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# Evaluation and Management Services



**What's Changed?**

Note: We removed information on intravitreal eye injections and the use of modifier 25 with minor procedures.



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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# Evaluation & Management Services

Use the revised CPT codes for other evaluation and management (E/M) services (except for prolonged services). This includes:

- Hospital inpatient and observation visits merged into a single code set
- New descriptor times, where relevant
- Revised CPT office or outpatient (O/O) E/M guidelines for levels of medical decision making (MDM)

## HCPCS Add-On Code G2211

HCPCS code G2211 is a Medicare-specific add-on code to describe certain complex E/M visits. You may consider an E/M visit inherently complex if:

- Your visits are the continuing focal point for all needed services, like a primary care visit
- Your visit is giving ongoing care for a single, serious condition or complex condition, like sickle cell disease or HIV

HCPCS code G2211 captures the inherent complexity of the E/M visit based on the ongoing relationship between the practitioner and patient. The complexity that HCPCS code G2211 captures isn't in the clinical condition. The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. See MLN Matters® article MM13473 and the CY 2026 PFS final rule for more information.

All providers who can bill Medicare for E/M services may report HCPCS code G2211 with the O/O E/M base codes and, starting January 1, 2026, with the home or residence E/M base codes.

You may report HCPCS code G2211 with:

- O/O E/M CPT codes 99202–99206 and 99211–99215
- Home or residence E/M CPT codes 99341–99342, 99344–99345, and 99347–99350

You must document the reason for billing the E/M visit. The visit must be medically reasonable and necessary for the practitioner to report HCPCS code G2211. In addition, the documentation would need to illustrate the medical necessity of the E/M visit.

Examples of supporting documentation for billing HCPCS code G2211:

- Information included in the medical record or in the claim's history for a patient and practitioner combination
- Diagnoses
- The practitioner's assessment and plan for the visit
- Other service codes billed

## HCPCS Code G2211 & Modifier 25

You may not report HCPCS code G2211 without reporting 1 of its base service codes. Except for the annual wellness visit (AWV), vaccine administration, and any Medicare Part B preventive service, we don't pay for HCPCS code G2211 when you report its base service code with modifier 25.

Beginning January 1, 2025, you may bill the O/O E/M visit complexity add-on code, HCPCS code G2211, when you report CPT codes 99202–99205 or 99211–99215 with modifier 25 by the same practitioner on the same day as:

- An AWV
- Vaccine administration
- Any Part B preventive service, including the initial preventive physical examination furnished in the O/O setting

## HCPCS Code G0136

We changed HCPCS code G0136 from the social determinants of health risk assessment to the physical activity and nutrition risk assessment. You can do this assessment during:

- E/M visits
- AWVs
- Behavioral health office visits

## Prolonged O/O E/M Visits

When you select the O/O E/M visit level using time, report the prolonged O/O E/M visit time using HCPCS add-on code G2212 for prolonged O/O E/M services. For more information, see the Prolonged Services section of this booklet.

# Critical Care Services

## CPT Codes 99291 & 99292

We use the definition of critical care visits in the CPT codebook and the CPT listing of bundled services for CPT codes 99291 and 99292:

- You directly deliver care to a critically ill or injured patient when 1 or more vital organ systems are acutely impaired
- A probability of imminent or life-threatening deterioration of the patient's condition exists
- You make high complexity decisions to treat single or multiple vital organ system failure or to prevent further life-threatening deterioration of the patient's condition that requires your full attention

During time spent providing critical care services, you can't provide services to any other patient. Bundled services that are included by CPT in critical care services and therefore not separately payable include:

- Interpretation of cardiac output measurements
- Chest x-rays
- Pulse oximetry
- Blood gases
- Gastric intubation
- Collection and interpretation of physiologic data like electrocardiograms (ECGs), blood pressures, and hematologic data
- Temporary transcutaneous pacing
- Ventilator management
- Vascular access procedures

See the Medicare Claims Processing Manual, Chapter 12, section 30.6.12.1 for more information.

When you provide 30–74 minutes of critical care services to a patient on a given day, report CPT code 99291.

- Only use CPT code 99291 once per date even if the time you spend isn't continuous on that date
- Report CPT code 99292 for additional 30-minute time increments you provide to the same patient
- You may add non-continuous time for medically necessary critical care services

## Concurrent Critical Care Services: Different Specialties

Concurrent care is when more than 1 practitioner provides services that are more extensive than consultative services at the same time. We cover the reasonable and necessary services of each practitioner providing concurrent care when each plays an active role in the patient's treatment.

