2023 Evaluation & Management Changes

Nursing, SNF, Psychiatric Residential Treatment Centers and		
Initial Nursing Facility	99304 (Straightforward or Low MDM) 25 Minutes	99305 (Moderate MDM) 35 Minutes
Subsequent Nursing Facility	99307 (Straightforward MDM) 10 Minutes	99308 (Low MDM) 15 Minutes
Nursing Facility Discharge	99315 (30 Minutes or less)	99316 (More than 30 minu

Consultations			
Skilled Nursing Facility	99252: (Straightforward MDM) 35 minutes	99253: (Low MDM) 45 minutes	9925 60 mi
Home/Residence	99242 (Straightforward MDM)	99243 (Low MDM)	9924
Prolonged Services: +99417 is selected for each 15 minutes beyond the time for 99245			

Home or Residence Services (Assisted Living,			
New Patients	99341 (Straightforward MDM) 15 Minutes	99342 (Low MDM) 30 Minutes	99344 (60 Min
Established Patients	99347 (Straightforward MDM) 20 Minutes	99348 (Low MDM) 30 Minutes	99349 (40 Min
Prolonged Services: +99417 is selected for each 15 minutes beyond the time for 99345 or			

Prolonged Services	
99358/99359 Prolonged Service on Date Other Than the Face-to-Face Evaluation and Manage (Not covered by Medicare)	
Less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.) 9	99358 X 1 AND 99359 X 1
105 minutes or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each ad
CPT: +993X0 Prolonged Nursing Facility E & M service(s) time with or without direct patient con service when the primary service level has been selected using total time, each 15 minutes of tot 99306, 99310, 99255)	
Initial Nursing Facility (99306)	+993X0 > 60 minutes on the date of the visit
Subsequent Nursing Facility (99310)	+993X0 > 60 minutes on the date of the visit
SNF Consultations (99255)	+993X0 >95 minutes on the date of the visit
Medicare: +GXXX2/+GXXX3 Prolonged Nursing or Home/Residence for each 15 minutes of total t	
Initial Nursing Facility (99306)	+GXXX2 >95 minutes 1 day before visit + date
Subsequent Nursing Facility (99310)	+GXXX2 >85 minutes 1 day before visit + date
New Pt. Home or Residence (99345)	+GXXX3 >141 minutes 3 days before visit + dat
Est. Pt. Home or Residence (99350)	+GXXX3 >112 minutes 3 days before visit + dat

2023 Evaluation & Management Services Guide

Hospital Inpatient, Observation, Emergency Department, Nursing Facility, Home or Residence Services

	Straightforward Complexity DX: Minimal Data: ≤ 1 Risk: Minimal	Low Complexity DX: Low Data: Limited Risk: Low	Moderate Complexity DX: Moderate Data: Moderate Risk: Moderate	High Complexity DX: High Data: Extensive Risk: High
MDM	MEDICAL DECISION MAKING - 2/3 components required			
	Straightforward	Low	Moderate	High
Complexity of Problem Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** -2 or more self-limited/minor problems -1 stable chronic illness -1 stable, acute illness -1 acute, uncomplicated illness/injury -1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** -1 or more chronic illness with exacerbation, progression or side effect from treatment -2 or more stable chronic illnesses -1 undiagnosed new problem w/ uncertain prognosis - 1 acute illness w/ systemic symptoms - 1 acute complicated injury	**High** -1 or more chronic illnesses w/ severe exacerbation, progression or side effect of treatment -1 acute or chronic illness/injury that poses a threat to life or bodily function
Data *Each unique test, order or document counts as 1 element within the category or subcategory in which it belongs	**Minimal or none**	**Limited** *(must meet 1 of 2 categories)* **Category 1: Tests and documents** Any combo of 2 from: -Review of prior external notes, each unique source *; -Review of the results of each unique test*; -Ordering of each unique test* OR **Category 2:** - Assessment requiring independent historian	**Moderate** *(must meet 1 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: -Review of prior external notes, each unique source *; -Review of the results of each unique test *; -Ordering of each unique test * -Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** -Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** -Discussion of management or test interpretation with external provider	**Extensive** *(must meet 2 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: -Review of prior external notes, each unique source *; -Review of the results of each unique test *; -Ordering of each unique test * -Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** -Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** -Discussion of management or test interpretation with external provider
Risk	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* - Prescription Drug Management - Decision regarding minor surgery w/ identified patient or procedure risk factors - Decision regarding elective major surgery without identified patient or procedure risk factors -Diagnosis or treatment significant limited by social determinants of health	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* - Drug therapy requiring intensive monitoring for toxicity -Decision regarding elective major surgery w/ 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

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Inpatient/Observation Services			
itial Inpatient/Observation	99221: (SF/Low MDM) 40 minutes	99222: (Moderate MDM) 55 minutes	99223: (High MDM) 75 minutes
dmit/Discharge Same Day	99234: (SF/Low MDM) 45 minutes	99235: (Moderate MDM) 70 minutes	99236: (High MDM) 85 minutes
ubsequent Inpatient/Observation	99231: (SF/Low MDM) 25 minutes	99232: (Moderate MDM) 35 minutes	99233: (High MDM) 50 minutes
ischarge	99238: 30 minutes or less	99239: More than 30 minutes	

