Split or Shared Billing: Solidify Your Understanding of 2024 CPT and Medicare Policies

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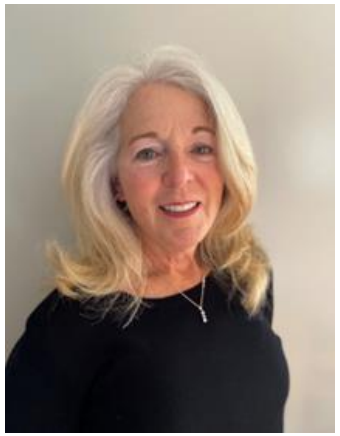
Presented By



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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Understand reporting requirements for split or shared E/M visits under the updated AMA E/M guidelines
  - Appropriately document and code split or shared facility-based visits based on time or medical decision-making
  - Grasp differences between Medicare policy and AMA CPT guidelines for billing split or shared services
  - Understand the guidelines for prolonged service billing

Shared/Split Services

Split (or Shared) Services

- CMS has revised the definition of “substantive portion” of a split (or shared) visit to reflect the 2024 revisions to the CPT E/M Guidelines

- The substantive portion may be based on
  - More than half of the total time spent by the physician and NPP performing the split (or shared) visit
  - **or**
  - a substantive part of the medical decision making
    - except concerning critical care visits which do not use MDM and only use time,
      - “substantive portion” continues to mean more than half of the total time spent by the physician and NPP performing the split (or shared) visit
  - Shared services may not be performed in place of service 11 (office)
  - HCPCS modifier FS (Split or shared) Evaluation and Management Services

Shared/Split Visit

- A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit.
- When time is being used for time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time.
- Distinct time: do not count shared time twice

Medical Decision-Making Elements

- For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s)
  - made or approved the management plan for the number and complexity of problems addressed at the encounter and
  - takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management .
  - By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM.

Complexity of Date to be Reviewed and Analyzed

- If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level
  - assessing an independent historian's narrative and
  - the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP,
    - because the relevant items would be considered in formulating the management plan.
  - Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP

Split/Shared Visit Example

A 56-year-old male is admitted to the hospital due to exacerbation of congestive heart failure. The patient presents with shortness of breath, fluid retention, and increased fatigue. The physician (MD) and nurse practitioner (NP) collaborate in providing care during the admission.

- The physician conducts a detailed history and physical examination (**20 minutes**,) orders and reviews diagnostic test (**10 minutes**,) coordinates with other specialists (**5 minutes**) and discusses treatment options with the patient and family (**10 minutes**.)
- The nurse practitioner performs a comprehensive review of the patient's medications and updates the medication list (**20 minutes**) and provides patient education on managing heart failure symptoms (**10 minutes**.)
- There were **10 minutes** of overlapping time with collaborative discussion between the MD and NP.

Split/Shared Visit Example

A 56-year-old male is admitted to the hospital due to exacerbation of congestive heart failure. The patient presents with shortness of breath, fluid retention, and increased fatigue. The physician (MD) and nurse practitioner (NP) collaborate in providing care during the admission.

- Unique Time (MD+NP): 45+30 = **75 minutes**
- Overlapping time (counted only once) = **10 minutes**
- Total Time: 75 minutes + 10 minutes = **85 minutes**

- **Billing code:** 99223
- **Provider:** Since the MD spent more than 50% of the total time (45 of 75 minutes) the service would be billed under the physician.

CPT 2024: The method of billing determines how split-shared substantive portion will be determined

- If code selection is based on **total time** on the encounter date, the provider who spends the most time providing either face-to-face or non-face-to-face time should report the split or shared visit.
- When **medical decision making (MDM)** is used for code selection, the practitioner who:
  - Made or approved the management plan for **problems addressed**, and
  - Takes responsibility for the **management risk**,
- … would be considered the clinician who did the substantive portion of the split or shared service.
- If **data** are used to select the MDM level, the clinician who performed an **independent interpretation** or **discussion of management or test interpretation** can report those categories.

Split or Shared: Place of Service

- The CPT manual does not specify place(s) of service where its split or shared guidelines apply. *However:*
  - Medicare's split or shared billing policy applies only in the facility setting.
  - In the physician's office, Medicare's incident-to rules continue to apply (not split/shared).