You may provide critical care services concurrently with more than 1 practitioner from more than 1 specialty to the same patient on the same day if the services meet the definition of critical care and aren't duplicative.

## Concurrent Critical Care Services: Practitioners in the Same Specialty & Same Group, Follow-Up Care

**CPT Codes 99291 & 99292**

When you provide the entire initial critical care service and report CPT code 99291, any provider in the same specialty and the same group providing care concurrently to the same patient on the same date should report their time using CPT code 99292 for additional time intervals.

- These providers shouldn't report CPT code 99291 more than once for the same patient on the same date
- When 1 provider begins the initial critical care service but doesn't meet the time needed to report CPT code 99291, another provider in the same specialty and group can continue to deliver critical care to the same patient on the same date
  - Combine the total time providers spent to meet the required time to bill CPT code 99291
  - Once you meet the cumulative time to report critical care service CPT code 99291, only 1 provider in the same specialty and group can report CPT code 99292 when they provide an additional 30 minutes of critical care services to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes)
  - The time spent on critical care visits must be medically necessary, and each visit must meet the definition of critical care

**Tip:** There are different billing rules when the critical care services are split between a physician and a non-physician practitioner (NPP). See the Split or Shared E/M Services section of this booklet.

## If-Then Scenarios for Critical Care Services (CPT Codes 99291 & 99292)

**IF**

### Initial Critical Care Services (CPT 99291)

A practitioner provides 30–74 minutes of direct critical care services to a critically ill or injured patient on a given day

**THEN:** Bill CPT code 99291 once for that date even if the time is non-continuous

**IF**

### Additional Time Beyond Initial Critical Care (CPT 99292)

Total time spent on critical care services for the same patient equals or exceeds 104 minutes

**THEN:** Bill 99291 for the first 74 minutes and add 99292 for each additional 30-minute increment

**IF**

### Same Group or Specialty Sharing Time

Multiple providers from the same group and specialty provide care to the same patient on the same day

**THEN:** They may collectively report 99291 once

If they spend over 104 minutes collectively, **then** report 99291 and 1 or more units of 99292 based on total time

**IF**

### Split or Shared Critical Care (Physician + NPP)

A physician and an NPP from the same group both provide critical care services **AND** the combined total time is ≥ 30 minutes

**THEN:** Bill under the provider who performed more than 50% of the time with the patient using modifier FS with 99291 or 99292

**IF**

### Same-Day E/M Visit and Critical Care

A patient receives a separate, non-critical E/M service earlier in the day **AND** later requires critical care

**THEN:** The E/M service must:

- Be medically necessary
- Occur before the critical care began
- Be distinct and non-duplicative
- Include modifier 25 on the E/M service code

**Table 1. Critical Care Billing**

| Situation | Code to Report | Key Points |
|---|---|---|
| Critical care time with patient is **30–74 minutes** (any time during the same day) | **99291** | Bill once per date, per patient |
| Critical care time with patient is ≥ **104 minutes** | **99291 + 99292** | 99292 for each additional 30 minutes beyond initial 74 minutes |
| Critical care time with patient is < **30 minutes** | **Do NOT bill 99291** | Doesn't meet threshold |
| Non-continuous critical care time with patient on the same day is **30–74 minutes** | **Bill 99291** | If medically necessary and meets coverage criteria |
| Non-continuous time with patient on the same day is ≥ **104 minutes** | **Bill 99291 + 99292 for each additional 30 minutes beyond initial 74 minutes** | Combine medically necessary time to meet 99291 threshold **(Only one 99291 per day)** |
| Multiple providers from **different specialties** caring for patient on same day | Each provider may bill **their own 99291 and 99292** | Services must be distinct and not duplicative |
| Multiple providers from the **same specialty and same group** caring for patient on same day | First provider: **99291**<br>Others: **99292** | Combine time to meet 99291 threshold **(Only one 99291 per day)** |
| 1st provider in the **same group or specialty** doesn't reach 30 minutes of care time with patient | Combine time with second provider; **bill 99291 once** | Then bill **99292** for additional 30-minute units |
| Services provided are bundled into 99291 and 99292 | **Do NOT bill separately** | Includes: x-rays, blood gases, ECGs, vent management, vascular access, etc. |

## Critical Care & Other Same-Day E/M Visits

You may bill hospital E/M visits the same day as critical care services in certain circumstances. See the Medicare Claims Processing Manual, Chapter 12, section 30.6.9 (A) for more information.

