2023 E/M Updates For Coding: Straightforward or Highly Complex?

A WEBINAR PRESENTED ON JANUARY 5, 2023

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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:
  - Recognize revised E/M services guidelines and descriptors
  - Assign codes for E/M services based on time or medical decision making, as applicable
  - Review examples of E/M documentation to support a level of service
  - Improve coding accuracy to reduce denials

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Evaluation and Management

- Additions – 1
- Revisions – 49
  - Some revisions were just to add “other qualified healthcare professional” to the descriptor
- Deletions – 25

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Evaluation and Management

- Deletions
  - ~~99217-99220 and 99224-99226~~ Observation care services (Initial, subsequent and discharge)
  - ~~99241~~ – Level “1” office consultation
  - ~~99251~~ – Level “1” inpatient consultation
  - ~~99318~~ – Annual nursing facility assessment
  - ~~99324-99328~~ – Domiciliary or rest home visits (new/established)
  - ~~99339~~ – Individual physician supervision of a patient in domiciliary or rest home
  - ~~99343~~ – Home visit with moderate MDM

Evaluation and Management

- Deletions
  - ~~99354-99357~~ – Prolonged services, with direct patient contact in outpatient/inpatient/OBS settings

What Types of E/M Services Does the 2023 Change Affect?

- Inpatient/observation services
- Consultation services
- Emergency department services
- Nursing facility services
- Home/residential services
  - **Office/other outpatient services implemented CY 2021*

Evaluation and Management – Inpatient/OBS

- ▲ 99221– **Initial** hospital inpatient **or observation care**, per day, with a medically appropriate history and/or exam, with straightforward or low MDM
  - Total time, 40 minutes must be met or exceeded
- ▲99222- **Initial** hospital inpatient **or observation care**, per day, with a medically appropriate history and/or exam, with moderate MDM
  - Total time, 55 minutes must be met or exceeded
- ▲99223 – **Initial** hospital inpatient **or observation care**, per day, with a medically appropriate history and/or exam, with **high** MDM
  - Total time, 75 minutes must be met or exceeded

Time counted is on the date of the encounter <AMA>

CMS clarified this is by calendar date <MPFS Final Rule, 575>

Evaluation and Management – Subsequent IP/OBS

- ▲99231– **Subsequent** hospital inpatient **or observation care**, with a medically appropriate history and/or exam, with straightforward or low MDM
  - Total time, 25 minutes must be met or exceeded
- ▲99232- **Subsequent** hospital inpatient **or observation care**, with a medically appropriate history and/or exam, with moderate MDM
  - Total time, 35 minutes must be met or exceeded
- ▲99233 – **Subsequent** hospital inpatient **or observation care**, with a medically appropriate history and/or exam, with **high** MDM
  - Total time, 50 minutes must be met or exceeded

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Evaluation and Management – Initial/Subsequent

- AMA Guideline Revisions
  - "First" or initial encounter vs. Subsequent
    - Patient has not received services from another physician/QHCP of the exact same specialty/subspecialty who belongs to the same group practice **during the stay**.
    - Advanced practitioners working with physicians are considered the exact same specialty/subspecialty.
  - "Subsequent" means the patient **HAS** been seen by another physician/QHCP of the exact same specialty/subspecialty who belongs to the same group practice **during the stay**.

Previously per the AMA, initial hospital care 99221-99223 codes were only reported for the initial encounter by the ADMITTING physician.

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Evaluation and Management – CMS Initial/Subsequent

- CMS Modified Definition
  - "First" or initial encounter vs. Subsequent
    - Patient has not received services from the physician/QHCP or another physician/QHCP of the ~~exact same specialty/subspecialty~~ who belongs to the same group practice **during the stay**.
  - "Subsequent" means the patient HAS received services from the physician/QHCP or another physician/QHCP of the ~~exact same specialty/subspecialty~~ who belongs to the same group practice **during the stay**.

"Physicians and NPPs are not classified as having the same specialty, and the **PFS does not recognize subspecialties**. However, we are continuing to consider whether we could better align this payment taxonomy with clinical practice, where we might consider NPPs as working in the same specialty as the physicians with whom they work, and/or recognize subspecialties"
< MPFS Final Rule, 568>

Evaluation and Management

- AMA Guideline Revisions
  - When the patient is admitted to the hospital as an IP/OBS in another site of service (ED, office, nursing facility), the services in the initial site may be separately reported.
    - Append modifier-25 (CAUTION!)
    - "When a patient is admitted to outpatient observation or as a hospital inpatient via another site of service (such as, hospital ED, office, nursing facility), all services provided by the practitioner in conjunction with that admission are considered part of the initial hospital inpatient or observation care when performed on the same date as the admission" *<MPFS Final Rule,591>*
      - However, prolonged services might be eligible in some circumstances.
    - However, if different DOS may be separately reported even if less than 24 hours *<MPFS Final Rule, 595>*
      - Example: Patient seen in office on Monday 4p (99214 billed), then decision to admit on Tuesday at 2p (99223) may be billed

Evaluation and Management

- AMA Guideline Revisions
  - If the services in the separate site are reported and the initial IP/OBS service is a consult service do NOT report 99221-99223, 99252-99255
    - Report a subsequent IP/OBS service 99231-99233 for the service provided in the facility.
      - This applies whether the consult took place on same date of admission or a date prior to the admission.

