# CPT® Code 99202 Details

## Code Symbols

MIPS : Merit Based Incentive Payment System

## Code Descriptor

**Office or other outpatient visit** for the evaluation and management of a new patient, which requires these 3 key components:

- **An expanded problem focused history;**
- **An expanded problem focused examination;**
- **Straightforward medical decision making.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

## CPT® Advice

No data Available

## Illustration

No data Available.

## Fee Schedule

| Medicare Physician Fee Schedules (MPFS) | |
|---|---|
| Sources: | 2019 National Physician Fee Schedule Relative Value File, GPCI19, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2019, MCR-MUE-PractitionerServices |
| Publisher: | CMS |
| Effective: | July 01, 2019 |
| Medicare Carrier/Locality: | ALASKA** 01-02102 |
| Conversion Factor: | 36.0391 |

**Note:** A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

**Code Status** A
**A** = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

| Medicare Fees | | | | | |
|---|---|---|---|---|---|
| | **National** | **Adjusted** | **26** | **TC** | **53** |
| Facility | $51.54 | $69.22 | $0.00 | $0.00 | $0.00 |
| Non Facility | $77.48 | $98.21 | $0.00 | $0.00 | $0.00 |

| RVU - Nonfacility | | | | | |
|---|---|---|---|---|---|
| | **National** | **Adjusted** | **26** | **TC** | **53** |
| Work RVU: | 0.93 | 1.40 | 0.00 | 0.00 | 0.00 |
| PE RVU: | 1.14 | 1.27 | 0.00 | 0.00 | 0.00 |
| Malpractice RVU: | 0.08 | 0.06 | 0.00 | 0.00 | 0.00 |
| Total RVU: | 2.15 | 2.73 | 0.00 | 0.00 | 0.00 |

| RVU - Facility | | | | | |
|---|---|---|---|---|---|
| | **National** | **Adjusted** | **26** | **TC** | **53** |
| Work RVU: | 0.93 | 1.40 | 0.00 | 0.00 | 0.00 |
| PE RVU: | 0.42 | 0.47 | 0.00 | 0.00 | 0.00 |
| Malpractice RVU: | 0.08 | 0.06 | 0.00 | 0.00 | 0.00 |
| Total RVU: | 1.43 | 1.92 | 0.00 | 0.00 | 0.00 |

| Global & Other Info | | |
|---|---|---|
| | **Global Split** | |
| Preoperative %: | 0 | |
| Intraoperative %: | 0 | |
| Postoperative %: | 0 | |
| Total RVU: | 0 | |
| Global Period (days): | XXX | |

**XXX** = The global concept does not apply to the code.

| | |
|---|---|
| Radiology Diagnostic Tests : | 99 |

**99** = Concept does not apply

| | |
|---|---|
| PC/TC Indicator : | 0 |

**0** = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

| | |
|---|---|
| Endoscopic Base Code : | None |

| Modifier Guidelines | | |
|---|---|---|
| | **Modifier** | **Rules(Click on rules for Details)** |
| MULT PROC | 51 | No multiple procedure payment adjustment |

**51** = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes

**0** = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

| | | |
|---|---|---|
| BILAT SURG | 50 | No 150% bilateral payment boost |

**50** = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.

**0** = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.

| | | |
|---|---|---|
| ASST SURG | 80 | Assistant payment allowed when supported |

**80** = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

**0** = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

| | | |
|---|---|---|
| CO-SURG | 62 | Co-surgeons not permitted |

**62** = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

**0** = Co-surgeons not permitted for this procedure.

| | | |
|---|---|---|
| TEAM SURG | 66 | Team surgeons not permitted |
| **66** = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services. | | |
| **0** = Team surgeons not permitted for this procedure. | | |
| MINIMUM ASST SURG | 81 | Assistant payment allowed when supported. |
| **81** = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. | | |
| **0** = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. | | |
| ASST SURG (QUALIFIED RESI. NA) | 82 | Assistant payment allowed when supported. |
| **82** = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s) | | |
| **0** = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. | | |
| PHYSICIAN SUPERVISION | *PS | Concept does not apply. |
| **PS** = This field is for use in post payment review. | | |
| **9** = Concept does not apply | | |

## Medically Unlikely Edits

**Source:** 2019 Medically Unlikely Edits (MUE)

**Publisher:** CMS

**Date:** July 01, 2019

| Services | MUE | MAI | MUE Rationale |
|---|---|---|---|
| **Practitioner Services** | 1 | 2 | Clinical: Data |
| **DME Supplier Services** | NA | NA | NA |
| **Facility Outpatient Services** | 1 | 2 | CMS Policy |

MAI 1: Line Edit

MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy

MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

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## LCD Details

### LCD Details for 99202

The chosen state has no LCD for this code/title. Please search All States to see if another state has an LCD for this code/title.