For other E/M services billed for the same patient on the same date as a critical care service, document that the other E/M service is:

- Medically necessary
- Provided before the critical care service at a time when the patient didn't require critical care
- Separate and distinct, with no duplicative elements from the critical care service provided later in the day

Use modifier 25 for same-day, significant and separately identifiable E/M services on the claim when you report critical care services unrelated to the other E/M service that you perform on the same date. You must also document the medical record with the relevant criteria for the respective E/M service you're reporting.

## Critical Care Services & Global Surgery

If you perform critical care unrelated to the surgical procedure during a global surgical period, you may get separate payment for the services. Medicare may pay for preoperative and postoperative critical care in addition to the procedure if:

- The patient is critically ill and requires the practitioner's full attention
- The critical care is above and beyond, and unrelated to, the specific anatomic injury or general surgical procedure performed, like trauma or burn cases

When a critical care service is unrelated to a procedure with a global surgical period or when 1 or more additional E/M visits provided on the same day are unrelated on the same day as another E/M service, use modifier FT on your claim.

If the surgeon fully transfers care to an intensivist and the critical care is unrelated, use the appropriate modifier to show the transfer of care. Surgeons will use modifiers 54 for surgical care only, or 55 for postoperative management only, on their claims. When the intensivist accepts the transfer of care, the intensivist will add both modifier 55 and modifier FT to your claim. Medical record documentation must support the claims.

# Initial Hospital Inpatient or Observation Care

## Observation Care Following the Initiation of Observation Services

**CPT Codes 99221–99223, 99231–99236, 99238 & 99239**

Bill hospital inpatient or observation care services using the revised hospital inpatient and observation care services code set:

- CPT codes 99221–99223
- CPT codes 99231–99236, 99238, and 99239

For patients admitted and discharged on the same date of service, bill hospital inpatient or observation care, including admission or discharge, using CPT codes 99234–99236.

The time you count toward hospital inpatient or observation care codes is per day. Per day, also called the encounter date, means the calendar date. When you use MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service.

- Report the date the patient encounter begins
- If you provide a continuous service before and through midnight, you may apply all the time to the date of the service you report, which is the calendar date the encounter starts
- You may only bill 1 of the hospital inpatient or observation care codes per calendar date for:
  - An initial visit
  - A subsequent visit
- Select a code that includes all the services (including admission and discharge) you provide on that date

The treating provider bills for the observation care codes. Practitioners who provide consultations, other evaluations, or services while the patient is getting hospital outpatient observation services must bill using the appropriate outpatient service codes.

When billing an initial hospital inpatient care or observation care service, a transition from observation care to inpatient care isn't a new stay. Medicare Administrative Contractors (MACs) will only pay you for 1 hospital visit per day for the same patient, even if the problems you treat aren't related.

**Tip:** In some cases, you may bill a prolonged code in addition to the hospital inpatient or observation care services base code. You may count time you spend on the same day with the same patient in multiple settings, or time you spend on a patient who transitions between outpatient and inpatient status, toward the hospital inpatient or observation care services base code and a prolonged code, if it applies.

# Prolonged Hospital Inpatient or Observation Care Services

## HCPCS Code G0316

Starting January 1, 2023, report prolonged services for certain hospital inpatient or observation care visits using HCPCS code G0316. You can report prolonged services when you use time to select your visit level and you exceed your total time for the highest-level visit by 15 or more minutes on medically necessary services. See the Prolonged Services section of this booklet for detailed reporting instructions.

## Initial Hospital Inpatient or Observation Care on the Day Following a Visit

**CPT Codes 99221–99223, 99231–99236, 99238 & 99239**

MACs pay both visits if you see a patient in the office on 1 day and they're admitted to the hospital as an inpatient or get observation care on the next day. This applies even if fewer than 24 hours has elapsed between the visit and the admission for hospital inpatient or placement in observation care.

## Initial Hospital Inpatient or Observation Care & Discharge on the Same Day

**CPT Codes 99221–99223, 99231–99236, 99238 & 99239**

Bill both hospital inpatient and observation care coding as follows:

- When you admit a patient to inpatient hospital or observation care for less than 8 hours on the same day, report the initial hospital inpatient or observation care from CPT code range 99221–99223
- Don't report hospital inpatient or observation discharge day management services, CPT codes 99238 or 99239, if the patient is in observation care for less than 8 hours
- When you admit a patient to inpatient hospital or observation care and discharge them on a different date, report an initial hospital inpatient or observation care from CPT code range 99221–99223 and a hospital inpatient or observation discharge day management service, CPT code 99238 or 99239
- When you admit a patient to inpatient hospital or observation care for 8 or more hours but less than 24 hours and discharge them on the same calendar date, report hospital inpatient or observation care services, including admission and discharge services, CPT code range 99234–99236

You must satisfy the E/M documentation guidelines for admission to and discharge from observation or hospital inpatient care. You must also meet and document the guidelines for history, examination, and MDM in the medical record.