Documentation of Shared Services

- If billing shared services, the documentation must identify the two individuals who performed the service. CMS points out that in prior years, they finalized a rule that tells us:
  - "any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document notes in the medical record…"

- It may be helpful for each individual to document their own participation in the record, in order to determine the substantive time.
- The record must identify the two individuals who performed the services, and the individual who performed the substantive portion (and therefore, bills the visit) must sign and date the medical record.

Also new in 2024: Multiple E/M services on the same date of service

- "Per day" codes – a single service is reported (aggregate MDM and time on the date of the encounters)
- Time spent in the ED by a provider who provides subsequent E/M services may be included in total time spent on the date of the encounter (barring ED service codes are not reported 99281-99285)
- If a patient is discharged and readmitted to the **SAME** facility on the same calendar date, report a subsequent care service (99231-99233) instead of a discharge or initial service.
  - Considered a single stay
  - However, if discharged and admitted to a **DIFFERENT** facility, this constitutes a new stay.

Hospital E/M Rules by Payer

Comparison of CPT Guidelines and CMS Policies

Hospital Evaluation and Management CPT Codes

- Expansion of the 2021 Office/Outpatient changes
- Extensive changes to:
  - Hospital Inpatient and Observation Care Services
  - Consultation codes for Inpatient and Outpatient
  - Emergency Department Services
  - Split (or Shared) visits

Hospital Observation Services

- The following codes are used to report initial and subsequent evaluation and management services provided to hospital inpatients and to patients designated as hospital outpatient "observation status.“
  - 99221-99223 Initial and 99231-99233 Subsequent, 99238-99239 Discharge
- Hospital inpatient or observation care codes are also used to report partial hospitalization services.
- For patients designated/admitted as “observation status” in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital.
- If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc), these codes may be utilized if the patient is placed in such an area.
- For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate

Encounters in Another Site

- When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility), the services in the initial site *may be separately reported.*
- Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date
  - This is a change from the “roll up” rule of one encounter, per patient, per day

Admission and Discharge Same Date

- For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.
- For the purpose of reporting an initial hospital inpatient or observation care service, a transition from observation level to inpatient does not constitute a new stay.◄

Initial Hospital Inpatient or Observation Care

CPT Code	History	Exam	MDM	Time
99221	Medically appropriate	Medically appropriate	Straightforward or Low	40 minutes
99222	Medically appropriate	Medically appropriate	Moderate	55 minutes
99223	Medically appropriate	Medically appropriate	High	75 minutes

Subsequent Hospital Inpatient or Observation Care

CPT Code	History	Exam	MDM	Time
99231	Medically appropriate	Medically appropriate	Straightforward or Low	25 minutes
99232	Medically appropriate	Medically appropriate	Moderate	35 minutes
99233	Medically appropriate	Medically appropriate	High	50 minutes

Hospital Inpatient or Observation Care (Including Admission and Discharge Services)

CPT Code	History	Exam	MDM	Time
99234	Medically appropriate	Medically appropriate	Straightforward or Low	45 minutes
99235	Medically appropriate	Medically appropriate	Moderate	70 minutes
99236	Medically appropriate	Medically appropriate	High	85 minutes
Discharge Services-				
99238				Less than 30 minutes
99239				More than 30 minutes

CMS Rule for Initial Hospital Inpatient or Observation Care

- 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 service you report (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 of the services (including admission and discharge) you provide on that date

CMS Rules for Multiple Providers

- The treating provider bills for the observation care codes. Individuals 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 or observation care service, a transition from observation status to inpatient status 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

CMS Tip

- In some cases, you may bill a prolonged code in addition to the Hospital Inpatient 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)

Billing Hospital Length of Stay and Discharge

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*
Same calendar date as admission or start of observation	8 or more hours	Same-Day admission/discharge*
Different calendar date than admission or start of observation	Less than 8 hours	Initial hospital services only*
Different calendar date than admission or start of observation	8 or more hours	Initial hospital services* and discharge day management

* Add Prolonged services if applicable

Medicare Prolonged Services Codes- 2023 CMS Rule

- G0316 – Prolonged **hospital in patient or observation care**, E&M service beyond the total time for the primary service;
- G0317 – Prolonged **nursing facility** E&M service beyond the total time for the primary service
- G0318 – Prolonged **home or residence** E&M service beyond the total time for the primary service.

