Medicare vs. CPT Policy for E/M, Split/Shared and Prolonged Visits: Manage Two Systems With Ease

A WEBINAR PRESENTED ON FEBRUARY 22, 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:
  - Report inpatient, observation, emergency department and nursing facility visits with the correct policy.
  - Train staff to follow both policies for combined E/M visits by a physician and a qualified health care professional.
  - Accurately calculate time and select codes for prolonged services.

What’s New for 2023?

New guidelines/definitions for:

- Hospital Inpatient and Observation Care Services
- Consultation codes for Inpatient and Outpatient
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services

CPT E/M Changes 2023

- Eliminate history and physical as elements for code selection
- Allow physicians to choose whether their documentation is based on Medical Decision Making (**MDM**) or **Time**
- Modifications to the Criteria for MDM (2021)
- New Time Ranges
- Deletion of observation care codes and level 1 inpatient and outpatient consult CPT codes (and more)
- Adoption of shorter Prolonged Services Code **99417 and 99418**

CMS E/M Changes 2023

- Adopted *most* CPT changes
  - Kept CMS billing guidelines
  - Will not cover prolonged service codes 99417-99418

Place of Service – No Change

- CPT – " … the place of service hasn't changed. … there is still a place of service distinction for reporting." – Barbara Levy, M.D., co-chair of the AMA's CPT/RUC Workgroup on E/M
- CMS - "At this time, we are not making changes to POS policy (including the POS that should be placed on a claim for a patient receiving observation care)."

Hospital Inpatient and Observation Care Services

- Deletion of Hospital Observation Services E/M Codes **99217-99220**
- Deletion Subsequent Observation Care **99224-99226**
- Revision of Hospital Inpatient and Observation Care Services E/M Codes **99221-99233** (Initial) and **99231-99233** (Subsequent)

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

Admission and Discharge Same Date

Hospital Inpatient or Observation Admission and Discharge	MDM	Time
99234	Straightforward/Low	45 minutes
99235	Moderate	70 minutes
99236	High	85 minutes
Prolonged Time		
99417 – CPT guidelines		15 min, begins at 85 minutes
G0316 – CMS guidelines		15 min, begins at 125 minutes Timeframe includes 3 days after

Admission and Discharge Same Date

- CPT 2023 guidelines

  For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate

- CMS 2023 Guidelines
- "8 to 24-hour rule" regarding payment of admission, discharge, or same-day admission/discharge codes, depending on the length of stay and whether the patient was discharged on a different calendar date than they were admitted
- CMS policy allows G0316 when patients may be in the hospital for short stays but still require significant practitioner time.

Consultation Codes for Inpatient and Outpatient

- 99241 and 99251 have been deleted.
- Updated guidelines reiterate that the **3 R's** must be met:
  - **Request**
  - **Render**
  - **Report**

  - CMS does not pay for Consultation codes but does recognize and pay for consultations. Report E/M by location, level of service and patient status

Consultation Codes for Inpatient and Outpatient

Office/Outpatient Consultation		
E/M Code	MDM	Time
99242	S.F.	20 – 29
99243	Low	30 – 39
99244	Moderate	40 – 54
99245	High	55 – 69

Inpatient/Observation Consultation		
E/M Code	MDM	Time
99252	S.F.	35 – 44
99253	Low	45 – 59
99254	Moderate	60 – 79
99255	High	80 – 94

Emergency Department Services

- No distinction is made between new and established patients in the emergency department.
- Time is not a descriptive component for the emergency department levels of E/M services.
- New for 2023
  - Code also admission to hospital inpatient/observation or to nursing facility as part of encounter in different setting, when performed (99221-99223, 99304-99306)

Emergency Department Services

Emergency Department Visit	
E/M Code	**MDM**
99281	May not require the presence of a physician or other QHP
99282	**Straightforward**
99283	**Low**
99284	**Moderate**
99285	**High**