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Evaluation and Management

- AMA Guideline Revisions
  - A transition from OBS →IP does NOT constitute a new stay.
    - Also approved by CMS <*MPFS Final Rule, 590*>
  - Total time is by calendar date however, if one service spans two DOS, it is reported on one DOS
    - Example 11:45p (Mon) →1:00a (Tues) = 75 minutes (99223 - Mon)
      - Report on the date the service **"began".** <*MPFS Final Rule, 575*>

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Evaluation and Management –IP/OBS Admit/Discharge Codes

- ▲ 99234– Hospital inpatient or observation care, including admission and discharge with a medically appropriate history and/or exam, with straightforward or low MDM
  - Total time, 45 minutes must be met or exceeded
- ▲99235- Hospital inpatient or observation care, including admission and discharge with a medically appropriate history and/or exam, with moderate MDM
  - Total time, 70 minutes must be met or exceeded
- ▲99236 – Hospital inpatient or observation care, including admission and discharge with a medically appropriate history and/or exam, with **high** MDM
  - Total time, 85 minutes must be met or exceeded

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Evaluation and Management

- AMA Guideline Revisions
  - 99234-99236 are used for patients admitted and discharged on the same DOS.
  - For patients admitted and discharged on a different DOS, use 99221-99223, 99231-99233, 99238-99239
    - Some payers may have time thresholds (e.g., 8 hours)

> When a patient has been admitted to inpatient hospital/OBS care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date, 99234-99236 shall be reported
> *<MPFS Final Rule, 583>*

  - 99234-99236 requires **TWO** or more encounters on the same date.
    - #1 initial admission encounter
    - #2 discharge encounter
  - Do not report 99234-99236 with initial IP/OBS care codes or discharge services when performed on the same DOS.
  - Not used for newborns admitted/discharged on same DOS – See 99463.

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Evaluation and Management – IP/OBS Discharge Services

- 99238 – Hospital inpatient **or observation care discharge** day management; ***30 minutes or less*** on the date of the encounter
- 99239 – Hospital inpatient **or observation care discharge** day management; **more than 30 minutes** on the date of the encounter

Rules also apply to OBS!

NOTE: Some payers may require exact start/stop times or exact time

"When the patient is **admitted to inpatient hospital care for less than 8 hours on the same date**, then Initial Hospital Care, from CPT code **range 99221 - 99223, shall be reported by the physician.**
***The Hospital Discharge Day Management service, CPT codes **99238 or 99239, shall not** be reported for this scenario.
<MPFS Final Rule, 582>

"When a patient is **admitted to inpatient initial** hospital care and then **discharged on a different calendar date,** the physician shall report an Initial Hospital Care from CPT code range **99221 - 99223 and a Hospital Discharge Day Management service, CPT code 99238 or 99239"**
<MPFS Final Rule, 583>

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Evaluation and Management

- AMA Guideline Revisions
  - Time is counted on the date of the encounter.
    - Does not have to be continuous
  - Discharge services including instructions, coordination of post-discharge services by other physicians/QHCPs may be reported with 99231-99233.
- CMS Guidance
  - The provider reporting discharge services (99238-99239) may not report for a Subsequent IP/OBS visit (99231-99233) on the same DOS *<MPFS Final Rule, 609>*
  - Only one provider may report 99238-99239 for any given inpatient/OBS stay
    - Reported by admitting physician
    - In the case of death, 99238-99239 should be reported by the provider personally pronouncing death.

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Evaluation and Management – IP/OBS "8-24 Hr. Rule" Summary

TABLE 22: Summary of Final Policy for the "8 to 24-Hour" Rule

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only*
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge*
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only*
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services* + discharge day management

*Plus prolonged inpatient/observation services, if applicable.

<MPFS Final Rule, 588>

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Evaluation and Management --- Work RVUs – IP/OBS

CPT code	2022 Work RVU	2023 Work RVU	Difference (+/-)
99221	1.92	1.63	↓
99222	2.61	2.60	↓
99223	3.86	3.50	↓
99231	0.76	1.00	↑
99232	1.39	1.59	↑
99233	2.00	2.40	↑
99234	2.56	2.00	↓
99235	3.24	3.24	=
99236	4.20	4.30	↑
99238	1.28	1.50	↑
99239	1.90	2.15	↑
+99417	0.61	0.61	=
+99418	N/A	0.81	N/A

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Evaluation and Management -- OP Consultations

- ▲ 99242 – Office **or outpatient consultation**, with a medically appropriate history and/or exam, with straightforward MDM
  - Total time, 20 minutes must be met or exceeded
- ▲ 99243 – Office **or outpatient consultation**, with a medically appropriate history and/or exam, with **low** MDM
  - Total time, 30 minutes must be met or exceeded
- ▲ 99244 – Office **or outpatient consultation**, with a medically appropriate history and/or exam, with **moderate** MDM
  - Total time, 40 minutes must be met or exceeded
- ▲ 99245 – Office **or outpatient consultation**, with a medically appropriate history and/or exam, with **high** MDM
  - Total time, 55 minutes must be met or exceeded