**Tip:** Per the CPT code descriptors, initial hospital inpatient or observation care services require a medically appropriate history and examination but won't be used to select your visit level. If you're working in hospitals, be aware of the documentation you need to bill under the Physician Fee Schedule (PFS), other payment systems, or conditions of participation.

Table 2 shows billing based on hospital length of stay and discharge date.

**Table 2. Billing Hospital Length of Stay and Discharge Date**

| Discharged On | Hospital Length of Stay | Codes to Bill |
|---|---|---|
| Same calendar date as admission or start of observation | Less than 8 hours | Initial hospital services only* |
| | 8 or more hours | Same-day admission and discharge* |
| Different calendar date than admission or start of observation | Less than 8 hours | Initial hospital services only* |
| | 8 or more hours | Initial hospital services* + discharge day management |

* Plus prolonged inpatient or observation services, if applicable.

# Hospital Outpatient Clinic Visits

## HCPCS Code G0463

Facilities report HCPCS code G0463 to describe assessing and managing a patient who gets care in a hospital outpatient department. Hospital outpatient departments can be on a hospital's main campus (on campus) or off campus (more than 250 yards from the main campus). We require hospital outpatient departments to report 1 of the appropriate modifiers, PN or PO, when reporting at an off-campus practice location.

- Use modifier PN for services at non-excepted, off-campus, provider-based departments (PBDs). We consider a service to be non-excepted if you performed it at an off-campus practice location on or after November 2, 2015.
- Use modifier PO for services at excepted off-campus PBDs. We consider a service to be excepted if you performed it at an off-campus practice location before November 2, 2015.

You may bill HCPCS code G0463 as a visit code in addition to a procedure code or on its own. Your documentation should clearly show the physician or qualified NPP ordered and performed the patient visit service. These services must be separate and distinct from any procedure performed.

- Include detailed documentation of the patient's condition, the patient's symptoms, and any tests or procedures you perform during the visit
- Identify the encounter separately from any procedure you perform

# Home or Residence Services

## CPT Codes 99341–99350

Starting January 1, 2023, the 2 E/M visit families called domiciliary, rest home or boarding home, or custodial care services and home services are now 1 E/M code family, home or residence services. Use the codes in this family to report E/M services you provide to a patient in:

- Their home or residence
- An assisted living facility
- Group home, not licensed as an intermediate care facility for people with intellectual disabilities
- Custodial care facility
- Residential substance abuse treatment facility

There are no changes to the care settings for the current families. They're in the newly merged family. This change removes CPT codes 99324–99337. Therefore, you can bill multiple place of service (POS) codes with the new merged family of CPT codes 99341–99350 for home or residence services:

- Home - POS 12
- Assisted Living Facility - POS 13
- Group Home - POS 14
- Custodial Care Facility - POS 33
- Residential Substance Abuse Treatment Facility - POS 55

## Prolonged Home or Residence E/M Visits

You may report reasonable and medically necessary prolonged services with the appropriate E/M codes when you provide a prolonged home or residence service that's beyond the usual E/M visit. When you select a home or residence E/M visit level using time, report prolonged home or residence E/M visit time using HCPCS add-on code G0318 prolonged home or residence E/M services. You must meet all the requirements for prolonged services. For more information, see the Prolonged Services section of this booklet.

# Nursing Facility Services

## CPT Codes 99304–99310, 99315–99316 & 99318

You can't bill an initial nursing facility (NF) service and another E/M service, like an office or other outpatient visit or an emergency department (ED) visit, on the same date of service for the same patient. You can count the time you spend providing services in another setting toward reporting prolonged NF services if you meet the requirements for reporting prolonged NF services.

# Prolonged Services

You may report prolonged E/M services for certain E/M visit families when the total visit time you spend with a patient exceeds a certain time threshold. Report prolonged E/M services using Medicare-specific coding. When reporting prolonged visits, you would report the codes for the primary service and the prolonged services.

Starting in 2024, for prolonged visits, the substantive portion is more than 50% of the practitioner's total time. See MLN Matters article MM13592 for more information.

## Prolonged O/O E/M Visits

### HCPCS Add-On Code G2212

When you select a visit level using time, you may report prolonged O/O E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services).

Table 3 gives reporting examples for prolonged O/O E/M visits.