### Article Details for 99202

The chosen state has no Article for this code/title. Please search All States to see if another state has an Article for this code/title.

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## NCD

No data available.

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## MEDICARE CCI

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

| Col B Code | Reason Edit | Modifier Indicator |
|---|---|---|
| 0362T | Misuse of column two code with column one code | 1 |
| 0373T | Misuse of column two code with column one code | 1 |
| 0469T | Misuse of column two code with column one code | 0 |
| 36591 | CPT Manual or CMS manual coding instructions | 0 |
| 36592 | CPT Manual or CMS manual coding instructions | 0 |
| 43752 | Misuse of column two code with column one code | 1 |
| 80500 | Standards of medical / surgical practice | 0 |
| 80502 | Standards of medical / surgical practice | 0 |
| 90863 | CPT Manual or CMS manual coding instructions | 0 |

| | | |
|---|---|---|
| 90940 | Standards of medical / surgical practice | 0 |
| 92002 | More extensive procedure | 0 |
| 92004 | More extensive procedure | 0 |
| 92012 | More extensive procedure | 0 |
| 92014 | More extensive procedure | 0 |
| 92227 | CPT Manual or CMS manual coding instructions | 1 |
| 92228 | CPT Manual or CMS manual coding instructions | 1 |
| 92531 | CPT Manual or CMS manual coding instructions | 0 |
| 92532 | CPT Manual or CMS manual coding instructions | 0 |
| 93561 | Misuse of column two code with column one code | 1 |
| 93562 | Misuse of column two code with column one code | 1 |
| 93792 | CPT Manual or CMS manual coding instructions | 1 |
| 93793 | CPT Manual or CMS manual coding instructions | 0 |
| 94002 | CPT Manual or CMS manual coding instructions | 0 |
| 94003 | CPT Manual or CMS manual coding instructions | 0 |
| 94004 | CPT Manual or CMS manual coding instructions | 0 |
| 94660 | CPT Manual or CMS manual coding instructions | 0 |
| 94662 | CPT Manual or CMS manual coding instructions | 0 |
| 95831 | Standards of medical / surgical practice | 0 |
| 95832 | Standards of medical / surgical practice | 0 |
| 95833 | Standards of medical / surgical practice | 0 |
| 95834 | Standards of medical / surgical practice | 0 |
| 95851 | Standards of medical / surgical practice | 0 |
| 95852 | Standards of medical / surgical practice | 0 |
| 96020 | CPT Manual or CMS manual coding instructions | 1 |
| 96105 | Standards of medical / surgical practice | 1 |
| 96116 | CPT Manual or CMS manual coding instructions | 1 |
| 96125 | Standards of medical / surgical practice | 1 |

| | | |
|---|---|---|
| 96130 | Standards of medical / surgical practice | 1 |
| 96132 | Standards of medical / surgical practice | 1 |
| 96136 | Standards of medical / surgical practice | 1 |
| 96138 | Standards of medical / surgical practice | 1 |
| 96146 | Standards of medical / surgical practice | 1 |
| 96150 | CPT Manual or CMS manual coding instructions | 0 |
| 96151 | CPT Manual or CMS manual coding instructions | 0 |
| 96152 | CPT Manual or CMS manual coding instructions | 0 |
| 96153 | CPT Manual or CMS manual coding instructions | 0 |
| 96154 | CPT Manual or CMS manual coding instructions | 0 |
| 96523 | CPT Manual or CMS manual coding instructions | 0 |
| 97151 | Misuse of column two code with column one code | 1 |
| 97153 | Misuse of column two code with column one code | 1 |
| 97154 | Misuse of column two code with column one code | 1 |
| 97155 | Misuse of column two code with column one code | 1 |
| 97156 | Misuse of column two code with column one code | 1 |
| 97157 | Misuse of column two code with column one code | 1 |
| 97158 | Misuse of column two code with column one code | 1 |
| 97802 | Misuse of column two code with column one code | 0 |
| 97803 | Misuse of column two code with column one code | 0 |
| 97804 | Misuse of column two code with column one code | 0 |
| 99091 | CPT Manual or CMS manual coding instructions | 0 |
| 99172 | CPT Manual or CMS manual coding instructions | 0 |
| 99173 | CPT Manual or CMS manual coding instructions | 1 |
| 99174 | Misuse of column two code with column one code | 1 |
| 99177 | Misuse of column two code with column one code | 1 |
| 99201 | HCPCS/CPT procedure code definition | 0 |
| 99211 | Misuse of column two code with column one code | 1 |