CMS Rule

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Table 3. Billing Prolonged Other E/M Visits

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	65 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	110 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	N/A	N/A	N/A
Emergency Department Visits	N/A	N/A	N/A
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	N/A	N/A	N/A

Prolonged Service Time

Prolonged Services with Direct Patient Contact

- 99417 Prolonged Service With Direct Patient Contact
  - Except with Office or Other Outpatient Services
  - For prolonged evaluation and management services on the date of an outpatient service, home or residence service, or cognitive assessment and care plan, use **99417**
    - **Excludes services less than 15 minutes**

Prolonged Service with E/M Service Outpatient

- #★✚▲99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)
- ►(Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483)◄
- ►(Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)◄

Reporting Outpatient Prolonged Services Time

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

Prolonged Services without Patient Contact

- Codes 99358 and 99359 are used when a prolonged service is provided on a **date other than** the date of a face-to-face evaluation and management encounter with the patient and/or family/caregiver.
- May be reported for prolonged services **in relation to any evaluation and management service on a date other than the face-to-face service**, whether or not time was used to select the level of the face-to-face service
  - 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour
  - + 99359 each additional 30 minutes (must exceed first hour by 15 minutes)
    - Do not report less than 30 minutes

Prolonged Services without Patient Contact

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	Code(s)
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99358 X 1 AND 99359 X 1
105 minutes or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes

Prolonged Clinical Staff Service

- Direction Supervision is required:
  - The physician or other qualified health care professional is present to provide direct supervision of the clinical staff

- #✚99415 Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
- #✚99416 each additional 30 minutes (List separately in addition to code for prolonged service)

Reporting Prolonged Clinical Staff Time

Code	Typical Clinical Staff Time	99415 Time Range (minutes)	99416 Start Point (minutes)
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

Consultations

Consultation Codes for Inpatient

- Deletion of Consultation Code 99251
- Revision of Consultation E/M Codes 99252-99255 and Guidelines
- A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem

- A “consultation” initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (eg, non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes.

Consultation Rules by Payer

- Commercial Payers may follow CPT Rules (some follow CMS)
  - Report 99252 – 99255 for Consultations
    - Document the name of the requesting provider
    - Reason for the consultation (including a history or workup and data)
    - Report the recommendation back to the requesting provider
      - Note- further workup can be ordered
      - The definition of “consultation” is not a “transfer of care”
- CMS Rules
  - In 2010 the consultation section of CPT codes was eliminated from the MPFS
  - Instructions were given to choose the appropriate level of Evaluation and Management
    - Place of service
    - Level of service documented

Consultations and Initial Inpatient Care

- In the case when the services in a **separate site** are reported and the initial inpatient or observation care service is a consultation service, do not report 99221, 99222, 99223, 99252, 99253, 99254, 99255.
- The consultant reports the subsequent hospital inpatient or observation care codes 99231, 99232, 99233 *for the second service on the same date*
- If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or other qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233)

Consultation Guidelines

- Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation-level patients, residents of nursing facilities, or patients in a partial hospital setting, and when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay.
- When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.
- Only one consultation may be reported by a consultant per admission. Subsequent consultation services during the same admission are reported using subsequent inpatient or observation hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310

Initial and Subsequent Consult

- The consultant reports the subsequent hospital inpatient codes 99231, 99232, 99233 *for the second service on the same date*
- If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or other qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233)

Multiple Consults on the Same Date

- In this instance, the admitting provider reports the initial hospital code and all others use subsequent hospital codes on the same date.
- This is another major change; as consultants normally use “initial inpatient” codes on the date of their initial evaluation, even if it is not on the first hospital day.
- Watch for instructions from CMS and payers that do not allow 99252-99255

Consultation Documentation

- Rule of R's
  - Referral from an appropriate source (this can include another provider of the same group IF the provider is a different specialty or subspecialty)
  - Review records related to prior patient care
  - Render an opinion and send a report back to the requestor