Nursing Facility Services

- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Deletion of Nursing Facility Services E/M Code 99318
- New for 2023:
  - High-level MDM for **initial** services:

Multiple morbidities requiring intensive management*: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.*

Nursing Facility Services

Initial Nursing Facility Care		
E/M Code	MDM	Time
99304	Low	25 – 34
99305	Moderate	35 – 44
99306	High	45 – 59

Subsequent Nursing Facility Care		
E/M Code	MDM	Time
99307	S.F.	10 – 14
99308	Low	15 – 29
99309	Moderate	30 – 44
99310	High	45 – 59

Nursing Facility Services

99315 – Nursing facility discharge management; 30 minutes or less total time on the date of the encounter

99316 – Nursing facility discharge management; more than 30 minutes total time on the date of the encounter

Home or Residence Services

- Deletion of Domicillary, Rest Home (e.g., Boarding Home), or Custodial Care Services
  - 99324-99328, 99334-99337
- Deletion of Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services
  - 99339, 99340

Home or Residence Services

- **Home** may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship).
- When selecting code level using time, do not count any travel time.

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Home or Residence Services

New Patient		
E/M Code	**MDM**	**Time**
99341	S.F.	15 – 29
99342	Low	30 – 59
99344	Moderate	60 – 74
99345	High	75 – 89

Established Patient		
E/M Code	**MDM**	**Time**
99347	S.F.	20 – 29
99348	Low	30 – 39
99349	Moderate	40 – 59
99350	High	60 – 74

Admission during another Encounter

- CPT 2023 Guidelines
- 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

- CMS 2023 Guidelines
- Retain current policy that, 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

Initial and Subsequent Visits

- CPT 2023 Guidelines
- Initial Service-the patient has not received any professional services from the physician or another QHP of the exact same specialty and subspecialty in the same group practice during the inpatient, observation or nursing facility stay

- CMS 2023 Guidelines
- Specifies that while the practitioner who orders the observation care for a patient may bill for observation care, other practitioners providing additional evaluations for the patient bill their services as O/O E/M codes.
- CMS is not making any changes to the use of the AI modifier

MDM or Total Time

Time

- **Time alone may be used** to select the appropriate code level for E/M services
- For coding purposes, time for these services is the **total time on the date of the encounter**.
- It includes both the face-to-face and non-face-to-face time personally spent by the provider on the day of the encounter

Time

- Physician/other qualified health care professional time includes the following activities, when performed:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures

Time

- Physician/other qualified health care professional time includes the following activities, when performed:
  - referring and communicating with other health care professionals**
  - documenting clinical information in the electronic or other health record
  - independently interpreting results** and communicating results to the patient/family/caregiver
  - care coordination**

*****(when not separately reported)***

Prolonged Services Code 99417

- The CPT Editorial Panel created a code for Prolonged Services. This new code captures shorter prolonged services (15-minute increments).
- **99417** has been updated and now may be used to report a prolonged office visit, office consultation, or other outpatient evaluation including home visits.

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

CMS Prolonged Services Code G2212

- CMS disagreed with how AMA defined their prolonged service code and created their own code with unique time requirements.

  ***G2212** Prolonged **office or other outpatient** evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total 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 (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)*

- To report **G2212**, - 15 minutes must have passed beyond the maximum time for 99205/99215.
- For example, this could be reported once for a new patient visit that lasts 89-103 minutes and for an established patient visit that lasts 69-83 minutes

Prolonged Services Code 99418

99418 Prolonged ***inpatient or observation*** 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.

- Direct patient contact prolonged services (99354-99357) were deleted.
- Codes 99417, 99418 are only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level service has been exceeded by 15 minutes.

Medicare Prolonged Services Codes

- **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.

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Federal Register Table

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

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Prolonged Services Example

A new patient is referred by her to a dermatologist for an opinion regarding a rash. The dermatologist spends a combined **90 minutes** preparing to see the patient (reviewing prior notes) obtaining the patient's extensive personal and family history, performing a full skin exam, counseling the patient and her spouse regarding diagnostic and treatment options, ordering medications and tests, documenting information in the EHR, and communicating with the PCP.