| | | |
|---|---|---|
| 99212 | Misuse of column two code with column one code | 1 |
| 99213 | Misuse of column two code with column one code | 1 |
| 99214 | Misuse of column two code with column one code | 1 |
| 99215 | Misuse of column two code with column one code | 1 |
| 99408 | Standards of medical / surgical practice | 0 |
| 99409 | Standards of medical / surgical practice | 0 |
| 99446 | CPT Manual or CMS manual coding instructions | 0 |
| 99447 | CPT Manual or CMS manual coding instructions | 0 |
| 99448 | CPT Manual or CMS manual coding instructions | 0 |
| 99449 | CPT Manual or CMS manual coding instructions | 0 |
| 99451 | CPT Manual or CMS manual coding instructions | 0 |
| 99452 | CPT Manual or CMS manual coding instructions | 0 |
| 99463 | Mutually exclusive procedures | 0 |
| 99605 | Misuse of column two code with column one code | 1 |
| 99606 | Misuse of column two code with column one code | 1 |
| G0102 | Standards of medical / surgical practice | 0 |
| G0117 | Standards of medical / surgical practice | 0 |
| G0118 | Standards of medical / surgical practice | 0 |
| G0245 | Standards of medical / surgical practice | 0 |
| G0246 | Standards of medical / surgical practice | 0 |
| G0248 | Misuse of column two code with column one code | 1 |
| G0250 | Misuse of column two code with column one code | 1 |
| G0270 | Misuse of column two code with column one code | 0 |
| G0271 | Misuse of column two code with column one code | 0 |
| G0396 | Standards of medical / surgical practice | 1 |
| G0397 | Standards of medical / surgical practice | 1 |
| G0406 | Mutually exclusive procedures | 0 |
| G0407 | Mutually exclusive procedures | 0 |

| | | |
|---|---|---|
| G0408 | Mutually exclusive procedures | 0 |
| G0425 | Mutually exclusive procedures | 0 |
| G0426 | Mutually exclusive procedures | 0 |
| G0427 | Mutually exclusive procedures | 0 |
| G0442 | Standards of medical / surgical practice | 1 |
| G0443 | Standards of medical / surgical practice | 1 |
| G0444 | More extensive procedure | 1 |
| G0445 | More extensive procedure | 1 |
| G0446 | More extensive procedure | 1 |
| G0447 | More extensive procedure | 1 |
| G0459 | Standards of medical / surgical practice | 0 |
| G0473 | More extensive procedure | 1 |
| G0508 | Mutually exclusive procedures | 0 |
| G0509 | Mutually exclusive procedures | 0 |
| G2011 | Standards of medical / surgical practice | 1 |

**Medicaid CCI Edits Alert**

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

| Col B Code | Reason Edit | Modifier Indicator |
|---|---|---|
| 0362T | Misuse of column two code with column one code | 1 |
| 0373T | Misuse of column two code with column one code | 1 |
| 0469T | Misuse of column two code with column one code | 0 |
| 36591 | CPT Manual or CMS manual coding instructions | 0 |
| 36592 | CPT Manual or CMS manual coding instructions | 0 |
| 43752 | Misuse of column two code with column one code | 1 |
| 80500 | Standards of medical / surgical practice | 0 |
| 80502 | Standards of medical / surgical practice | 0 |