  - Do not use Consultations when there is a transfer of care
  - Medicare Crosswalk is followed for coding Medicare patients

Office or Other Outpatient Consultations

CPT Code	History	Exam	MDM	Time
99242	Medically appropriate	Medically appropriate	Straightforward	20 minutes
99243	Medically appropriate	Medically appropriate	Low	35 minutes
99244	Medically appropriate	Medically appropriate	Moderate	40 minutes
99245	Medically appropriate	Medically appropriate	High	55 minutes

Consultation codes are not payable by Medicare. Crosswalk to the appropriate location and level of service to find another code

Inpatient or Observation Consultations

CPT Code	History	Exam	MDM	Time
99252	Medically appropriate	Medically appropriate	Straightforward	35 minutes
99253	Medically appropriate	Medically appropriate	Low	45 minutes
99254	Medically appropriate	Medically appropriate	Moderate	60 minutes
99255	Medically appropriate	Medically appropriate	High	80 minutes

Consultation codes are not payable by Medicare. Crosswalk to the appropriate location and level of service to find another code

2023 Level of Service rules

Changes from the 2021 Office/Outpatient Grid only apply to Inpatient/Facility

History and/or Examination are Not Scored

- E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed.
- The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.
- The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Level of Service- Two Options for Coding

- Based on Medical Decision Making
  - Straightforward
  - Low
  - Moderate
  - High

- Based on Time
  - Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently.
  - Time is not a descriptive component for the emergency department levels of E/M services
  - For coding purposes, time for these services is the total time on the date of the encounter.

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

Low	Low
	• 2 or more self-limited or minor problems;
	or
	• 1 stable chronic illness;
	or
	• 1 acute, uncomplicated illness or injury
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• Any combination of 2 from the following:
		  • Review of prior external note(s) from each unique source*;
		  • review of the result(s) of each unique test*;
		  • ordering of each unique test*
		or
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
			Low risk of morbidity from additional diagnostic testing or treatment

Moderate
 	
1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health
			
			• Decision regarding hospitalization or escalation of hospital level care

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			
			• Parenteral controlled substances

Medical Decision Making-

- The 2023 Medical Decision-Making Grid differs from the 2021 Office version by adding hospital-based scenarios to the existing grid
- Number and Complexity of Problems Addressed at the Encounter
  - Straightforward
  - Low
    - 2 or more self limited or minor problems
    - 1 stable, chronic illness;
    - 1 acute, uncomplicated illness or injury;
    - 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
  - Moderate
  - High

Problem Addressed

- A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.
- This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.
  - Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
  - Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
- For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission.
  - It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

Medical Decision Making

- Amount and/or Complexity of Data to Be Reviewed and Analyzed
  - Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
  - Low
    - Category 1: Tests and documents
      - Review of prior external note(s) from each unique source
      - Review of the result(s) of each unique test
      - Ordering of each unique test
    - Category 2: Assessment requiring an independent historian) (this is an element in Category 1 for Moderate and High)
  - Moderate/High
    - Category 2: Independent Interpretation of Tests (not separately reported)
    - Category 3: Discussion of Management or test interpretation with external physician/other qualified health care professional/appropriate source* (not separately reported)

Selecting Level of Service Based on Time

- When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver.
- For coding purposes, time for these services is the total time on the date of the encounter.
- It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (eg, whether on or off the inpatient unit or in or out of the outpatient office).

Qualifying Activities for Time

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/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/caregiver
- Care coordination (not separately reported)