Total Time	Billing
20 – 29	99242
30 – 39	99243
40 – 54	99244
55 – 69	99245
70 – 84	99245 **and** 99417
85 – 99	99245 **and** 99417 x 2

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Prolonged Services Example

Total Time	Billing
25 – 34	99231
35 – 49	99232
50 – 64	99233
65 – 79	99233 **and** 99418
80 – 94	99233 **and** 99418 x 2
95 – 110	99233 **and** 99418 x 3

A patient is admitted with multiple complex chronic problems. On the morning of day 4 of the admission, the hospitalist spends a combined **75 minutes** reviewing labs, examining the patient, and discussing goals of treatment with the patient and family. That evening, after another discussion and shared medical decision making with the family, a consultation is placed with the Palliative Care team.

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

Inpatient Prolonged Services

CPT 2023 Guidelines

- 99418 Prolonged inpatient or observation 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 inpatient and observation Evaluation and Management service)
- Example: add to 99223 after 90 minutes

CMS 2023 Guidelines

- G0316 Prolonged inpatient E/M service beyond the total time of the primary service
  - When the primary service code has been selected using time on the date of the primary service
  - Time threshold to report Prolonged is 105 minutes for initial inpatient visit
  - Time threshold to report Prolonged is 80 minutes for Subsequent IP/Observation visit
  - Timeframe is the Date of visit

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	
99418	Prolonged Service		90	105 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	
99418	Prolonged Service		65	80 min to add G0316
Hospital	**Discharge**	**MDM**	**Time**	
99238	Discharge under 30 minutes		> 30	
99239	Discharge over 30 minutes		< 30	Do not add G0316

Nursing Facility Prolonged Service

CPT 2023 Guidelines

- 99418 Prolonged inpatient or observation 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 inpatient and observation Evaluation and Management service)
- Example: add to 99306 after 60 minutes

CMS 2023 Guidelines

- G0317 Prolonged inpatient E/M service beyond the total time of the primary service
  - When the primary service code has been selected using time on the date of the primary service
  - Time threshold to report Prolonged is 95 minutes for initial NF visit
  - Time threshold to report Prolonged is 85 minutes for subsequent NF visit
  - Timeframe is the 1 day before visit, date of visit and 3 days after

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Nursing Facility Prolonged Service - CPT and CMS

		CPT Guidelines		CMS Guidelines
Nursing Facility Initial		**MDM**	**Time**	
99304	SNF Initial visit	SF/ Low	25	Time on date of visit only
99305	SNF Initial Visit	Moderate	35	
99306	SNF Initial Visit	High	45	
99418	Prolonged Service		60	95 minutes to add G0317
Nursing Facility Subsequent		**MDM**	**Time**	
99307	SNF Subsequent visit SF	SF/ Low	10	
99308	SNF Subsequent visit Low	Moderate	15	
99309	SNF Subsequent visit Moderate		30	
99310	SNF Subsequent visit High	High	45	
99418	Prolonged Service		60	85 minutes to add G0317
Nursing Facility Discharge		**MDM**	**Time**	
99315	Discharge under 30 minutes		> 30	
99316	Discharge over 30 minutes		< 30	Do not add G0317

Home or Residence Prolonged Service

CPT 2023 Guidelines

- 99418 Prolonged inpatient or observation 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 inpatient and observation Evaluation and Management service)
- Example: add to 99345 after 90 minutes

CMS 2023 Guidelines

- G0318 Prolonged inpatient E/M service beyond the total time of the primary service
  - When the primary service code has been selected using time on the date of the primary service
  - Time threshold to report Prolonged is 140 minutes for initial Home visit
  - Time threshold to report Prolonged is 110 minutes for subsequent home visit
  - Timeframe is the 1 day before visit, date of visit and 3 days after

