

# Home-Based Medical Care: Evaluation and Management (E/M) Guidelines – 2026

## Purpose

This resource is intended to serve as a reference for home-based providers that review the Evaluation and Management (E/M) documentation and coding guidelines on the criteria needed to support billing for the different service levels for the home visit CPT range (CPT Codes 99341-99350). This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

- Selection of appropriate E/M Services is based on the following:
  - Medical Decision Making (MDM) or
  - Total time for E/M services performed on the date of the encounter.
  - Domiciliary, rest home, or custodial care services are billed with home and residence services codes (99341-99350).
  - It is a common misconception that patients must meet Medicare’s definition of “homebound” to receive primary medical care in the home. Homebound status is only required for skilled home health services. Patients are not required to be confined to the home to receive house calls. Per the CMS Claims Processing Manual, for home services provided by a qualified provider using CPT codes 99341–99350, the beneficiary does not need to be confined to the home.
- Selection of E/M services based on MDM:
  - A medically appropriate history and exam should still be documented when performed
  - Depending on the clinical circumstances, a medically appropriate history (HPI, ROS, PFH) and exam may be brief or extensive. The E/M revisions only clarify that the length and formatting are no longer part of the code level determination. Practitioners must remain aware of medicolegal, ethical and professional standards of documentation.
  - Level of decision-making is based on two out of the three elements: 1) number and complexity of problems addressed at the encounter; 2) amount and/or complexity of data to be reviewed and analyzed; 3) risk of complications and/or morbidity or mortality of patient management
- Selection of E/M Services based on Time
  - Total time includes both face to face time and non-face to face time spent by the provider on the date of the encounter.
    - A face-to-face encounter by the provider with the patient is required
    - Non-face-to-face time includes time spent before (e.g. preparing to see the patient, reviewing old records, test results, etc.), during (the face-to-face encounter) and after the encounter (e.g. documenting in the EHR, coordinating care, etc.)
    - Reporting total time no longer requires >50% of time be in counseling and coordination of care.

- Report a definitive amount of time spent (e.g.: 45 minutes). Avoid stating total time in approximation or range of minutes
- Keep in mind that total time does not include the following, performance of other services that are reported separately, travel time (time entering & leaving the home), clinical staff time.
- Best practice is to provide a time-qualification statement that states the amount of time spent and a summary of how that time was spent.
  - Provider's qualification statement should include what is pertinent to the patient's encounter.
  - Total time reported should qualify rationally for medical necessity purposes

## E/M grid – Home and Residence Services

Code	Level of MDM 2 of 3	Typical Time Range (minutes)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99341 (New) 99347 (Established)	Straightforward	99341 (15 minutes) 99347 (20 minutes)	<b>Minimal</b> 1 self-limited or minor problem	<b>Minimal or none</b>	<b>Minimal risk</b> of morbidity from additional diagnostic testing or treatment
99342 (New) 99348 (Established)	<b>Low</b>	99342 (30 minutes) 99348 (30 minutes)	<b>Low</b> <ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems; or</li> <li>• 1 stable chronic illness; or</li> <li>• 1 acute, uncomplicated illness or injury</li> <li>• 1 stable acute illness</li> <li>• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care</li> </ul>	<b>Limited</b> (Must meet the requirements of at least <b>1 of the 2 categories</b> ) <ul style="list-style-type: none"> <li>• <b>Category 1:</b> Tests and documents <b>Any combination of 2 from the following:</b> <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test</li> </ul> </li> <li>or</li> <li>• <b>Category 2:</b> Assessment requiring an independent historian(s)</li> </ul>	<b>Low risk</b> of morbidity from additional diagnostic testing or treatment
99344 (New) 99349 (Established)	<b>Moderate</b>	99344 (60 minutes) 99349 (40 minutes)	<b>Moderate</b> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or</li> <li>• 2 or more stable chronic illnesses; or</li> <li>• 1 undiagnosed new problem with uncertain prognosis; or</li> <li>• 1 acute illness with systemic symptoms; or</li> <li>• 1 acute complicated injury</li> </ul>	<b>Moderate</b> (Must meet the requirements of at least <b>1 out of 3 categories</b> ) <ul style="list-style-type: none"> <li>• <b>Category 1:</b> Tests, documents, or independent historian(s) <b>Any combination of 3 from the following:</b> <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test</li> <li>• Assessment requiring independent historian(s);</li> </ul> </li> <li>or</li> <li>• <b>Category 2:</b> Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</li> <li>or</li> <li>• <b>Category 3:</b> Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)</li> </ul>	<b>Moderate risk</b> of morbidity from additional diagnostic testing or treatment <b>Examples only:</b> <ul style="list-style-type: none"> <li>• Prescription drug management</li> <li>• Decision regarding minor surgery with identified patient or procedure risk factors</li> <li>• Decision regarding elective major surgery without identified patient or procedure risk factors</li> <li>• Diagnosis or treatment significantly limited by social determinants of health</li> </ul>
99345 (New) 99350 (Established)	<b>High</b>	99345 (75 minutes) 99350 (60 minutes)	<b>High</b> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or</li> <li>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</li> </ul>	<b>Extensive</b> (Must meet the requirements of at least <b>2 out of 3 categories</b> from the Moderate field above)	<b>High risk</b> of morbidity from additional diagnostic testing or treatment <b>Examples only:</b> <ul style="list-style-type: none"> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision regarding elective major procedure with identified patient or procedure risk factors</li> <li>• Decision regarding emergency major surgery</li> <li>• Decision regarding hospitalization or escalation of hospital-level care</li> <li>• Decision not to resuscitate or to de-escalate care because of poor prognosis</li> <li>• Parenteral controlled substances</li> </ul>



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