Evaluation & Management Updates

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Welcome!

Please read the participation tips below as we are using a Webex Events platform.

- All participants phones have been muted.
- All questions should be asked by using the Webex Chat feature.

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Agenda

- E/M Introductory Guidelines
- Inpatient and Observation Care Services
- Consultations
- Emergency Department
- Prolonged Services
- E/M Edits
- Q/A

(American Medical Association, 2022)

E/M Introductory Guidelines

2021 Office Visit Revisions

Summary of E/M Revisions for 2021

Office or Other Outpatient Services

A. Medically appropriate history and/or examination required and documented
B. MDM or Total Time used to determine level of care on the date of encounter
C. CPT 99201 & 99202 require Straightforward MDM in 2020
D. Specific to E/M *Office and Other Outpatient Services.*

(American Medical Association, 2022)

Evaluation & Management

Overview of 2023 E/M Updates

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Overview of 2023 E/M Updates

Comprehensive restructure of the general E/M Guidelines now that the entire set of E/M services will use a single set of guidelines.

(American Medical Association, 2022)

Overview of 2023 E/M Updates

A shorter 15-minute prolonged service add-on code (99417)

- To be reported only when the minimum time **required when coding based on time for 99205 or 99215** has been exceeded by 15 minutes.

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Evaluation and Management Service Guidelines

Inpatient & Observation Care

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Inpatient & Observation Care

- Deletion of observation CPT® codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99233,99231-99233,99238-99239).
- Retention of revised Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236).

(American Medical Association, 2022)

Inpatient & Observation Care

*An initial service may be reported when the patient has not received any professional services from the physician or other QHP or another physician or other QHP 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.

(American Medical Association, 2022)

Inpatient & Observation Care

- Consistent for all inpatient services and new section in E/M introductory guidelines
- Similar to “new” and “established” patient definitions except related to the stay vs. last 3 years
- A transition from observation level to inpatient does not constitute a new stay.

(American Medical Association, 2022)

Inpatient & Observation Care

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 (e.g., 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

(American Medical Association, 2022)

Inpatient & Observation Care

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). This instruction applies whether the consultation occurred on the date of the admission or a date prior to the admission. It also applies for inpatient consultations reported with any appropriate code (e.g., office or other outpatient visit or office or other outpatient consultation).

(American Medical Association, 2022)

Inpatient & Observation Care

Code Descriptor Example

▲**99221** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99221	40
99222	55
99223	75
Prolonged (993X0)*	90 mins or longer

*CMS G-codes proposed for prolonged services

(American Medical Association, 2022)

Subsequent Hospital Inpatient or Observation Care

Code Descriptor Example

★▲**99231** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99231	25
99232	35
99233	50
Prolonged (993X0)*	65 mins or longer

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

Code Descriptor Example

▲**99234** **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99234	45
99235	70
99236	85
Prolonged (993X0)*	100 mins or longer

(American Medical Association, 2022)

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

Guidelines

- Used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.
- Codes 99234, 99235, 99236 require two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter. For a patient admitted and discharged at the same encounter (i.e., one encounter), see 99221, 99222, 99223.
    - *CMS Proposes to accept term “calendar date” as the same as “per day”, with retention of special rules for these code
- If less than 8-hour stay only use 99221-99223, **NOT** 99234-99236
- If 8 or more, but less than 24 hours, even if two dates, **use only 99234-99236**

(American Medical Association, 2022)

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

Code Descriptor Example and Guideline Revisions

▲**99238 Hospital inpatient or observation discharge day management**; 30 minutes or less on the date of the encounter

▲**99239** More than 30 minutes on the date of the encounter

(For hospital inpatient or observation care including the admission and discharge of the patient on the same date, see 99234, 99235, 99236)

Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family/caregiver and coordination of post-discharge services may be reported with 99231, 99232, 99233.

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Evaluation & Management Service Guidelines

Consultations

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Consultations

- Retain the consultation codes, with minor, editorial revision to the code descriptors.
- Deletion of confusing guidelines, including the definition of “transfer of care”.
- Deletion of lowest level office (99241) and inpatient (99251) consultation codes to align with four levels of MDM.

(American Medical Association, 2022)

Consultations

- 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 physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

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Consultations

★▲**99242** **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99242	20
99243	30
99244	40
99245	55
Prolonged (99417)	70 mins or longer

(American Medical Association, 2022)

Consultations

★▲**99252** **Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99252	35
99253	45
99254	60
99255	80
Prolonged (993X0)	95 mins or longer

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Evaluation and Management Service Guideline

Emergency Department Services

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Emergency Department Services

- Time is **NOT** a factor in the Emergency Department setting
- Time is **NOT** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters by the same physician or QHP with several patients over an extended period of time.

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Emergency Department Services

- Maintained the existing principle that time cannot be used as a key criterion for code level selection.
- Modified MDM levels to align with office visits and maintain unique MDM levels for each visit.