Documentation of Time

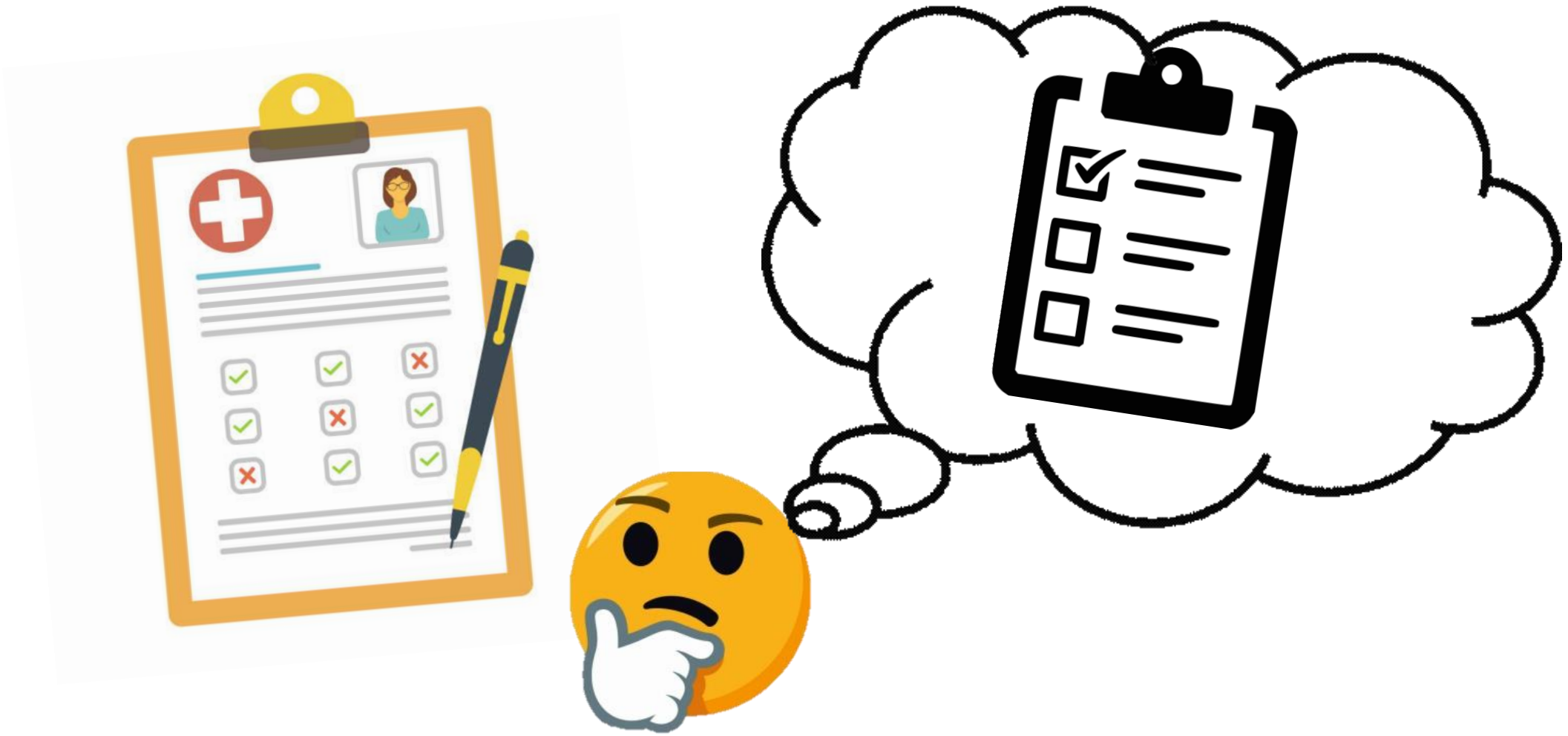
The clinical note should reflect the details of all the activities provided during the time period allowed

It is not necessary to break down how time was spent

A time statement at the end of the note is sufficient

Example: Time spent on patient care 95 minutes today, including review of prior records, lab results, discussion with Dr. Moore, and the patient's daughter.

Putting it all together



Chief complaint: Dysphagia

The pt is a 80 y.o.male with PMH of EtOH abuse, GERD, DM, HTN, and subarachnoid hematoma. Patient was admitted to Mercy Hospital on 9/27 with dysphagia and weight loss. CT abdomen/pelvis on 9/27 was notable for mediastinal and left hilar lymphadenopathy suspicious for malignancy. Barium study on 9/28 revealed focal high-grade luminal stenosis of the mid esophagus with apple core appearance consistent with malignancy; there is also a concern of perforation. EGD performed on 09/29 which showed significant extrinsic compression of his esophagus. Subsequent path report showing squamous mucosa with severe active esophagitis (including increased eosinophils, up to 18/HPF) and associated ulceration.

