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Guide to 2023 Evaluation and Management Changes

April 2023

Contents

Updates to Evaluation and Management Services in 2023: Overview

The American Medical Association has released the new guidelines for Evaluation and Management (E/M) services which will go into effect on **January 1, 2023**. The guidelines have been updated to bring all the services in line with the 2021 Evaluation and Management changes to office and outpatient E/M CPT ® codes[1].

Changes to CPT Code Descriptions and Guidelines

Coding component	2022	2023
History and Exam	▪ Used as two of the three components (in addition to medical decision making) to select all E/M services (except office and outpatient services).	▪ History and exam will no longer be used to select any E/M service, but a "medically appropriate history or examination" must be performed to report inpatient, observation, discharge, consultations, or critical care services. ▪ The level of service will be determined by either Medical Decision Making (MDM) OR time.
Hospital vs observation	▪ Codes split between observation and inpatient for initial, subsequent, and discharge.	▪ Codes combined for hospital inpatient and observation care rather than two categories (Hospital Inpatient and Observation Care and Discharge Services).
Initial vs Subsequent	▪ Initial = report the first hospital encounter by admitting physician. * ▪ Other physicians use inpatient consultation OR subsequent hospital care codes. ▪ Subsequent = services on days after date of initial admission	▪ Initial = when patient has not received any professional services from physician/QHP in same specialty/subspecialty/group during stay ▪ Subsequent=if patient has received services during stay by same specialty/subspecialty/group and physician QHP other than the admitting physician.
Time	▪ Face to face activities only. ▪ May only be reported if counseling/coordination is 50% of encounter.	▪ Includes both face-to-face and non-face-to-face activities. ▪ 50% rule no longer applies. ▪ Continuous service over two calendar dates = 1 service on one date

[1] CPT Copyright 2022 American Medical Association. All rights reserved.

Prolonged Services	▪ Reported 31 minutes to 1 hour beyond usual service in the inpatient/observation setting.	▪ New code created for 15-minute service in the inpatient/observation setting.

*Admitting physician to use modifier AI to indicate principal physician of record

Updates to Split/Shared Time Definitions for E/M Services

CPT

The distinct time personally spent by the physician *and* other QHP (Qualified Health care Professional) on the date of the encounter is summed as total time. The provider with the substantive portion (of the visit will bill and receive reimbursement.

Centers for Medicare and Medicaid Services (CMS)

CMS is postponing changes to split/shared services in the facility/institutional setting to allow more time for discussion and implementation planning.

2021 Errata and Technical Corrections to E/M Guidelines

Updates to definitions of time, services reported separately, presenting problems, risk of patient management, amount and complexity of data will be included in the descriptions and information available for E/M services for 2023. More information on the clarifications and updates regarding the 2021 changes can be found on ASCO Practice Central.

2023 Evaluation and Management Changes

Guideline Updates, Clarifications, and Corrections

This resource highlights updates to, clarifications of, and corrections for the 2023 Evaluation and Management services guidelines. Please refer to the AMA's 2023 CPT E/M Descriptors and Guidelines for more details and the revisions in their entirety.

General Guidelines

Services Reported Separately

"Physician" terminology has been removed, which will allow for independent reporting of services rather than incident-to reporting as applicable.

History and/or Examination

The new guidelines include details regarding history and/or examination stating that E/M codes determined by level of service include a medically appropriate history and/or physical examination when performed, falling in line with the guidelines previously established for the office and other outpatient services. These are not elements of level of service selection for these E/M codes.

Level of Service selection based on Medical Decision Making

As level of service is now determined by medical decision making and time, the definitions for history, social history, and system review no longer apply. The definitions for presenting problems are now applicable, but in more detail, to the number and complexity of problems addressed which is found in the "Selecting a Level of Service based on Medical Decision Making" section of the guidelines[2].

Number and Complexity of Problems Addressed at the Encounter

Risk in this section relates directly to the risk from the condition and is separate from that of the risk of management. The problem address is the problem being managed by the reporting physician or other qualified healthcare professional on the date of the encounter. For hospital inpatient and observation services, this may be different from the problem on admission and may not be the cause of admission or continued stay.

New

[2] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes". 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A short term problem having a low risk of morbidity and requiring treatment in a hospital inpatient or observation setting. A full recovery is expected with low risk of mortality with treatment.
Stable, acute illness: A new or recent problem that is improved after initiation of treatment, but resolution is not yet complete.

Revisions

Chronic illness with exacerbation, progression, or side effects of treatment: Removal of language excluding consideration of hospital level care.

Chronic illness with severe exacerbation, progression, or side effects of treatment: Revision of language to include escalation in the level of care rather than possibly requiring hospital level care.

Acute or chronic illness or injury that poses a threat to life or bodily function: Introduction of inclusion of language that symptoms may present as a condition that could pose a potential threat to life or bodily function in which the evaluation and treatment is consistent with the potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

This section relates to the tests and sources reviewed or analyzed at the encounter. For 2023, there are no significant additions or revisions to the guidelines.