**Table 3. Codes for Billing Prolonged O/O E/M Visits**

| Codes | Total Time Required for Reporting* |
|---|---|
| CPT code 99205 | 60–74 minutes |
| CPT code 99205 x 1 and HCPCS code G2212 x 1 | 89–103 minutes |
| CPT code 99205 x 1 and HCPCS code G2212 x 2 | 104–118 minutes |
| CPT code 99215 | 40–54 minutes |
| CPT code 99215 x 1 and HCPCS code G2212 x 1 | 69–83 minutes |
| CPT code 99215 x 1 and HCPCS code G2212 x 2 | 84–98 minutes |
| CPT code 99215 x 1 and HCPCS code G2212 x 3 or more for each additional 15 minutes | 99 minutes or more |

* Total time is all the reportable time, including prolonged time, you spend with the patient on the date of service of the visit.

You may also report prolonged cognitive impairment assessment and care management services, primary service CPT code 99483, using G2212, the Medicare-specific code for prolonged O/O services.

These criteria apply when you bill HCPCS code G2212:

- Use for services beyond the maximum time of the primary service you select using total time on the date of the primary service
- Use for each additional 15 minutes beyond the maximum time you provide, with or without direct patient contact
- List separately in addition to CPT codes 99205, 99215, or 99483 for office or other outpatient E/M services
- Don't report HCPCS code G2212 on the same date of service as codes as CPT codes 99358, 99359, 99415, or 99416
- Don't report HCPCS code G2212 for less than 15 additional minutes

See the American Medical Association (AMA) E/M Services Guidelines, Guidelines for Selecting Level of Service Based on Time section for qualifying activities.

You may count these activities when:

- You use time to select your visit level
- Your services are medically reasonable and necessary

You'll find 3 new Medicare-specific HCPCS codes (1 per E/M family) for billing prolonged other E/M services listed in Table 4.

## Prolonged Other E/M Visits

### HCPCS Codes G0316, G0317 & G0318

Starting January 1, 2023, report prolonged other E/M services using HCPCS codes G0316, G0317, and G0318. Other E/M services include:

- Inpatient visits
- Observation visits
- NF visits
- Home or residence visits

For timed visits, you may report prolonged other E/M services with the highest visit level when your total visit time exceeds a certain threshold.

- Don't report prolonged services with ED visits or critical care services
- Prolonged services give you payment for additional practitioner time that you didn't already account for in your primary service
- You can count your time spent providing qualifying activities when you perform them, and the total time spent is at least 15 minutes beyond the total time shown below

Table 4 summarizes billing prolonged other E/M services.

**Table 4. Billing Prolonged Other E/M Visits**

| Primary E/M Service | Prolonged HCPCS Code* | Time Threshold to Report Prolonged | Count Physician/NPP Time Spent Within This Time Period (Surveyed Timeframe) |
|---|---|---|---|
| Initial Inpatient or Observation (IP/Obs.) Visit (CPT code 99223) | G0316 | 90 minutes | Date of visit |
| Subsequent IP/Obs. Visit (CPT code 99233) | G0316 | 65 minutes | Date of visit |
| IP/Obs. Same-Day Admission/Discharge (CPT code 99236) | G0316 | 110 minutes | Date of visit to 3 days after |
| IP/Obs. Discharge Day Management (CPT codes 99238–99239) | N/A | N/A | N/A |
| ED Visits | N/A | N/A | N/A |
| Initial NF Visit (CPT code 99306) | G0317 | 95 minutes | 1 day before visit + date of visit + 3 days after |
| Subsequent NF Visit (CPT code 99310) | G0317 | 85 minutes | 1 day before visit + date of visit + 3 days after |
| NF Discharge Day Management | N/A | N/A | N/A |
| Home/Residence Visit New Pt (CPT code 99345) | G0318 | 140 minutes | 3 days before visit + date of visit + 7 days after |
| Home/Residence Visit Estab. Pt (CPT code 99350) | G0318 | 110 minutes | 3 days before visit + date of visit + 7 days after |
| Cognitive Assessment and Care Planning (CPT code 99483) | G2212 | 100 minutes | 3 days before visit + date of visit + 7 days after |
| Consults | N/A | N/A | N/A |

* You must use time to select your visit level.

## Prolonged NF Services

### HCPCS Code G0317

Starting January 1, 2023, report prolonged NF services using Medicare-specific coding (HCPCS code G0317). You can report prolonged services when you use time to select your visit level and you exceed the total time for the highest-level visit by 15 or more minutes providing reasonable and medically necessary services. You can't bill prolonged services with codes for NF discharge-day management.