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Emergency Department Services

Articulated current practice that was not explicit in CPT code set.

- May be used by physicians and QHPs other than just the ED staff
- Critical care may be reported in addition to ED service for clinical change

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Emergency Department Services

Code Descriptor Overview

Modified to conform with office visits (i.e., linear progression of MDM and "99211-like " staff supervision code).

CPT Code	Previous Description	New Description
99281	Straightforward	May not require Physician /QHP
99282	Low	Straightforward
99283	Moderate	Low
99284	Moderate	Moderate
99285	High	High

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Emergency Department Services

Code Descriptors

▲**99281 Emergency department visit** for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional

▲**99282 Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making

▲**99283 Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making

▲**99284 Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making

▲**99285 Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making

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Evaluation and Management Service Guideline

Prolonged Service

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Prolonged Services

- Deletion of direct patient contact prolonged service codes (99354-99357). These services will now be reported through either the code created in 2021, office prolonged service code (99417) or the new inpatient or observation or nursing facility service code (993X0).
  - 99417 is also used for Home or Residence prolonged services

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Prolonged Services

- Creation of a new code (993X0) to be analogous to the office visit prolonged services code (99417). This new code is to be used with the inpatient or observation or nursing facility services.
- Retain 99358, 99359 for use on dates other than the date of any reported
    - ‘total time on the date of the encounter” service.

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Prolonged Services with Direct Patient Care

- (99354, 99355 have been deleted. 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.)
- (99356, 99357 have been deleted. For prolonged evaluation and management services on the date of an inpatient or observation or nursing facility service, use 993X0.)
- 99417 may not be used with psychotherapy services.

(American Medical Association, 2022)

Prolonged Service With or Without Direct Patient Care

- Code 99417 is used to report prolonged total time (i.e., combined time with and without direct patient contact) provided by the physician or QHP on the date of office or other outpatient services, office consultation, or other outpatient evaluation and management services.

- Code 993X0 is used to report prolonged total time (i.e., combined time with and without direct patient contact) provided by the physician or QHP on the date of an inpatient evaluation and management service.

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Prolonged Service With or Without Direct Patient Care

- When reporting 99417, 993X0, the initial time unit of 15 minutes should be added once the time in the primary E/M code has been surpassed by 15 minutes. (Minimal time for 99205, 99215.)

- Time spent performing separately reported services other than the primary E/M service and prolonged E/M service is not counted toward the primary E/M and prolonged services time.

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Prolonged Service With or Without Direct Patient Care

#★✚▲**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)

(Do not report 99417 for any time unit less than 15 minutes)

#★✚●**993X0** 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)

(Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)

(Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359)

(Do not report 993X0 for any time unit less than 15 minutes)

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Prolonged Service With or Without Direct Patient Care

CMS created three new HCPCS II G-codes :

- GXXX1

  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 (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services).

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Prolonged Service With or Without Direct Patient Care

CMS created three new HCPCS II G-codes :

- GXXX2
  Prolonged **nursing facility** evaluation and management service(s); each additional 15 minutes

- GXXX3
  Prolonged **home or residence** evaluation and management service(s); each additional 15 minutes

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Prolonged Services

TABLE 18: Proposed 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)	GXXX1	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	GXXX1	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	GXXX1	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)	GXXX2	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	GXXX2	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)	GXXX3	141 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	GXXX3	112 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning	n/a	n/a	n/a
Consults	n/a	n/a	n/a

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Evaluation & Management Service

E/M Edit D172

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E/M Edit

CATEGORY	Reason For Denial	CPT Code(s)	Edit Criteria
Discharge Services	Deny hospital discharge services (99238-99239) when 99238 or 99239 has been billed the previous day.	99238, 99239	Deny 99238, 99239 when 99238, 99239 has been billed previous day.
Discharge Services	Deny hospital discharge services (99238- 99239) when 99238 or 99239 has been billed and paid for the subsequent date of service.	99238, 99239	Deny 99238, 99239 when 99238, 99239 has been the subsequent day.

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E/M Edit

Category	Reason for Denial	CPT Code(s)	Edit Criteria
E/M Services with Preventive Medicine Visits	Deny problem-oriented E/M services billed with preventive medicine services, unless the E/M service is billed with modifier 25.	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	Deny codes when billed with 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429 unless modifier 25 is on code.
Evaluation and Management Services with Critical Care	Deny E/M services (99201-99215, 99221-99223, 99231-99233, 99460) when billed with critical care service (99291) and the place of service is the same, except when evaluation and management services (including critical care services) are appended with modifier 25.	99202-99215, 99221-99223, 99231-99233, 99460	Deny codes when billed with 99291 & POS is same, unless 25 modifier is on code.
Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services	Deny initial neonatal intensive care service 99477 when reported subsequent to the date of admission.	99477	Deny 99477 when 99477 has been billed subsequent to date of admission.

