2023 E/M DOCUMENTATION TRAINING FOR OFFICE AND OTHER OUTPATIENT VISITS & HOSPITAL ENCOUNTERS

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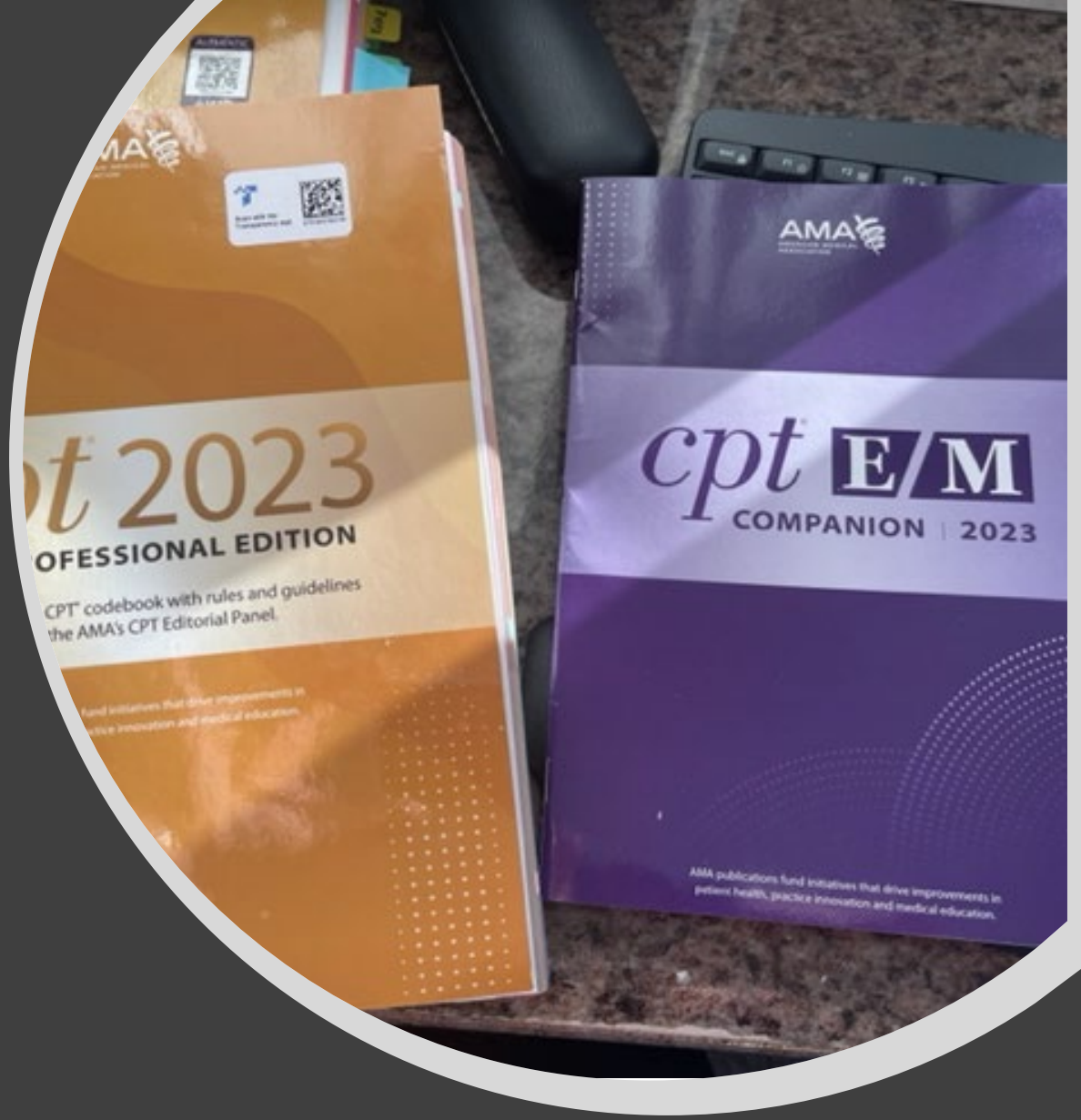

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Terry is a past member of the National Advisory Board for AAPC, past Chair of the AAPCCA, and AAPC National and Regional Conference Educator. Ms. Fletcher is an Advisory Board Member for ICD10Monitor.com and frequent guest of Talk Ten Tuesday, an Educator for McVey Seminars, MGMA, CHIA, BC Advantage, AAPC, AHIMA, Medlearn, NSCHBC and her company Terry Fletcher Consulting, Inc., presenting over 100 specialty coding, billing and compliance Teleconferences, Webinars and Conference Sessions every year.

