

## 2023 Evaluation and Management Changes: Inpatient, Observation, and Discharge Updated April 2024

### 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 combined observation and inpatient services into one code set. Observation CPT® codes 99217, 99218-99220, 99224-99226 were deleted as of January 1, 2023.

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

For the full set of guidelines, be sure to refer to the 2024 American Medical Association CPT Professional Edition.

### Inpatient and Observation Evaluation and Management Services

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

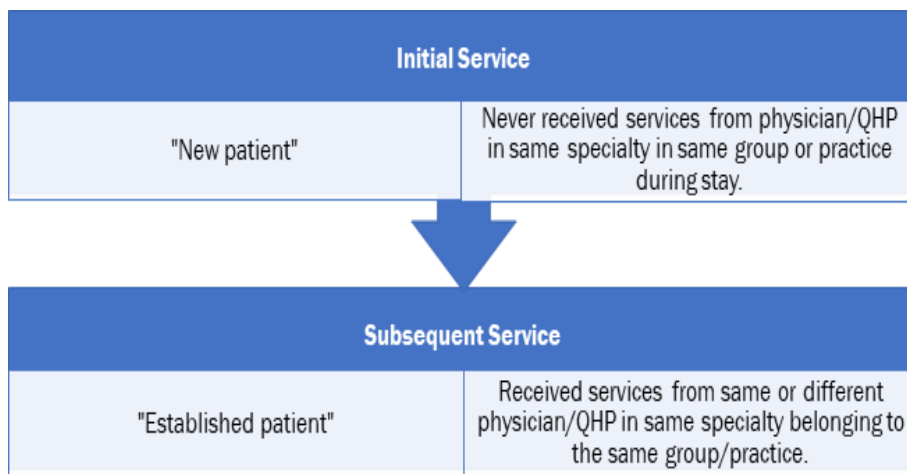
Service Type	Initial	Subsequent	Same Day	Discharge
CPT® codes	99221-99223	99231-99233	99234-99236	99238-99239

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.<sup>1</sup> In 2023, the definitions of initial and subsequent services were revised for consistency with the guidelines for office and outpatient evaluation and management services.<sup>2</sup>

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.



### 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

<sup>1</sup> CPT® 2022 Professional Edition. Chicago, IL: American Medical Association, 2021.

<sup>2</sup> American Medical Association. "2023 Evaluation and Management (E/M) Code and Guideline Changes". 2022. [2023 CPT E/M descriptors and guidelines](#)

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. <sup>3</sup>

In 2023, all E/M services (except for Emergency Room visits) 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 no longer applies. The time noted in the code description must be met or exceeded to report a specific code<sup>4</sup>.

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

### 2023 Update

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.

### 2024 Update

CPT added guideline language to be more in line with that of the CMS calculation.

- Hospital/Observation services less than 8 hours: Report only from the initial hospital/observation codes 99221-99223.
- Hospital/Observation services greater than 8 hours and discharged on the same calendar date: Report from the admission/discharge codes 99234-99236. These codes are to only be used by the physician/QHP who performs both the initial and discharge services.
- Hospital/observation services greater than 8 hours and discharged on different calendar date: Report from the initial hospital/observation codes 99221-99223 and from the discharge management codes 99238-99239.

<sup>3</sup> CPT® 2022 Professional Edition. Chicago, IL: American Medical Association, 2021.

<sup>4</sup> 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 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<sup>5</sup> 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.<sup>5</sup>

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.

2024 Time Guidelines	
<8 hours	<ul style="list-style-type: none"><li>• Initial Services: 99221, 99222, 99223</li><li>• No discharge day services</li></ul>
8 hours < 24 hours	<ul style="list-style-type: none"><li>• Same Day Admission and Discharge Services: 99234, 99235, 99236</li></ul>
>24 hours	<ul style="list-style-type: none"><li>• Date of Admission Services: 99221-99223</li><li>• Date of Discharge Services: 99238, 99239</li></ul>

## 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.

In the 2024 updates, CPT guidelines for split/shared services indicates that split or shared service code level selection can be based on time or medical decision making with language directing how substantive portion based on medical decision making is to be determined. CMS has adopted this framework. *Please see ASCO’s [Split/Shared E/M Service resource](#).*

CMS Definition of Substantive Portion	
2023	2024
<ul style="list-style-type: none"> <li>▪ Two options (select one):               <ol style="list-style-type: none"> <li>1. One of the three key components (history, exam, or MDM). The component must be performed in its entirety by the billing practitioner OR</li> <li>2. More than half of the total time spent by the physician and NPP performing the split (or shared) visit.</li> </ol> </li> <li>▪ One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner).</li> </ul>	<ul style="list-style-type: none"> <li>Two options (select one):               <ol style="list-style-type: none"> <li>1. More than half of the total time spent by the physician and NPP performing the split (or shared) visit ONLY.</li> <li>2. Substantive portion of MDM must meet CPT guideline criteria.</li> </ol> </li> </ul>

### 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:

<b>1</b>	<b>Determine who provided the substantive portion of the visit.</b>	2023: Either history, exam, or MDM OR more than half the total time.
<b>2</b>	<b>Enter documentation in the patient's medical record.</b>	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.
<b>3</b>	<b>Select the appropriate CPT code</b>	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**).



## Resources

### American Medical Association

2024 CPT Professional Edition

[2023 CPT E/M descriptors and guidelines](#)

### American Society of Clinical Oncology

[ASCO Coding and Reimbursement](#)

[Guide to 2023 Evaluation and Management Changes](#)

[Split/Shared E/M Services](#)

### Centers for Medicare and Medicaid

[CMS CY 2023 PFS Proposed Rule](#)

[CMS CY 2023 PFS Final Rule](#)

[CMS CY 2024 PFS Final Rule](#)

[Medicare Claims Processing Manual: Chapter 12 - Physicians/Non-physician Practitioners](#)