2023 Evaluation & Management (E/M) Coding Changes and RHC Updates

PRESENTER

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Impact of Clinical Documentation

Agenda

- Review of Major E/M Revisions for 2021 Office or Other Outpatient Services
- 2023 E/M Changes for Home/Residence, Nursing Facility and Hospital
- “Problem-Oriented” versus “Preventive” E/M services
- Preventive Services: CPT versus Medicare Codes
- Updates for RHC Telehealth
- Exercises: Calculating Medical Decision Making for E/M Level

The Medical Record

- According to CMS, §482.24(c)(1) *All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.*
- CMS states "*providers should submit adequate documentation to ensure that claims are supported as billed*" and that each note must "stand alone" to support services claimed.
- When "Incident-To" billing is employed, know the rules (*ex. established patients with established problems and compare scope of services*).
- The medical record is the proof you may need to support payment and prevent claims of fraud/abuse.
- The medical record also serves as a legal document beyond billing to include malpractice/liability scenarios.
- The medical record provides continuity of care for the patient.

CMS Signature Requirements

- CMS suggests that a "timely" record entry is one that occurs within 24-48 hours. Occasionally, up to 72 hours is acceptable. Many payers require this as a CoP. Check your individual payer agreements.

What should I do if I have not signed an order or medical record?	You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records.

Complying with Medicare Signature Requirements

Impact of Insurance on Documentation

- Does documentation change based on insurance type?
  - Role of the CPT in "coding"
  - We use the codes for "billing" purposes that can differ by payer!
- CPT does not "imply any health insurance coverage or reimbursement policy."
- The AMA does not pay healthcare claims.
- Payment rules come from various payers in their participation agreements/ contract.
- Medicare sets the trends in the industry so we will use CMS as our foundation here…but realize that commercial insurance variations exist, and payment/billing differences are normal and legal.

Rural Health Clinic Basics

Independent vs. Provider-based RHCs

Are you self-owned as a part of an LLC/corporation/traditional clinic ownership OR are you owned by another entity such as a hospital system, CAH, or larger entity that owns one or more RHCs?

- Instead of getting paid fee-for-service (FFS) Medicare, and possibly Medicaid, pays you ~80% of an All-Inclusive Rate (AIR) for "valid encounters."
- Being independent vs. provider-based changes how you will bill for diagnostic tests (i.e., x-ray, EKG, ultrasound) via split billing, lab services, and surgical procedures performed outside of your RHC/FQHC.
- RHCs use modifier –CG on the first line item on most claims to identify the main reason the visit was performed as well as the single line item which will identify the total amount the patient's coinsurance will be based on.
- Medicare Part B patients must meet the same annual deductible and for visits owe **20% of the TOTAL ALLOWABLE CHARGES** rather than 20% of the Medicare Physician Fee Schedule amount via RBRVS

Rural Health Clinic Basics

Patient Cost Sharing

2023 RHC patient deductible ($226) is the same as they have in traditional doctor's offices.

- For valid AIR encounters the RHC patient coinsurance is **20% of your TOTAL ALLOWABLE CHARGES** from the first line on the CMS1450 (UB) form that carries modifier –CG.
  - ✓ Line #1 on the claim also should include your charges for that code as well as the allowable charges for all allowable codes below it all totaled on the Line #1's codes carrying –CG.
  - ✓ Your MAC should pay ~80% of the AIR rate.

- Independent and provider-based RHCs in a hospital with 50 or more beds **the AIR rate is <u>capped</u> at $126** for 2023 with ~ $13 annual increases to up to $190 in 2028 as per the RHC Modernization Act of 2021.
  - ✓ If you are a provider-based RHC owned by a hospital with less than 50 beds, you likely get paid an AIR based on your recent cost report rather than at "cost" as in the past.
  - ✓ Most preventive services have $0 coinsurance or deductible.