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Terry also is a host and multiple podcast guest for the Healthcare Industry. – see >>

Talk Ten Tuesdays
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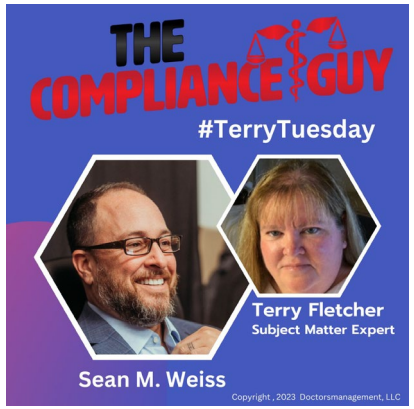

CodeCast
PODCAST
CODING, REIMBURSEMENT & COMPLIANCE
Terry Fletcher

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Revisiting 2021 E/M Rules – Office Visits

- As of Jan. 1st , 2021 Evaluation and Management level of service for office or other outpatient services can be determined using one of two approaches:
- Medical Decision Making - extensive clarifications were provided in the guidelines to help define the elements of MDM
- Time - the total time spent on the date of encounter which incorporates both face-to-face and non-face-to-face services and has clear time ranges for each code

New vs. Established Patients – 2021/2023

►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.

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.◄

Definitions |Abbreviations

Providers - This term references physicians, nurse practitioners, and physician assistants for purposes of today's training..

Those recognized by CMS in the category as non-physician providers (NPPs) and/or qualified health care professionals (QHPs) or Advanced Practice Providers (APPs)

Common Challenges and Opportunities

- Appropriate documentation of ***prescription drug management*** continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate.
- Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided.
- Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: *"Stable hypertension; continue Valsartan 10 milligrams, will refill for 4 months until next follow-up visit."*
- Simply stating that the medication list was reviewed ***will not*** meet the definition of prescription management.

Prescription Drug Management

- It would have been helpful if 2021 DG had provided a definition within guidelines of RX management to finally put to rest much ambiguity within the auditing world, but unfortunately AMA did not.
- There are many MACs that do have published guidance on this topic, and Noridian is pretty clear. Their guidance states: *".. prescription drug management is the initiation, continuation, discontinuation, or modification of any prescription medication. This does NOT include medications that are OTC and prescriptions that are ONLY prescribed for insurance benefits*."
- Keep in mind that patient convenience and reimbursement rules NEVER make such determinations. A key word in the description that causes confusion is "management". Oftentimes, coders/auditors hear the word management and infer that this would mean a longtime use of a prescription drug; but look up the word.

Management in healthcare is defined as: *the coordination and administration of tasks to achieve a goal.*

How to determine RX Management?:

1. Did it require prescriptive authority
2. Is the provider of record managing the RX?


TiME

Time-Based E/M: What can be included?

- *"For coding purposes, time for the services is the total time on the date of the encounter. It includes both the face-to-face 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 healthcare professional and does not include time in activities normally performed by clinical staff."*

CPT® also says that the time of the physician/other qualified health care professional can include reviewing separately obtained history. But the time of the clinical staff member who obtains that history *may not* be included.

Per CPT: Physician/or other qualified health care professional time includes the following E/M activities, when performed:

These statements have to be specific to what the patient is receiving and not generic.

- § preparing to see the patient (e.g., review of tests not separately reported)
- § obtaining and/or reviewing separately obtained history (not documented by staff)
- § performing a medically appropriate examination and/or evaluation
- § counseling and educating the patient/family/caregiver (not provided by staff or a pamphlet)
- § ordering medications, tests, or procedures (not separately reported)
- § 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)

If using “Time” to level your encounter, Tell the patient’s story….

Document This

I spent 32 minutes today caring for Sally (examining patient, documenting in her chart, ordering a sleep study, and discussing her case with Dr. _____ a Cardiologist to determine if the heart murmur heard today on examination was anything to be concerned with)

Patient returns for follow-up of hypertension, which is well-controlled on medication and diabetes, non-insulin dependent, management.

Due to the patient’s extreme fatigue, I will order a thyroid panel as I believe it is unrelated to pregnancy

Decrease Lipitor to _____ as patient has lost 75 lbs and through diet modifications and has reduced cholesterol levels

Not This

- ❑ 50% of the time spent in today’s visit was counseling and coordination of care
- ❑ Patient returns for follow-up
- ❑ Will order labs for further workup
- ❑ Med list reviewed
- ❑ Continue Meds
- ❑ Spent 25 minutes examining and counseling patient
- ❑ Spent 7 minutes synthesizing the medical record