Risk of Complications and/or Morbidity or Mortality of Patient Management

Risk in this section relates directly to the risk resulting from patient management at an encounter and is associated with the risk of complications and morbidity and/or mortality as a consequence of the problems addressed at the encounter and applies to patient management decisions made by the reporting physician or other QHP (Qualified Health care Professional) as part of the encounter. This is separate from the risk of the condition.

New

"Parenteral controlled substances" is included as a new example for 2023.

Revisions

The decision regarding hospitalization now includes added language regarding "escalation of hospital level care."

Additional Revisions

Clarifications and updates made in the 2021 technical correction were officially added to the guidelines. Details regarding these corrections can be found in ASCO's resource "2021 E/M Changes Updates and Clarifications".

Time

Time for E/M services, except for emergency department services which are not time-based, is defined in the service descriptors and is attributed to the total time on the date of the encounter.

When prolonged time occurs, the total time on the date of the encounter accounting for care of the patient, both face-to-face and non-face-to-face, should be documented in the medical record if used to select the level of service.

Hospital Inpatient and Observation Care Services

Terms that were uncertain or created misunderstanding were removed from the guidelines to create consistency and clarity.

Initial Versus Subsequent Changes

Historically, initial hospital services were reporting on the date of admission, typically by the admitting physician. Any services performed on other dates occurring after the date of admission were reported with subsequent service codes. In 2023, the definitions of initial and subsequent services are being revised to be more consistent with the evaluation and management services.

Initial services will fall more in line with the definition of a new patient and would be reported if a patient has not received any professional services during the stay from the physician or other QHP (Qualified Health care Professional) (Qualified Health care Professional) or another other physician or QHP in the same specialty who belongs to the same group/practice. Subsequent services are similar to established patient visits in that they would be used if a patient has received any services during the stay from the physician or other QHP or another physician or QHP in the same group. A transition from observation to inpatient will not indicate a new stay.

New or established patient

When admission occurs during the course of an encounter of another site of service, the services associated with the other site may be reported separately.

Consultations

A consultation may not be reported with the consultation codes if requested by patient and/or family. Consultations must be requested by a physician, other qualified healthcare professionals, or another appropriate source. Consultations performed in anticipation of, or related to, an admission that is managed by another physician or QHP, and the consultants performed an encounter after admission, the inpatient encounter should be reported as a subsequent hospital service code. This applies regardless of the appropriate code used for the consultation and if the consult is on the date of admission or a date before admission.

Terms that were uncertain or created misunderstanding were removed from the guidelines to create consistency and clarity. For example, previously "transfer of care" definition included a long explanation involving the process in which a physician or other qualified healthcare professional provided management for some of all a patient's problems transfers care to another non-consultative provider and will no longer provider care for the specified conditions but may provide care for other conditions. The services will now be defined as provided for the management of the patient's entire care or for the care of a specific condition or problem.

Prolonged Services

Currently	2023

• 99354-99357: Inpatient, Observation,Consultation
• 99417: Office and outpatient office visits
• 99358-99359: Outside of the encounter
	• Date of encounter
	  • 99415-99416: Clinical staff time
	  • 99417: Office and outpatient office visits
	  • 99418: Inpatient, Observation, Consultation
	• Outside of encounter
	  • 99358, 99359

Please note that CMS (Center for Medicare and Medicaid Services) has their own codes and guidelines for reporting prolonged services which can be found in the 2023 PFS (Physician Fee Schedule) Final Rule[3].

[3] Centers for Medicare and Medicaid Services. "Revisions to Payment Policies Under the Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023". 2022, November 18. CMS-1770-F | CMS

2023 Evaluation and Management Changes:
Selecting a Code Based on Time

Starting on **January 1st, 2023**, providers may select inpatient, observation discharge, and consultation services Evaluation and Management (E/M) services based on either **time** or **medical decision making**.

Currently (CY 2022), inpatient, observation, discharge, and consultation services are selected based on history, exam, and medical decision making. The services may only be reported based on time *if* 50% of the visit is spent on counseling and/or coordination of care. As of 2023, the 50% rule will no longer apply, following the guidelines for office and outpatient E/M services (CPT ® codes 99202-99215).

Time Requirements

Each CPT code description will be accompanied by a **definitive time requirement**, rather than a "typical" time. The time noted in the code description must be met or exceeded to report the corresponding service.

Example

2022	2023
99222- Initial hospital care is **typically 50 minutes** spent at the bedside and on the patient's hospital floor or unit. [4]	99222- Initial hospital inpatient or observation care requires **55 minutes must be met or exceeded** when using total time on the date of the encounter for code selection. [5]

Activities That Count Towards Time

In 2021, the definition of time for office and outpatient services was amended to encompass **both face to face and non-face to face activities** on the date of service. The same principle will apply to inpatient, observation, discharge, and consultation services in 2023.