Level 4's and 5's significantly decreased time requirement

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Evaluation and Management

- AMA Guideline Revisions
  - "Other Outpatient" refers to consults performed in the ED, home/residence
  - Deletion of the "transfer of care" definition due to lack of need (but also likely the continued lack of clarity even with the best of intent). ☺
  - Deletion of who may document specific consult communications (i.e., requesting or consulting) in the medical record however, a request does need to be made by a physician/QCHP.
  - For **prolonged** office/OP consultation services 70+ minutes, use **+99417** in addition

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Evaluation and Management

- ▲99252 – Inpatient *or observation* consultation, with a medically appropriate history and/or exam, with straightforward MDM
  - Total time, 35 minutes must be met or exceeded
- ▲99253 – Inpatient *or observation* consultation, with a medically appropriate history and/or exam, with **low** MDM
  - Total time, 45 minutes must be met or exceeded
- ▲99254 – Inpatient *or observation* consultation, with a medically appropriate history and/or exam, with **moderate** MDM
  - Total time, 60 minutes must be met or exceeded
- ▲99255 – Inpatient *or observation* consultation, with a medically appropriate history and/or exam, with **high** MDM
  - Total time, 80 minutes must be met or exceeded

Level 4's and 5's significantly decreased time requirement

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Evaluation and Management

- AMA Guideline Revisions
  - When a patient is admitted as an IP by another physician/QCHP who requests the consult, the consultant should report an initial IP/OBS code (99221-99223) instead of a consult code. (* Only stated in *CPT E/M Companion, page 12* by AMA)
  - Only **ONE** IP/OBS consult may be reported by a consultant per admission of a patient.
    - Subsequent services may be reported with (99231-99233) or (99307-99310)
  - For **prolonged** IP/OBS consultation services 95+ minutes, use **+99418** in addition

NEW code

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Evaluation and Management

- ▲+99417 – Prolonged **outpatient E/M** service **with or without** direct patient contact beyond the required time of the primary service, each 15 mins
  - Time must be used as the leveling factor
  - Added other services it can now be used in conjunction with
  - Can be reported with 99205, 99215, **99245, 99345, 99350, 99483**
- ●+ 99418 – Prolonged **inpatient/observation** E/M service **with or without** direct patient contact beyond the required time of the primary service, each 15 mins
  - Time must be used as the leveling factor
  - Can be reported with 99223, 99233, 99236, 99255, 99306, 99310

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Evaluation and Management – Prolonged Services IP/OBS

- CMS Guidance – Let's make this complicated!
  - G0316 -- Prolonged **hospital inpatient or observation care** evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact
    - Can be reported with 99223, 99233 and 99236
    - Must provide a full 15+ minutes beyond the total time
    - Remember Medicare does not recognize consults (99242-99255)!
  - But what did they use to measure the time? Not just the CPT definitions!

CPT Code	Total Time	AMA threshold	CMS threshold
99223	75 mins	90+ mins	105+ mins
99233	50 mins	65+ mins	80+ mins
99236	85 mins	100+ mins	125+ mins

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Evaluation and Management

TIME CANNOT BE USED TO LEVEL

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- ▲ 99281 – Emergency department visit *that may not require the presence of a physician/QHCP*
- ▲99282 – Emergency department visit, which requires a medically appropriate history and/or exam, and **straightforward MDM**
- ▲99283 – Emergency department visit, which requires a medically appropriate history and/or exam, and **low MDM**
- ▲ 99284 – Emergency department visit, which requires a medically appropriate history and/or exam, and **moderate MDM**
- ▲ 99285 – Emergency department visit, which requires a medically appropriate history and/or exam, and **high MDM**

Evaluation and Management

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- AMA Guideline Revisions
  - Clarification of reporting critical care and ED services when performed on the same DOS if the patient's condition changes.

If an ED visit is performed and then the patient requires critical care later in the day, the provider may report both services with modifier-25 on the critical care service. Must be medically necessary, and that the service is separate and distinct, with no duplicative elements from the critical care service <*MPFS Final Rule, 618*>

  - Modifier-25 would be necessary to distinguish the separate services (not mentioned specifically in the CPT guidelines) but generally covered when separate E/M services are reported to use the "appropriate modifier".
    - Many other modifiers can also be seen in conjunction with ED services (-59, -52, -52 etc.).
  - Providers who see patients in the ED for their own convenience must report (99202-99215) for the service.

Evaluation and Management – ED Services

- CMS Guidance
  - Providers who send their patient to the ED to determine if IP/OBS should occur and sees the patient in the ED along with advice from the ED physician *<MPFS Final Rule, 617>*
    - If IP/OBS care occurs, the provider only reports Initial IP/OBS code (99221-99223)
      - All services performed in conjunction with the admission are bundled on that DOS
      - The ED physician reports ED service (99282-99285)
    - If evaluated and sent home, both providers report an ED service (99282-99285)
    - Provider who sends the patient to the ED must personally SEE the patient in the ED to report their services – NO TELEPHONE!