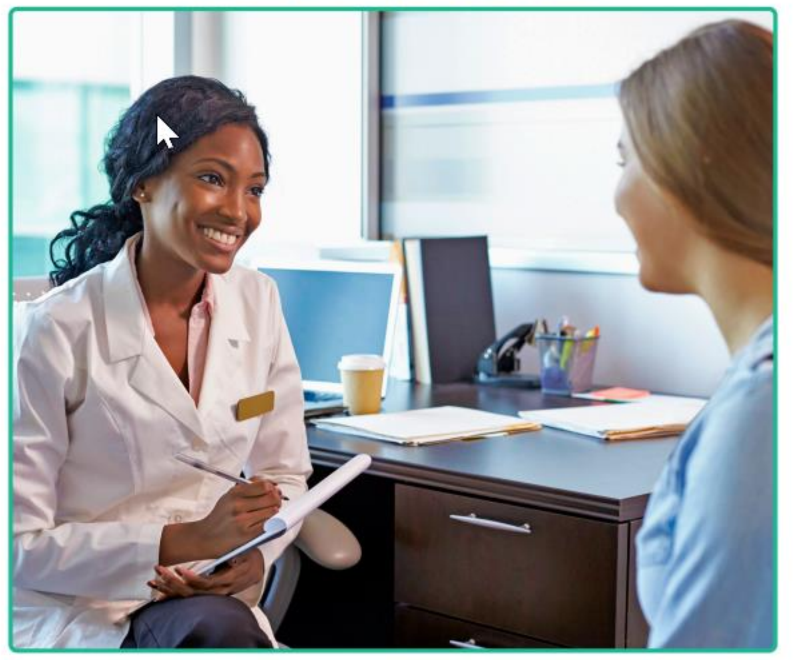
Special RHC & FQHC Considerations

- Medicare Benefit Policy Manual, Chapter 13
- Multiple visits may be allowed on the same day (Section 40.3)
    - Patient seen and treated at two distinct times and for two distinct purposes
    - Medical and a mental health visit performed on same date of service
    - **RHCs only**… IPPE and medical and/or mental health visit on the same date (up to 3-4 visits)

- Medicare Claims Processing Manual, Chapter 9

Reference the CMS Fact Sheets

Federally Qualified Health Center



Rural Health Clinic

Our HIPAA Code Sets

CPT ® - *What did you do?*

- CPT is currently identified as Level I of the Healthcare's Common Procedural Coding System (HCPCS).
- Created by the AMA and their documentation rules aren't licensed to others who also publish manuals!
- Most codes are updated January 1st each year–but vaccine product codes can be updated twice a year.

HCPCS II - *What did you do and/or what supplies were used?*

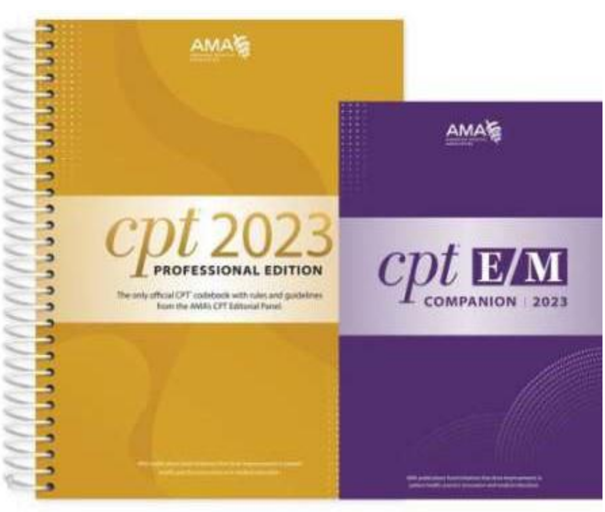
- HCPCS-II is currently identified by the Centers for Medicare and Medicaid Services (CMS) as Level II of the HCPCS.
- Created by CMS as a supplement to Level I CPT codes.
- Many "temporary" codes (i.e.. Q0091) and permanent codes with different update schedules.
- Supplies, DME, many specific CMS preventive medicine services are found here.

ICD-10-CM - *Why did you do perform a service?*

- Overseen by the Cooperating Parties (AHA, AMA, CMS, NCHS).
- New codes become effective on October 1 each year.

2023 CPT Layout

- Introduction
- **Evaluation and Management (99xxx)**
- Anesthesia (0xxxx)
- Surgery (1xxxx – 6xxxx)
- Radiology (7xxxx)
- Pathology and Laboratory (8xxxx)
- Medicine (9xxxx)
- Category II (xxxxF)- outcomes measures
- Category III (xxxxT)- emerging technology
- Appendix A-T
  - Category I and II codes released by September, effective January
  - Cat III codes released Jan 1, effective July 1



AMA, 2023 CPT®

Types of CPT Codes

- **Category I**: Procedures that are consistent with contemporary medical practice and are widely performed.
- **Category II**: Supplementary tracking codes that can be used for performance measures.
- **Category III**: Temporary codes for emerging technology, services, and procedures. These codes help foster more thorough and efficient documentation and help with proper utilization and reporting of new technologies.

Evaluation and Management (E&M) History

CPT was first published in 1966 but E&M guidelines were not introduced in 1992. E&M guidelines were later revised in 1995, 1997, 2021 and most recently, 2023.

- 1992 E&M documentation guidelines were based entirely on time
- 1995 E&M documentation guidelines were forged using a methodology of counting "*body areas*" and/or "*organ systems*"
- 1997 E&M documentation guidelines were drafted using a methodology of counting "*elements*" or "*bullets*"
- Some relaxed restrictions were approved in 2019 (became official with 2020 MPFS Final Rule) and sweeping changes took effect January 2021 for office/outpatient E&M codes, and in January 2023 for hospital, nursing facility and home visits. These changes have taken place for a multitude of reasons:
  - Reduce documentation burden for qualified providers
  - Eliminate "note bloat" and need to "re-document" certain aspects of the record
  - Reduce professional dissatisfaction and provider "burnout"
  - Encourage more time with patients and less time with unnecessary paperwork

Problem-Oriented vs. Preventive E&M

- A preventive E/M service differs from a problem-oriented E/M service because one lacks a chief complaint or presenting problem

- Introductory pages in the E&M section of CPT provide some excellent tables [*code selection charts*] designed to assist users with assigning the accurate 'levels' of E&M service
  - Who are you seeing?
    - New, initial, established, subsequent, consultation, etc.
  - Where are you seeing them?
    - RHC, FQHC, other outpatient, inpatient, ED, nursing facility, home, etc.
  - Why are you seeing them?
    - Preventive? Problem-oriented?

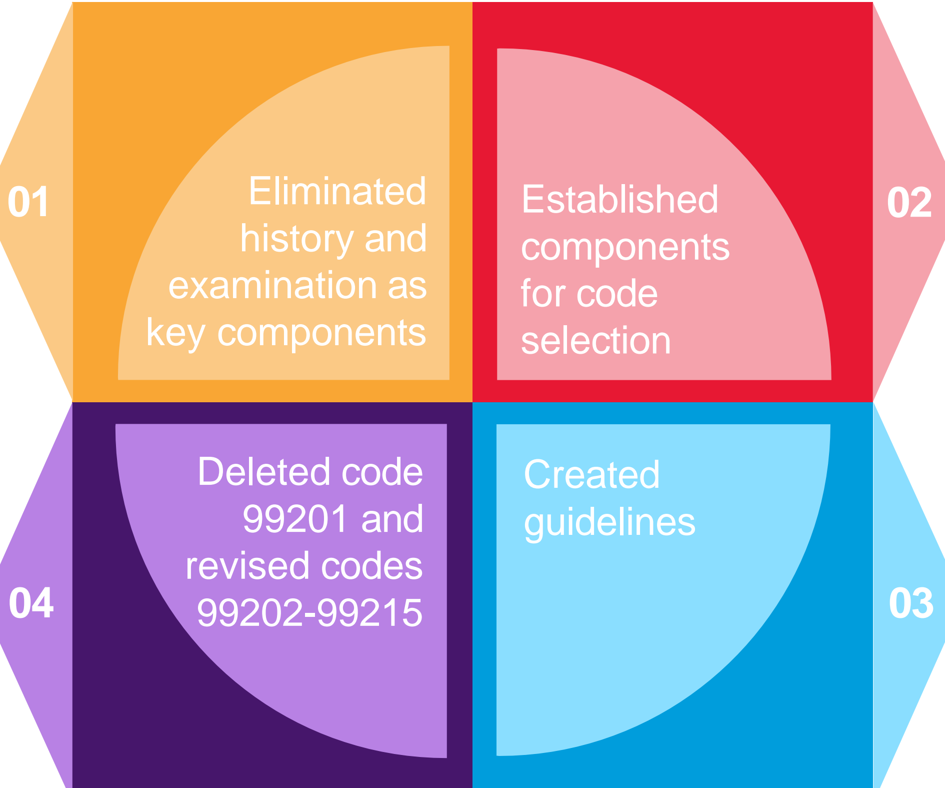
What Changed and When?

- ***Only*** Office or Other Outpatient E/M Visit codes (CPT codes 99201-99215)
- Effective **January 1, 2021**

- *Observation, Inpatient, Emergency, Nursing Facility, Home, etc.,* ***changes are effective as of January 1, 2023!!!***

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

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



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

Codes 99201 and 99202 both required straightforward MDM in 2020

Specific to E/M office and other outpatient services

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

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

The level of the MDM as defined for each service

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

- Extensive clarifications in the guidelines to define the elements of MDM
- *Total* time spent on the date of the encounter
  - Including non-face-to-face services
  - Clearer time ranges for each code
- Addition of a shorter 15-minute prolonged service add-on code (99417)
  - To be reported only when the minimum time **required when coding based on time for 99205 or 99215** has been exceeded by 15 minutes

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Review of Changes Impacting E&M Code Selection Introduced in 2021

- The "*new*" E&M guidelines only applied to codes 99202-99215. These were used to report office and other outpatient services.
- Time in the office and other outpatient setting is no longer defined as *face-to-face* time
- Medical decision making requires reference to the new terms in 2021 CPT for office and other outpatient services (e.g., *unique test, independent historian, independent reviewer, external*, etc.)
- The traditional framework for selecting E&M services (e.g., history, physical examination, medical decision making, etc.) were still required for non-office/outpatient evaluation and management services (ED, Obs, etc.).
- Providers were not *required* to document HPI (2019) but must review/confirm
- Auditing E&M services requires a firm understanding of MDM and TIME as defined in CPT
  - Of course, auditing based on time seems easier in pure evaluation and management services
  - Be mindful of macros and templates… do not "clone" times to appear like all cases are the same
  - Using time requires the provider to carve out time offering other services, so MDM is typically the going to be the best option in these cases

Provider *chooses* whether documentation is based on MDM or Total Time for Office E/M

Medical Decision Making:

- ***Same 4 complexities:***
  - Straightforward
  - Low
  - Moderate
  - High

- ***Still 2 of 3 elements***:
  - Required to get a level
  - Highest two scoring elements

Revised: Medical Decision-Making Grid-Office E/M

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** • 2 or more self-limited or minor problems; **or** • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 **99214**	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • 2 or more stable chronic illnesses; **or** • 1 undiagnosed new problem with uncertain prognosis; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis AMA Revised MDM Grid

Revised: Elements of Medical Decision Making-Office E/M

Elements of Medical Decision Making		
Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

MDM includes establishing diagnoses, assessing the status of a conditions, and/or selecting a management/treatment option and is defined by the 3 above listed elements.

Revised MDM Grid:

- Removed unclear terms, like “mild” and defined previously vague concepts (such as “acute or chronic illness with systemic symptoms”).
- Re-defined the Data element to move away from simply counting tasks to focusing on tasks that affect the management of the patient (independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external provider).
- Risk of complications or morbidity of patient management can now include social determinants of health and reasons behind decisions not to admit a patient or intervene in some way.