Physician/Qualified Healthcare Professional time includes:

- ☑ Preparing to see the patient (e.g., review of tests)

[4] American Medical Association. (2021). *CPT® 2022 Professional Edition.*
[5] American Medical Association. (2022, June 30). *CPT® Evaluation and Management (E/M) code and guideline changes.* https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

- ☑ 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, and procedures
- ☑ Referring and communicating with other health care professionals
- ☑ 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

The following activities do <u>not</u> count towards the time of the service:

- **The performance of other services that are reported separately.**
- **Travel.**
- **Teaching that is general and not limited to discussion that is required for the management of a specific patient.**
- **Activities not occurring on the date of service.**

Split/Shared E/M Services

CPT defines a split/shared visit as "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." In the 2023 guidelines, language was added to include "counseling, educating, and communicating results to the patient/family/caregiver" in the time personally spent by the physician and other qualified healthcare professionals:

> *"When time is being used to select the appropriate level of services for which 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."*[6]

It is important to note the guidance on split/shared services from CPT differs from the CMS policy on split/shared E&M services as outlined in the 2023 Medicare Physician Fee Schedule Final Rule. When reporting a split/shared service to a payer, be sure to reference the appropriate guidelines and policies.

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[6] American Medical Association. (2022, June 30). *CPT® Evaluation and Management (E/m) code and guideline changes*. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

2023 Evaluation and Management Changes: Medical Decision Making Simplified

Starting on **January 1st, 2023**, providers may select the level of inpatient, observation, discharge, and consultation evaluation and Management (E/M) services based on either time or **medical decision making**, apart from encounters in the Emergency Room.

Selecting a Level of Service based on Medical Decision Making

The medical decision-making elements associated with evaluation and management services consists of three components:

1. Problem: The number and complexity of problems addressed.
2. Data: Amount and/or complexity of data to be reviewed and analyzed.
3. Risk: Risk of complications and/or morbidity or mortality of patient management.

To select the level of an E/M service, **two** of the three elements of medical decision making must be met or exceeded.

Code Selection Steps

The American Medical Association's Medical Decision-Making table serves as a guide for selecting the appropriate E/M code based on MDM. The code selection should point directly back to the criteria as outlined for each code and level[7].

Step 1 – Problem: Select the applicable number and complexity of problems addressed at the encounter.

The number and complexity of complexity of problems addressed at the encounter is divided into four levels: minimal, low, moderate, and high. Each level has specific criteria for the conditions addressed. To correctly identify the appropriate level, it is important to understand the "problem" definitions.

[7] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes." 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Code	Level of MDM	Number and Complexity of Problems Addressed
99211	N/A	N/A
99202 99212 99221 99231 99234 99242 99252	Straightforward	Minimal ❑ 1 self-limited or minor problem
99203 99213 99221 99231 99234 99243 99253	Low	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 hospital inpatient or observation level of care
99204 99214 99222 99232 99235 99244 99254	Moderate	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
99205 99215 99223 99233 99236 99245 99255	High	High ❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or ❑ 1 acute or chronic illness or injury that poses a threat to life or bodily function

Clarifying "Problem" Definitions

It is important to understand how different types of illness are defined to correlate it to the appropriate level of MDM and E/M code.

Stable, acute illness: A problem that is new or recent and for which treatment has been initiated. Patient may be improved and stable, but resolution is not yet complete.

Example: Respiratory infection under treatment and monitoring for resolution.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity requiring treatment. Treatment requires hospital inpatient or observation setting.

Example: Uncomplicated appendicitis.

Chronic illness with exacerbation, progression, or side effects of treatment: Includes an intent to control progression and requires additional supportive care or attention to treatment for side effects

Example: Progression during cancer treatment; Proctitis during radiation treatment for prostate cancer.

Chronic illness with severe exacerbation, progression, or side effects of treatment: Carries a significant risk of morbidity and may require an escalation in the level of care.

Example: Malignant pleural effusion requiring indwelling pleural catheter, patient with ovarian cancer with abdominal carcinomatosis undergoing chemo presenting with acute colonic obstruction.

Acute of chronic illness or injury that poses a threat to life or bodily function: Associated with illness or injury that poses a threat to life or bodily function in the *near future* without treatment. This can include symptoms that may indicate a condition which poses a *potential* threat to life and bodily function but work up and management of the symptoms must be associated with this level of severity.

Example: Pulmonary embolism, stroke, myocardial infarction, anaphylaxis.

For additional definitions and clarifications, refer to the "Number and Complexity of Problems Addressed at the Encounter" in the "2023 Evaluation and Management Services guidelines".[8]

Step 2 – Data: Select the amount and/or complexity of data to be reviewed or analyzed.