Auditing Based on Time

- Time is based on the total time (both face-to-face and non face-to-face) *personally spent by the provider* or QHP on E/M services on the date of the encounter.
- Time on the date of service does not have to be consecutive
- Provider may list only time spent uniquely for one patient, may not list the same period of time for more than one patient
- Time my be used whether or not counseling and/or coordination of care dominates the service.
- Time is based on a range, and the range is exact. The Provider should list the minutes of the total visit for that encounter and be able to support it.
- When using time to level an E/M, the time statement must be documented by provider within the note and must state their best estimate of the exact time spent in care of the patient on the date of the encounter.
- Start and stop times are not required to be documented, nor is it necessary to itemize times spent on each different activity. Providers should not list a range of time, or use "greater than or less than" language.
- CPT: "The appropriate time should be documented in the medical record when it is used as the basis for code selection." If time is not documented, or is an insufficient time for the minimum code, MDM must be used to level the encounter

Audit reminders when scoring "time"

- Providers should *not* include time spent performing or reading EKGs, x-rays or other point-of-care tests that are being billed separately.
- Time should also *not* be counted for other services such as care coordination or tobacco cessation counseling that are billed separately.
- Providers should *not* include any time spent by their staff.
- Only time on the same date as the face-to-face visit may be counted. For instance, reviewing a chart the day prior to the visit will not count towards total time. If a physician is waiting to speak to another physician regarding the same patient, there is an exception that within 1-2 days that time can be added* but this would mean a chart would have to stay open until the completed phone call. (not recommended).

Q: *Is it okay for providers to use time always? Does the provider have to document everything they did in the time it took?*

A: Yes, but we wouldn't recommend it.

Providers have to document time and what they did to reach that time. They are not just trying to meet a coding threshold. The medical record, especially in a hospital setting, each provider needs to know what the other providers are doing and what the response of treatment has been. The reason is, this information may impact what the consulting physician(s) need to order, or how they need to modify treatment, or that they're not conflicting in medical treatment.

There might be instances where a patient isn't responding well to medication, and it's changed. It's important for another physician to know why and what occurred. So, don't just look at the medical record from a coding standpoint. The number one reason why we have medical documentation is to support care delivered from a clinical perspective as well as quality initiatives that we have as well as to support services in a possible legal challenge. Documentation should not just be looked at from the lens of coding and billing, but from a plausibility perspective. Make it Make Sense.

Payer audits are reflecting "medically unbelievable days". i.e., 10 level 5 visits all timed in a 4-hour patient block, or generic statements of time – not specific to this patient.

Number and Complexity of Problems Addressed
2023
MDM
(Element 1)

MDM – Three Elements

- Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

- Medical decision making in the office and other outpatient services code set is defined by three elements:

1. Number and complexity of problems addressed;
2. Amount and/or complexity of data reviewed; and analyzed
3. Overall risk of complications, morbidity, and/or mortality.

MDM – The number and complexity of problem(s) that are addressed during the encounter.

1. The number and complexity of problem(s) that are addressed during the encounter.

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, exam, 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.

PROBLEMS ADDRESSED

This is an important clarification. How do we define “evaluated or treated”? When the condition is discussed in the HPI (history of present illness), or in the assessment and plan. Mentioning, “he has a history of…” or the inclusion of it on the problem list does not meet the 2021 CPT E/M criteria of evaluated and treated.

Example where an extra diagnosis cannot be counted as addressed:

- One internist sees a patient with CKD (Chronic Kidney Disease) and notes “managed by nephrologist.” This would *not* be counted as a problem on that date of service.
- A PCP sees a patient with known CAD (Coronary Artery Disease) and notes “managed by cardiologist” or “will follow with cardiologist”. This would not be counted as a problem on that date of service. Yes, the ICD-10-CM code would be added as a secondary diagnosis, but the physician would not get MDM credit for it because this diagnosis was not “addressed”.

Example where an extra diagnosis CAN be counted as addressed:

- Internist sees a patient with hypertension, and the need to change the hypertension medication. The internist notes the creatinine level, and that she won’t prescribe a beta blocker because the patient has CKD. This problem was evaluated and *can* be counted as “addressed” meaning evaluated and treated, in the MDM calculation.
- Cardiologist sees a patient in follow up for hypertension and CAD, and this patient is also reporting post COVID continued muscle aches that will not go away with simple OTC medication. The cardiologist, notes in the record of these complaints, also queries the patient on the COVID, and determines the actually tested positive, and were sick with COVID-19, and were not treated for the muscle aches and recommends a PCP or pain management referral. This CAN be counted as addressed.

Of Note:

- If the clinician recommends a diagnostic test based on the risk/benefit analysis, but patient declines the test or treatment it is still counted.
- Now a referral without an evaluation is *not* counted as a problem. “Patient wants a referral to the rheumatologist” isn’t sufficient. The HPI or Exam, or a discussion in the assessment, would need to describe the patient’s debilitating arthritis, or chronic joint pain not relieved by treatment, etc. to reflect insight and a clear path to the Medical Decision of a specialty referral.

MDM Updates – Number and Complexity of Problems Addressed 2023
LOW LEVEL COMPLEXITY

Low Level Complexity: 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.*

Revision: Examples removed

- *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.*

Moderate Complexity Level – 2023

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.

