Common CPT Codes

FOR YOUR MEDICAL PRACTICE

A reference guide for CPT® codes used in everyday medical practices.

BY **OPTIMANTRA**

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How to Use Your CPT Code Guide

This downloadable list is ideal for printing and posting at workstations or including in staff training binders.

What You'll Find in This Guide

- Criteria for when to use each CPT code, including complexity and provider time involved.
- Bullet points outlining key components such as medical decision making (MDM), counseling, procedures, and time thresholds.
- Grouping by clinical category to help you quickly locate relevant codes.

How to Use CPT Codes Correctly

1. Select the code that matches the patient encounter based on complexity, time spent, and services provided.
2. Understand some codes are time-based or complexity-based: Use whichever is dominant for the encounter.
3. Ensure documentation supports code use: Clear, detailed notes justify the level of care and services rendered.
4. Use add-on codes appropriately: Some codes for prolonged or additional procedures are billed in conjunction with primary codes.
5. Stay up-to-date with coding guidelines: Requirements can vary by insurer and may change over time.

Evaluation & Management Codes (E/M)

99202 – New patient office visit, straightforward

- New patient with minor or uncomplicated condition
- Straightforward medical decision making
- Total time: 15–29 minutes
- Select based on either time or MDM

99203 – New patient office visit, low complexity

- New patient with low-complexity condition (e.g., mild acute illness or stable chronic condition)
- Low-level medical decision making
- Total time: 30–44 minutes
- Select based on either time or MDM

99204 – New patient office visit, moderate complexity

- New patient with moderately complex issue requiring workup or new treatment
- Moderate-level medical decision making
- The provider must engage in moderate-level data review, evaluation, and management.
- Total time: 45–59 minutes
- Select based on either time or MDM

99205 – New patient office visit, high complexity

- New patient with multiple or severe problems
- Extensive data review, thorough examination and high-level medical decision making, with possible specialist coordination
- Total time: 60–74 minutes
- Select based on either time or MDM

99211 – Established patient, minimal (nurse visit)

- Established patient only
- Minimal complexity
- No physician/QHP involvement required
- Typically 5 minutes or less with clinical staff

Evaluation & Management Codes (E/M)

99212 – Established patient, straightforward

- Established patient
- Straightforward decision-making for routine follow-up or stable condition
- Total time: 10–19 minutes

99213 – Established patient, low complexity

- Established patient
- Low-complexity problem or stable chronic condition
- Expanded history and exam
- Total time: 20–29 minutes
- Select based on time or low MDM

99214 – Established patient, moderate complexity

- Established patient
- Moderate-complexity problems or worsening chronic conditions
- Total time: 30–39 minutes
- Select based on time or moderate MDM

99215 – Established patient, high complexity

- Established patient
- Multiple serious issues or intensive care required
- The provider engages in extensive data review, coordination with other providers, or in-depth patient counseling.
- Total time: 40–54 minutes
- Select based on time or high-level MDM

99417 – Prolonged services (add-on to 99215 or 99205)

- Add-on when time exceeds 99205 or 99215
- 15+ minutes beyond base code
- Involves in-depth history-taking, counseling, coordination with other providers, or extensive documentation.
- Time-based only (not for MDM-based coding)
- Use G2212 for Medicare patients

Emergency Department Visits

99283 – ED visit, moderate severity
- Expanded history and exam
- Low to moderate-level MDM
- For conditions needing prompt care but not life-threatening
- Includes limited diagnostic testing or treatment interventions

99284 – ED visit, moderate to high severity
- Significant threat to health (not immediately life-threatening)
- Detailed history and examination
- Moderate to high-level MDM
- Often involves multiple diagnostic tests and treatment interventions

99285 – ED visit, high severity
- Acute, severe symptoms that are an immediate threat to life/physiologic function
- Comprehensive history and examination
- High-level MDM
- Multiple diagnostic tests, urgent interventions, and coordination of care
- For critical or unstable patients requiring rapid assessment and treatment

Preventive and Physical Exams

99385 – Preventive exam, new patient age 18–39
- Routine wellness exam focused on prevention
- New Patients, Ages 18–39
- Not used for diagnosing or managing active conditions
- If additional problems are addressed, bill separate E/M with -25 modifier

