E/M 2023: Advancing Landmark Revisions Across More Settings of Care

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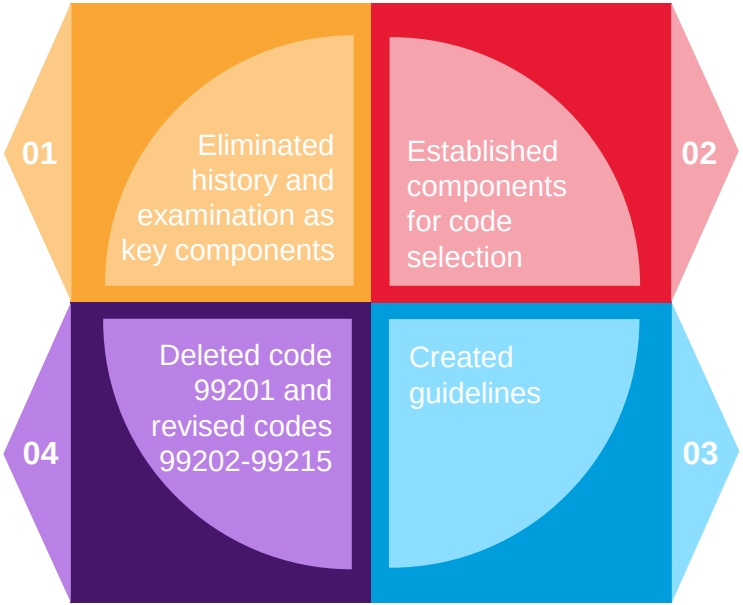
Agenda

- **Refresher: 2021 Office Visit Revisions**
- **2023: Updates to the Remaining E/M Codes That Used History/Exam/MDM**
  - E/M Introductory Guidelines
  - Inpatient and Observation Care Services
  - Consultations
  - Emergency Department Services
  - Nursing Facility Services
  - Home and Residence Services
  - Prolonged Services
- **Q&A**

Refresher:
2021 Office Visit Revisions

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

Continue to require a **medically appropriate history** and/or examination



Use either **MDM** level or **Total Time** on the date of the encounter

Codes 99201 and 99202 both required straightforward MDM in 2020

Specific to E/M office and other outpatient services

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

Select the appropriate level of E/M services based on the following:

The level of the MDM as defined for each service

OR

The total time for E/M services performed on the date of the encounter.

- Extensive clarifications in the guidelines to define the elements of MDM
- *Total* time spent on the date of the encounter
  - Including non-face-to-face services
  - Clearer time ranges for each code
- Addition of 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

2023:
Updates to the Remaining E/M Codes That Used History/Exam/MDM

Guiding Principles: E/M Workgroup & CPT® Editorial Panel

The CPT/RUC Workgroup on E/M expanded the scope of their work to include the other E/M families of services to reduce the burden of having two separate sets of E/M Guidelines in the CPT code set.

The Workgroup continued their work by following their existing **guiding principles** related to the group's ongoing work product:

- To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible
- To decrease the need for audits
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

Overview of 2023 E/M Changes

- **E/M Introductory Guidelines –** Update and consolidation
- **Hospital Observation Services –** Deletion (99217-99220)
- **Hospital Inpatient and Observation Care Services –** Revision
- **Consultations E/M codes –** Deletion and revision
- **Emergency Department Services –** Revision
- **Nursing Facility Services –** Deletion and revision
- **Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services –** Deletion
- **Home or Residence Services –** Deletion and revision
- **Prolonged Services –** New code, deletion and revision

E/M

EFFECTIVE

Jan. 1, 2023

E/M Introductory Guidelines

Evaluation and Management (E/M) Services Guidelines*

- Comprehensive restructure of the general E/M Guidelines now that the entire set of E/M services will use a single set of guidelines.
- Addition of clarifying guidelines related to:
  - Ordering a test that was considered, but not executed.
  - Minor editorial revisions made to MDM table to incorporate several clarifications related to inpatient hospital care.
  - Addition of a definition of major and minor surgery.
  - Clarification of activities that cannot be used to count total time, including:
    - Time spent in the performance of other services reported separately
    - Travel
    - Teaching that is general and not limited to discussion that is required for the management of the specific patient
  - Addition of guidelines clarifying the following concepts: analyzing a test, defining a unique test, discussion requiring an interactive exchange between QHPs and reporting a combination of data elements.

*Note that many of these revisions were included as technical corrections for the 2021 CPT code set

Update to Medical Decision Making Table

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
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 or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Update to Medical Decision Making Table

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
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	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from 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)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Inpatient and Observation Care Services

Inpatient and Observation Care Services

High Level Summary

- Deletion of observation CPT® codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99223, 99221-99233, 99238-99239).
- Editorial revisions to the code descriptors to reflect the structure of total time on the date of the encounter or level of medical decision making when selecting code level.
- Retention of revised Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236).
- Revision of guidelines.

Inpatient and Observation Care Services
Guidelines

- *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.*
    - 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.