Consultations				
npatient or Observation onsultations	99252: (Straightforward MDM) 35 minutes	99253: (Low MDM) 45 minutes	99254: (Moderate MDM) 60 minutes	99255: (High MDM) 80 minutes

Emergency Department Services					
mergency Dept. Services	99281 No Provider Required	99282 Straightforward MDM	99283 Low MDM	99284 Moderate MDM	99285 High MDM

Prolonged Services	
99358/99359 Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact (Not covered by Medicare)	
ss than 30 minutes	Not reported separately
)-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
5-104 minutes (1 hr. 15 min. - 1 hr. 44 min.) 9	99358 X 1 AND 99359 X 1
05 minutes or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes
PT: +993X0 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact eyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes f total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)	
itial IP/Obs. Visit (99223)	+993X0 > 90 minutes on the date of the visit
ubsequent IP/Obs Visit (99233)	+993X0 > 65 minutes on the date of the visit
/Obs Same-Day Admission/Discharge (99236)	+993X0 > 100 minutes on the date of the visit
edicare: +GXXX1 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time r the primary service (when the primary service has been selected using time on the date of the primary service); each additional 5 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to PT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services)	
itial IP/Obs. Visit (99223)	+GXXX1 >105 minutes on the date of the visit
ubsequent IP/Obs Visit (99233)	+GXXX1 >80 minutes on the date of the visit
/Obs Same-Day Admission/Discharge (99236)	+GXXX1 >125 minutes on date of the visit to 3 days after

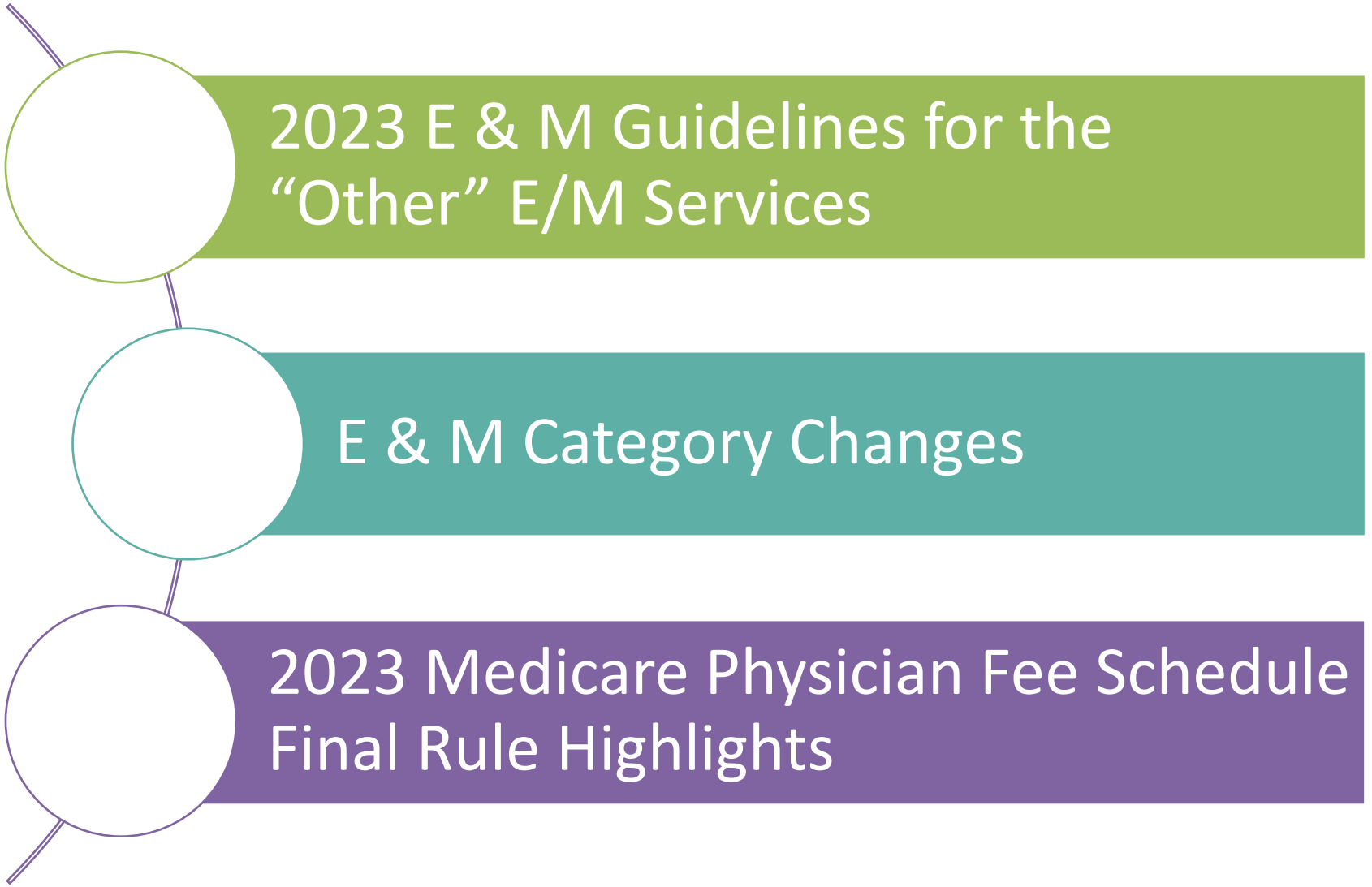
Presenter: Lynn Handy CPC, CPC-I, COC, CCS-P, LPN
Vice President of Education & Consulting Services

MANAGED RESOURCES

Your Presenter

Lynn Handy
CPC, CPC-I, COC, CCS-P, LPN

Agenda


2023 E & M Guidelines for the "Other" E/M Services
E & M Category Changes
2023 Medicare Physician Fee Schedule Final Rule Highlights

General Disclaimer

The information contained in today's webinar is intended to be used for educational purposes only. The comments, statements, views and opinions expressed in this webinar reflect the view of the presenter and the information contained in this presentation is accurate as of November 2022.