Evaluation and Management --- Work RVUs

CPT code	2022 Work RVU	2023 Work RVU	Difference (+/-)
99281	0.48	0.25	↓
99282	0.93	0.93	=
99283	1.60	1.60	=
99284	2.74	2.74	=
99285	4.00	4.00	=

Evaluation and Management

May be used once per admission, per physician regardless of LOS

- ▲99304 – Initial nursing facility care, per day, with a medically appropriate history and/or exam and **straightforward or low-level** MDM
  - Total time, 25 minutes must be met or exceeded
- ▲99305– Initial nursing facility care, per day, with a medically appropriate history and/or exam and **moderate** MDM
  - Total time, 35 minutes must be met or exceeded
- ▲99306 – Initial nursing facility care, per day, with a medically appropriate history and/or exam and **high** MDM
  - Total time, 45 minutes must be met or exceeded
  - For prolonged services 60+ minutes, use **+99418** in addition

CPT 99304-99306 is used for the initial comprehensive assessment *<MPFS Final Rule, 629>*

Utilize same "initial" and "subsequent" definitions for both AMA and CMS

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Evaluation and Management

- ▲99307 – Subsequent nursing facility care, per day, with a medically appropriate history and/or exam and **straightforward** MDM
  - Total time, 10 minutes must be met or exceeded
- ▲99308 – Subsequent nursing facility care, per day, with a medically appropriate history and/or exam and **low** MDM
  - Total time, 15 minutes must be met or exceeded
- ▲99309 – Subsequent nursing facility care, per day, with a medically appropriate history and/or exam and **moderate** MDM
  - Total time, 30 minutes must be met or exceeded
- ▲99310 – Subsequent nursing facility care, per day, with a medically appropriate history and/or exam and **high** MDM
  - Total time, 45 minutes must be met or exceeded
  - For prolonged services 60+ minutes, use **+99418** in addition

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Evaluation and Management

- 99315 – Nursing facility **discharge** management; ***30 minutes or less*** total time on the date of the encounter
- 99316 – Nursing facility **discharge** day management; **more than 30 minutes** total time on the date of the encounter
  - Time does not have to be continuous on a DOS
  - CMS Guidance *<MPFS Final Rule, 640>*
    - Must be a face-to-face visit
    - Should be reported on the date of the visit even if the patient is discharged on a different calendar date.
    - If a patient expires, discharge services may be reported by the provider who personally performed the death announcement

Evaluation and Management

- AMA Guideline Revisions
  - Nursing facility service codes may be used for skilled nursing, psychiatric residential treatment centers and *[*INTERMEDIATE]* care facilities for those with intellectual disabilities.
    - Place of service codes should be reported to identify the type of facility and care.
  - Typically, these codes are reported by the "principal" physician or admitting physician who oversees the patients care vs those providing specialty care.
    - Some payers may require modifiers such as –AI to distinguish providers using these categories.
    - Other providers may use other E/M services (consults or subsequent NF visits)
  - Transitions between skilled nursing facility level of care and nursing facility level of care does not constitute a "new stay".
    - Also supported by CMS *<MPFS Final Rule, 627>*

Evaluation and Management

- AMA Guideline Revisions
  - For MDM, the number and complexity of problems addressed is considered there is a unique definition added specifically for nursing facility care.
    - ***Multiple morbidities requiring intensive management = HIGH (for # and complexity of problems addressed)***
      - A set of conditions, syndromes or functional impairments that likely to require frequent medication changes or treatment changes and/or re-evaluations.
      - Patient has significant risk of worsening medical (including behavioral) status and runs risk for admission (or re-admission) to the hospital.
  - This added definition does NOT alter the requirement that at least one out of the other two elements in MDM (data, risk mortality/morbidity) must be met for overall MDM

Evaluation and Management

- AMA Guideline Revisions
  - When the patient is admitted to the nursing facility in another site of service (e.g., ED) on the same DOS by the same provider separate E/M services may be reported with modifier-25.
    - CAUTION!

The services furnished on the same DOS in other sites of service including ED, office are bundled into the initial NF code when performed by the same provider
<MPFS Final Rule, 626>

Time spent furnishing a visit in another setting can be counted towards prolonged services (+G3016)
<MPFS Final Rule, 629>

  - When a patient is seen in another site of service and the initial NF services is a consult by the same physician on the same date, the "consultant" should report the subsequent NF codes (99307-99309) for the second service.
  - Hospital IP/OBS discharge services may be reported separately even on the same DOS.
    - However, time related to the IP/OBS service may NOT be added for NF code selection
    - Also supported by CMS *<MPFS Final Rule, 628>*

Evaluation and Management --- Work RVUs - NFs

CPT code	2022 Work RVU	2023 Work RVU	Difference (+/-)
99304	1.64	1.50	↓
99305	2.35	2.50	↑
99306	3.06	3.50	↑
99307	0.76	0.70	↓
99308	1.16	1.30	↑
99309	1.55	1.92	↑
99310	2.35	2.80	↑
99315	1.28	1.50	↑
99316	1.90	2.50	↑

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Evaluation and Management

- +99418 – Prolonged **inpatient/observation** E/M service **with or without** direct patient contact beyond the required time of the primary service, each 15 mins
  - Time must be used as the leveling factor
  - Can be reported with 99223, 99233, 99236 99255, **99306, 99310**

Includes nursing facility services

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Evaluation and Management – Prolonged Services IP/OBS

- CMS Guidance
  - G0317 -- Prolonged **nursing facility** evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact
    - Can be reported with 99306, 99310
    - Must provide a full 15+ minutes beyond the total time
    - Remember Medicare does not recognize consults (99252-99255)!