Revision: Examples deleted

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. *Revision: Examples deleted*

High Level of Complexity - 2023

► 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 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*.◄

There will be no "required" level of history or exam for E/M Visits (scoring), but there still needs to be a medically appropriate history and exam to determine medical necessity

From the AMA Website for 2022 :

- *"Office or other outpatient services include a medically appropriate history and/or physical examination when performed. The nature and extent of the history and/or physical exam is determined by the treating physician or other qualified healthcare professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g. by patient portal or questionnaire) that is reviewed by the reporting physician or other qualified healthcare professional. The extent of history and physical examination is not an element in selection of office or other outpatient services."*[1]
- It will be the physician's (provider's) responsibility to make sure their history and exam is problem pertinent, while protecting the clinical integrity of the documentation and legal expectations of included information.
- The AMA MDM Grid measures the complexity of problems addressed with expressive statements such as acute, uncomplicated illness or injury, undiagnosed new problem with uncertain prognosis, acute illness with systemic symptoms, and chronic illness with exacerbation. While the history and exam elements are not used for leveling a service, a descriptive history and exam, will support medical necessity of the service, meet the CPT "medically appropriate History and/or Exam" requirement of visit encounters, and will ensure that the coder or auditor will understand the complexity of problems addressed to the extent necessary to determine medical decision-making accurately.

Exam Documentation Tips – 2021/2023 rules

A clear description of all problems managed, evaluated and/or treated on the date of service, as well as the severity and acuity of those problems.

If managing chronic conditions, listing them alone does not meet the 1st element of MDM. Also, include the status of those conditions. , i.e. *“Patient presents today for management of non-insulin dependent type 2 diabetes, which is well managed by diet, exercise and at home glucose testing. No new complaints or problems”*

Make sure there are exam elements “problem pertinent” to the presenting problem. A “medically appropriate” exam still has to exist to support medical necessity of the encounter.

If providing a Telehealth audio and video visit, the elements you are able to glean should be included in the documentation, and the elements you cannot should also be mentioned.

Watch for inconsistencies in the exam. If the History has a complaint, but the exam states WNL or not addressed, this can negate the record.

DATA POINTS REVISION 2023
MDM
(Element 2)

Understanding the Data Points

- Physicians should be aware that, for the purposes of medical decision making, they *cannot* count labs at both the time of the order and the follow-up appointment when reviewed. These tests should be counted on the date that they are ordered only, and not when the patient returns. ***(p6 CPT 2023)***

Giving a provider credit for a "Discussion of management or test interpretation" – w/external physician or QHP/source (**Category 3** under Data Points of MDM level 4/5):

Examples Discussion of Management:

1. Physical Therapist – is concerned that the patient is unable to ambulate > 20 feet and recommends SNF placement.

My response: I would say yes here because of the acuity of the condition, and because the patient's care seems to be getting elevated due to progression. I would also want to know if the PT saw the patient in person and when. I know that isn't mandated for this, but I had a recent PT give advice to a provider who followed it, and they hadn't seen the patient in a year and it was not appropriate advice for the current status of the patient.

2. **Case management** – Previous Pulmonary Stenting procedure done, performed at an outside hospital not affiliated with the IR group. The IR physician called the Cardiologist to discuss the procedure report. This was used to determine if further stenting should be done, or if this was a shunt procedure for a congenital defect.

Well documented and contributory to the IR plan of care.

3. **IR Physician discusses a previous diagnostic procedure performed by a different IR in their practice**. – No credit under CAT 3. This is considered one provider, if same specialty, same group practice.

* This must be an interactive exchange and *not* through intermediaries

Assessment Requiring an Independent Historian-2023

At the low level of complexity, this component of work is “rated” as Category 2, but once we move to Moderate and High it shifts to Category 1

<u>However, the concept and guidelines do not change</u>

►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. ◄

The reader of the note cannot assume that since the child is only 5 years old, that someone else provided the current symptomology and automatically provides credit for this component. The provider should document in a way that this information is clear, such as, “The mother reports…”

• Controversy can arise when we see a patient who appears to be of sound mind, of reasonable age and reason, but there is an add-in within the documentation of the encounter from another source, like a spouse who is in the room with the patient during the encounter and has additional information that either conflicts or omitted by the patient.

Category 2: Moderate or High (Level's 4/5) Only has one component: Independent Interpretation

► **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.◄

** Also, if you "ordered" the test, there is no independent part of the test now. You would use the CAT 1 "ordered" element.*


Public
health
emergency

- **PHE currently slated to go through 4/11/2023**
Source: www.phe.gov
HHS Secty Xavier Becerra the 12th renewal since the beginning of the PHE (1/31/2020)

- **** It was announced that the end of the PHE will be 5.11.2023***

RENEWAL OF DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic and to allow for an organized and coordinated transition from this unprecedented public health emergency, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective February 11, 2023, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, July 19, 2021, October 15, 2021, January 14, 2022, April 12, 2022, July 15, 2022, October 13, 2022, and January 11, 2023, that a public health emergency exists and has existed since January 27, 2020, nationwide.