2023 E & M Changes

- As part of the ongoing updates to E/M visits and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023.
- Similar to the approach CMS finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation, CMS is proposing to adopt most of these changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023.
- This revised coding and documentation framework would include CPT code definition changes (revisions to the Other E/M code descriptors).

The E & M Changes

- New descriptor times (where relevant).
- Revised interpretive guidelines for levels of medical decision making.
- Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
- Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

Guideline Changes

- E/M Introductory Guideline Changes related to:
  - Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239,
  - Consultations codes 99242-99245, 99252-99255,
  - Emergency Department Services codes 99281-99285,
  - Nursing Facility Services codes 99304-99310, 99315, 99316,
  - Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350

Deletions & Revisions

- Deletion of Hospital Observation Services E/M codes 99217-99220
- Deletion of Consultations E/M codes 99241 and 99251
- Deletion of Nursing Facility Services E/M code 99318
- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-**99328**, 99334-99337, 99339, 99340
- Deletion of Home or Residence Services E/M code 99343
- Deletion of Prolonged Services E/M codes 99354-99357
  - Establishment of Prolonged Services E/M code 993X0 and guidelines

- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines
- Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines
- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines

New and Established Patients

- Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.
  - A new patient is one who has not received any 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, within the past three years.
  - An established patient is one who has received 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, within the past three years. See Decision Tree for New vs Established Patients.

New and Established Patients

- In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available.
- 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.

- ****Medicare will continue to not recognize subspecialties for the purposes of defining an initial vs. subsequent service**. CMS does not recognize subspecialties, so the agency would not allow different subspecialists to report separate initial visits.

Initial and Subsequent Services

- Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service.
- For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.
  - An initial service is when the patient has not received any 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 inpatient, observation, or nursing facility admission and stay.
  - A subsequent service is when the patient has received professional service(s) 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 admission and stay.

Transitions of level of Care

- For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay.
- For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

History and/or Examination

- E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed.
- The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.
- The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

2023 Medical Decision-Making Guidelines

Effective Date: January 1, 2023

Medical Decision Making

- The same 3 categories apply:
  - The number and complexity of problem(s) that are addressed during the encounter.
  - The amount and/or complexity of data to be reviewed and analyzed.
  - The risk of complications and/or morbidity or mortality of patient management

2023 Medical Decision-Making Guide

MDM	Straightforward Complexity DX: Minimal Data: None or 1 Risk: Minimal	Low Complexity DX: Low Data: Limited Risk: Low	Moderate Complexity DX: Moderate Data: Moderate Risk: Moderate	High Complexity DX: High Data: Extensive Risk: High
MEDICAL DECISION MAKING - 2/3 components required				
	Straightforward	**Low**	**Moderate**	**High**
Complexity of Problems Addressed at the Encounter	**Minimal** • 1 self-limited or minor problem	**Low** • 2 or more self-limited/minor problems • 1 stable chronic illness • **1 stable, acute illness** • 1 acute, uncomplicated illness/injury • **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	**Moderate** • 1 or more chronic illness with exacerbation, progression or side effect from treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem w/ uncertain prog 1 acute illness w/ systemic symptoms • 1 acute complicated injury	**High** • 1 or more chronic illnesses w/ severe exacerbation, progression or side effect of treatment • 1 acute or chronic illness/injury that poses a threat to life or bodily function
Data *Each unique test, order or documents contributes to the combination of 2 or 3 in this category	**Minimal or none**	**Limited** *(must meet 1 of 2 categories)* **Category 1: Tests and documents** Any combo of 2 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * OR **Category 2:** • Assessment requiring independent historian	**Moderate** (*must meet 1 of 3 categories*) **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	**Extensive** *(must meet 2 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another physician /other qualified health care professional OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider
Risk	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription Drug Management • Decision regarding minor surgery w/ identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significant limited by social determinants of health	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/ 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**

Number and Complexity of Problems Addressed at the Encounter

- Multiple new or established conditions may be addressed at the same time and may affect MDM.
- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Problem(s) Addressed

- **Problem Addressed**: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.
  - This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.
- Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
- Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
- **For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.**

ED Nurse (Triage) Visit

- **Minimal problem**: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Acute Conditions

- **Acute, uncomplicated illness or injury**: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.
- **Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care**: ***A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.***
- **Stable, acute illness**: ***A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.***
- **Acute illness with systemic symptoms**: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system.
- **Acute, complicated injury**: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic Conditions

- **Stable, chronic illness**: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant..
- **Chronic illness with exacerbation, progression, or side effects of treatment:** A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects
- **Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or Chronic Conditions

- **Undiagnosed new problem with uncertain prognosis**: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
- **Acute or chronic illness or injury that poses a threat to life or bodily function**: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. **Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.**

- **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 Care Only)

The amount and/or complexity of data to be Reviewed and Analyzed divided into three Categories

1. **Tests, documents, orders, or independent historian(s)**.
   - Each unique test, order or document is counted to meet a threshold number
   - Ordering a test is included in the category of test result(s) and the review of the test result is part of the current encounter and not a subsequent encounter.
   - This includes information obtained from multiple sources or interprofessional communications that are not separately reported.