| | | |
|---|---|---|
| 90863 | CPT Manual or CMS manual coding instructions | 0 |
| 90940 | Standards of medical / surgical practice | 0 |
| 92002 | More extensive procedure | 0 |
| 92004 | More extensive procedure | 0 |
| 92012 | More extensive procedure | 0 |
| 92014 | More extensive procedure | 0 |
| 92227 | CPT Manual or CMS manual coding instructions | 1 |
| 92228 | CPT Manual or CMS manual coding instructions | 1 |
| 92531 | CPT Manual or CMS manual coding instructions | 0 |
| 92532 | CPT Manual or CMS manual coding instructions | 0 |
| 93561 | Misuse of column two code with column one code | 1 |
| 93562 | Misuse of column two code with column one code | 1 |
| 93792 | CPT Manual or CMS manual coding instructions | 1 |
| 93793 | CPT Manual or CMS manual coding instructions | 0 |
| 94002 | CPT Manual or CMS manual coding instructions | 0 |
| 94003 | CPT Manual or CMS manual coding instructions | 0 |
| 94004 | CPT Manual or CMS manual coding instructions | 0 |
| 94660 | CPT Manual or CMS manual coding instructions | 0 |
| 94662 | CPT Manual or CMS manual coding instructions | 0 |
| 95831 | Standards of medical / surgical practice | 0 |
| 95832 | Standards of medical / surgical practice | 0 |
| 95833 | Standards of medical / surgical practice | 0 |
| 95834 | Standards of medical / surgical practice | 0 |
| 95851 | Standards of medical / surgical practice | 0 |
| 95852 | Standards of medical / surgical practice | 0 |
| 96020 | CPT Manual or CMS manual coding instructions | 1 |
| 96105 | Standards of medical / surgical practice | 1 |
| 96116 | CPT Manual or CMS manual coding instructions | 1 |

| | | |
|---|---|---|
| 96125 | Standards of medical / surgical practice | 1 |
| 96130 | Standards of medical / surgical practice | 1 |
| 96132 | Standards of medical / surgical practice | 1 |
| 96136 | Standards of medical / surgical practice | 1 |
| 96138 | Standards of medical / surgical practice | 1 |
| 96146 | Standards of medical / surgical practice | 1 |
| 96150 | CPT Manual or CMS manual coding instructions | 0 |
| 96151 | CPT Manual or CMS manual coding instructions | 0 |
| 96152 | CPT Manual or CMS manual coding instructions | 0 |
| 96153 | CPT Manual or CMS manual coding instructions | 0 |
| 96154 | CPT Manual or CMS manual coding instructions | 0 |
| 96155 | CPT Manual or CMS manual coding instructions | 0 |
| 96523 | CPT Manual or CMS manual coding instructions | 0 |
| 97151 | Misuse of column two code with column one code | 1 |
| 97153 | Misuse of column two code with column one code | 1 |
| 97154 | Misuse of column two code with column one code | 1 |
| 97155 | Misuse of column two code with column one code | 1 |
| 97156 | Misuse of column two code with column one code | 1 |
| 97157 | Misuse of column two code with column one code | 1 |
| 97158 | Misuse of column two code with column one code | 1 |
| 97802 | Misuse of column two code with column one code | 0 |
| 97803 | Misuse of column two code with column one code | 0 |
| 97804 | Misuse of column two code with column one code | 0 |
| 99091 | CPT Manual or CMS manual coding instructions | 0 |
| 99172 | CPT Manual or CMS manual coding instructions | 0 |
| 99173 | CPT Manual or CMS manual coding instructions | 1 |
| 99174 | Misuse of column two code with column one code | 1 |
| 99177 | Misuse of column two code with column one code | 1 |