February 9, 2023 /s/

Date Xavier Becerra

Telehealth PAYER Definitions:

- Medicare has the most specific, detailed explanation of what is considered "Telehealth".
- A/V must be available and used to report E/M Office Visits 99202-99215, Hospital Visits 99221-99233, G-codes ER, Hospital, Etc.
- This rule can be found on the CMS FFS FAQ sheet for Telehealth– Google it.
- Synchronous audio-video link with patient (Patient and Physician) MUST be able to see and speak to each other via audio and video application, such as Skype or FaceTime.
- Public facing chat options, like TikTok, Facebook Live, Twitch, or Vimeo are not options as they allow audiences to join).
- Verbal Consents are mandatory for all Telehealth Services and must be well documented. They are valid for a year from the first documented consent. – Have you updated your consents?
- There MUST be an AUDIO and VIDEO 2-way discussion with the provider to be able to bill for an office or hospital visit.
- If no audio AND VIDEO feed, this is reported as a phone call (audio only) visit 99441-99443 (physicians/NPPs) during the PHE.

How does an MD/DO or a QHP (NPP) bill for a Telehealth Service that would have been an office visit (during PHE)?

If an Audio and Visual visit was performed for an established patient who was at home, physician was in his office, consent given and documented, presenting problem appropriate history and exam, and medical decision-making was moderate, you would code:

99214-95 and POS 11*

*This has been extended for Medicare through 2024. Check individual Commercial payer contracts for continued Telehealth OV coverage. Many have let their coverages expire.

Audio Only Encounter

Patient Name: xx
DOB: xx
MRN: xx

Due to the pandemic of coronavirus, this visit was done via audio call and initiated upon the request/approval of the patient. The patient has requested we use cell to cell for audio only call as she was unable to come into the clinic today and did not have an audio and video option. I informed the patient that this may not be HIPAA protected. I reviewed the patient's clinical situation and findings as listed in their chart and discussed results and plan as documented in this note.

Dear Dr. xx,

I the pleasure of speaking with your patient today in virtual consultation at the xx Interventional Radiology Clinic regarding her renal angiomyolipoma. As you will recall she underwent successful left renal myolipoma embolization xx and is now here to discuss follow-up imaging. We had a 22-minute discussion/consultation including time for communication and image review however, the patient was on an audio only call and did not view the images personally. She is doing well and has had no complaints.

She was recently found to have markedly elevated serum iodine levels. She reports a long history of taking oral iodine supplements. She wishes to avoid iodinated contrast which would be critical for performance of the CT angiogram to reassess the effects of our embolization procedure. After speaking with you today by phone, given your concern regarding her thyroid function and iodine levels,

I spoke with my MRI colleagues who confirmed that performing an MRI/MR angiogram of the kidney would be equivalent. Therefore, we will plan for MRI/MRA. She indicates that she does have claustrophobia so we will give her 5 mg oral Valium beforehand. Assuming imaging goes without incident, then we will plan for a 12-month follow-up study and annual studies x2 and then extending out every 3 years afterwards for long-term follow-up via the xx Interventional Radiology Clinic.

Thank you for taking my call today. If you have any questions or concerns in this regard, please feel free to contact me directly or through the xx Interventional Radiology Clinic at xxx xxx xxxx.

Warmest regards,

CC: xx Urology,

Total time with the patient on the call = 22 minutes (99443)

What NOT to bill for under 1135 Waiver

What NOT TO BILL FOR:

- Normally, a practice does *not* conduct a visit or initiate a call to a patient when their labs come back normal, or to give test results. They usually just provide access to the "normal" results via the patient portal, or they may have an MA or RN call the patient with test results (not separately payable).
- Most practices will only require a visit with the patient for abnormal labs or tests that lead to further treatment discussions.
- The practice should continue the same practice with telemedicine that they have used in the past for communicating labs and test results. Communicating normal labs to a patient is normally not a reason to substantiate a medically necessary visit of any kind. This could be seen as "acting in bad faith" and would expose your practice to an audit.
- Calling patients to "check in" on them. That is not something you would normally charge for during normal times. This is not the time to charge for it now.
- Do not solicit patient for Telehealth appointments
- Do not charge to refill prescriptions
- Do not charge for MA (Medical Assistant) work now being performed by physicians due to staff shortages

FYI – after May 11th PHE Ends on Telehealth

- Audio only Telehealth (99441-99443) was extended (Medicare only) through 2024 for some services, but “payment parity” only extended through 2023.