The second step in the selection process is calculating the amount and complexity of data to be reviewed and analyzed. "Data" is defined as certain data elements that are ordered, reviewed, analyzed, or independently interpreted as further specified in the MDM table located in the AMA's Evaluation and Management guidelines.[7]

Code	Level of MDM	Amount and/or Complexity of Data to Be Reviewed and Analyzed

[8] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes." 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

99211	N/A	N/A
99202 99212 99221 99231 99234	Straightforward	Minimal ❑ Minimal or none
99203 99213 99221 99231 99234	Low	Low (Must meet at least 1 of 2 categories) ❑ Category 1: Tests and documents At least 2 of the following: ▪ Review of prior external note(s) from each unique source ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test OR ❑ Category 2: Assessment requiring an independent historian(s)
99204 99214 99222 99232 99235	Moderate	Moderate (Must meet at least 1 out of 3 categories) ❑ Category 1: Tests, documents, or independent historian(s) Any combination of any 3 of the following: ▪ Review of prior external note(s) from each unique source ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test ▪ Assessment requiring an independent historian(s) OR ❑ Category 2: Independent interpretation of tests ▪ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) OR ❑ Category 3: Discussion of management or test interpretation ▪ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
99205 99215 99223 99233 99236	High	High (Must meet at least 2 out of 3 categories) ❑ Category 1: Tests, documents, or independent historian(s) Any combination of 3 of the following: ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test ▪ Ordering of each unique test

		▪ Assessment requiring an independent historian(s) OR ❑ Category 2: Independent interpretation of tests ▪ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) OR ❑ Category 3: Discussion of management or test interpretation ▪ Discussion of management or test interpretation with external physician/other health care professional/appropriate source (not separated reported)

Clarifying "Data" Definitions

Ordered: A test may normally be performed but after shared decision making, the test is not ordered due to risk or necessity. These tests may still be counted, but considerations must be documented. Ordering a test and review of the result(s) as part of the encounter is included in the category of test results.

Analyzed: Tests are counted on the order in which the results are reported (see "Ordered" above). For example, if a test is recurring, the test is counted when the result is reported and not when it is ordered. Ordering a test may include those that were considered but not performed after shared decision making.

Unique: Unique tests do not include overlapping elements and are defined by CPT® code set. Multiple results of one unique test reviewed at a visit count for one test. A unique source is a clinician in one group or different specialty or unique entity. Review of all materials from a unique source count towards one element of data in medical decision making.

Independent Historian: An individual that provides a history when the patient is unable to provide a complete or adequate history, or it is determined that the patient's history needs to be confirmed by another source. The history does not have to be obtained in person but must be obtained directly from an independent source. This does not include translation. Make sure to document why independent history is needed.

Independent interpretation: This cannot be included in determining a level of service if the test being interpreted is independently reported by the provider reporting the E/M service and must be performed for a test that is reported by CPT code. The interpretation should be documented.

Appropriate source: An appropriate source is defined as professionals who are not health care related but participate in the management of the patient (ex. social worker, lawyer). Appropriate sources do not include family or informal caregivers.

Example: Data elements can be combined for a summation of the parts. For instance, to evaluate potential progression, a provider may order a CT of the pelvis, along with a urinalysis, and review a specialist's note. This would account for 3 of the "test" requirements in category 1 (tests, documents, independent historians) for the amount of data to be reviewed and analyzed and result in a moderate level of this element.

For additional definitions and clarifications, refer to the "Amount and/or Complexity of Data to be Reviewed and Analyzed" portion in the "Evaluation and Management Services guidelines."[9]

Step 3: Risk of Complications and/or Morbidity or Mortality of Patient Management

The risk of complications and/or morbidity in this section of the MDM relates directly to the risk associated with *appropriate treatment* rather than the treatment itself.

High risk of morbidity includes revised examples for 2023 which comprise of the decision regarding escalation of hospital-level care, like moving to a nursing facility, and parenteral controlled substances.

Code	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A
99202 **99212** **99221** **99231** **99234**	Straightforward	Minimal ❑ Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213** **99221** **99231** **99234**	Low	Low ❑ Low risk of morbidity from additional diagnostic testing or treatment
99204 **99214** **99222** **99232** **99235**	Moderate	Moderate ❑ Moderate risk of morbidity from additional diagnostic testing or treatment Examples: ▪ Prescription drug management ▪ Decision regarding minor surgery with identified risk factors

[9] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes." 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

		▪ Decision regarding elective major surgery without identified risk factors ▪ Social determinants of health affecting diagnosis or treatment
99205 **99215** **99223** **99233** **99236**	High	High ❑ High risk of morbidity from additional diagnostic testing or treatment Examples: ▪ Drug therapy requiring intensive monitoring for toxicity ▪ Decision regarding major elective surgery with identified risk factors ▪ Decision regarding emergency major surgery ▪ Decision regarding hospitalization or escalation of hospital-level care ▪ Decision not to resuscitate or de-escalate care due to poor prognosis ▪ Parenteral controlled substances

Clarifying "Risk" Definitions

Each level of MDM is associated with a level of risk of morbidity from additional diagnostic testing or treatment, as outlined in the MDM table.