# Split or Shared E/M Services

A split or shared visit is an E/M visit that both a physician or an NPP in the same group perform in a facility setting. In accordance with applicable law and regulations, either the physician or NPP can bill the service if they provide it independently. We pay the practitioner who performs the substantive portion of the visit.

Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record. You must include the designated modifier on the claim to identify that the service was a split or shared visit. See the AMA E/M Services Guidelines and MLN Matters article MM13592 for more information.

**Tip:** Facility setting is an institutional setting in which payment for services and supplies provided incident to physician or NPP professional services is prohibited under our regulations.

## Rules for Reporting Split or Shared E/M Services Between a Physician & an NPP

### Hospital Inpatient, Hospital Outpatient & ED Visits

Beginning January 1, 2024, the physician or NPP who provides more than 50% of the total time or the substantive part of MDM should bill for the visit. See MLN Matters article MM13592 for more information.

### Critical Care Services

- Since critical care visits don't use MDM to define the service, the substantive portion isn't determined using MDM. The substantive portion means more than 50% of the total time spent by the practitioners.
- Unlike other E/M services, critical care services can include additional activities that are bundled into the critical care visit CPT codes 99291 and 99292. There's a unique list of qualifying activities for split or shared critical care. Refer to the CPT codebook for preferred descriptions.
- The same documentation rules apply for split or shared critical care visits as for other types of split or shared E/M visits.

### Skilled Nursing Facility E/M Visits

- You may bill skilled nursing facility (SNF) E/M visits as split or shared visits if they meet the rules for split or shared visit billing, except for SNF E/M visits that a physician must perform in their entirety.
- NF visits don't meet the definition of split or shared services because "incident to" payment is available in the NF setting. See FAQs: Split (or Shared) Visits and Critical Care Services for more information.

### Billing & Documentation

- Use modifier FS for split or shared E/M visits to report these services on claims. This tells us that even though you're submitting the claim under 1 practitioner's NPI, 2 practitioners performed the visit.
- To bill split or shared critical care services, report CPT code 99291. If you spend 104 or more cumulative total minutes providing critical care, report 1 or more units of CPT code 99292. Add modifier FS to the critical care CPT codes on the claim.
- No matter where the split or shared visit took place, documentation in the medical record must include:
  - The identity of both the physician and NPP who perform the visit
  - The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record

Submit the claim using the NPI for the practitioner who performed the substantive portion of the visit. That practitioner must also sign and date the medical record.

Table 5 shows the definition of the substantive portion for E/M visit code families.

**Table 5. Definition of Substantive Portion for E/M Visit Code Families**

| E/M Visit Code Family | 2024–2025<br>Definition of Substantive Portion |
|---|---|
| Other Outpatient* | More than 50% of total time or a substantive part of the MDM |
| Inpatient, Observation, Hospital, and SNF* | More than 50% of total time or a substantive part of the MDM |
| ED | More than 50% of total time or a substantive part of the MDM |
| Critical Care | More than 50% of total time |

* You can't bill office visits or NF visits as split or shared services because "incident to" payment is available in those settings.

### Distinct Time

You only count distinct time for split or shared E/M services. When providers jointly meet with or discuss the patient, you can only count the time of 1 provider.

### Qualifying Time

You can count time spent on these activities toward total time to decide the substantive portion regardless of whether the activities involve direct patient contact:

- Preparing to see the patient (for example, reviewing tests)
- Obtaining or reviewing separately obtained history
- Performing a medically appropriate exam or evaluation
- Counseling and educating the patient, family, or 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, or caregiver
- Coordinating care (not separately reported)

This provision doesn't apply to critical care visits. You can't count time spent on these activities:

- Traveling
- Performing other services you reported separately
- Teaching that's general and isn't limited to discussing the management of a specific patient

For all split or shared visits, one of the providers must have face-to-face, in-person contact with the patient, but it doesn't necessarily have to be the provider who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact and is determined by the proportion of total time, not whether the time involves patient contact.

You can report split or shared visits for:

- New and established patients
- Initial and subsequent visits
- Prolonged services

Table 6 summarizes reporting prolonged services for split or shared visits.

**Table 6. Reporting Prolonged Services for Split or Shared Visits**

| E/M Visit Code Family | 2024–2025 Substantive Portion Must Be Time |
|---|---|
| Other Outpatient* | More than 50% of the practitioners combined total time |
| Inpatient, Observation, Hospital, and SNF* | More than 50% of the practitioners combined total time |
| ED | N/A |
| Critical Care | N/A |

* You can't bill office visits as split or shared services.