2. **Independent interpretation of tests.**
   - The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

3. **Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source**

2023 Medical Decision-Making Guide

MDM	Straightforward Complexity DX: Minimal Data: None or 1 Risk: Minimal	Low Complexity DX: Low Data: Limited Risk: Low	Moderate Complexity DX: Moderate Data: Moderate Risk: Moderate	High Complexity DX: High Data: Extensive Risk: High
MEDICAL DECISION MAKING - 2/3 components required				
	Straightforward	**Low**	**Moderate**	**High**
Complexity of Problems Addressed at the Encounter	**Minimal** • 1 self-limited or minor problem	**Low** • 2 or more self-limited/minor problems • 1 stable chronic illness • **1 stable, acute illness** • 1 acute, uncomplicated illness/injury • **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	**Moderate** • 1 or more chronic illness with exacerbation, progression or side effect from treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem w/ uncertain prog 1 acute illness w/ systemic symptoms • 1 acute complicated injury	**High** • 1 or more chronic illnesses w/ severe exacerbation, progression or side effect of treatment • 1 acute or chronic illness/injury that poses a threat to life or bodily function
Data *Each unique test, order or documents contributes to the combination of 2 or 3 in this category	**Minimal or none**	**Limited** *(must meet 1 of 2 categories)* **Category 1: Tests and documents** Any combo of 2 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * OR **Category 2:** • Assessment requiring independent historian	**Moderate** (*must meet 1 of 3 categories*) **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	**Extensive** *(must meet 2 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another physician /other qualified health care professional OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider
Risk	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription Drug Management • Decision regarding minor surgery w/ identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significant limited by social determinants of health	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/ 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**

Services Reported Separately

- The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service.
- Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.
- The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

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

- **Analyzed:** The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment.
- Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.
- Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed.
- In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

What is a Unique Test?

- **Test:** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.
- **Unique:** A unique test is defined by the CPT code set.
  - When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test.
  - Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count.
  - A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Data Definitions

- **Independent historian(s):** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met.
  - It does not include translation services.
  - The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.
- **Independent interpretation**: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary.
  - This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test.
  - A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Risk of complications, morbidity and/or mortality of patient management

- **Risk:** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).
- For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
- Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.
- The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

2023 Medical Decision-Making Guide

MDM	Straightforward Complexity DX: Minimal Data: None or 1 Risk: Minimal	Low Complexity DX: Low Data: Limited Risk: Low	Moderate Complexity DX: Moderate Data: Moderate Risk: Moderate	High Complexity DX: High Data: Extensive Risk: High
MEDICAL DECISION MAKING - 2/3 components required				
	Straightforward	**Low**	**Moderate**	**High**
Complexity of Problems Addressed at the Encounter	**Minimal** • 1 self-limited or minor problem	**Low** • 2 or more self-limited/minor problems • 1 stable chronic illness • **1 stable, acute illness** • 1 acute, uncomplicated illness/injury • **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	**Moderate** • 1 or more chronic illness with exacerbation, progression or side effect from treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem w/ uncertain prog 1 acute illness w/ systemic symptoms • 1 acute complicated injury	**High** • 1 or more chronic illnesses w/ severe exacerbation, progression or side effect of treatment • 1 acute or chronic illness/injury that poses a threat to life or bodily function
Data *Each unique test, order or documents contributes to the combination of 2 or 3 in this category	**Minimal or none**	**Limited** *(must meet 1 of 2 categories)* **Category 1: Tests and documents** Any combo of 2 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * OR **Category 2:** • Assessment requiring independent historian	**Moderate** (*must meet 1 of 3 categories*) **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	**Extensive** *(must meet 2 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another physician /other qualified health care professional OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider
Risk	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription Drug Management • Decision regarding minor surgery w/ identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significant limited by social determinants of health	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/ 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**

Prescription Drug Management

Managing a condition with a prescription medication

- Adding, Removing or Changing a medication

What if you don't change anything?

- Are you managing a condition with a prescription medication"
  - How is the patient doing on the medication?
  - Are they having any side effects of the medication?
  - Did you document a statement that you want the patient to continue the medication?

Drug therapy requiring intensive monitoring for toxicity

- **Drug therapy requiring intensive monitoring for toxicity**: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
- The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.
- The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases.
- Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly.
- The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify.
- The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.
  - An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles.
  - Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

The Same Four (4) levels of MDM:

Straightforward
Low
Moderate
High

- The concept of the level of medical decision making does not apply to code 99211 or 99281.
- To qualify for a particular level of MDM, two of the three elements for that level of decision making must be met or exceeded (concept unchanged from current guidelines)
  - The number and complexity of problem(s) that are addressed during the encounter
  - The amount and/or complexity of data to be reviewed and analyzed
  - The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s).

