Atrium Health

E/M LEVELS OF SERVICE

EMERGENCY ROOM VISITS: Select E/M code based on Medical Decision Making

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making
99281	May not require the presence of a MD or APP	N/A
99282	Requires a medically appropriate history and/or examination	Straightforward
99283	Requires a medically appropriate history and/or examination	Low
99284	Requires a medically appropriate history and/or examination	Moderate
99285	Requires a medically appropriate history and/or examination	High

NURSING FACILITY CARE – INITIAL AND SUBSEQUENT

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99304	Requires a medically appropriate history and/or examination	Straightforward or Low	25
99305	Requires a medically appropriate history and/or examination	Low	35
99306	Requires a medically appropriate history and/or examination	Moderate	50
99307	Requires a medically appropriate history and/or examination	Straightforward	10
99308	Requires a medically appropriate history and/or examination	Low	20
99309	Requires a medically appropriate history and/or examination	Moderate	30
99310	Requires a medically appropriate history and/or examination	High	45

NURSING FACILITY DISCHARGE SERVICES

CPT Code	Discharge	Documentation Requirements	TIME MAY INCLUDE
99315	30 MINUTES **OR LESS**	Does not require documentation of time	✓Final Exam ✓Discussion of nursing facility stay ✓Preparation of discharge records, Rx and/ referral forms ✓Instructions for cont. care to all relevant caregivers (even if the time spent by the MD is not continuous)
99316	**MORE THAN** 30 MINUTES	Requires documentation of time in notes	

OFFICE VISITS – NEW PT: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99202	Requires a medically appropriate history and/or examination	Straightforward	15
99203	Requires a medically appropriate history and/or examination	Low	30
99204	Requires a medically appropriate history and/or examination	Moderate	45
99205	Requires a medically appropriate history and/or examination	High	60

OFFICE VISITS – ESTABLISHED PT: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines		Medical Decision Making	Total Time
99211 Non-MD visit (e.g. RN, Pharmacist)	May not require the presence of a MD or APP MD must review note and co-sign	EXAMPLE QUALIFYING VISITS: * BP checks * Glucose checks * + PPD reading Document interval history & vitals – discuss results **Services should be medically necessary and appropriately documented in the medical record.**		N/A
99212	Requires a medically appropriate history and/or examination		Straightforward	10
99213	Requires a medically appropriate history and/or examination		Low	20
99214	Requires a medically appropriate history and/or examination		Moderate	30
99215	Requires a medically appropriate history and/or examination		High	40

OUTPATIENT CONSULTATIONS: Report using I-Codes in EPIC (I1702 – I1705) / (I1712 – I1715)
NEW / ESTABLISHED: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99242	Requires a medically appropriate history and/or examination	Straightforward	20
99243	Requires a medically appropriate history and/or examination	Low	30
99244	Requires a medically appropriate history and/or examination	Moderate	40
99245	Requires a medically appropriate history and/or examination	High	55

PROLONGED SERVICES – OUTPATIENT

CPT Code	With or w/o direct patient contact on the date of an E/M beyond the required time of the primary service when selected based on Total Time	Total Time
+99417	Report in conjunction with 99205, 99215, 99215, 99245, 99345, 99350, 99483	Each 15 min
+G2212 (Medicare)	Do not report on the same DOS as 90833, 90836, 90838, 99358, 99359, 99415, 99416	Each 15 min

E/M LEVELS OF SERVICE

Atrium Health

INITIAL INPATIENT or OBSERVATION CARE

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99221	Requires a medically appropriate history and/or examination	Straightforward or Low	40
99222	Requires a medically appropriate history and/or examination	Moderate	55
99223	Requires a medically appropriate history and/or examination	High	75

SUBSEQUENT INPATIENT or OBSERVATION CARE

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99231	Requires a medically appropriate history and/or examination	Straightforward or Low	25
99232	Requires a medically appropriate history and/or examination	Moderate	35
99233	Requires a medically appropriate history and/or examination	High	50

HOSPITAL INPATIENT or OBSERVATION Admitted and Discharged on the SAME Calendar Date

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99234	Requires a medically appropriate history and/or examination	Straightforward or Low	45
99235	Requires a medically appropriate history and/or examination	Moderate	70
99236	Requires a medically appropriate history and/or examination	High	85