Pulmonary, oncology and thoracic surgery were consulted. As GI unable to pass standard EGD, at this point he will likely require surgical intervention for both biopsy and esophageal +/-bronchial stenting. This was discussed with Dr. House who is in agreement that he would benefit from thoracic surgery evaluation and likely intervention."

During my interview, patient c/o abdominal pain, mainly on R side, relieved with IV morphine. He otherwise has no complaint.

Prob	Min	Low	Moderate	High
	1 self-limited problem	**2** self-limited problems; **1** stable chronic illness; **1** acute, uncomplicated illness or injury	**1+** chronic illnesses with exacerbation, progression; **2+** stable chronic illnesses; **1** new problem with uncertain prognosis; **1** acute illness with systemic symptoms; **1** acute complicated injury	**1+** chronic illnesses with severe exacerbation; **1** acute or chronic illness or injury that poses a threat to life or bodily function

Data	M	Limited	Moderate	Extensive
	none	❑ **2 of:** ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ❑ **Independent interpretation**	❑ **3 of:** ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ **Independent interpretation** ❑ **Conference**	❑ **3 of:** ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ **Independent interpretation** ❑ **Conference**

Risk	M	Low	Moderate	High
	Min imal risk	Low risk of morbidity from additional diagnostic testing or treatment	*Examples:* • Prescription drug management • Diagnosis or treatment significantly limited by **social determinants of health**	*Examples:* • Decision regarding elective major surgery with risk factors • Decision regarding hospitalization or escalation of hospital-level care • Decision not to de-escalate care because of poor prognosis • Parenteral controlled substances

Prob	Min	Low	Mod	High
Data	Min	Low	Mod	Ext
Risk	Min	Low	Mod	High
MDM	**SF**	**Low**	**Mod**	**High**

Imaging and procedures:

CT abdomen/pelvis i9/27 was notable for mediastinal and left hilar lymphadenopathy suspicious for malignancy.

Barium study on 9/28 revealed focal high-grade luminal stenosis of the mid esophagus with apple core appearance consistent with malignancy; there is also a concern of perforation.

EGD performed on 09/29 which showed significant extrinsic compression of his esophagus. Subsequent path report showing squamous mucosa with severe active esophagitis (including increased eosinophils, up to 18/HPF) and associated ulceration.

Assessment and Plan:

The pt is a 80 y.o.male with PMH of EtOH abuse, GERD, DM, HTN, subarachnoid hematoma, was transferred to Mercy Hospital for thoracic surgery consultation for esophageal perforation in the setting of dysphagia due to mass effect on the esophagus.

#dysphagia #esophageal obstruction #mediastinal and left hilar lymphadenopathy #esophageal perforation

P/w dysphagia and weight loss. Dysphagia likely due to esophageal obstruction 2/2 mass-effect of mediastinal and left hilar lymphadenopathy. There is a concern for esophageal malignancy. Biopsy during EGD showed squamous mucosa with severe active esophagitis and associated ulceration, basically non-diagnostic. Barium swallow test showed esophageal perforation. Pulm, onc, thoracic surgery reviewed the case together, given risk of bronchoesophageal fistula, EBUS is not recommended. Given impending obstruction of the left mainstem bronchus, esophageal perforation that may require stenting of his esophagus and PEG tube placement, patient likely requires surgical intervention for both biopsy and esophageal +/-bronchial stenting. This was discussed with Dr. House thoracic surgeon who would evaluate patient on Monday

-NPO, hold all PO meds -D5NS with 20mEq KCl at 75ml/h

-IV protonix daily

-IV morphine PRN pain

	Min	Low	Moderate	High
Prob	1 self-limited problem	2 self-limited problems; 1 stable chronic illness; 1 acute, uncomplicated illness or injury	1+ chronic illnesses with exacerbation, progression; 2+ stable chronic illnesses; 1 new problem with uncertain prognosis; 1 acute illness with systemic symptoms; 1 acute complicated injury	1+ chronic illnesses with severe exacerbation; 1 acute or chronic illness or injury that poses bodily function