Coding by Time

- When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver.
  - For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.
- For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).
- It includes time regardless of the location of the physician or other qualified health care professional (eg, whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

Shared or Split Services Time

- A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit.
- When time is being used 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.
- Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

Work Included when Time Coding

- Physician or other qualified health care professional time includes the following activities, when performed:
  - preparing to see the patient (eg, review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)

Copy and Paste

- Avoid cloning the note from previous visits
  - Especially in the Assessment & Plan
    - **If any part of your Assessment & Plan is copied from a previous note it must be updated or amended to reflect the status of the patient's condition at the time of the current visit.**
- Quote from CMS:
  - "This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in healthcare institutions that is not broadly addressed. For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable."

- OIG: https://www.reliasmedia.com/articles/30939-8216-copy-and-paste-8217-fraud-targeted-by-cms-and-oig
  - "Copy and paste" is a feature common to almost all computer programs that allows the user to quickly select text and reproduce it elsewhere instead of typing it again. Though useful, the Department of Health and Human Services' Office of Inspector General (OIG) is warning that copy and paste can lead to fraudulent billing, and the Centers for Medicare and Medicaid Services (CMS) is vowing to pursue any providers who abuse the feature.

Concurrent Care

- Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.
- In order to determine whether concurrent physicians' services are reasonable and necessary, the A/B MAC (B) must decide the following:
  - 1. Whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis, and
  - 2. Whether the individual services provided by each physician are reasonable and necessary.

Concurrent Care

- Once it is determined that the patient requires the active services of more than one physician, the individual services must be examined for medical necessity, just as where a single physician provides the care. For example, even if it is determined that the patient requires the concurrent services of both a cardiologist and a surgeon, payment may not be made for any services rendered by either physician which, for that condition, exceed normal frequency or duration unless there are special circumstances requiring the additional care.
- The A/B MAC (B) must also assure that the services of one physician do not duplicate those provided by another, e.g., where the family physician visits during the postoperative period primarily as a courtesy to the patient.
- A/B MACs (B) should have sufficient means for identifying concurrent care situations. A correct coverage determination can be made on a concurrent care case only where the claim is sufficiently documented for the A/B MAC (B) to **determine the role each physician played in the patient's care** (i.e., the condition or conditions for which the physician treated the patient). If, in any case, the role of each physician involved is not clear, the A/B MAC (B) should request clarification.

Hospital Inpatient and Observation Care Services

- The following codes are used to report initial and subsequent evaluation and management services provided to hospital inpatients and to patients designated as hospital outpatient "observation status." Hospital inpatient or observation care codes are also used to report partial hospitalization services.
- For patients designated/admitted as “observation status” in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc), these codes may be utilized if the patient is placed in such an area.
- For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.
- Total time on the date of the encounter is by calendar date. When using MDM or total time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one calendar date. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service.

Hospital Inpatient and Observation Care Services

- ▲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.
- ▲99222 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 moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- ▲99223 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 high level of medical decision making.
  - When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- ►(For services of 90 minutes or longer, use prolonged services code 993X0)◄

Admission after another service

- 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.
- Unlikely Medicare or Commercial payers will agree
- **Transitions between types of care.** CMS agrees with the AMA facility guidelines that if a patient transitions from observation to inpatient status it does not constitute a new stay in the facility. However, when a patient is admitted to observation or inpatient status during a visit on the same day at a different site of service (e.g., office, hospital ED or nursing facility), Medicare will continue to consider that visit bundled as part of the initial hospital inpatient or observation care service. The AMA in its 2023 E/M guidelines states that the admission in another setting should be separately billable with modifier 25.

Swing Bed Policy

- **Medicare will continue its swing-bed policy.** CMS will keep the policy that: "If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes … apply." When the hospital bills the inpatient care as nursing facility care, then nursing facility E/M codes apply.

Hospital Inpatient and Observation Care Services

- In the case when the services in a separate site are reported and the initial inpatient or observation care service is a consultation service, do not report 99221, 99222, 99223, 99252, 99253, 99254, 99255. The consultant reports the subsequent hospital inpatient or observation care codes 99231, 99232, 99233 for the second service on the same date.
- For the purpose of reporting an initial hospital inpatient or observation care service, a transition from observation level to inpatient does not constitute a new stay.

Subsequent Hospital Inpatient or Observation Care

- ★▲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.
- ★▲99232 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 moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- ★▲99233 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 high level of medical decision making.
  - When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
- ►(For services of 65 minutes or longer, use prolonged services code 993X0)◄

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

- The following codes are used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.
  - For patients admitted to hospital inpatient or observation care and discharged on a different date, see 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239.
- 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 (ie, one encounter), see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed on the same date.
- (For discharge services provided to newborns admitted and discharged on the same date, use 99463)

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

- Medicare does not agree on the AMA use of the admit/discharge codes
- **8-24-hour rule remains in place.** CMS finalized its plan to continue to apply the 8-to-24-hour rule for the newly consolidated inpatient or observation and discharge codes to deter what the agency views as the potential for duplicative payments.
- That means that:
  - For stays of less than eight hours, report initial hospital or observation services (**99221**-**99223**).
  - When the hospital admission is at least eight but less than 24 hours, report same day admission and discharge from hospital (**99234**-**99236**).
  - When a patient is admitted for more than 24 hours you should report an initial hospital/observation code for the date of admission (**99221**-**99223**) and hospital discharge day management code (**99328**-**99239**).