## General Principles of E/M Documentation

Clear and concise medical record documentation is critical to giving patients quality care and getting correct and prompt payment for services. Medical records chronologically report a patient's care and records-related facts, findings, and observations about the patient's health history.

Medical record documentation helps you evaluate and plan the patient's immediate treatment and watch their health care over time.

Your MAC may ask for documentation to make sure a service is consistent with the patient's insurance coverage and to confirm:

- The site of service
- The medical necessity and appropriateness of the diagnostic or therapeutic services
- That you report services correctly

General principles of medical record documentation apply to all medical and surgical services and settings.

While E/M services vary, like the nature and amount of physician work needed, these general principles help make sure medical record documentation is correct for all E/M services:

- The medical record should be complete and legible
- Your documentation of each patient encounter should include the:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
- If you don't document the date, the legible name of the observer, and your rationale for ordering diagnostic and other services, it should be easily inferred
- Past and present diagnoses should be accessible to you or the consulting physician
- You should identify appropriate health risk factors
- You should document the patient's progress, response to and changes in treatment, and revision of diagnosis
- Documentation in the medical record should report the diagnosis and treatment codes you report on the health insurance claim form or billing statement

Document services during the encounter or as soon as possible after the encounter to keep the medical record accurate.

## Common Sets of Codes Used to Bill for E/M Services

When billing for a patient's visit, select codes that best characterize the services you give during the visit. A billing specialist or alternate source may review your documentation before you send the claim. A reviewer may help you choose codes that show the services you give to the patient. You must make sure:

- Your claim correctly shows your services
- The medical record documentation supports the level of service you report to a payer
- You don't use the volume of documentation to decide the specific level of service to bill

Your services must meet the medical necessity guidelines in the statutes, regulations, and manuals and the medical necessity criteria in the National Coverage Determinations and Local Coverage Determinations, if any exist for the service reported on the claim. For every service billed, you must show the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

### HCPCS

HCPCS is the code set you use to report procedures, services, drugs, and devices you provide in the office, hospital outpatient facility, ambulatory surgical center, or other outpatient facility. This system includes CPT codes the AMA develops and supports.

### ICD-10-CM

ICD-10-CM is a code set you use to report medical diagnoses on all claims for services you provide in the U.S.

### ICD-10-PCS

ICD-10-PCS is a code set facilities use to report inpatient procedures and services they give patients in U.S. hospital inpatient health care settings.

### E/M Services Providers

To get payment from Medicare for E/M services, your state must allow you to bill for E/M services within your scope of practice.

## Choosing the Code That Characterizes Your Services

To bill Medicare for E/M services, you must choose a CPT code that best represents the:

- Patient type
- Setting of service
- Level of E/M service you provide the patient

### Patient Type

For purposes of billing office and outpatient E/M services, we identify patients as either new or established, depending on previous encounters with the provider. When billing in the facility setting, we identify patient services by either initial or subsequent visit type.

**New Patient:** A person who didn't receive any professional services from the physician, NPP, or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

**Established Patient:** A person who receives professional services from the physician, NPP, or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

### Setting of Service

We categorize E/M services into different settings depending on where you provide the service. Examples of settings include:

- O/O setting
- Hospital inpatient
- ED
- NF

### Level of E/M Service You Provide the Patient

We organize the code sets to bill for E/M services into categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category.

To bill any code, the:

- Services you provide must meet the definition of the code
- Code must reflect the services you provide

Medical necessity is the primary reason we pay for a service. It wouldn't be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is more appropriate.

- As of January 1, 2023, for most E/M visit families, choose the visit level based on the level of MDM or the amount of time you spend with the patient
- For some types of visits (like ED visits), use only MDM or only time to bill

The CPT E/M guidelines for MDM apply. For all E/M visits, your history and physical exam must meet the descriptions in the code descriptors, but they don't affect visit level selection. When you use time to select the visit level, you must provide services for the full time.

- The general CPT rule about the midpoint for certain timed services doesn't apply
- If you use time to support billing the E/M visit, document the medical record with the time spent with patient using a start and stop time or the total time

### Chief Complaint

A chief complaint (CC) is a short statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words, like the patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly show the CC.

For more information, review the CY 2025 PFS final rule and the CPT E/M webpage.

### History & Examination

When you perform E/M codes that have levels of services, they include a medically appropriate history or physical examination. The treating physician or other qualified health care professional reporting the service determines the nature and extent of the history or physical examination. The care team may collect information, and the patient or caregiver may supply information directly through an electronic health record portal or questionnaire that's reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination isn't an element in selection of the level of these E/M service codes.

