Inpatient AND Observation Status

Type of visit	CPT Codes	MDM Level	Minimum Time *Must be documented by provider in note*	Description/Tips
Initial Admission Visit	99221	Straightforward or Low	40 minutes	These codes are used for the first visit by the Admitting provider/group during the current admission. *Discharge services – see page 2.* Prolonged service code 99418/G0316 can be used with CPT 99223 once 90 minutes of time is spent. Coding staff will review prolonged service quantity as multiple units can be billed dependent on the total amount of time spent.
	99222	Moderate	55 minutes	
	99223	High	75 minutes	
Initial Consultation Visit	99252	Straightforward	35 minutes	These codes are used for the first visit by the Consultative provider/group during the current admission. Prolonged service code 99418 can be used with CPT 99255 once 95 minutes of time is spent. Coding staff will review prolonged service quantity as multiple units can be billed dependent on the total amount of time spent.
	99253	Low	45 minutes	
	99254	Moderate	60 minutes	
	99255	High	80 minutes	
Subsequent Visit	99231	Straightforward or Low	25 minutes	These are used for the subsequent day visits after the initial admission date. Only one visit can be billed by the group per calendar date. Prolonged service code 99418/G0316 can be used with CPT 99233 once 65 minutes of time is spent. Coding staff will review prolonged services to determine quantity of units billed.
	99232	Moderate	35 minutes	
	99233	High	50 minutes	

Emergency Dept Consults

Type of visit	CPT Codes	MDM Level	Minimum Time *Must be documented by provider in note*	Description/Tips
Initial Visit	99242	Straightforward	20 minutes	These codes are used when consults are requested in the Emergency Department. CPT 99202-99215 is used when the patient is seen in the ED for the convenience of the provider (consultation requirements not supported). Prolonged service code 99417 can be used with CPT 99245 once 70 minutes of time is spent. Coding staff will review prolonged service quantity as multiple units can be billed dependent on the total amount of time spent.
	99243	Low	30 minutes	
	99244	Moderate	40 minutes	
	99245	High	55 minutes	

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Critical Care Services

Type of visit	CPT Codes	MDM Level	Minimum Time *Must be documented by provider in note*	Description/Tips
Critical care less than 30 minutes (age 6 and older)	99223/99233	High	Less than 30 minutes documented	Critical care of less than 30 minutes is included in the E/M work for that day. It is still important to include the critical care time and statement in the note to support high-complexity decision making was done. CPT code will be based on initial or subsequent service at the time of critical care. If this is the first visit and time doesn't support billing critical care services, then 99223 should be selected. If a subsequent visit, then 99233 is used.
Adult Critical Care (age 6 and older)	99291	N/A	30-74 minutes	Used for the initial critical care time spent. This excludes separately reportable service time. Critical care codes are used if the initial admission is for critical care services. Initial admission/consultation codes are not used. The time must be documented in the note and specify that this was critical care time. Best statement is X minutes spent in critical care with separately reported service time excluded.
Adult Critical Care (age 6 and older)	99291 & 99292	N/A	75 minutes or more	Used with 99291 when critical care time exceeds 74 minutes. Multiple units of this code are allowed depending on the total amount of critical care time spent.
Pediatric Critical Care (age 2 to 5 years)	99475 (initial) & 99476 (subsequent)	N/A	Per Day Code	The initial care code is used for the first date of service that the patient meets critical care criteria. The subsequent codes would be used for the following days when the patient is critical.
Pediatric Critical Care (age 29 days to 24 months)	99471 (initial) & 99472 (subsequent)	N/A	Per Day Code	The initial care code is used for the first date of service that the patient meets critical care criteria. The subsequent codes would be used for the following days when the patient is critical.

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Additional Guidance

- Global Period Services - This guidance applies only to the provider/group who performed the procedure.
    - Prior to surgery, an E/M is billable for the encounter where the decision for the procedure is made. This can be done the day prior or the day of the surgery. This could have also occurred during an office visit prior.
    - After the surgery, there are no professional fee E/M services billable during the global period unless the reason for the visit is separate from the procedure.

- Discharge services are not billable for post operative, outpatient status or OP Occupying status patients. If the provider is the admitting provider for an inpatient/observation admission, discharge CPT codes 99238 – 99239 are used.
    - **CPT 99238** – Discharge services of 30 minutes or less on the date of discharge. Time spent on prior dates is not counted in these codes.
    - **CPT 99239** – Discharge services of greater than 30 minutes on the date of discharge. Time spent MUST be documented in the note to support billing this code.

- Prolonged Services – These codes are used in addition to the highest-level E/M code set for outpatient or inpatient services. The codes are in 15-minute increments, with multiple units allowed to be billed.
    - **CPT 99418** - Inpatient or Observation prolonged services, used with CPT 99223, 99233, 99236, etc.
    - **CPT 99417** – Outpatient prolonged services, used with CPT 99425, 99205, 99215, etc.

- Split/Shared E/M visits - Shared visits between the physician and APP with billing provider determined by whichever performed the substantive portion of the visit. The substantive portion is either more than 50% of the total time spent or two out of three MDM elements. There is an auto-text available for use (/sharedemstatement) to assist in documentation of the substantive portion.
    - Both providers are to place a charge, then coding will review to see which provider's documentation meets criteria for the substantive portion and will credit the other charge.

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