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

- ▲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.
- ▲99235 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 moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
- ▲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.
  - When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
- ►(For services of 100 minutes or longer, use prolonged services code 993X0)◄

Hospital Inpatient or Observation Discharge Services

- The hospital inpatient or observation discharge day management codes are to be used to report the total duration of time on the date of the encounter spent by a physician or other qualified health care professional for final hospital or observation discharge of a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.
- The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms.
- All services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status.
  - For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.
- 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.

Hospital Inpatient or Observation Discharge Services

- 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)
  - (For discharge services provided to newborns admitted and discharged on the same date, use 99463)

Prolonged Services

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

Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact

- 99358 and 99359 are used when a prolonged service is provided on a date other than the date of a face-to-face evaluation and management encounter with the patient and/or family/caregiver.
- Must be in relation to any E & M service on a date other than the face-to-face service, whether or not time was used to select the level of the face-to-face service.
- However, it must relate to a service or patient which (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact

- Do not report 99358, 99359 for time without direct patient contact reported in other services, such as:
  - care plan oversight services (99374-99380),
  - chronic care management by a physician or other qualified health care professional (99437, 99491),
  - principal care management by a physician or other qualified health care professional (99424, 99425, 99426, 99427),
  - home and outpatient INR monitoring (93792, 93793),
  - medical team conferences (99366-99368),
  - interprofessional telephone/Internet/electronic health record consultations (99446, 99447, 99448, 99449, 99451, 99452), or
  - online digital evaluation and management services (99421, 99422, 99423).
- 99358 Prolonged evaluation and management service before and/or after direct patient care; 30-74 minutes
- ✚99359 each additional 30 minutes (List separately in addition to code for prolonged service)
  - (Use 99359 in conjunction with 99358)

Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	**Code(s)**
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99358 X 1 AND 99359 X 1
105 minutes or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

- Codes 99415, 99416 are used when an evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time with the patient and/or family/caregiver.
  - The physician or other qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.
  - Used to report the total duration of face-to-face time with the patient and/or family/caregiver spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous.
  - Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

- Codes 99415, 99416 may be reported for no more than two simultaneous patients and the time reported is the time devoted only to a single patient.
- For prolonged services by the physician or other qualified health care professional on the date of an office or other outpatient evaluation and management service (with or without direct patient contact), use 99417. Do not report 99415, 99416 in conjunction with 99417.
- Facilities may not report 99415, 99416.
  - #✚99415 Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
    - (Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)
    - (Do not report 99415 in conjunction with 99417)
    - Prolonged service of less than 30 minutes total duration on a given date is not separately reported.
    - Used only once per date, even if the time spent by the clinical staff is not continuous on that date.
  - #✚99416 each additional 30 minutes (List separately in addition to code for prolonged service)
    - (Use 99416 in conjunction with 99415)
    - (Do not report 99416 in conjunction with 99417)

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

- The starting point for 99415 is 30 minutes beyond the typical clinical staff time for ongoing assessment of the patient during the office visit. The Reporting Prolonged Clinical Staff Timetable provides the typical clinical staff times for the office or other outpatient primary codes, the range of time beyond the clinical staff time for which 99415 may be reported, and the starting point at which 99416 may be reported.

Code (Minutes)	Typical Clinical Staff Time	99415 Time Range (Minutes)	99416 Start Point
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

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

- +99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services, office consultation, or other outpatient evaluation and management services (ie, 99205, 99215, 99245, 99345, 99350, 99483).
- +99418 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an inpatient evaluation and management service (ie, 99223, 99233, 99236, 99255, 99306, 99310). Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service.

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

- #★✚▲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)
- #★✚●99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)
  - ►(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 Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

- When reporting 99417, 99418, 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.
  - For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (ie, 75 minutes) on the date of the encounter.
  - For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (ie, 55 minutes) on the date of the encounter.
- 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 Services: CMS Final Rule

- CMS has created 3 new HCPCS codes to report prolonged service similar to what they did creating G2212 for Outpatient prolonged services.
- Time must exceed the highest time value for the highest-level code in the category.
  - +G0316: Prolonged hospital inpatient or observation care
  - +G0317: Prolonged nursing facility E & M service
  - +G0318: Prolonged home or residence E & M service

Telehealth Services

- For CY 2023, CMS is finalizing a number of policies related to Medicare telehealth services, including making several services that are temporarily available as telehealth services for the PHE available at least through CY 2023 in order to allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List.
- They finalized their proposal to extend the duration of time that services are temporarily included on the telehealth services list during the PHE for at least a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

Telehealth Services

- CMS confirmed their intention to implement the telehealth provisions in sections 301 through 305 of the CAA, 2022, via program instruction or other subregulatory guidance to ensure a smooth transition after the end of the PHE.
- These policies, such as:
  - allowing telehealth services to be furnished in any geographic area and in any originating site setting (including the beneficiary's home);
  - allowing certain services to be furnished via audio-only telecommunications systems; and
  - allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, will remain in place during the PHE for 151 days after the PHE ends.
- The CAA, 2022, also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