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E/M Edit

Example 1. Preventive & Problem Focused E/M Visit

During the female adult preventative exam, the physician identifies a palpable solitary lump in her right breast. The physician finds this “significant” enough to require additional work, and to perform the key components of a problem-oriented E/M service. So 99395 would be reported for the preventative visit, and 99213-25 would be reported for the visit related to the breast lump.

Initial Preventative Physical Exam (IPPE)	**Annual Wellness Visit (AWV)**	**Routine Preventative Physical Exam**
Review of medical and social health history, and preventative services education	Initial visit to develop or update a personalized prevention plan, and perform a health risk assessment (G0438 once per lifetime)	Exam performed without relationship to treatment or diagnosis, for a specific illness, symptom, complaint or injury
Covered only once (per lifetime) within 12 months of Part-B enrollment	Covered once every 12 months (G0439 every subsequent year after initial AWV)	Ø Not covered by Medicare; **Prohibited by Statute**
Patient pays nothing (if provider accepts assignment)	Patient pays nothing (if provider accepts assignment)	Ø Patient pays 100% out of pocket, but gives the allowable for the patient to pay
HCPCS Code: G0402 *Also known as the Welcome to Medicare Preventative Visit”	HCPCS Code: G0438/G0439	CPT: 99381-99397

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E/M Edit

Critical care and other same-day evaluation and management (E/M) visits	Physicians in the same group who are in the same specialty must bill and be paid for services under the PFS as though they were a single physician If more than one E/M visit is provided on the same date to the same patient by the same physician, or by more than one physician in the same specialty in the same group, only one E/M service may be reported, unless the E/M services are for unrelated problems Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. This general policy is intended to ensure that multiple E/M visits for a patient on a single day are medically necessary and not duplicative. In situations when a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation notes that 1) the other E/M visit was provided before the critical care and at a time when the patient did not require critical care; 2) the services were medically necessary; and 3) the services were separate and distinct with no duplicative elements from the critical care services occurring later in the day. Additionally, the modifier -25 should be appended to the critical care services on the claim for this day.

(American Medical Association, 2022)

E/M Edit

Category	Reason for Denial	CPT Code(s)	Edit Criteria
New Patient Visits	Deny a new patient visit when any service has previously been billed within the last three years for claims billed with Bill Types 12X (Hospital inpatient part B), 13X (Hospital outpatient), 14X (Hospital other part B), 71X (Rural health clinic), 72X (Clinic hospital based or independent renal dialysis center), 73X (Clinic freestanding) or 79X (Clinic-other).	99202, 99203, 99204, 99205	Deny code when one of same codes billed within last 3 years with bill types 12X (Hospital inpatient part B), 13X (Hospital outpatient), 14X (Hospital other part B), 71X (Rural health clinic), 72X (Clinic hospital based or independent renal dialysis center), 73X (Clinic freestanding) or 79X (Clinic-other).
New Patient Visits	Deny a new patient visit when any service has previously been billed within the last three years by the same facility.	99202, 99203, 99204, 99205	Deny code when previously biled within last 3 years by same facility.
Newborn Care Services	Deny 99463 (Initial hospital or birthing center care, per day for evaluation and management of normal newborn infant admitted and discharged on same date) when billed and the newborn has previously received newborn care services the previous day.	99463	Deny 99463 when billed the previous day.
Newborn Care Services	Deny 99461 (Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center) when billed and the newborn has previously received newborn care services the previous day.	99461	Deny 99461 when billed the previous day.

(American Medical Association, 2022)

E/M Edit

Category	Reason for Denial	Reason for Denial	CPT Code(s)	Edit Criteria
Observation Services	Deny 99217 (Observation care discharge) or 99238-99239 (Hospital discharge day management) when billed and 99234-99236 (Observation or inpatient hospital care including admission and discharge on the same day) was billed the previous day.	99217, 99238, 99239	Deny code when 99234 - 99236 has been billed the previous day.	Deny code when 99234 - 99236 has been billed the previous day.
Observation Services	Deny 99217 (Observation care discharge day) when billed with 99221-99223 (Initial hospital care) on the same date of service by the same provider.	99217	Deny 99217 when billed with 99218 - 99220 on same DOS by same provider.	Deny 99217 when billed with 99218 - 99220 on same DOS by same provider.
Observation Services	Deny 99217 (Observation care discharge day) when 99221-99223 (Initial hospital care) was billed the previous day.	99217	Deny 99217 when 99221 - 99223 was billed the previous day.	Deny 99217 when 99221 - 99223 was billed the previous day.
Observation Services	Deny 99221-99223 (Initial hospital care) when 99217 (Observation care discharge) has already been paid for the subsequent day.	99221 - 99223	Deny code when 99217 has already been paid for the subsequent day.	Deny code when 99217 has already been paid for the subsequent day.

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Thank
you !