99386 – Preventive exam, new patient age 40–64
- Routine wellness exam focused on prevention
- New Patients, Ages 40–64
- Includes early detection, screenings, counseling, and immunizations
- If additional problems are addressed, bill separate E/M with -25 modifier

Preventive and Physical Exams

99395 – Preventive exam, established patient age 18–39

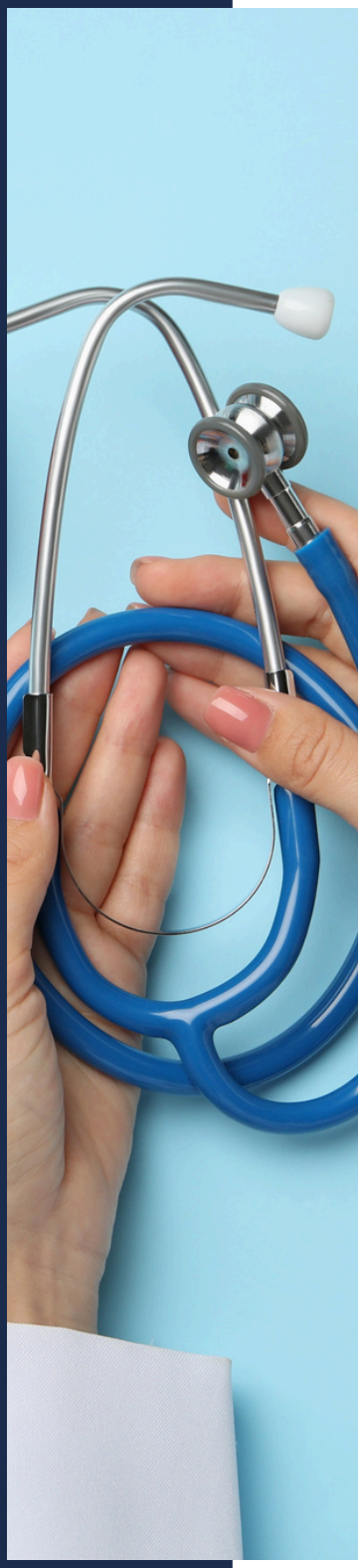
- Routine wellness exam focused on prevention
- Existing Patients, Ages 18–39
- Supports early detection, patient education, and long-term health planning
- Not used for diagnosing or managing active conditions
- If additional problems are addressed, bill separate E/M with -25 modifier

99396 – Preventive exam, established patient age 40–64

- Routine wellness exam focused on prevention
- Existing Patients, Ages 40–64
- Focus on proactive wellness and risk reduction through screening, education, and early intervention
- Not used for diagnosing or managing active conditions
- If additional problems are addressed, bill separate E/M with -25 modifier

99397 – Preventive exam, established patient age 65+

- Annual wellness visit for seniors
- Existing Patients, Ages 65+
- Focused on preventive care, not treatment or evaluation of new/existing conditions
- Includes comprehensive history, examination, and counseling
- If additional problems are addressed, bill separate E/M with -25 modifier



Mental and Behavioral Health

90833 – Psychotherapy (16–37 min) with E/M

- Both psychotherapy and medical evaluation during the same visit
- Face-to-face psychotherapy for 16–37 minutes
- Document both medical and therapeutic components
- Always billed in conjunction with an E/M code

90836 – Psychotherapy (45 min) with E/M

- Both psychotherapy and medical evaluation during the same visit
- Face-to-face psychotherapy for 45 minutes
- Document both E/M and therapy components
- Always billed in conjunction with an E/M code

90837 – Individual psychotherapy (60 minutes)

- 60-minute, face-to-face session (in-person or telehealth) with continuous, active therapeutic engagement
- High level of complexity, depth, or duration of care
- Documentation must include:
  - Diagnosis-specific therapeutic interventions used (e.g., CBT, DBT, psychodynamic)
  - Patient progress
  - Duration of the session
  - Time spent (must justify 60 minutes)

90846 – Family/couples therapy (without patient)

- 50-minute session with family/caregiver
- No patient present
- Focus on relational dynamics, education, and support related to the patient's condition

Injections, Infusions, and Vaccines

96365 – Initial IV infusion (up to 1 hour)

- Initial therapeutic/prophylactic/diagnostic infusion
- Single drug or substance infusion
- Up to 1 hour
- Administration occurs in an outpatient setting or a similar clinical setting
- Use CPT 96368 for additional infusions