Telehealth Services

- CMS will allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person.
- These claims will require the modifier “95” to identify them as services furnished as telehealth services. Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends.
- The Telehealth Originating Site Facility Fee has been updated for CY 2023, which can be found with the list of Medicare Telehealth List of Services at the following website: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Services to be Removed from the Medicare Telehealth Services List After 151 Days Following End of the PHE

HCPCS	Short Descriptor
77427	Radiation tx management x5
92002	Eye exam new patient
92004	Eye exam new patient
93750	Interrogation vad in person
94002	Vent mgmt inpat init day
94003	Vent mgmt inpat subq day
94004	Vent mgmt nf per day
94664	Evaluate pt use of inhaler
96125	Cognitive test by hc pro
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat (deleted from the PFS for CY 2023
99325	Domicil/r-home visit new pat (deleted from the PFS for CY 2023
99326	Domicil/r-home visit new pat (deleted from the PFS for CY 2023
99327	Domicil/r-home visit new pat (deleted from the PFS for CY 2023
99328	Domicil/r-home visit new pat (deleted from the PFS for CY 2023
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient (deleted from the PFS for CY 2023)
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min
99468	Neonate crit care initial
99471	Ped critical care initial
99475	Ped crit care age 2-5 init
99477	Init day hosp neonate care

Consultations

- 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 previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

Consultations

- A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.
- A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
- A “consultation” initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (eg, 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.
- To report services when a patient is admitted to hospital inpatient, or observation status, or to a nursing facility in the course of an encounter in another setting, see Initial Hospital Inpatient or Observation Care or Initial Nursing Facility Care.

Inpatient or Observation Consultations

- Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation-level patients, residents of nursing facilities, or patients in a partial hospital setting, and when 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.
- 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.
- Only one consultation may be reported by a consultant per admission. Subsequent consultation services during the same admission are reported using subsequent inpatient or observation hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).
  - (For an inpatient or observation consultation requiring prolonged services, use 993X0)
  - (99251 has been deleted. To report, use 99252)

Inpatient or Observation Consultations

- ★▲99252 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
  - When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- ★▲99253 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and 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.
- ★▲99254 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- ★▲99255 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
  - When using total time on the date of the encounter for code selection, 80 minutes must
- ►(For services 95 minutes or longer, use prolonged services code 993X0)◄

Emergency Department Services

- Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes and critical care services are provided.
- For evaluation and management services provided to a patient in observation status, see 99221, 99222, 99223 for the initial observation encounter and 99231, 99232, 99233, 99238, 99239 for subsequent or discharge hospital inpatient or observation encounters.

Emergency Department Services

- For procedures or services identified by a CPT code that may be separately reported on the same date, use the appropriate CPT code. Use the appropriate modifier(s) to report separately identifiable evaluation and management services and the extent of services provided in a surgical package.
- If a patient is seen in the emergency department for the convenience of a physician or other qualified health care professional, use office or other outpatient services codes (99202-99215).
- 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 with several patients over an extended period of time.

Emergency Department Services

- ▲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

Split or Shared Visits: CMS Final Rule

- For CY 2023, we finalized a year-long delay of the split (or shared) visits policy we established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the "substantive portion," of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements:
  - History.
  - Performing a physical exam.
  - Medical Decision Making.
- Spending time (more than half of the total time spent by the practitioner who bills the visit).
- As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the "substantive portion" instead of using total time to determine the substantive portion, until CY 2024.

Nursing Facility Services

Nursing Facility Services

- The following codes are used to report evaluation and management services to patients in:
  - nursing facilities and skilled nursing facilities.
  - psychiatric residential treatment center and
  - immediate care facility for individuals with intellectual disabilities.
- Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visit.
- These services are performed by the principal physician(s) and other qualified health care professional(s) overseeing the care of the patient in the facility.
  - 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

- The types of care (eg, skilled nursing facility and nursing facility care) are reported with the same codes.
- Place of service codes should be reported to specify the type of facility (and care) where the service(s) is performed.
- 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.
  - The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged.

Initial Nursing Facility Care

- When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, 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.
- Hospital inpatient or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately.

Initial Nursing Facility Care

- Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay.
- They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional. Skilled nursing facility initial comprehensive visits must be performed by a physician.
- Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation.
- Initial services by other physicians and other qualified health care professionals who are performing consultations may be reported using initial nursing facility care codes (99304, 99305, 99306) or inpatient or observation consultation codes (99252, 99253, 99254, 99255). This is not dependent upon the principal care professional's completion of the initial comprehensive services first.

Initial Nursing Facility Care

- 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.
  - ▲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.
  - ▲99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
    - When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
  - ▲99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high 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.
  - ►(For services 60 minutes or longer, use prolonged services code 993X0)◄

Subsequent Nursing Facility Care

- ★▲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.
- ★▲99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
  - When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- ★▲99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- ★▲99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high 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.
- ►(For services 60 minutes or longer, use prolonged services code 993X0)◄

Nursing Facility Discharge Services

- The nursing facility discharge management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient.
- The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms.
- 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 & Residence Services

Home or Residence Services

- The following codes are used to report evaluation and management services provided in a home or residence.
- Home may be defined as:
  - private residence,
  - temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).
  - 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.
- For services in an intermediate care facility for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, see Nursing Facility Services.
- When selecting code level using time, do not count any travel time.
- To report services when a patient is admitted to hospital inpatient, observation status, or to a nursing facility in the course of an encounter in another setting, see Initial Hospital Inpatient and Observation Care or Initial Nursing Facility Care.