A frequent assumption regarding patients with cancer is whether undergoing chemotherapy ("Drug therapy requiring intensive monitoring for toxicity") is automatically considered "high risk" However, that is not always the case.

Monitoring should not be for therapeutic levels but to assess side effects from treatment. A drug requiring monitoring for toxicity may have the potential to cause serious morbidity or death. Long-term monitoring should be performed at least on a quarterly basis. Monitoring is included in the MDM when it is considered as part of management of the patient.

For additional definitions and clarification, refer to the "Risk of Complications and/or Morbidity or Mortality of Patient Management" portion in the "Evaluation and Management Services guidelines."[10]

Putting It All Together

[10] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes." 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

After the level of each of the categories is determined, the level of service for the evaluation and management code can be determined. Again, two of the three elements must be met or exceeded to report the applicable E/M code.

Example: A moderate E/M code (99214) would be reported if:

A patient presented with a new progression of bone metastasis while under treatment for breast cancer (moderate problems addressed).

The physician reviewed the most recent CT scan (low level of data reviewed).

It is determined the patient will have a change in chemotherapy due to the progression. (moderate/high level of risk dependent on the chemotherapy plan).

Example: A low-level E/M code (99203, 99213) would be reported if:

A patient presented with a stable history of breast cancer no longer on treatment (low level or problems addressed).

The physician conducted a review of tumor marker, CBC, CMP (moderate level of data reviewed).

A CT scan was ordered for the next visit (low level of risk of morbidity/mortality).

Additional Considerations When Selecting a Code:

- Comorbidities and underlying diseases are *not* considered in selecting a level of E/M service unless they are addressed as part of the service and their presence increases the amount of data to be reviewed/analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis of a condition does not necessarily determine the complexity or risk. Presenting symptoms that represent a highly morbid condition may require extensive evaluation to determine the ultimate diagnosis.

2023 Evaluation and Management Changes:
Inpatient, Observation, and Discharge
Code Family Combination

In calendar year 2022, initial, subsequent, and discharge codes for hospital-based evaluation and management services are divided into two categories: observation and inpatient services. The American Medical Association (AMA) adopted changes to these services beginning in January 2023 which combines observation and inpatient services into one code set. Observation CPT® codes 99217, 99218-99220, 99224-99226 will be deleted as of January 1, 2023.

2022	2023
Observation Services Initial: 99218-99220 Subsequent: 99224-99226 Discharge: 99217	**Hospital Inpatient and Observation Care Services** Initial: 99221-99223 Subsequent: 99231-99233 Same Day Admission & Discharge: 99234-99236 Discharge: 99238-99239
Inpatient Services Initial: 99221-99223 Subsequent: 99231-99233 Discharge: 99238-99239	
Inpatient and Observation Services Admission and Discharge: 99234-99236	

For the full set of guidelines, be sure to refer to the American Medical Association's "2023 CPT E/M descriptors and guidelines".[11]

[11] American Medical Association. "2023 Evaluation and Management (E/M) Code and Guideline Changes". 2022. 2023 CPT E/M descriptors and guidelines

Inpatient and Observation Evaluation and Management Services

All inpatient or observational services will be reported with the following CPT codes:

Service Type	Initial	Subsequent	Same Day	Discharge
CPT® codes	99221-99223	99231-99233	99234-99236	99238-99239

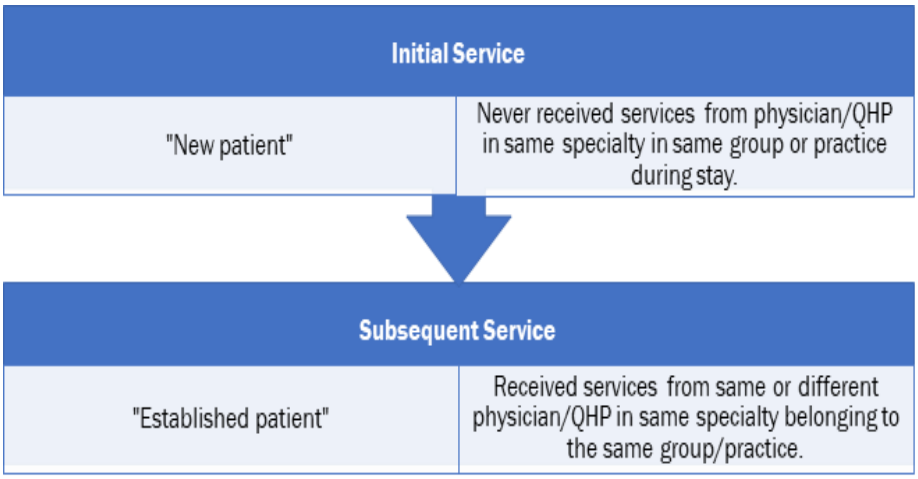
An admission stay encompasses both observation and inpatient services; a change in status does not account for a new stay. When admission occurs during an encounter at another site of service (such as an office setting), the services associated with the other site may be reported separately.