Home or Residence Prolonged Service- CPT and CMS

		CPT Guidelines		CMS Guidelines
Home Visit Initial		**MDM**	**Time**	**CMS**
99341	Home Visit New Prob Focused	Straightforward	15	3 days before visit + date of visit + 7 days after
99342	Home Visit New EPF	Low	30	
99344	Home Visit New Moderate	Moderate	60	
99345	Home Visit New High	High	75	
99417	Prolonged Service		90	140 minutes to add G0318
Home Visit Established		**MDM**	**Time**	**CMS**
99347	Home Visit New Prob Focused	Straightforward	20	3 days before visit + date of visit + 7 days after
99348	Home Visit New EPF	Low	30	
99349	Home Visit New Moderate	Moderate	40	
99350	Home Visit New High	High	60	
99417	Prolonged Service		75	110 minutes to add G0318

Qualifying Activities for Time-based Reporting

- 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
  - Same date for payers following CMS guidelines
  - See previous charts to count physician/NPP time spent within surveyed timeframe

- 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.
  - Note the “detail” in the statement, not a cloned note.

What Didn’t Change?

- There was a high level of anticipation this year for facilities and medical groups who use NPP’s and Physicians performing Shared/Split Visits
- The rules for these services have not changed
- The provider who performs the substantive portion of the shared/split service will be the billing provider

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

Split/shared Coding

- CPT 2023 Guidelines
- Time-based under CPT guidelines. Option for level-based E/M excluding ED.
- Does not determine who bills or receives reimbursement.

- CMS 2023 Guidelines
- MDM component or time-based for critical care and level-based E/M excluding office visits.
- Substantive portion.

CMS 2023 Final Rule

- Clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, or medical decision making — or more than half of the total practitioner time spent to define the substantive portion — instead of using total time to determine the substantive portion
  - Instead of requiring providers to use the substantive portion definition of “more than half of the total time” on Jan. 1, 2023, CMS is proposing to delay the policy implementation until CY 2024 after receiving feedback from stakeholders.
  - Delaying the split/shared visit policy implementation until 2024 gives providers a transition year to get acclimated to the 2023 E/M guidelines and get their practices up to speed on the incoming changes.

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.

Imaging and procedures:

CT abdomen/pelvis 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.

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

-IV zofran PRN nausea

#DM

-ISS

#HTN

BP wnl.

-hold home PO meds

-monitor BP, may add IV BP meds if elevated

#HLD

-hold home statin

#Hyponatremia

Likely hypovolemic.

-monitor

-IVF as above

Diet - NPO

DVT ppx Lovenox

Code Full

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MDM Components

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

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

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**

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

What Didn't Change?

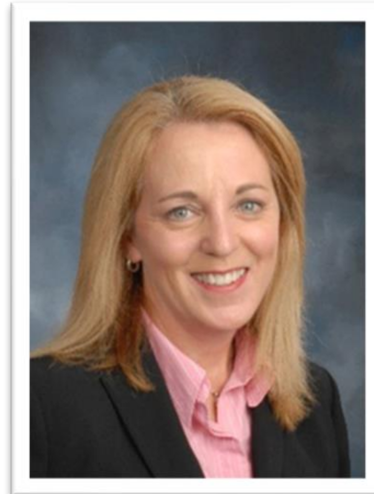
DOCUMENTATION IS STILL CRITICAL!

- The primary function of the medical record is to convey important medical information in order to ***deliver optimal care to the patient***.
- A secondary function of the medical record is for ***medicolegal*** purposes.
- Lastly the medical record acts as a sort of ***invoice***.

Takeaways

- Compare the Final CMS policy with the CPT Changes
  - See crosswalk for Medicare billing (by facility type)
- Understand the different Prolonged Services Codes
  - Prolonged Services CPT codes are not payable by CMS
  - CMS new HCPCS codes may not be reportable to other payers
- Provide Training for all providers and clinical staff
  - Documentation changes will be required for MDM elements
  - Documenting actual time

Questions & Answers



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To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your "Enter" key.

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