| | | |
|---|---|---|
| 99201 | HCPCS/CPT procedure code definition | 0 |
| 99211 | Misuse of column two code with column one code | 1 |
| 99212 | Misuse of column two code with column one code | 1 |
| 99213 | Misuse of column two code with column one code | 1 |
| 99214 | Misuse of column two code with column one code | 1 |
| 99215 | Misuse of column two code with column one code | 1 |
| 99408 | CPT Manual or CMS manual coding instructions | 1 |
| 99409 | CPT Manual or CMS manual coding instructions | 1 |
| 99446 | CPT Manual or CMS manual coding instructions | 0 |
| 99447 | CPT Manual or CMS manual coding instructions | 0 |
| 99448 | CPT Manual or CMS manual coding instructions | 0 |
| 99449 | CPT Manual or CMS manual coding instructions | 0 |
| 99451 | CPT Manual or CMS manual coding instructions | 0 |
| 99452 | CPT Manual or CMS manual coding instructions | 0 |
| 99463 | Mutually exclusive procedures | 0 |
| 99605 | Misuse of column two code with column one code | 1 |
| 99606 | Misuse of column two code with column one code | 1 |
| G0102 | Standards of medical / surgical practice | 0 |
| G0117 | Standards of medical / surgical practice | 1 |
| G0118 | Standards of medical / surgical practice | 1 |
| G0245 | Standards of medical / surgical practice | 0 |
| G0246 | Standards of medical / surgical practice | 0 |
| G0248 | Misuse of column two code with column one code | 1 |
| G0250 | Misuse of column two code with column one code | 1 |
| G0270 | Misuse of column two code with column one code | 0 |
| G0271 | Misuse of column two code with column one code | 0 |
| G0396 | Standards of medical / surgical practice | 1 |
| G0397 | Standards of medical / surgical practice | 1 |

| | | |
|---|---|---|
| G0406 | Mutually exclusive procedures | 0 |
| G0407 | Mutually exclusive procedures | 0 |
| G0408 | Mutually exclusive procedures | 0 |
| G0425 | Mutually exclusive procedures | 0 |
| G0426 | Mutually exclusive procedures | 0 |
| G0427 | Mutually exclusive procedures | 0 |
| G0442 | Standards of medical / surgical practice | 1 |
| G0443 | Standards of medical / surgical practice | 1 |
| G0444 | More extensive procedure | 1 |
| G0445 | More extensive procedure | 1 |
| G0446 | More extensive procedure | 1 |
| G0447 | More extensive procedure | 1 |
| G0459 | Standards of medical / surgical practice | 0 |
| G0473 | More extensive procedure | 1 |
| G0508 | Mutually exclusive procedures | 0 |
| G0509 | Mutually exclusive procedures | 0 |
| G2011 | Standards of medical / surgical practice | 1 |
| H0049 | Standards of medical / surgical practice | 1 |
| H0050 | Standards of medical / surgical practice | 1 |

## HCPCS Crossref

G0463 : Hospital outpatient clinic visit for assessment and management of a patient
G0466 : Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit
G0501 : Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)
G0511 : Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
G0512 : Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an

RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month
G9868 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes
G9869 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes
G9870 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes

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## Modifier Crossref

25 : Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
27 : Multiple Outpatient Hospital E/M Encounters on the Same Date
32 : Mandated Services
33 : Preventive Services
57 : Decision for Surgery
80 : Assistant Surgeon
81 : Minimum Assistant Surgeon
82 : Assistant Surgeon (when qualified resident surgeon not available)
95 : Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
99 : Multiple Modifiers
AF : Specialty physician
AG : Primary physician
AK : Non participating physician
AQ : Physician providing a service in an unlisted health professional shortage area (hpsa)
AS : Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
CR : Catastrophe/disaster related
EP : Service provided as part of medicaid early periodic screening diagnosis and treatment (epsdt) program
ET : Emergency services
FP : Service provided as part of family planning program
G0 : Telehealth Services For Diagnosis, Evaluation, Or Treatment, Of Symptoms Of An Acute Stroke
GA : Waiver of liability statement issued as required by payer policy, individual case
GC : This service has been performed in part by a resident under the direction of a teaching physician
GE : This service has been performed by a resident without the presence of a teaching physician under the primary care exception
GF : Non-physician (e.g. nurse practitioner (np), certified registered nurse anesthetist (crna), certified registered nurse (crn), clinical nurse specialist (cns), physician assistant (pa)) services in a critical access hospital
GJ : "opt out" physician or practitioner emergency or urgent service
GR : This service was performed in whole or in part by a resident in a department of veterans affairs medical center or clinic, supervised in accordance with va policy
GV : Attending physician not employed or paid under arrangement by the patient's hospice provider
GW : Service not related to the hospice patient's terminal condition
HA : Child/adolescent program
HB : Adult program, non geriatric
HC : Adult program, geriatric
HD : Pregnant/parenting women's program
HU : Funded by child welfare agency
KX : Requirements specified in the medical policy have been met
PD : Diagnostic or related non diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days

Q0 : Investigational clinical service provided in a clinical research study that is in an approved clinical research study
Q1 : Routine clinical service provided in a clinical research study that is in an approved clinical research study
Q5 : Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
Q6 : Service furnished under a fee-for-time compensation arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
QJ : Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 cfr 411.4 (b)
TH : Obstetrical treatment/services, prenatal or postpartum

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## CPT® Lay Terms

The provider sees a new patient for an office visit or other outpatient encounter to treat one or more medical problems of low to moderate severity.