- New patients were allowed to be seen under the PHE, but once the PHE ends, only established patients will be able to receive Telehealth services, reverting back to the original rule that there “..has to be an established patient relationship..” to engage in Telehealth services.

- OCR (Office of Civil Rights) office announced after the OMNIBUS Bill was signed into law, that even though Telehealth will still be allowed through 2024, the non-HIPAA platforms that were allowed, (e.g. Skype and FaceTime), will no longer be an option. Patients and Providers will have to engage in HIPAA secured platforms for the delivery of Telehealth.

- Behavioral Health Services will continue to be allowed under Audio and Video and Audio only rules, with some restrictions and identifying modifiers, i.e. *-FQ if Audio and Video is unavailable*

- The POS (Place of Service) can continue to be the POS that would have been appropriate if the patient was seen in-person. However, POS 10 can be used when the patient’s originating site is their home. Reimbursement may be based on facility rates instead of non-facility rate.

On to 2023 (Hospital)

In summary, embracing the updated E/M guidelines can reduce “note bloat” and unnecessary clinician burden.

To achieve these goals, physicians should emphasize their rationale for care decisions during the clinic visit and avoid boilerplate language that doesn’t add value to the patient “story.”

Organizations should endeavor to educate their physicians and coders about the new guidelines in multiple ways and with regular feedback.

Further, it’s important to audit notes to ensure that physicians are coding appropriately and in-line with the updated recommendations.

As of 2023, CPT® now has streamlined all of the DGs (Documentation Guidelines) to match the 2021 rules for OOVs with many of the hospital E/M codes.

Per AMA 2023 Webinar August 2022

2023 Hospital/Observation E/M

Updated E/M Guidelines for Hospital Inpatient and Observation Care

- ➢There are 2 subcategories: Initial vs. Subsequent. (“New” vs. “Established” does not apply)
- ➢An initial service is when the patient has not received any professional services from a provider of the exact same specialty and subspecialty who belongs to the same group practice, *during the inpatient, observation, or nursing facility admission and 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.
- ➢For reporting Initial vs. Subsequent hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. This means that the initial visit may be an admit into Observation while the subsequent visits on following days may be Observation or Inpatient.

Initial Services – 2023

►Some categories apply to both new and established patients (eg, hospital inpatient or observation care, or nursing facility care). 99221 – 99223: Initial hospital inpatient or observation care, per day

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.*

Consult from members of the same group-inpatient/observation 2023

- Patient is admitted by their cardiologist on 2/1/2023 for chest pain and SOB. The patient is scheduled for a cardiac cath later the same date. The patient develops an arrythmia the next morning and the Electrophysiologist is called in to consult on the patient the next day (2/2). Both physicians are members of the same group practice.

Physician #1 uses the initial hospital codes 99221-99223 for the admit with the –AI modifier

EP Physician (a subspecialty of cardiology), uses the 99233-99231 for their consult, per CPT® 2023.

Subsequent Service – 2023 Hospital/Facility

► 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. – 99231-99233 initial or observation subsequent hospital services, per day (Medicare inpatient only)

Time for Hospital Codes-2023

- Inpatient services have a specific time as opposed to a time range 99221 – 99233
- Nursing Facility Services have a specific time as opposed to a time range 99304 - 99309

Hospital Time Based Codes

CPT Code for the service (POS may adjust reimbursement with payers)	Total Time on a specific Date of Service Must be met or exceeded
99221 (Inpatient Hospital or Observation Care)	40 minutes
99222 (Inpatient Hospital or Observation Care)	55 minutes
99223 (Inpatient Hospital or Observation Care)	75 minutes

Fiscal Impact to Hospital E/M Medicare

CPT	DESCRIPTION	STATUS CODE	MCA 2023 Final	MCA 2022 Final	$ Difference	% Difference	RVU 2023 Final	RVU 2022 Final
99221	1st hosp ip/obs sf/low 40	A	$83.36	$100.70	($17.34)	-17.2%	2.46	2.91
99222	1st hosp ip/obs moderate 55	A	$130.46	$135.31	($4.85)	-3.6%	3.85	3.91
99223	1st hosp ip/obs high 75	A	$173.84	$198.29	($24.46)	-12.3%	5.13	5.73

Rules for Direct Admits from another location to Inpatient/observation – CPT® 2023

►When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date. ◄

(CMS does *NOT* agree with this direction. Medicare states that *one* visit per day for the same diagnosis or related encounter should be billed. You will have conflicting payer policy on this).

More on Consults and an Admitting doc asking a consultant to follow a patient CPT® 2023 (P.15-16)

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). – But how far back does this encounter refer to? AMA needs to clarify

For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate. 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

Example of a requested in-patient consult 2023

- Patient was seen in consultation for a pre-op for hip surgery on 1/10/2023. Patient was cleared by their Cardiologist and high-risk medications modified. (99202-99215)
- Patient was admitted to the inpatient hospital on 1/15/2023 for staged hip surgery by his orthopedic surgeon.
- Orthopedic surgeon called the Cardiologist and asked him to consult the patient and follow during stay.