Home or Residence Services: New Patients

- ▲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.
- ▲99342 Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
  - When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
  - ►(99343 has been deleted. To report, see 99341, 99342, 99344, 99345)◄
- ▲99344 Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- ▲99345 Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
  - When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- ►(For services 90 minutes or longer, see prolonged services code 99417)◄

Home or Residence Services: Established Patients

- ▲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.
- ▲99348 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
  - When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- ▲99349 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
  - When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- ▲99350 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
  - When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- ►(For services 75 minutes or longer, see prolonged services code 99417)◄

Chronic Pain Management

New for 2023

Chronic Pain Management and Treatment Services

- CMS finalized new HCPCS codes, and valuation for chronic pain management and treatment services (CPM) for CY 2023.
  - G3002 (Chronic pain treatment monthly first 30 minutes) and
  - G3003 (Additional 15 minutes Chronic pain management) ,
- CMS believes the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

Chronic Pain Management and Treatment Services

- Medicare has not historically recognized the team-based approach to pain management and treatment — including aspects such as person-centered care planning, medication management, and coordination between providers — that is often needed to manage chronic pain in ways that result in better outcomes.
- So, for the first time, Medicare will provide payments for team-based, comprehensive management and treatment of chronic pain.
- The finalized codes include a bundle of services furnished during a month that they believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders.

Chronic Pain Management and Treatment Services

- They finalized the CPM codes to include the following elements in the code descriptor:
  - diagnosis; assessment and monitoring;
  - administration of a validated pain rating scale or tool;
  - the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs and desired outcomes;
  - overall treatment management;
  - facilitation and coordination of any necessary behavioral health treatment;
  - medication management;
  - pain and health literacy counseling;
  - any necessary chronic pain related crisis care;
  - and ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy, complementary and integrative care approaches, and community-based care, as appropriate.

Chronic Pain Management and Treatment Services

- G3002: Chronic Pain Management and Treatment
  - Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month.
    - 30 minutes must be met or exceeded
- G3003: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for G3002).
  - 15 minutes must be met or exceeded.

Chronic Pain Management and Treatment Services

- CMS is finalizing that any of the CPM in person components included in HCPCS codes G3002 and G3003 may be furnished via telehealth, as clinically appropriate, in order to increase access to care for beneficiaries.
- The initiating visit must be furnished in-person
- G3002 and G3003 are added to the Medicare Telehealth Services list on a Category I basis.

Colorectal Cancer Screening

- For CY 2023, we are finalizing, as proposed, two updates to expand our Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations.
  - First, we are expanding Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment and coverage limitation from 50 to 45 years.
  - Second, we are expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal cancer screening, where a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.
    - A functional outcome of our policy for a complete colorectal cancer screening will be that, for most beneficiaries, cost sharing will not apply for either the initial stool-based test or the follow-on colonoscopy.

Global Surgical Package Valuation

- CMS sought public comment on strategies for improving the Global Surgical Package valuation.
- CMS still believes that there is strong evidence suggesting that the RVUs for global packages are inaccurate and will continue to welcome additional insights from interested parties as they consider appropriate next steps.

Other Services to watch for:

- Request for Information: Medicare Potentially Underutilized Services
- Opioid Treatment Programs (OTPs)
- Audiology Services
- Dental and Oral Health Services
- Skin Substitutes
- Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts
- Preventive Vaccine Administration Services
- Clinical Laboratory Fee Schedule (CLFS)
- Medicare Ground Ambulance Data Collection System
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
  - Chronic Pain Management and Behavioral Health Services
  - Telehealth Services
  - Conforming Technical Changes to the In-Person Requirements for Mental Health Visits
  - Specified Provider-Based RHC Payment Limit Per-Visit

Fact Sheets/Blogs and Links

- For a fact sheet on the CY 2023 Quality Payment Program proposed changes
  - https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1972/2023%20Quality%20Payment%20Program%20 Proposed%20Rule%20Resources.zip
- For a fact sheet on the proposed Medicare Shared Savings Program changes
  - https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule-medicare-shared-savings-program
- For a CMS blog on the proposed behavioral health changes
  - https://www.cms.gov/blog/strengthening-behavioral-health-care-people-medicare

References

- CMS Fact Sheet: Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule, November 1, 2022
- Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 42 CFR Parts 405, 410, 411, 414, 415, 423, 424, 425, and 455 [CMS-1770-P] RIN 0938-AU81, Proposed Rule
- AMA CPT Evaluation and Management (E/M) Code and Guideline Changes, Effective January 1, 2023
  - CPT is a registered trademark of the American Medical Association. Copyright 2022. American Medical Association. All rights reserved. It is important to note that further CPT Editorial Panel (Panel) or Executive Committee actions may affect CPT codes and/or descriptors. For this reason, code numbers and/or descriptor language in the CPT code set may differ at the time of publication.

Thank You!

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