### Clinical Responsibility

The provider spends approximately 20 minutes face–to–face with a new patient and/or the patient's family in the provider's office or in another outpatient setting to evaluate and manage the patient's medical problems, which are usually of low to moderate severity. The provider's evaluation consists of all three of these components: an expanded problem–focused history, an expanded problem–focused physical examination, and straightforward medical decision making. She may provide additional services, including counseling or coordination of care with other healthcare professionals or agencies, if necessary.

### Terminology

Outpatient:  A person receiving medical care that does not require admission to a hospital.

### Tips

The appropriate evaluation and management, or E/M, service level is based on the medical necessity of performing the key components of the service and also on review of the documentation of the key E/M criteria of the history, exam, and medical decision–making elements.

For other new patient E/M services, select the appropriate code from the range 99202–99205, New Patient Office or Other Outpatient Services.

Use time as the controlling factor to report an office and/or other outpatient visit if more than 50% of the visit is comprised of counseling and coordination of care.

Report a separate and significant E/M service, including outpatient visits with codes 99201–99215 on the same day as another service or procedure.  In most of these cases it is appropriate to append a modifier to the E/M service code.

**Additional Info**

**E/M Terms Easy Reference Guide:**

**CC:** Chief Complaint: A concise statement, usually in the patient's words, explaining the main reason for the visit. Look for a symptom, problem, condition, or diagnosis.

**Dx:** Diagnosis

**Hx:** History

**HPI:**  History of Present Illness: The HPI consists of these eight areas:

1. Location is the place on the patient's body where the symptoms exist (the lower back, for instance).

2. Context is what the patient was doing when the problem occurred (such as "patient had lower back pain after standing on his feet all day").

3. Quality represents the chief complaint or signs or symptoms. So if a patient reports with a sharp pain in her shoulder, "sharp" is the quality.

4. Timing is the time of day the patient experienced the signs and symptoms. If the notes say, "Pain after standing for long periods, last two weeks," "after standing for long periods" is the timing.

5. Severity shows just how serious the patient's condition is. Providers often show severity in their notes with a scale of 1 (least painful) to 10 (most painful).

6. Duration is how long the patient's signs and symptoms have been present (for instance, "Patient has had sharp/severe shoulder pain, last three weeks").

7. Modifying factors are what the patient did herself to alleviate pain or exacerbate the symptoms (for example, "Patient's low back pain was worsened by continuing to stand for long periods" or "Pain improved when patient sat for 15–20 minutes").

8. Associated signs and symptoms are any other problems the patient has in addition to the chief complaint (such as blurred vision, an associated symptom of migraines). For most upper–level E/M codes, the provider must cover and document in the HPI a minimum of four of these points.

**MDM:** Medical Decision Making: After gathering information, the clinician must decide what to do. That thinking process, which takes into account risk factors, is medical decision making.

**PFSH:** Past Family and Social History: "Past history" can be medical history, surgical history, and other personal history. "Family history" includes medical events in the patient's family line, such as hereditary diseases that put the patient at risk. "Social history" reviews the individual's past and current activities, such as smoking history, alcohol history, or sexual history.

**ROS:** Review of Systems: An ROS is an inventory of body systems or symptoms about which the provider asks the patient to help establish a diagnosis. CPT® breaks the body into these systems: constitutional symptoms; eyes, ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breasts); neurologic; psychiatric; endocrine; hematologic/lymphatic; allergic/immunologic.

## CPT® Guidelines

**Section Specific Guideline**

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 16) or initial nursing facility care (page 26).

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

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## Upcoming and Historical Information

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| **01-01-2013** | Code Changed |

**Previous Descriptor**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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|---|---|
| **01-01-2008** | Code Changed |

**Previous Descriptor**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

| | |
|---|---|
| **01-01-2007** | Code Changed |

**Previous Descriptor**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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|---|---|
| **01-01-2006** | Code Changed |

**Previous Descriptor**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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|---|---|
| **01-01-1992** | Code Added |