CPT Code	Total Time	AMA threshold	CMS threshold
99306	45 mins	60+ mins	95+ mins
99310	45 mins	60+ mins	85+ mins

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Evaluation and Management

- ▲ 99341 – Home **or residence** visit, **new pt** with a medically appropriate history and/or exam and **straightforward** MDM
  - Total time, 15 minutes must be met or exceeded
- ▲ 99342 – Home **or residence** visit, **new pt** with a medically appropriate history and/or exam and **low** MDM
  - Total time, 30 minutes must be met or exceeded
- ▲ 99344– Home **or residence** visit, **new pt** with a medically appropriate history and/or exam and **moderate** MDM
  - Total time, 60 minutes must be met or exceeded
- ▲ 99345 – Home **or residence visit, new pt** with a medically appropriate history and/or exam and **high** MDM
  - Total time, 75 minutes must be met or exceeded
  - For prolonged services, 90+ minutes – Use **+99417** in addition

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Evaluation and Management

- ▲ 99347 – Home **or residence** visit, **established patient** with a medically appropriate history and/or exam and **straightforward** MDM
  - Total time, 20 minutes must be met or exceeded
- ▲ 99348 – Home **or residence** visit, **established patient** with a medically appropriate history and/or exam and **low** MDM
  - Total time, 30 minutes must be met or exceeded
- ▲99349– Home **or residence** visit, **established patient** with a medically appropriate history and/or exam and **moderate** MDM
  - Total time, 40 minutes must be met or exceeded
- ▲99350 – Home **or residence visit,** **established patient** with a medically appropriate history and/or exam and **high** MDM
  - Total time, 60 minutes must be met or exceeded
  - For prolonged services, 75+ minutes – Use **+99417** in addition

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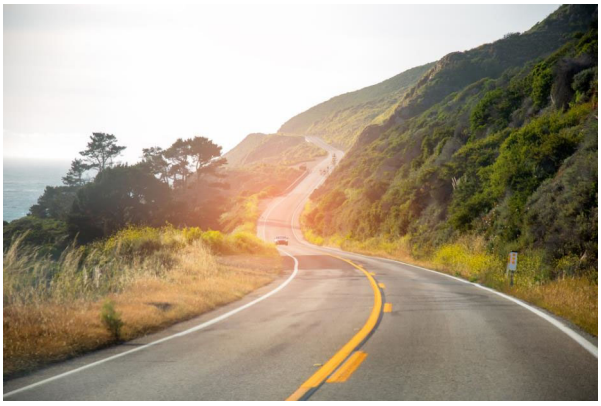
Evaluation and Management



- AMA Guideline Revisions
  - If code level is based on time, travel time is **NOT** counted.
  - Care Plan Oversight for these services should now be reported with either chronic care management (99437 or 99491) or principal care management (99424-99425)

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Evaluation and Management --- Work RVUs – Home/Residence

CPT code	2022 Work RVU	2023 Work RVU	Difference (+/-)
99341	1.01	1.00	↓
99342	1.52	1.65	↑
99344	3.38	2.87	↓
99345	4.09	3.88	↓
99347	1.00	0.90	↓
99348	1.56	1.50	↓
99349	2.33	2.44	↑
99350	3.28	3.60	↑

Evaluation and Management

- ▲ +99417 – Prolonged **outpatient E/M** service **with or without** direct patient contact beyond the required time of the primary service, each 15 mins
  - Time must be used to as leveling factor
  - Added other services it can now be used in conjunction with
  - Can be reported with 99205, 99215, 99245, **99345, 99350**, 99483

Evaluation and Management – Prolonged Services -Home

- CMS Guidance – Let's make this complicated!
  - G0318 -- Prolonged **home or residence** evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact
    - Can be reported with 99345, 99350
    - Must provide a full 15+ minutes beyond the total time

CPT Code	Total Time	AMA threshold	CMS threshold
99345	75 mins	90+ mins	141+ mins
99350	60 mins	75+ mins	112+ mins

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Evaluation and Management – Cognitive Assessment Planning

- ▲99483
- Revised total time spent on the date of the encounter from 50 to 60 minutes.