Orthopedic reported surgery only

Cardiologist reports 99233-99231 subsequent hospital for the consult during this stay, since there was a related consult (E/M) prior to anticipated admit.

Medicare Rule on Inpatient/OBS codes

Medicare Policy Manual, Chapter 12 30.6.8.A

A. Who May Bill Observation Care Codes
A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.

For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services.
This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. **All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.**

For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate, during the same "stay". For information regarding hospital billing of observation services, see Chapter 4, §290.

Medicare Inpatient/OBS codes- Final Rule 1770F

CMS Final Rule

P.597

Response: We thank commenters for their feedback. We will continue to engage with the public and review our policies in light of the consolidation of the Hospital Inpatient and Observation Care codes.

At this time, **we are not making changes to POS policy (including the POS that should be placed on a claim for a patient receiving observation care)**. We are also not changing policies affecting billing, at this time, when multiple practitioners furnish E/M services to the same patient on the same day (**such as the policy in Chapter 12 of the Medicare Claims Processing Manual (IOM 100-04), section 30.6.8.A, which specifies that while the practitioner who orders the observation care for a patient may bill for observation care (99221-99223), other practitioners providing additional evaluations for the patient bill their services as O/O E/M codes. (99212-99205)**

We are also not currently making any changes to current policy on the use of the -AI modifier (Meaning that if you are the admitting inpatient provider, for a Medicare patient, the –AI modifier needs to be on the claim).

Prolonged Services
2023

PROLONGED SERVICES

Reporting Prolonged Services 2023 - Hospital

+99418 (replaces placeholder 993X0) Prolonged inpatient and observation E/M services time

3 new G codes (one per E/M family). These are:

- **G0316 for reporting prolonged hospital inpatient or observation services**
- **G0317 for prolonged nursing facility services**
- **G0318 for prolonged home or residence services**

For Hospital Services, the +99418 cannot be added to a hospital code (99223, 99233, etc.) until the time threshold has been met or exceeded and only for the highest level of service.

Prolonged Services Hospital

CPT®	Time (in minutes) must be met or exceeded
99221	40
99222	55
99223	75
●+99418 (G0316)	90 minutes or longer

Medicare-specific coding for prolonged Other E/M services and created 3 new G codes (one per E/M family). These are:

- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services (no CPT® crosswalk)

* Services MUST have documented an additional 15 minutes above the time thresholds. There is no ½ way on time, it must be 15 minutes in addition to the base code.

Split/Shared Visits 2023

2023 Split (Shared Visits)

- In the final rule, CMS clarifies and refines policies related to split (or shared) evaluation and management (E/M) visits:
- Split (or shared) E/M visits are defined as visits *provided in a facility setting* by a physician and a non-physician provider in the same group. The practitioner who provides the *substantive portion* of the visit or the greater time of the visit, if the encounter qualifies for time, would bill for the visit.
- For 2023, AMA and CMS agreed to continue with the substantive portion determined based on medical history, physical exam, medical decision-making or more than half of the total time.
- The provider who bills for (reports) the Split/Shared Visit would append the modifier –FS to reflect that this was a split and/or shared visit.

Final Rule: Documentation Requirements –Examples- Shared/Split Visits 2023

- *"We also are clarifying that when one of the three key components is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill.*
- *For example, if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed."* page 430 FR 2022 Physician Fee Schedule Final Rule CMS-1751-F

Split (or Shared) E/M Visits CPT®

The 2023 CPT® Professional Edition, 5th paragraph on the left, it states, *"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....."* I think many providers/coders are missing that statement. What it means is that even though non-face-to-face work can be included in the encounter, whether it be by time or MDM value, both providers still have to have a face-to-face with the patient to report it.

If there is no face-to-face by one provider, I would not count their input.

Is this a Split/Shared Visit?

PATIENT IS ADMITTED TO THE HOSPITAL AND THE NP SEES THE PATIENT FIRST AND WORKS THEM UP. THE PHYSICIAN IS CONSULTED OVER THE PHONE OR BY TEXT AND COMES TO SEE THE PATIENT LATER IN THE DAY. THE DOCUMENTATION REFLECTS NP'S SIGNATURE AND THE PHYSICIAN SIGNS OFF WITH DOCUMENTED AGREEMENT WITH THE NP PLAN. NO TIME IS LISTED.

WHO CAN BILL OUT THE INITIAL HOSPITAL VISIT?

THE NP. THERE IS NO DOCUMENTED > TIME OR SUBSTANTIVE PORTION OF WORK BY ANYONE BUT THE NP.

CMS is watching and will review

- 2023 Report the service under the clinician who provides the substantive portion or greater time of the service
- Identify the physician and NPP who performed the visit
- The individual who performed the substantive portion of the visit must sign and date the medical record
- Use modifier -FS: split shared Evaluation and Management service
- CMS can now identify and review split/shared services for data mining

Nursing Facility Visits

Nursing Facility Services (NEW FOR 2023 MDM Nursing Facility visits only

A new high-level MDM option is available for the first MDM element of "Number and complexity of problems addressed" only for Nursing Facility Visits being leveled using MDM:

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

This type is:

- Multiple morbidities requiring intensive management: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

Initial Nursing Facility Care – Guidelines

- An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice during the stay.

- When the patient is admitted to the nursing facility in the course of an encounter in another site of service (e.g., hospital emergency department, office), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date. **CMS Does not agree with this AMA rule. 1 visit per day/stay*

- When advanced practice nurses or physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

- For reporting initial nursing facility care, transitions between skilled nursing facility level of care and nursing facility level of care do *not* constitute a new stay.

Initial Nursing Facility Care Code Descriptor Example

▲99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

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

CPT®	Time (in minutes) (Must be met or exceeded)
99304	25
99305	35
99306	45
99418 (Prolonged Care)*	60 minutes or longer

*• G0317 for prolonged nursing facility services

Nursing Facility Discharge Services

- CPT 99315-99316
- Time-based codes, no prolonged care allowed.
- Used to report the total duration of all cumulative time spent by provider (including any NPP visits) (on the date of discharge face-to-face visit) for the final nursing facility discharge of a patient.
- This discharge visit may be performed on a date prior to the date the patient leaves the facility. (but has to be documented that there is no anticipation of a change in the patient's condition prior to discharge).

Questions?

Questions?

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Submit a question? Please see next slide on how to join our Coding Corner Membership

Coding Corner Network Membership

The Coding Corner Network Membership is an online Q&A coding assistance service for “members only” offered by Terry Fletcher Consulting, Inc. You have 2 options for membership.

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- Billing and Collection Questions
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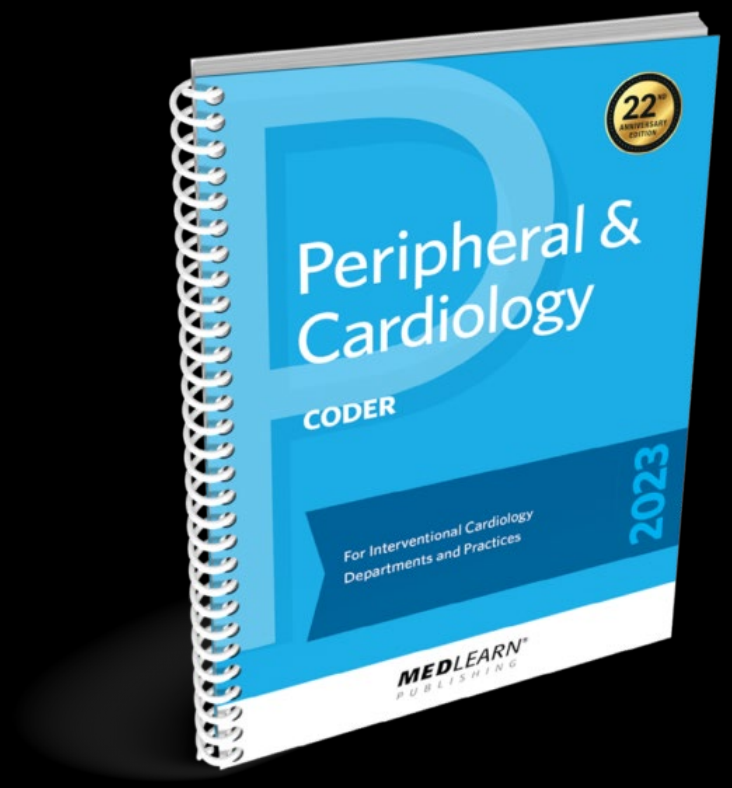
An, in-depth help with cardiac cath and interventional coding, peripheral procedural coding including carotids, lower extremities, renal, visceral and more… by author Terry Fletcher



- The combining of peripheral procedures into cardiac cath labs has created challenges for coders. Do you struggle pinpointing the key words and phrases in already highly complex documentation? Is there consistency in your procedural reports, or do they vary from physician to physician?
- Is there confusion about modifiers based on location (POS) or encounter status of the patient? If you answered “yes” to either of these questions, MedLearn Publishing’s *Peripheral & Cardiology Coder* book supports your coding accuracy and, ultimately, your revenue stream.
- Count on the experts behind this popular, practical resource to explain, step by step, how procedures are performed, the subtle differences between “like” procedures. The *Peripheral & Cardiology Coder* will also guide you on how to zero in on key words, acronyms, and phrases in the physician documentation to arrive at the correct CPT® codes.
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