96369 – IV infusion (more than 1 hour)

- IV infusion therapy for therapeutic, prophylactic, or diagnostic purposes
- Lasts over 1 hour, but less than 8 hours
- Single drug or substance infusion
- Outpatient or clinical setting
- Administration occurs in an outpatient setting or a similar clinical setting

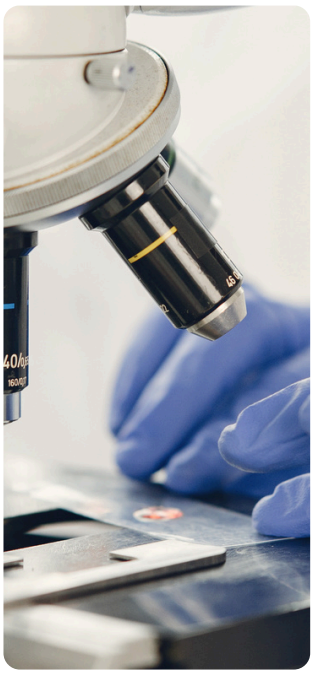
96372 – Subcutaneous or IM injection

- A subcutaneous or intramuscular injection of a therapeutic, prophylactic, or diagnostic substance
- Single dose injection (use CPT 96360 for additional injections in the same encounter)
- Does not require a complex method of administration (e.g. IV)
- Part of a clinical procedure and not included under other codes (e.g. vaccines, allergy shots, or medications for chronic conditions).

90658 – Influenza vaccine product only

- Seasonal flu vaccine, specifically the trivalent or quadrivalent flu vaccine (0.5 mL)
- This code applies only to the vaccine product itself, not the administration service.
- Report admin separately (e.g., 90471)

Laboratory and Diagnostic Tests



36415 – Routine blood draw

- A blood specimen is collected by venipuncture for diagnostic testing, screening, or lab analysis
- Not used for complex blood draws like arterial puncture or apheresis
- The blood is collected for routine check-ups, monitoring, or when specific tests are required as part of the medical treatment plan

80053 – Comprehensive Metabolic Panel

- Ordering a comprehensive metabolic panel to evaluate a patient's overall metabolic health
- Ordered for routine screening, chronic disease monitoring, or preoperative evaluations
- Document medical necessity, relevant clinical findings, and interpretation of results with any subsequent management decisions

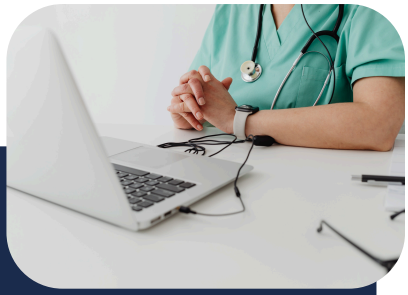
93010 – ECG interpretation only

- Covers physician interpretation and written report of a 12-lead electrocardiogram
- No equipment use or electrode placement included—technical component is billed separately
- Billed by physicians who review the ECG, but did not perform the test

71045 – Chest X-ray, single view

- Radiologic examination of the chest with one frontal view (e.g., PA or AP)
- Commonly used as an initial diagnostic tool for respiratory or cardiac symptoms
- Does not include interpretation, professional and technical parts may be billed separately

Telehealth Services



99442 – Telephone E/M (11–20 minutes)

- Patient-initiated call to discuss new or existing concerns
- 11-20 minutes on clinical discussion
- Must involve MDM and cannot be delegated to non-clinical staff
- Not related to an E/M service from the past 7 days
- Does not result in a scheduled E/M service within 24 hours/soonest available

99443 – Telephone E/M (21–30 minutes)

- Patient-initiated telephone consultation including clinical discussion
- 21-30 minutes with an established patient
- Must involve medical decision making
- Not related to an E/M service from the past 7 days
- Does not result in a scheduled E/M service within 24 hours or the soonest available slot

Physical Medicine & Occupational Therapy

97110 – Therapeutic exercise

- One-on-one structured exercises for functional improvement
- Must document exercise type, reason for use, and total one-on-one time
- Insurers typically require progress notes that show measurable improvement, a plan of care, and updates to justify continued therapy under this code

97112 – Neuromuscular re-education

- Aimed at improving balance, posture or proprioception
- One-on-one, billed in 15-minute units
- Commonly used for patients with neurological conditions or musculoskeletal injuries

97124 – Massage therapy

- Medically necessary soft tissue massage for improving soft tissue function, reducing pain, or increasing range of motion.
- Must document type of technique and purpose
- Differs from 97140 (manual therapy) in that 97124 focuses solely on massage techniques, while 97140 includes joint mobilization and myofascial release.