Inpatient and Observation Care Services
Guidelines

*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 (eg, 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.****

*** CMS proposes to retain policy of only reporting ONE E/M service per calendar date

Inpatient and Observation Care Services
Guidelines

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 (eg, office or other outpatient visit or office or other outpatient consultation).

Initial Hospital Inpatient or 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

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

*CMS G-codes proposed for prolonged services

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

*CMS G-codes proposed for prolonged services

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

Hospital Inpatient or Observation 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.

Consultations

Consultations

High Level Summary

- 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.
- If payer considers consultation codes status “I”, the inpatient/observation or office visit codes may be used for consults.
    - CPT® Editorial Panel anticipated Medicare would not recognize Consultation codes.
    - For example, use “Initial Hospital or Observation” and CPT® now aligns with current practice with removal of *“by the admitting physician”* from “Initial” care.

Consultations

Guidelines—All previously existing concepts

- 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.
- A “consultation” initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (e.g., non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes.
- The consultant’s opinion and any services that were ordered or performed must also be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

Office or Other Outpatient Consultations

Code Descriptor Example

★▲**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

Inpatient or Observation Consultations

Code Descriptor Example

★▲**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

Emergency Department Services

Emergency Department Services

High Level Summary

- Maintained the existing principle that time cannot be used as a key criterion for code level selection.
- Editorial revisions to the code descriptors to reflect the code structure approved in the office visit revisions.
- Modified MDM levels to align with office visits and maintain unique MDM levels for each visit.
- Existing CPT® code numbers maintained (analogous to office visit revisions).
    - Rationale for retention was familiarity with current numbers and implementation concerns, if changed
- 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

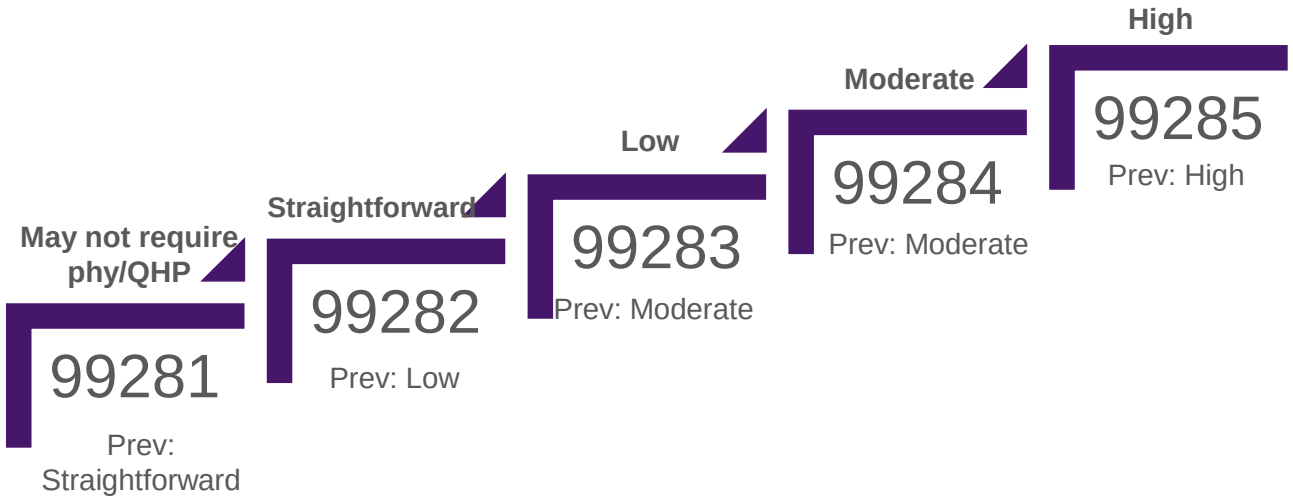
Emergency Department Services
Guidelines

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.

Emergency Department Services
Code Descriptor Overview

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



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

Nursing Facility Services

Nursing Facility Services

High Level Summary

- Editorial revisions to the code descriptors to reflect the new standard E/M code structure.
- Revision to nursing facility guidelines with new “problem addressed” definition of “multiple morbidities requiring intensive management,” to be considered at the high level for initial nursing facility care.
    - Intentionally did not add to the MDM Table, first column, in the E/M guidelines
- Deletion of code 99318 (annual nursing facility assessment). This existing service will be reported through the subsequent nursing facility care services (99307-99310) or Medicare G codes.
- Not all “initial care” codes are the mandated comprehensive “admission assessment” and may be used by consultants.
- Use subsequent visit when the principal physician’s team member performs care before the required comprehensive assessment.

Nursing Facility Services
Guidelines

- The principal physician is sometimes referred to as the admitting physician, and is the physician who oversees the patient's care as opposed to other physicians or other qualified health care professionals who may be furnishing specialty care.
- These services are also performed by physicians or other qualified health care professionals in the role of a specialist performing a consultation or concurrent care. Modifiers may be required to identify the role of the individual performing the service.

Nursing Facility Services
Guidelines

- When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a high-level MDM-type specific to initial nursing facility care by the principal physician or other qualified health care professional is recognized. This type is:
    - ***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.