	M	Limited	Moderate	Extensive
Data	none	❑ 2 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ❑ Independent interpretation	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ Conference	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ Conference

	M	Low	Moderate	High
Risk	Minimal risk	Low risk of morbidity from additional diagnostic testing or treatment	*Examples:* • Prescription drug management • Diagnosis or treatment significantly limited by **social determinants of health**	*Examples:* • Decision regarding elective major surgery with risk factors • Decision regarding hospitalization or escalation of hospital-level care • Decision not to de-escalate care because of poor prognosis • Parenteral controlled substances

Prob	Min	Low	Mod	High
Data	Min	Low	Mod	Ext
Risk	Min	Low	Mod	High
MDM	SF	Low	Mod	High

Subjective:

The patient is a 62-year-old male who was admitted for acute exacerbation of chronic obstructive pulmonary disease (COPD) with respiratory distress. He reports a history of COPD, hypertension, and diabetes mellitus type 2. The patient reports increased shortness of breath, cough, and wheezing. He is concerned about his ability to manage his symptoms at home.

Objective:

The patient's vital signs were stable upon admission, with an oxygen saturation of 92% on 2L nasal cannula. Physical examination revealed diffuse wheezing and diminished breath sounds bilaterally. The patient's blood glucose was elevated at 192 mg/dL.

Assessment:

The patient has a history of COPD, hypertension, and diabetes mellitus type 2. He is currently experiencing an acute exacerbation of COPD with respiratory distress. The patient's blood glucose is elevated, indicating uncontrolled diabetes.

Plan:

- Order a chest x-ray to assess for pulmonary infiltrates.
- Prescribe albuterol/ipratropium nebulizer treatments every 4 hours and prednisone 40 mg daily for 5 days to manage the acute exacerbation of COPD.
- Start insulin therapy with a sliding scale to control the patient's elevated blood glucose.
- Coordinate with the social worker to arrange for home health services, including respiratory therapy and diabetes education, for the patient upon discharge.
- Review the chest x-ray and laboratory results, and update the treatment plan as needed.
- Spend a total of 50 minutes on counseling, coordinating care, ordering and reviewing tests, and documenting clinical information into the EHR.

	Min	Low	Moderate	High
Prob	1 self-limited problem	2 self-limited problems; 1 stable chronic illness; 1 acute, uncomplicated illness or injury	1+ chronic illnesses with exacerbation, progression; 2+ stable chronic illnesses; 1 new problem with uncertain prognosis; 1 acute illness with systemic symptoms; 1 acute complicated injury	1+ chronic illnesses with severe exacerbation; 1 acute or chronic illness or injury that poses a threat to life or bodily function

	M	Limited	Moderate	Extensive
Data	none	❑ 2 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ❑ Independent **historian**	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ **Conference**	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ **Conference**

	M	Low	Moderate	High
Risk	Min imal risk	Low risk of morbidity from additional diagnostic testing or treatment	*Examples:* • Prescription drug management • Diagnosis or treatment significantly limited by **social determinants of health**	*Examples:* • Decision regarding elective major surgery with risk factors • Decision regarding hospitalization or escalation of hospital-level care • Decision not to de-escalate care because of poor prognosis • Parenteral controlled substances

Prob	Min	Low	Mod	High
Data	Min	Low	Mod	Ext
Risk	Min	Low	Mod	High
MDM	SF	Low	Mod	High

Hospital Inpatient and Observation Care Services

Initial Inpatient/Observation Care		
E/M Code	MDM	Time
99221	Low	40 - 54
99222	Moderate	55 - 74
99223	High	75 - 89

Subsequent Inpatient/Observation Care		
E/M Code	MDM	Time
99231	Low	25 - 34
99232	Moderate	35 - 49
99233	High	50 - 64

Subjective:

The patient is a 62-year-old male who was admitted for acute exacerbation of chronic obstructive pulmonary disease (COPD) with respiratory distress. He reports a history of COPD, hypertension, and diabetes mellitus type 2. The patient reports increased shortness of breath, cough, and wheezing. He is concerned about his ability to manage his symptoms at home.