### MDM

Include the MDM in the CPT codes and services you submit on your claims. When selecting a level of MDM for these services, review the AMA's E/M Services Guidelines for a detailed breakdown of the elements of MDM.

# Other Considerations

## Chronic Pain Management

Chronic pain is persistent or recurrent pain lasting longer than 3 months. When billing monthly chronic pain management (CPM) services beginning in 2023, use these 2 HCPCS codes:

### HCPCS G3002: CPM Services

HCPCS code G3002 describes a monthly bundle for CPM and treatment services, including:

- Diagnosis, assessment, and monitoring
- Administering a validated pain rating scale or tool
- Developing, implementing, revising, and maintaining a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes
- Overall treatment management
- Facilitating and coordinating any necessary behavioral health treatment
- Medication management
- Pain and health literacy counseling
- Any necessary chronic pain-related crisis care
- Ongoing communication and coordinating care between providers furnishing care (like physical therapy and occupational therapy, complementary and integrative approaches, and community-based care), as appropriate

These criteria apply:

- Requires an initial face-to-face visit of at least 30 minutes provided by a physician or other qualified health professional
- First 30 minutes personally provided by physician or other qualified health care professional per calendar month
- You must meet or exceed 30 minutes
- You must develop and maintain a person-centered plan
- Billable per calendar month
- You must provide the appropriate elements of the code bundle specific to each patient
- You don't have to provide all the bundled elements listed above every month

**HCPCS G3003: Add-On Code for CPM Services**

- Use HCPCS code G3003 to bill for each additional 15 minutes of CPM and treatment by a physician or other qualified health care professional per calendar month
- List separately in addition to HCPCS code G3002
- You must meet or exceed 15 minutes per calendar month

## Consultation Services

**CPT Codes 99252–99255 & 99242–99245**

Medicare doesn't recognize these CPT codes for Part B payment purposes:

- Inpatient consultation codes, CPT codes 99252–99255
- O/O consultation codes, CPT codes 99242–99245

Medicare recognizes these telehealth consultation codes for payment:

- HCPCS codes G0406–G0408
- HCPCS codes G0425–G0427

If you provide services using CPT consultation codes, you should report the correct E/M visit code to bill for these services.

## Teaching Physician Services

You can select the O/O E/M visit level to bill based on the total time you personally spent with the patient or based on MDM. If you're using total time to select the visit level, only count time the teaching physician spent performing qualifying activities listed by CPT. This can include time spent with or without direct patient contact on the date of the encounter. It can also include the time the teaching physician is present when the resident performs these activities.

Starting January 1, 2022, you may include the time a teaching physician is present with the patient when determining E/M visit level. Under the primary care exception, you can only use MDM to select the visit level. This limits the possibility of inappropriate coding based on residents' inefficiencies instead of a measure of the time for the services. See the Medicare Claims Processing Manual, Chapter 12, section 100.1.1(C) for more information.

As referenced in the Medicare Claims Processing Manual, Chapter 12, section 100.1.1(A), for purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- The teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident
- The participation of the teaching physician in the management of the patient

Physicians, residents, or nurses can demonstrate the presence of the teaching physician during E/M services by making notes in the medical record.

A teaching physician or resident must be physically present when students contribute or participate in performing a billable service. The service must meet the requirements in this section for teaching physician billing. This requirement doesn't apply to the student taking a review of systems or past family and social history.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including:

- History
- Physical exam
- MDM

The teaching physician must personally perform or re-perform the physical exam and MDM activities of the E/M service being billed but may verify any student documentation of them in the medical record rather than re-documenting this work.

As referenced in the Medicare Claims Processing Manual, Chapter 12, section 100.1.4, for procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20–30 minutes may be paid only if the teaching physician is physically present for 20–30 minutes. Don't add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the patient or time spent by the teaching physician alone with the patient.

## Telehealth Services

We pay for specific Part B services a physician or practitioner provides via 2-way, interactive technology called telehealth. Telehealth substitutes for an in-person visit and generally involves 2-way, interactive technology that permits communication between the practitioner and patient.

See the Telehealth & Remote Monitoring booklet for information on:

- Originating and distant sites
- Annual changes and currently covered telehealth
- Billing and payment
- Home health telehealth
- Remote monitoring

Visit the CMS Telehealth webpage for more information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

## Resources

- CY 2025 Medicare PFS Final Rule fact sheet
- Evaluation & Management Visits
- Evaluation and Management (E/M) Visit FAQs Physician Fee Schedule (PFS)
- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual