: 2, ED Patients

History: Epf

Exam: comprehensive

MDM: Moderate

Example: 3, SNF INITIAL

History: Detailed

Exam: comprehensive

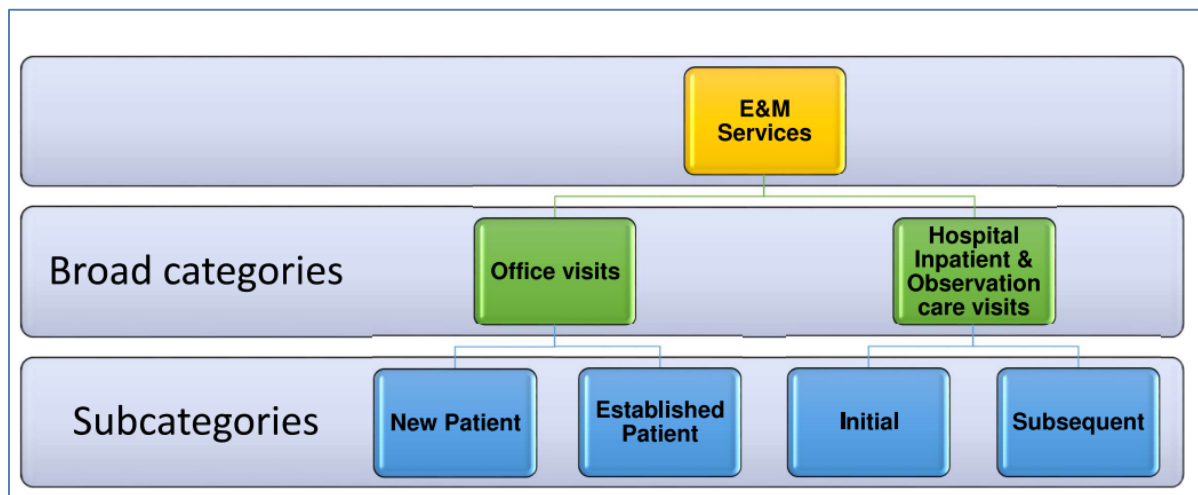
MDM: Moderate

Example: 4 Hospital in Patient Subsequent

History: EPF

Exam: Detailed

MDM: Low



Type of Patient – Outpatient Vs Inpatient





IP: a patient who attends a hospital for treatment staying there overnight AND TAKING TREATMENT.

Inpatient Hospital/observation Codes:

Initial	Subsequent	Discharge
99221	99231	99238
99222	99232	99239
99223	99233	

Initial -> 1st day

Subsequent -> from 2nd day

Discharge codes:

99238 -> 30 minutes or less

99239 -> more than 30 minutes

1st day MD Documenting -> Detailed History, Detailed Exam, High MDM

2nd day MD Documenting -> EPF History, EPF Exam, Straight Forward MDM

3rd day MD Documenting -> Detailed History, Detailed Exam, Moderate MDM

4th day patient discharged -> 40 minutes

Same day Admit & Discharge

- ➔ Admit & Discharge happen in same DOS (morning admitted & evening discharged)
- ➔ Location: Hospital & Observation
- ➔ 99234
- ➔ 99235
- ➔ 99236

Example:

Total time spent with patient admission & discharge is 53 minutes_____

OP: a patient who attends a hospital for treatment without staying there overnight.

Outpatient Services - New Vs Established Patient	
New Patient	Established Patient
<ul style="list-style-type: none"> ➤ Patient treated for the first time ➤ Encounter after 3 years ➤ Patient moved from one State to another State ➤ Same Hospital / Clinic Examination by different specialty Physician ➤ Patient treated by different practice group physician ➤ Initial Consultation for Medicare patient ➤ No information as established 	<ul style="list-style-type: none"> ➤ Follow-up or Subsequent visit ➤ Encounter within 3 years ➤ Her / His Physician / Family Physician ➤ Same Hospital / Clinic Examination by different Physician of same specialty ➤ Patient treated by same practice group physician ➤ Subsequent consultation ➤ Any relationship, which shows patient was treated by physician within 3 years

*** Out Patient Services:**

New Patient:

A new patient is one who has not received any professional services from the physician or other qualified healthcare professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

• **Established Patient:**

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.

Office or Other Outpatient Services

Patient: New				
Code	99202	99203	99204	99205
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	15	30	45	60

Office or Other Outpatient Services

Patient: Established					
Code	99211	99212	99213	99214	99215
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	N/A	X	X	X	X
Medical Decision Making (MDM) Level					
Straightforward		X			
Low			X		
Moderate				X	
High					X
Or					
Total Time (On Date of the Encounter)					
Minutes	N/A	10	20	30	40

- MDM is moderate for NP
- MDM is moderate for EP
- 40 minutes total time with the New patient?
- 40 minutes total time with the Established patient?

#★+ 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)

➔ *CPT Changes: An Insider's View 2021, 2023*

➔ *CPT Assistant Nov 20:3, Jan 21:4, Aug 22:3-7, Nov 22:1, Dec 22:3, Mar 23:14*

► (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)

#★+ 99418 Prolonged inpatient or observation 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 inpatient and observation **Evaluation and Management** service)

➔ *CPT Changes: An Insider's View 2023*

➔ *CPT Assistant Aug 22:3-7, Oct 22:1, Nov 22:1, Jan 23:20, Mar 23:14*

(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)

(Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359)

Critical care is defined as the direct delivery by a physician of medical care for a critically ill or critically injured patient. Critical illness acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care requires high complexity medical decision-making to assess, manipulate and support vital organ system function in order to treat single or multiple vital organ system failure.

- 1) Central nervous system failure
- 2) Circulatory failure
- 3) Shock
- 4) Acute renal failure
- 5) Acute hepatic failure
- 6) Acute metabolic failure
- 7) Respiratory failure

These services are based on TIME. Minimum time requirement for critical care is 30 mints. Less than 30 minutes critical care not reportable. If not having sufficient time to code cc use appropriate EM codes.

Critical care: OP any age

99291	<p>Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes</p> <p>➔ <i>CPT Assistant</i> Summer 92:18, Summer 93:1, Summer 95:1, Jan 96:7, Apr 97:3, Dec 98:6, Nov 99:3, Apr 00:6, Sep 00:1, Dec 00:15, Jul 02:2, Feb 03:15, Oct 03:2, Aug 04:7, 10, Oct 04:14, May 05:1, Jul 05:15, Nov 05:10, Jul 06:4, Dec 06:13, Nov 07:5, Jan 09:5, Mar 09:3, Jul 09:10, Aug 11:10, Sep 11:3, Jul 12:13, Feb 13:17, May 13:6, May 14:4, Aug 14:5, Oct 14:14, Feb 15:10, May 16:3, Aug 16:9, Oct 16:8, Jun 18:9, Dec 18:8, Jul 19:10, Aug 19:8, Dec 19:14, Jan 20:12, Feb 20:7</p>
+ 99292	<p>each additional 30 minutes (List separately in addition to code for primary service)</p> <p>➔ <i>CPT Assistant</i> Summer 92:18, Summer 93:1, Summer 95:1, Jan 96:7, Apr 97:3, Dec 98:6, Nov 99:3, Apr 00:6, Sep 00:1, Dec 00:15, Feb 03:15, Oct 03:2, Aug 04:10, Oct 04:14, Jul 05:15, Nov 05:10, Jul 06:4, Dec 06:13, Nov 07:5, Jan 09:5, Mar 09:3, Aug 11:10, Sep 11:3, Feb 13:17, May 13:6, May 14:4, Aug 14:5, Oct 14:14, Feb 15:10, May 16:3, Aug 16:9, Jun 18:9, Dec 18:8, Jul 19:10, Aug 19:8, Dec 19:14, Feb 20:7</p> <p>(Use 99292 in conjunction with 99291)</p>

Total Duration of Critical Care Codes

less than 30 minutes	appropriate E/M codes
30-74 minutes (30 minutes - 1 hr, 14 min.)	99291 X 1
75-104 minutes (1 hr, 15 min. - 1 hr, 44 min.)	99291 X 1 AND 99292 X 1
105-134 minutes (1 hr, 45 min. - 2 hr, 14 min.)	99291 X 1 AND 99292 X 2
135-164 minutes (2 hr, 15 min. - 2 hr, 44 min.)	99291 X 1 AND 99292 X 3
165-194 minutes (2 hr, 45 min. - 3 hr, 14 min.)	99291 X 1 AND 99292 X 4
195 minutes or longer (3 hr, 15 min. - etc.)	99291 and 99292 as appropriate (see illustrated reporting examples above)

Coding Tip

Services Included in Critical Care Services

For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93598), chest X rays (71045, 71046), pulse oximetry (94760, 94761, 94762), blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data); gastric intubation (43752, 43753); temporary transcutaneous pacing (92953); ventilatory management (94002-94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed that are not listed above should be reported separately. Facilities may report the above services separately.

CPT Coding Guideline, Critical Care

NICU CRITICAL CARE: BASED AGE AND INITIAL OR SUBSEQUENT:

- 99468 Initial inpatient neonatal critical care**, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Nov 11:5, May 14:4, Feb 15:10, Oct 15:8, May 16:3, Jun 18:9, Dec 18:8
- 99469 Subsequent inpatient neonatal critical care**, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Nov 11:5, May 14:4, Feb 15:10, Oct 15:8, May 16:4, Jun 18:9, Dec 18:8
- 99471 Initial inpatient pediatric critical care**, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Nov 11:5, Feb 15:10, May 16:3, Jun 18:9, Dec 18:8
- 99472 Subsequent inpatient pediatric critical care**, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Nov 11:5, Feb 15:10, May 16:4, Jun 18:9, Dec 18:8
- 99475 Initial inpatient pediatric critical care**, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Feb 15:10, May 16:3, Jun 18:9, Dec 18:8
- 99476 Subsequent inpatient pediatric critical care**, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- ➔ *CPT Changes: An Insider's View 2009*
 - ➔ *CPT Assistant* Feb 15:10, May 16:4, Jun 18:9, Dec 18:8

Services included in NICU:



Vascular access procedures

Peripheral vessel catheterization (36000)

Other arterial catheters (36140, 36620)

Umbilical venous catheters (36510)

Central vessel catheterization (36555)

Vascular access procedures (36400, 36405, 36406)

Vascular punctures (36420, 36600)

Umbilical arterial catheters (36660)

Airway and ventilation management

Endotracheal intubation (31500)

Ventilatory management (94002-94004)

Bedside pulmonary function testing (94375)

Surfactant administration (94610)

Continuous positive airway pressure (CPAP) (94660)

Monitoring or interpretation of blood gases or oxygen saturation (94760-94762)

Car Seat Evaluation (94780-94781)

Transfusion of blood components (36430, 36440)

Oral or nasogastric tube placement (43752)

Suprapubic bladder aspiration (51100)

Bladder catheterization (51701, 51702)

Lumbar puncture (62270)

CC with other procedure: 99291-25, OTHER PROCEDURE **OR** 9947X-25, OTHER PROCEUDRE



Q1. 50 year old patient having cardiac arrest came to E/D. MD performing CC for 40 minutes along with MD ordering chest x-ray one view and ECG data collection, central venous catheter placement, endotracheal intubation, and ventilation management?

Q2. 50 year old patient having cardiac arrest came to E/D. MD performing CC for 25 minutes along with MD ordering chest x-ray one view and ECG interpretation, central line placement, endotracheal intubation. MD documented History-Detailed, Exam-Comp, and MDM-High.

Q3. 10 month old patient moved to NICU setting and MD ordering central line placement, endotracheal intubation, and ventilation management.

Q4. 10 month old patient having cardiac arrest came to E/D. MD performing CC for 50 minutes along with MD ordering chest x-ray one view and ECG data collection, central line placement, endotracheal intubation, and ventilation management?

Consultations

A consult is provided by a physician whose opinion or advice is requested by another physician about a specific clinical problem or issue.

Consultations may also be requested by **nurse practitioners or physician assistants**.

The name of the requesting clinician and the reason for the consultation must be recorded in the documentation. The results and recommendations of the consult must be sent to the requesting physician

As of January 1, 2010, MEDICARE no longer pays inpatient (or outpatient) consults

If RRR not meeting consultation codes are not reportable-Use appropriate EM codes

If Medicare patients consultation codes are not reportable-Use appropriate EM codes

1. Detailed History, Comprehensive exam, Moderate MDM-IP consultation RRR present
2. Detailed History, Comprehensive exam, Moderate MDM-OP consultation RRR present
3. Detailed History, Comprehensive exam, Moderate MDM-IP consultation Report missing

CONSULTATIONS

- **Three R's of consultation:**

- **Request**

- Request from an appropriate requestor
 - Medical necessity must be documented in patient's chart

- **Render**

- After evaluation of the patient the consulting physician writes a progress note rendering his/her opinion

- **Respond to requestor**

- After the consult is provided, the consultant prepares a written report of his/her findings, which is provided to the appropriate requestor (referring MD)
 - Written response in the Inpatient setting would be done in the patient's chart for the referring physician to see (shared chart)

Office or Other Outpatient Consultations

Patient: New or Established				
Code	99242	99243	99244	99245
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	55

Inpatient or Observation Consultations

Patient: New or Established				
Code	99252	99253	99254	99255
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	35	45	60	80



Preventive Medicine Services

Preventive Medicine: New Patient 99381-99387

Preventive Medicine: Established Patient 99391-99397

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

Usual EM+ Preventive service=99XXX-25, Preventive service

Example:

Q1. 50 year old coming to office for general wellness exam. While doing examination physician identified chest pain, and lump in the breast. Physician done general checkup and for new problem related documented detailed history. Detailed exam, moderate MDM for chest pain. Office consultation visit