CPT code	2022 Work RVU	2023 Work RVU	Difference (+/-)
99483	3.44	3.84	⬆

- Prolonged services (+99417) may be reported with 99483
- CMS Guidance
  - G2212 (Prolonged OP visit) may be reported with 99483
  - Must provide a full 15+ minutes beyond the total time

CPT Code	AMA threshold
+99417	75+ mins
G2212	100+ mins

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Prolonged Services – CMS Summary

TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

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	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 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
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe, and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

<MPFS Final Rule, 667>

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POINT TO PONDER??

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CPT E/M MDM "Grid"
Level of Medical Decision Making (MDM)

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Code		99221 (Initial) 99231 (Subsequent)		99222 (Initial) 99232 (Subsequent)	99223 (Initial) 99233 (Subsequent)
Level of MDM (Based on 2 out of 3 Elements of MDM)	N/A	Straightforward/Low		Moderate	High
1 Number and Complexity of Problems Addressed at the Encounter	N/A	Minimal • 1 self-limited **or** minor problem	Low • **2** or more self-limited or minor problems **or** • **1** stable chronic illness **or** • **1** acute, uncomplicated illness or injury **or** • **1** stable acute illness **or** • **1** acute uncomplicated illness or injury requiring 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	High • **1** or more chronic illnesses with severe exacerbation, progression or side effect of treatment **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function
2 Amount and/or Complexity of Data To Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 out of 3 categories	N/A	Minimal or None	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 note9s) from each unique source, • Review of the results of each unique test, • ordering of each unique test or **Category 2: Assessment requiring an independent historian** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health (not separately reported) **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)	Extensive *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other QHCP (not separately reported) **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other QHCP/appropriate source (not separately reported)
3 Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	Minimal risk of morbidity from additional diagnostic testing or treatment •**Examples : rest, gargles, elastic bandages, superficial dressings	Low risk of morbidity from additional diagnostic testing or treatment •** *Examples: minor surgery w/o identified risk factors, PT OT therapy, IV fluids w/o additives*	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	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive for toxicity, • Decision regarding elective major surgery with identified patient or procedure risk factors, • Decision regarding emergency major surgery, • Decision regarding hospitalization, or escalation to hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Elements of Medical Decision Making

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E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Stable, acute illness** – A problem that is new/recent for which treatment has been initiated. The patient is improved and while resolution may not be complete, is table with respect to this condition.
  - **Acute, uncomplicated illness/injury requiring IP/OBS level care** – A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little/no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in IP/OBS setting.

New Additions to MDM Grid

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E/M – Based on MDM

- Complexity of problems addressed -- MDM Focus
  - Multiple new or established conditions may be addressed at the same time
  - Comorbidities/underlying conditions are ONLY considered in selecting a level if they are ADDRESSED and their presence increases amount of data reviewed/analyzed or increases risk of complications.
  - Do not count individual symptoms that are integral to a condition
  - For inpatient/OBS, addressed is the problem status on the date of the encounter, which may be different than on admission.
    - Example: Admitted for acute severe CHF decompensation (High), day 4 CHF has stabilized (Low or Moderate)

Key Word is ADDRESSED!!

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MDM – Risk of Morbidity/Mortality

- Parenteral **controlled** substances
  - Parenteral = xzgxyfshj%fir nsnxyjwji4lm{js%g~%f%wtzyj%tymjw%mfs%ymj%fqr jsyfw~%nfsfq%
    -r tzym%yt%fszx.3

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MDM – Risk of Morbidity/Mortality

- Decision regarding hospitalization *or escalation of hospital-level care*
  - Discussion of possible hospitalization is also included, even if the decision ends up being no.

Does NOT include merely sending a patient to the Emergency Room

Separately Reported "Professional Components"

- Separately reportable services

►The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.◄

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

73090 Radiologic examination; forearm, 2 views
CPT Changes: An Insider's View 2001
CPT Assistant Sep 01:8, Apr 02:14

73092 upper extremity, infant, minimum of 2 views

<Source: 2023 CPT Manual>

Separately Reported "Professional Components"

- How can I tell if there is a separate "professional component" for a service?
  - https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf
  - https://www.cms.gov/medicare/physician-fee-schedule/search/overview
  - "Modifier" and/or "PCTC" Column

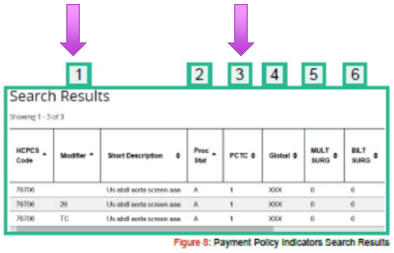

Figure 8: Payment Policy Indicators Search Results

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Let's Practice!!

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Case Study # 1 – ED

- 19-year-old male with history of asthma with increased “breathing problems”

2 weeks ago the patient's asthma worsened to the point he was using his inhaler 10-14 times a day with temporary relief. He was being woken up due to his shortness of breath. He also reports slight wheezing.

Today, he ran out of his inhaler prompting him to come to the ED.

Denies any fevers or rhinorrhea.

REVIEW OF SYSTEMS
Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion, ear pain, rhinorrhea and sore throat.
Respiratory: Positive for shortness of breath and wheezing. Negative for cough.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.
Genitourinary: Negative for dysuria.
Musculoskeletal: Negative for arthralgias and back pain.
Skin: Negative for rash.
Neurological: Negative for weakness and numbness.