Initial Nursing Facility Care

Guidelines

- An initial service may be reported when the patient has not received any face-to-face 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 the patient is admitted to the nursing facility in the course of an encounter in another site of service (e.g., hospital emergency department, office), 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.*
- When advanced practice nurses or physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.
- For reporting initial nursing facility care, transitions between skilled nursing facility level of care and nursing facility level of care do not constitute a new stay.

* Potential conflict with CMS

Initial Nursing Facility Care

Code Descriptor Example

▲**99304** Initial nursing facility 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)*
99304	25
99305	35
99306	45
Prolonged (993X0)*	60 mins or longer

*CMS G-codes proposed for prolonged services

Subsequent Nursing Facility Care

Code Descriptor Example

★▲**99307** Subsequent nursing facility care, per day, for the evaluation and management of a 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, 10 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99307	10
99308	15
99309	30
99310	45
Prolonged (993X0)*	60 mins or longer

*CMS G-codes proposed for prolonged services

Nursing Facility Discharge Services

Code Descriptor Example

The nursing facility discharge management codes are to be used to report the total duration of time spent by a physician or other QHP for the final nursing facility discharge of a patient.

- The codes include, as appropriate, time spent in final examination of the patient, discussion of the nursing facility stay, and instructions are given for continuing care to all relevant caregivers, preparation of discharge records, prescriptions, and referral forms. Time for this service includes the total time spent on that date even if it is not continuous.
- These services require a face-to-face encounter with the patient and/or family/caregiver that may be performed on a date prior to the date the patient leaves the facility.
- Code selection is based on the total time on the **date of the discharge management face-to-face encounter.**

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

▲**99316** More than 30 minutes total time on the date of the encounter

Home and Residence Services

Home and Residence Services

High Level Summary

- Editorial revisions to the code descriptors to reflect the new standard E/M code structure.
- The domiciliary or rest home CPT® codes (99234-99340) were deleted and merged with the existing home visit CPT codes (99341-99350).
- Elimination of duplicate MDM Level New Patient code (99434)

Home or Residence Services
Guidelines

- Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel or cruise ship).
  - Existing definition
- These codes are also used when the residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility or residential substance abuse treatment facility.
  - Existing CMS Place of Service rules, but now codified in the CPT code set.
- When selecting code level using time, do not count any travel time.
  - Updated in 2021 Technical Correction

Home or Residence Services

Code Descriptor Example

▲**99341** **Home or residence visit** for the evaluation and management of a new 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, 15 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99341	15
99342	30
99344	60
99345	75
Prolonged (99417)*	90 mins or longer

*CMS G-codes proposed for prolonged services

Home or Residence Services

Code Descriptor Example

▲**99347** **Home or residence visit** for the evaluation and management of an 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)*
99347	20
99348	30
99349	40
99350	60
Prolonged (99417)*	75 mins or longer

*CMS G-codes proposed for prolonged services

Prolonged Services

Prolonged Services

High Level Summary

- 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
- 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.

Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)

High Level Summary

- (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.

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Guidelines

- 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.
- 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.

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Code Descriptors

#★✚▲**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)

Prolonged Services

CMS Proposed Rule

- **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).

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

Prolonged Services

CMS Proposed Rule

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

Split or Shared Visits
Addressing Questions

CPT®

- Relates to how TOTAL TIME is counted, not to who reports the service.
- Both must have face-to-face work and CPT does not address who reports.

CMS

- Concept is focused on who reports and the rules regarding “substantive portion” in the facility setting.
- Outpatient and Inpatient facilities (except NF level of care) allowed and can use either majority of total time (not just F2F) on date of the encounter or one of 3 main elements (History, Exam, MDM).
- 2023 NPRM proposes to continue to allow one of these three into 2023. (CPT E/M Guidelines will only have level definitions for MDM.)

Questions?

- **2023: Updates to the Remaining E/M Codes That Used History/Exam/MDM**
- **2023: Updates to the Rest of E/M**
  - E/M Introductory Guidelines
  - Inpatient and Observation Care Services
  - Consultations
  - Emergency Department Services
  - Nursing Facility Services
  - Home and Residence Services
  - Prolonged Services

Stay Informed With AMA Resources

The **CPT® Evaluation and Management microsite** provides information on landmark revisions to the E/M section of the CPT code set, and links to related tools and information, including **E/M revisions to code descriptors and guidelines from 2021 through 2023**.

ama-assn.org/cpt-evaluation-management

AMA Ed Hub™ offers free learning modules on many topics, including landmark revisions to E/M office visit documentation. See how the revisions impact your work and earn CME credits.

edhub.ama-assn.org/cpt-education

Find your COVID-19 Vaccine CPT Codes is an AMA tool designed to help determine the appropriate CPT code combination for the type and dose of vaccine being used.

ama-assn.org/find-covid-19-vaccine-codes

Designed to address the needs of developers and creators of health technology and services, the **CPT Developer Program** offers access to AMA-published content from Current Procedural Terminology (CPT) during the crucial stages of development.

developer.ama-assn.org

The **AMA Center for Health Equity** was created to embed health equity across the organization so that health equity becomes part of the practice, process, action, innovation and organizational performance and outcomes.

ama-assn.org/delivering-care/health-equity

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