Objective:

The patient's vital signs were stable upon admission, with an oxygen saturation of 92% on 2L nasal cannula. Physical examination revealed diffuse wheezing and diminished breath sounds bilaterally. The patient's blood glucose was elevated at 192 mg/dL.

Assessment:

The patient has a history of COPD, hypertension, and diabetes mellitus type 2. He is currently experiencing an acute exacerbation of COPD with respiratory distress. The patient's blood glucose is elevated, indicating uncontrolled diabetes.

Plan:

- Order a chest x-ray to assess for pulmonary infiltrates.
- Prescribe albuterol/ipratropium nebulizer treatments every 4 hours and prednisone 40 mg daily for 5 days to manage the acute exacerbation of COPD.
- Start insulin therapy with a sliding scale to control the patient's elevated blood glucose.
- Coordinate with the social worker to arrange for home health services, including respiratory therapy and diabetes education, for the patient upon discharge.
- Review the chest x-ray and laboratory results, and update the treatment plan as needed.
- Spend a total of 50 minutes on counseling, coordinating care, ordering and reviewing tests, and documenting clinical information into the EHR.

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Prob	Min	Low	Moderate	High
	1 self-limited problem	2 self-limited problems; 1 stable chronic illness; 1 acute, uncomplicated illness or injury	1+ chronic illnesses with exacerbation, progression; 2+ stable chronic illnesses; 1 new problem with uncertain prognosis; 1 acute illness with systemic symptoms; 1 acute complicated injury	1+ chronic illnesses with severe exacerbation; 1 acute or chronic illness or injury that poses a threat to life or bodily function

Data	M	Limited	Moderate	Extensive
	none	❑ 2 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ❑ Independent historian	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ Conference	❑ 3 of: ➢ Review of *external note*(s) ➢ review of test ➢ ordering of test ➢ *Independent historian*(s) ❑ Independent interpretation ❑ Conference

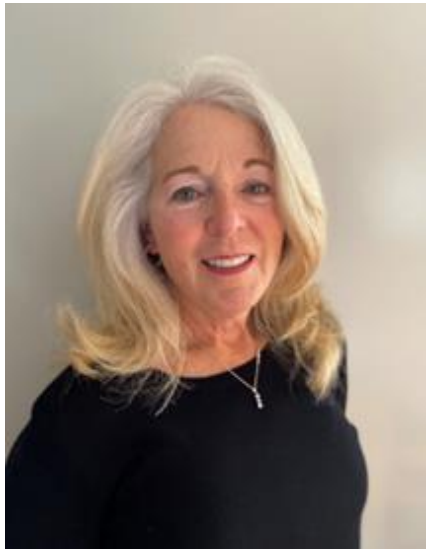
Risk	M	Low	Moderate	High
	Minimal risk	Low risk of morbidity from additional diagnostic testing or treatment	*Examples:* • Prescription drug management • Diagnosis or treatment significantly limited by **social determinants of health**	*Examples:* • Decision regarding elective major surgery with risk factors • Decision regarding hospitalization or escalation of hospital-level care • Decision not to de-escalate care because of poor prognosis • Parenteral controlled substances

Prob	Min	Low	Mod	High
Data	Min	Low	Mod	Ext
Risk	Min	Low	Mod	High
MDM	**SF**	**Low**	**Mod**	**High**

Inpatient Prolonged Service – CPT and CMS

		CPT Guidelines		CMS Guidelines
Hospital	**Initial**	**MDM**	**Time**	
99221	Initial Admission, Low	SF/ Low	40	Time on date of visit only
99222	Initial Admission, Moderate	Moderate	55	
99223	Initial Admission, High	High	75	90 min to add G0316
Hospital	**Subsequent**	**MDM**	**Time**	
99231	Inpt Follow Straightforward	SF/ Low	25	
99232	Inpt Follow Moderate	Moderate	35	
99233	Inpt Follow High	High	50	65 min to add G0316
Hospital	**Discharge**	**MDM**	**Time**	
99238	Discharge under 30 minutes		> 30	
99239	Discharge over 30 minutes		< 30	Do not add G0316

Questions & Answers



Nancy M. Enos, FACMPE, CPC-I, CPMA, CEMC, CPC emeritus,
Principal, Enos Medical Coding

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