Initial Versus Subsequent Services

Historically, initial hospital services were reported on the date of admission, typically by the admitting physician. Any services performed on other dates occurring *after* the date of admission were reported with subsequent service codes.[12] In 2023, the definitions of initial and subsequent services are being revised for consistency with the guidelines for office and outpatient evaluation and management services.[13]

Initial services mirror the definition of a new patient and would be reported if a patient has not received any professional services during the stay from the physician or other qualified health care professional (QHP) or another other physician or QHP in the same specialty who belongs to the same group/practice. Subsequent services are like established patient visits as they would be used if a patient has received any services during the stay from the physician or other QHP or another physician or QHP in the same group.

[12] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.
[13] American Medical Association. "2023 Evaluation and Management (E/M) Code and Guideline Changes". 2022. 2023 CPT E/M descriptors and guidelines



Time

In 2021, the definition of time changed for office and outpatient services to include both face-to-face and non-face-to-face activities. Time for hospital services and other outpatient services remained defined by face-to-face activities **only** and required counseling and coordination of care to account for more than 50% of the encounter. [14]

In 2023, all E/M services (except for Emergency Room visits) will have time determined by face-to-face and non-face-to-face activities. The level of service can be selected by all time spent on the date of the encounter. The requirement of selecting a code based on time if the encounter was 50% counseling and coordination of care will no longer apply. The time noted in the code description must be met or exceeded to report a specific code[15].

Service	Initial	Subsequent	Same Day	Discharge
CPT® codes & Time	99221 – 40 min	99231 – 25 min	99234 – 45 min	99238 > 30 min
	99222 – 55 min	99232 – 35 min	99235 – 70 min	99239 ≤ 30 min
	99223 – 75 min	99233 – 50 min	99236 – 85 min	

CPT Guidelines: Calculation of Time Over Multiple Calendar Days

[14] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.
[15] American Medical Association. "2023 Evaluation and Management (E/M) Code and Guideline Changes". 2022. 2023 CPT E/M descriptors and guidelines

If a service is continuous before and after midnight, all the time attributed to the service is applied to and reported on one date of service.

Example: if the service began at 11:00 pm and crossed the midnight threshold to 2:00 am, three hours would be counted and reported on one date of service.

CMS Guidelines: Calculation of Time Over Multiple Calendar Days

CMS adopted CPT's revised definition of a calendar day for hospital services in the 2023 Physician Fee Schedule Final Rule[16] with a caveat. For inpatient, observation, and discharge services reported to CMS, the billing practitioner may only bill one hospital initial, subsequent, same day, or discharge visit **once per calendar date**. CMS maintains their 8-to-24-hour policy as admissions and discharges may happen around the clock.[24]

Example: The provider spent 1 hour of time with the patient and on other activities supporting patient care.

Reporting Scenarios

- Patient admitted at 11pm, discharged at 4am (less than 8 hours): Report 99222 (initial service). No discharge services would be reported.
- Patient admitted at 11pm, discharged at noon (more than 8 hours, less than 24 hours): Report 99234 (same day admission and discharge).
- Patient admitted at 11pm Monday, discharged on Wednesday (more than 24 hours): Report 99222 (Initial service) and the appropriate discharge CPT (99238, 99239) on date of discharge.

CMS Guidelines	
<8 hours	• Initial Services: 99221, 99222, 99223 • No discharge day services
8 hours < 24 hours	• Same Day Admission and Discharge Services: 99234, 99235, 99236
>24 hours	• Date of Admission Services: 99221- 99223

[16] Centers for Medicare and Medicaid Services. "Revisions to Payment Policies Under the Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023". 2022, November 18. CMS-1770-F | CMS

- Date of Discharge Services: 99238, 99239

Split (or Shared) Evaluation and Management (E/M) Services

The Centers for Medicare and Medicaid Services (CMS) describe a split (or shared) visit as an evaluation and management service (E/M) that is performed "split" or "shared" by both a physician and non-physician practitioner (NPP) who are in the same group. CMS has not defined "group" at this time but will be monitoring claims and considering input from stakeholders regarding the description.

Split/shared visits may be provided to both new and established patients, and for initial and subsequent visits in the inpatient hospital and observation setting.

Setting

The split/shared services policies pertain to the facility and institutional setting, in which payment for services and supplies furnished "incident to" a physician or practitioner's professional services is prohibited. Split/shared rules are not applicable in an office setting as "incident to" rules apply.

The applicable place of service (POS) codes is: Inpatient facility (POS 21), Emergency Department (POS 23), Outpatient On Campus (POS 22), Outpatient Off Campus (POS 19).

Definition of Substantive Portion

For calendar year 2023, the definition of substantive portion remains the same as in calendar year 2022:

1. One of the three key components (history, or exam, or MDM). The component must be performed in its entirety by the billing practitioner OR
2. More than half of the total time spent by the physician and NPP performing the split (or shared) visit.