Physical Medicine & Occupational Therapy

97140 – Manual therapy techniques

- Manual therapy techniques applied to one or more regions of the body
- One-on-one, 15-minute increments
- Includes mobilization, manual traction or lymph drainage
- Detailed records of the techniques used, areas treated, duration, and patient response are essential for billing and reimbursement.

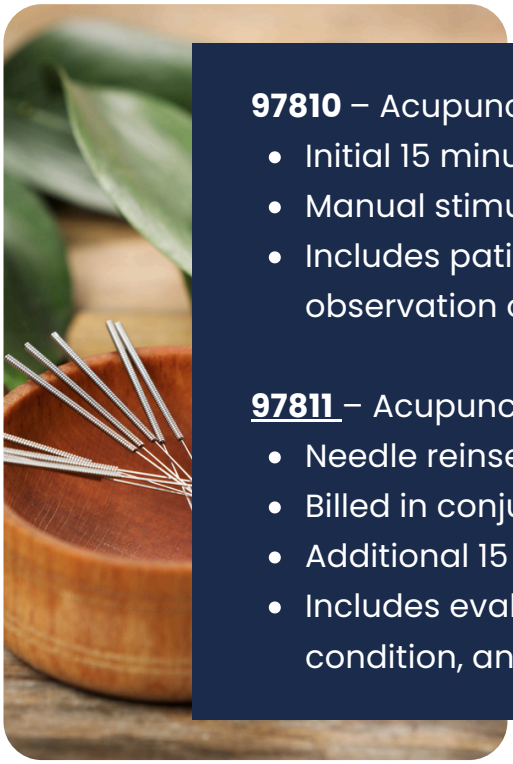
97530 – Therapeutic activities

- One-on-one therapeutic activities used to improve functional performance
- Dynamic, goal-directed tasks (e.g. lifting, bending, reaching, or balance training)
- Billed in 15-minute increments with active patient participation throughout

97026 – Infrared therapy

- Must be medically necessary, not purely for comfort or wellness.
- Application for reducing inflammation, increasing range of motion, or supporting recovery post-injury.
- Must document clinical rationale, treatment area, and duration
- Infrared application as an adjunct to another service (e.g., massage or chiropractic adjustment) can be billed separately if documented appropriately.

Acupuncture



97810 – Acupuncture, initial 15 minutes (no electrical stimulation)

- Initial 15 minutes face-to-face
- Manual stimulation only without electrical stimulation
- Includes patient assessment, selection of acupuncture points, observation of needle response, and development of treatment plan

97811 – Acupuncture, additional 15 minutes (no electrical stimulation)

- Needle reinsertion with manual stimulation (no electrical stimulation)
- Billed in conjunction with 97810
- Additional 15 minutes face-to-face care (Can't bill if below 8 minutes)
- Includes evaluation of point effectiveness, re-assessment of patient's condition, and adjustment of treatment plan

Special Procedures

11980 – Hormone pellet insertion

- Subcutaneous office-based HRT pellet placement, under sterile technique
- The pellets themselves are billed separately using HCPCS supply codes
- Document type of hormone, dosage, insertion site, sterile technique, and patient consent
- Follow-up care, pellet removal, or refill visits are not included

90999 – Unlisted dialysis service

- Use when no existing code applies
  - Typically used when providing non-standard dialysis services or emerging treatments that fall outside established definitions
- Must include detailed documentation describing the service performed and its medical necessity

99233 – Subsequent hospital visit, high complexity

- Follow-up visit during inpatient or observation stay
- High MDM or 50+ minutes total time
  - Typically reflects a complex or worsening condition requiring close management.
- Typically includes detailed exam, medication adjustments, and care coordination

Your CPT Coding Companion; Simplify with OptiMantra

Accurate coding is essential for efficient billing and clean claims. This guide is designed to support quick, confident documentation.

With OptiMantra, you can seamlessly apply these codes within your workflow; auto-generating superbills, minimizing errors, and saving valuable time.

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thank you!