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Case Study # 1 – ED

PHYSICAL EXAM
INITIAL VS

BP: 131/74 (08/31/22 2328), Heart Rate: 100 bpm (08/31/22 2328), Resp: (!) 35 (08/31/22 2328), Pulse: 100 (08/31/22 2328), Temp: 98.5 °F (36.9 °C) (08/31/22 2328), Temp src: Oral (08/31/22 2328), SpO2: 98 % (08/31/22 2328), Height: 5' 5" (165.1 cm) (08/31/22 2328), Weight: 61.2 kg (135 lb) (08/31/22 2328), BMI (Calculated): 22.47 (08/31/22 2328)
No LMP for male patient.

Physical Exam
Vitals and nursing note reviewed.
Constitutional:
General: He is not in acute distress.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Mouth/Throat:
Mouth: Mucous membranes are moist.
Pharynx: Oropharynx is clear.
Eyes:
Conjunctiva/sclera: Conjunctivae normal.
Cardiovascular:
Rate and Rhythm: Regular rhythm. Tachycardia present.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal.
Breath sounds: Wheezing (Scattered expiratory throughout) present.
Abdominal:
Palpations: Abdomen is soft.
Tenderness: There is no abdominal tenderness. There is no guarding.
Musculoskeletal:
General: No tenderness. Normal range of motion.
Cervical back: Normal range of motion. No tenderness.
Skin:
General: Skin is warm and dry.
Comments: **Scaly eczematous rash.**
Neurological:
Mental Status: He is alert and oriented to person, place, and time.
Motor: No weakness.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.

Lab and Imaging Orders

Completed
CBC WITH DIFFERENTIAL
COMPREHENSIVE METABOLIC PANEL
INFLUENZA A/B, RSV AND COVID-19 PCR PANEL

MDM

Summary Statement:
19 yo m with h/o asthma, eczema c/o cough congestion and wheeze for the past week
Not hypoxic, +scattered wheeze on arrival
Breath sounds improved with nebs, steroids
Covid neg
Pt reassured
Will dc with mdi, steroid burst
Referred for pmd f/u

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Case Study # 1 – ED

99284

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	Code	99281	99282	99283	99284	99285
	Level of MDM (Based on 2 out of 3 Elements of MDM)	N/A	Straightforward	Low	Moderate	High
1	Number and Complexity of Problems Addressed at the Encounter	N/A	Minimal • 1 self-limited or minor problem	Low • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute uncomplicated illness or injury or • 1 stable acute illness or • 1 acute uncomplicated illness or injury requiring 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	High • 1 or more chronic illnesses with severe exacerbation, progression or side effect of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function
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3	Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	Minimal risk of morbidity from additional diagnostic testing or treatment •** *Examples: rest, gargles, elastic bandages, superficial dressing*	Low risk of morbidity from additional diagnostic testing or treatment • ** *Examples: minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives*	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	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive for toxicity, • Decision regarding elective major surgery with identified patient or procedure risk factors, • Decision regarding emergency major surgery, • Decision regarding hospitalization, or escalation to hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Elements of Medical Decision Making

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Case Study # 2 – ED

- 30 year-old female with “toe injury”

30-year-old female who was working at like a special services, trying to load a resident onto the wheelchair bus and dropped the wheelchair lift onto her right great toe. Brought in for evaluation.

ROS:
Negative except as described in HPI

PE:
ED Triage Vitals [10/20/22 1542]

Temp	Heart Rate	Resp	BP	SpO2
36.1 °C (97 °F)	**95**	**16**	**126/90**	**100 %**

Physical Exam
Vitals and nursing note reviewed.

Skin:
Comments: **Laceration and skin tear over right great toe, dorsal aspect, distal to interphalangeal joint**

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Case Study # 2 – ED

ED MEDS:

Medications

oxyCODONE-acetaminophen (PERCOCET) 5-325 mg 1 tablet (1 tablet oral Given 10/20/22 1558)
HYDROcodone-acetaminophen (NORCO) 5-325 mg Disp: #12 tablet - ED DOSE PACK 1 Package (1 Package oral ED take home pack 10/20/22 1700)

ED IMAGES:

X-ray toe 2 or more views right
Final Result
IMPRESSION:
Great toe terminal phalanx fracture.

Risk of Complications, Morbidity, and/or Mortality
Presenting problems: moderate
Diagnostic procedures: low
Management options: low

MDM

Number of Diagnoses or Management Options

Nondisplaced fracture of distal phalanx of right great toe, initial encounter for closed fracture: new and requires workup
Diagnosis management comments: Patient has a distal phalanx fracture of right great toe, there is a laceration and some skin tear on dorsal aspect. Pain was treated which helped tremendously. She declined any stitches and I do not think that that would be as helpful anyways. She did not tolerate any kind of pressure dressing so light dressing was placed, Coban was placed and then she wore a postop shoe. Declined crutches. Recommended follow-up if pain is not improving or she develops any dislocation of the fracture. Sent ED kit of Norco home, has no additional concerns or questions and will follow up as needed.