Per the 2023 Medicare Physician Fee Schedule Final Rule (MPFS), CMS is delaying the implementation of the definition of "substantive portion" as more than half of the total time ONLY until **January 1, 2024**[17].

[17] Centers for Medicare and Medicaid Services. "Revisions to Payment Policies Under the Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023". 2022, November 18. CMS-1770-F | CMS

CMS Definition of Substantive Portion	
2023	**2024 (Proposed)**
▪ Two options (select one): 1. One of the three key components (history, exam, or MDM). The component must be performed in its entirety by the billing practitioner OR 2. More than half of the total time spent by the physician and NPP performing the split (or shared) visit. ▪ One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner).	▪ More than half of the total time spent by the physician and NPP performing the split (or shared) visit ONLY. * ▪ One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner). ▪ The substantive portion could be entirely with OR without direct patient contact (face to face or non-face to face activities). *The policy regarding split/shared visits will be finalized in the 2024 MPFS final rule.

Prolonged E/M Services

If the requirements for the both the primary E/M service and the prolonged service are met, the physician or practitioner who spent more than half the total time would bill for the primary E/M visit and the prolonged service code (either HCPCS code G2212 or G0316). More information about prolonged E/M services in 2023 can be found in the "Important Updates to Evaluation and Management Services in 2023" on ASCO's Coding and Reimbursement page.

Reporting

Distinct Time

If the practitioners jointly meet with or discuss the patient, the time may only be attributed to the practitioner who performed the substantive part of the visit (more than half the total time).

Modifier

When reporting a split/shared visit to CMS, modifier -FS must be appended to the appropriate code to indicate it's a split/shared visit. CPT modifier -52 describes a reduced service and should not be used to indicate a split/shared service.

Documentation

To appropriately capture a split/shared visit in the medical record, the physician *and* NPP who performed the visit must be identified. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

Reimbursement

Payment is made to the practitioner who performs the substantive portion of the visit. To report under the physician NPI (and therefore receive 100% of the PFS amount), a substantive portion of the visit must be performed by the physician. The service cannot be reported under the physician if the substantive portion was performed by the NPP.

Reporting Steps

When reporting a split or shared E/M service, consider three steps:

1	**Determine who provided the substantive portion of the visit.**	2023: Either history, exam, or MDM OR more than half the total time.
2	**Enter documentation in the patient's medical record.**	Identify both the physician and NPP that performed the service. Practitioner who performed the substantive portion of the visit must sign and date the medical record.
3	**Select the appropriate CPT code**	Append modifier -FS to the selected code.

Reporting Examples

Example 1

NPP spends 10 minutes with the patient

Physician spends 15 minutes with the patient.

Total time= 25 minutes

The **physician** spent the substantive portion of the visit with the patient (more than half of 25 minutes). Therefore, the **physician** would report the service.

Example 2

NPP spends 20 minutes with the patient

Physician spends 10 minutes with the patient.

Total time= 30 minutes

The **NPP** spent the substantive portion of the visit with the patient (more than half of 30 minutes). Therefore, the service must be reported by the **NPP** and NOT the physician. The payment for the service would be 85% of the PFS amount.

Example 3

NPP spends 10 minutes with the patient

Physician spends 15 minutes with the patient.

Total Distinct time: 25 minutes (Physician performed the substantive portion)

The physician and NPP met for 5 minutes to discuss the patient (joint time).

Total Time: 25 minutes of distinct time + 5 minutes of joint time= 30 minutes

The **physician** spent the substantive portion of the visit in distinct time. The 5 minutes of joint time would be attributed to the billing provider (in this case, the **physician**).

2023 Evaluation and Management Services Changes:

Prolonged Services

For **CY 2023**, two new prolonged services codes will be available for a 15-minute prolonged service in the inpatient or observation setting. These codes mirror the 15-minute prolonged services codes introduced in 2021 for the office and outpatient setting (CPT code 99417 and HCPCS code G2212). [18]

The Centers for Medicare and Medicaid Services created their own code to describe a 15-minute prolonged services code in the inpatient and outpatient setting, which has slightly different reporting guidelines than CPT code 99418. However, the codes have many of the same attributes, as outlined below.

	CPT Code 99418	HCPCS Code G0316
Code Description	Prolonged inpatient or observation evaluation and management service(s) of 15 minutes **beyond the reported time** of the primary service (CPT® code 99223, 99233, 99236, 99255, 99306, 99310).	Prolonged hospital inpatient or observation care evaluation and management service(s) with or without direct patient contact 15 minutes **beyond the total time** for the primary service (either CPT® code 99223, 99233, 99236)
Reportable To	**Private payers** only, unless otherwise directed to use HCPCS code G3016	**CMS** only, unless otherwise directed by a private payer
Reporting Guidelines	▪ Primary service selected based on time only (not medical decision making). ▪ With or without direct patient contact. ▪ May be reported for a **15-minute** unit of service.	▪ Primary service selected based on time only (not medical decision making). ▪ With or without direct patient contact. ▪ May only be reported when an additional **15 minutes** is spent on the service according to the CMS corrections notice.