HOSPITAL INPATIENT or OBSERVATION DISCHARGE SERVICES

CPT Code	Discharge	Documentation Requirements	TIME MAY INCLUDE
99238	30 MINUTES **OR LESS**	Does not require documentation of time	✓Final Exam ✓Discussion of hospital stay ✓Preparation of discharge records, Rx and/ referral forms ✓Instructions for cont. care to all relevant caregivers (even if the time spent by the MD is not continuous)
99239	**MORE THAN** 30 MINUTES	Requires documentation of time in notes	

INPATIENT CONSULTATIONS: Report using I-codes in EPIC (I1722 – I1725)

NEW / ESTABLISHED: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99252	Requires a medically appropriate history and/or examination	Straightforward	35
99253	Requires a medically appropriate history and/or examination	Low	45
99254	Requires a medically appropriate history and/or examination	Moderate	60
99255	Requires a medically appropriate history and/or examination	High	80

CRITICAL CARE SERVICES – TIME BASED

CPT Code	Time Spent	Documentation Requirements
Use appropriate E/M Code	**LESS THAN** 30 MINUTES	✓**Documentation should reflect the requirements for the CPT code selected**
99291	30 - 74 MINUTES	*The provider's note should indicate:* ✓The patient's condition is life threatening or they are in imminent danger of organ failure ✓ The details of assessment, treatment plan & any other services provided ✓ The amount of time spent giving care ****Not all visits to the ICU qualify as Critical Care****
+99292	**EACH ADDITIONAL** 30 MINUTES	

INPATIENT NEONATAL & PEDIATRIC CRITICAL CARE SERVICES

CPT Code	DESCRIPTION
99468	**INITIAL** inpatient **neonatal** critical care, per day, for neonate **28 days old or younger**
99469	**SUBSEQUENT** inpatient **neonatal** critical care, per day, for neonate **28 days old or younger**
99471	**INITIAL** inpatient **pediatric** critical care, per day, infant or young child, **29 days – 24 months old**
99472	**SUBSEQUENT** inpatient **pediatric** critical care, per day, infant or young child, **29 days – 24 months old**
99475	**INITIAL** inpatient **pediatric** critical care, per day, infant or young child, **2 – 5 years old**
99476	**SUBSEQUENT** inpatient **pediatric** critical care, per day, infant or young child, **2 – 5 years old**

PROLONGED SERVICES – INPATIENT OR OBSERVATION

CPT Code	With or w/o direct patient contact on the date of an E/M beyond the required time of the primary service when selected based on Total Time	Total Time
+99418	Report in conjunction with 99223, 99233, 99236, 99255, 99306, 99310	Each 15 min
+G0316 (Medicare)	Do not report on the same DOS as 90833, 90836, 90838, 99358, 99359	Each 15 min

Atrium Health

Revised: 2024

E/M Visit Code Criteria

To qualify for a particular level of medical decision making, two of the three MDM elements for that level of medical decision making must be met or exceeded

Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • 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 hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • Any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test **OR** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	**Moderate** • 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	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) OR **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported); OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/ other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High	**High** • 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	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) OR **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported); OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/ other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to deescalate care because of poor prognosis • Decision regarding parenteral controlled substances

Time Based E/M

Total provider time on the date of the encounter: Time includes both the face-to-face and non-face-to-face time personally spent by the physician or APP on the day of the encounter (includes time in activities that require the physician or APP and does not include time in activities normally performed by clinical staff).

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

- Document the total amount of encounter time in minutes
- Documentation must clearly describe what was done (e.g., obtaining history, performing exam, counseling/education, ordering tests/medications, referrals/coordination of care).

Encompass SmartPhrase (SE Region): .TimeAttestation

Shared Visit Between MD and Advanced Practice Providers

***For shared visits between MD and APP (PA/NP/CNM)*:**

- **Substantive** is defined by CPT and CMS as more than half of the total time spent by the physician and NPP or a substantive part of the MDM. Performance of a substantive part of the MDM requires that the provider made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, the provider has performed two of the three elements used in the selection of the code level based on MDM.
- One of the providers must have face-to-face contact with the patient, but it does not have to be the MD or the provider with the "substantive" portion.
- Shared visits must be provided in an inpatient or outpatient hospital setting (provider-based clinic (POS 22)). Visits cannot be shared in an office setting (POS 11).
- The MD should not change/amend the APP documentation or use a teaching physician attestation to link to the APP documentation.
- Both the MD and APP must sign the medical record documentation.
- The documentation should reflect, "This is a shared visit with_____."
- For shared ***critical care services***, the provider who spends more than half of the cumulative time in qualifying activities will be the billing provider.