NOTE: If the ED physician did perform a separate laceration repair it would be reported separately

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Case Study # 2 –ED

99283

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Code		99281	99282	99283	99284	99285
Level of MDM (Based on 2 out of 3 Elements of MDM)		N/A	Straightforward	Low	Moderate	High
1	Number and Complexity of Problems Addressed at the Encounter	N/A	**Minimal** • 1 self-limited or minor problem	**Low** • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute uncomplicated illness or injury or • 1 stable acute illness or • 1 acute uncomplicated illness or injury requiring 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	**High** • 1 or more chronic illnesses with severe exacerbation, progression or side effect of treatment or • 1 acute or chronic illness or injury that poses a threat to life o bodily function
2	Amount and/or Complexity of Data To Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 out of 3 categories	N/A	Minimal or None	**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 results of each unique test, • ordering of each unique test or **Category 2: Assessment requiring an independent historian** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health (not separately reported) **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)	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other QHCP (not separately reported) **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with extern physician/other QHCP/appropriate source (not separately reported)
3	Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	**Minimal risk of morbidity from additional diagnostic testing or treatment** • *** Examples: rest, gargles, elastic bandages, superficial dressing*	**Low risk of morbidity from additional diagnostic testing or treatment** • *** Examples: minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives*	**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	**High risk of morbidity from additional diagnostic testing or treatment Examples only:** • Drug therapy requiring intensive for toxicity, • Decision regarding elective major surgery with identified patient or procedure risk factors, • Decision regarding emergency major surgery, • Decision regarding hospitalization, or escalation to hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Elements of Medical Decision Making

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Case Study #3 – OBS

- **Chief Complaint:** Dizziness, presyncope

History of present illness: Pt seen and examined at the bedside is an 84 y.o. male with known history of diabetes mellitus, aortic stenosis who is being admitted for further evaluation of dizziness, presyncopal episode. Today he was in the hot tub and when he stood up he felt dizzy, felt like he would pass out. A friend helped him sit down a chair. He was then brought to the ED. Patient denies any chest pains. He says he has been having episode of lightheadedness and his primary care doctor has discontinued his antihypertensives and decreased his Flomax. He denies any shortness of breath with exertion. He claims to be active and exercises regularly.

In the ED his blood pressure was 100/67, heart rate 102. He was noted to have a blood sugar of over 400. Head CT showed no acute abnormality. He was started on IV fluids. He was likewise given aspirin. EKG showed no acute ST-T wave changes. Repeat blood sugar was 347. Patient claims to be compliant with his medications. He is on insulin at night. He denies any new medication.

Lab Data:

General health panel

	10/26/22 1203
WBC	13.3*
HGB	14.4
HCT	43.5
PLT	245

	10/26/22 1203
NA	136
K	4.9
CL	98
CO2	24
CA	9.7
BUN	21
CREAT	1.36*
GLUCOSE	418*

TOTALPROTEIN	6.8
ALBUMIN	4.0
BILITOTAL	0.4
ALKPHOS	75
AST	11
ALT	10

EKG: first one done in ER on 10/26/2022, normal sinus rhythm, right bundle blanch block, first-degree AV block,

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Case Study #3 – OBS

CXR: No acute pathology
Head CT no acute pathology

Assessment/Plan:

1. Presyncopal episode
   Episode of dizziness and lightheadedness
   Aortic stenosis? Cardiac event?
   -Patient will be monitored in telemetry
   -Obtain orthostatic blood pressure
   His primary care doctor has recently discontinued his lisinopril and decreased his tamsulosin dose about a week ago because of his lightheadedness and soft blood pressure.

Echocardiogram ordered to assess aortic stenosis. Last echocardiogram by Cardiology was in 2020 where he was noted to have moderate AS with AVA of 1.3 cm. He saw cardiology once in 2020 and has had no follow-up
Consider Holter monitoring in the outpatient if work-up is negative

2. DM type II with neuropathy
   Hyperglycemia
   Blood sugar was over 400 on admission. Patient claims to be compliant with his medications.
   Will give him glargine tonight with monitoring of blood sugars
   will adjust his blood sugars accordingly

3. History of BPH
   Continue Flomax at bedtime
   Dose recently decreased by PCP

4. Mild AKI
   Gentle hydration

Admission status; observation

Time: 45 minutes spent on the date of the encounter.

Initial Minutes / Code
40 / 99221
55 / 99222
75 / 99223

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Case Study #3 – OBS

99222

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Code		99221 (Initial) 99231 (Subsequent)		99222 (Initial) 99232 (Subsequent)	99223 (Initial) 99233 (Subsequent)
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Elements of Medical Decision Making

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Questions & Answers

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O
Director of HIM and Coding
HCPro, a Simplify Compliance

To Submit a Question: Go to the chat pod located in the lower left corner of your screen. Type your question in the text box, then click on the "Send" button.

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http://events.hcpro.com/materialspub.cgi?YHHA010523A

We kindly request that this link be forwarded to everyone in your group who attended the program.

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