[18] American Medical Association. "CPT® Evaluation and Management (E/M) Code and Guideline Changes". 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Inpatient & Observation Prolonged Services Reporting Examples:
Reporting CPT Code 99418 vs. HCPCS Code G0316

Primary Service

99236- 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 high level of medical decision making.

CPT Code 99418

The time for the prolonged service (99418) begins after the **required** time for the primary service has been met. The prolonged services CPT code may be reported when the full 15 minutes *after* the time of the primary service is reached.

CPT Code 99418 Reporting Example	
CPT Code 99236	85 minutes
CPT Code 99418	15 minutes
Total Time	**100 minutes (Report CPT codes 99236 + 99418)**

HCPCS Code G0316

A correction notice[19] to the 2023 Medical Physician Fee Schedule Final Rule[20] states G0316 may only be reported when 15 minutes beyond the **total** time of the primary procedure is reached.

HCPCS Code G0316 Reporting Example	
CPT Code 99236	75 minutes Prolonged Service period begins at 95 minutes (the total time of the service)

[19] Medicare and Medicaid Programs, CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes, Corrections. 15 March 2023.
[20] Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

HCPCS Code G0316	15 minutes
Total Time	110 minutes (Report CPT code 99236 + HCPCS code G0316)

Other Prolonged Services Updates

As of January 1, 2023, Prolonged Services with Direct Patient Contact (99354-99357) will be deleted from the American Medical Association CPT Professional Edition as it overlaps with the work of CPT codes 99417 and 99418 (as well as HCPCS codes G2212 and G0316).

CPT codes 99358 and 99359 describe prolonged services on a different day than the primary E/M service. The codes are still included in the 2023 AMA CPT Professional Edition; however, CMS is making them "inactive" as of January 1, 2023. Therefore, the codes will not be reportable for Medicare claims.

2023 Evaluation and Management Changes:

Consultations

Reporting

Consultation services are described with CPT codes 99242-99245 (office and outpatient) and 99252-99255 (inpatient and observation). A consultation is provided by a physician or qualified healthcare professional at the request of another physician, qualified healthcare professional, or other professional source. Consultations may not be initiated by a patient, family member, or caregiver.[21]

Office and Outpatient Consultations (CPT codes 99242-99245)

Follow up services initiated by the consulting provider or patient are reported with established patient office and outpatient evaluation and management services (CPT codes 99212, 99213, 99214, 99215). If the management of the patient's care (either in its entirety or for a specific condition) is transferred to the consulting provider, the next visit should be reported with the appropriate new or established office and outpatient evaluation management codes (CPT codes 99202-99215).

Inpatient and Observation Consultations (99252-99255)

In an inpatient and observation setting consultations may only be reported if the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay.

Only one consultation service may be reported by a consultant per admission. If a consultation occurs before or in relation to an admission with a subsequent encounter or occurs in subsequent visits, the appropriate subsequent inpatient or observation hospital care code should be reported (CPT codes 99231-99233).

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[21] American Medical Association. "2023 Evaluation and Management (E/M) Code and Guideline Changes". 2022. 2023 CPT E/M descriptors and guidelines

Reimbursement

Consultation services are not reimbursable under the Medicare Physician Fee Schedule but will remain in the AMA CPT Professional Edition in 2023. Private payer reimbursement for consultations may differ, therefore be sure to check policies for details.

Changes in 2023

The code descriptions and guidelines for consultation services will be updated along with the other Evaluation and Management services in 2023.

2022	2023
▪ Selection based on history, exam and medical decision making	▪ Selection based on medical decision making or time, but an appropriate history and/or exam should still be performed
▪ Time in code description is noted as a "typical" time (ex. "Typically, 60 minutes are spent face-to-face with the patient and/or family."	▪ Time in code description is a specific number of minutes that must be met or exceeded on a date of service (ex. "When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded".)
▪ Time only includes the time spent face-to-face with the patient and/or family.	▪ Time includes face-to-face and non-face-to face activities.
▪ Consultation codes may only be reported based on time if 50% of the visit is counseling and/or coordination of care.	▪ Consultation codes may be reported based on time whether the visits are 50% counseling and/or coordination of care.
▪ A prolonged service may not be reported with consultation services.	▪ A prolonged service code (99417, G2212, or 993X0) may be appended consultation codes if the requirements have been met.
▪ CPT code 99241 may be reported in an office or outpatient setting for a patient with self-limited or minor problems.	▪ CPT code 99241 will be deleted.
▪ CPT code 99251 may be reported in an inpatient setting for a patient with self-limited or minor problems.	▪ CPT code 99251 will be deleted.
▪ Inpatient and observation consultation services are two separate sets of CPT codes.	▪ Inpatient and observation consultation services have been combined into one code set.