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New Patient Office/Outpatient Visits (2020) the "**old way**"

99201	99202	99203	99204	99205
Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Straightforward	Straightforward	Low	Moderate	High

Start in highest level…new patients required **3/3 key components** prior to 2021

New Patient Office/Outpatient Visits (2021 and later) the "**new way**"

99201	99202	99203	99204	99205
Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Straightforward	Straightforward	Low	Moderate	High

MDM or TIME are used to determine level of service

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	• 1 self-limited issue • 1 minor problem	Straightforward
99203 99213	• 2+ self-limited problems • 2+ minor problems • 1 stable chronic illness • 1 acute uncomplicated illness/injury	Low
99204 99214	• 1 or more chronic issues with exacerbation • 2+ stable chronic illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 Acute illness with systemic symptoms • 1 Acute complicated illness	Moderate
99205 99215	• 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment • 1 acute or chronic illness or injury posing threat to life/function	High

****99211 does not require MDM and CPT code 99201 was deleted January 2021****

Source: AMA Revisions to MDM, effective 1/1/2021

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Number and Complexity of Problems Addressed

Define the problem:

- Self limited/minor – Runs its course without need for treatment/follow up
- Acute uncomplicated – short term with low risk of morbidity (e.g., allergic rhinitis)
- Chronic with exacerbation – acutely worsening/poorly controlled (e.g., asthma exacerbation)
- Undiagnosed new – new condition likely to result in high risk of morbidity (e.g., breast lump)
- Chronic with severe exacerbation - severe progression or side effects of treatment with significant risk of morbidity that may require hospital care (e.g., COPD with severe exacerbation)

Terms For Needed for MDM Determination

- ***Problem***: refers to a "*disease, condition, illness, injury, symptom, sign, finding, complaint or other matter, with or without a diagnosis being established at the time of the encounter*"
- **Problem Addressed or Managed**: will refer to one "evaluated or treated at the encounter". Its important to mention that comorbidities or underlying disease are not to be considered in selecting the E&M level of service unless they are clearly addressed.
- ***Test***: refers to "*imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test*"
  - HINT: If a TEST is ordered AND reviewed as part of a particular encounter, it is only counted ONCE

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	Straightforward
99203 99213	**Limited** (Must meet at least 1 of the following 2 categories) **Category 1: Tests and Documents** Any 2 of the following: • **1**. Review prior external notes, **2.** Review results of EACH unique test, **3.** Order of EACH unique test ***or*** **Category 2: Assessment requiring "Independent Historian(s)"**	Low
99204 99214	**Moderate** (Must meet at least **1 of the following 3** categories) **Category 1: Tests, Documents and Independent Historian(s)** Any combination of 3 of the following: • **1.** Review of prior external note(s) from each unique source, **2.** Review results of each unique test, **3.** order of each unique test, **4.** Assessment requiring independent historian(s) ***or*** **Category 2: Independent interpretation of test performed by another provider (not billed) *or*** **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	Moderate
99205 99215	**Extensive** (Must meet at least **2 of the following 3** categories) **Category 1**: **Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test; **4.** Assessment requiring an independent historian(s) ***or*** **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); ***or*** **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional (not billed)	High

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Terms For Needed for MDM Determination

- **External**: "*External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization*"
- **External physician or other qualified healthcare professional**: "*An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty*"
- **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*"
- **Independent Interpretation**: "T*he 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*"

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • OTC	Low
99204 99214	**Moderate risk of morbidity from additional diagnostic testing or treatment** • Prescription drug management (rx) • Decision for minor surgery with identified patient or procedure risk factors • Decision for elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by *social determinants of health (SDoH)*	Moderate
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis	High

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Revised: Coding by Time

- Based on specific minimum time, not "typical time" as before

- Allowed whether or not counseling and/or coordination of care dominates the service

- Only applies when code selection is based on time and not MDM

- Represents total **provider** time on the same calendar date of service

- Total time should not include time spent by clinical/support staff

- More than one provider addressed-count only 1 person per minute

Revised: Coding by Time

Specific provider activities that may be included in total time are as follows:

- Preparing to see the patient (reviewing test results, etc.)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and education the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregivers
- Care coordination (not reported separately)

Time Associated With Office/Outpatient E&M

- CPT codes 99202-99215 are reserved for outpatient and ambulatory settings. All patients are outpatient until an actual admission occurs
- Per CMS, “time must meet or exceed the specific CPT code billed and should not be ‘rounded’ to the next higher level”. Do not apply the “midpoint” concept for E&M codes
    - 99202- 15-29 minutes
    - 99203- 30-44 minutes
    - 99204- 45-59 minutes
    - 99205- 60-74 minutes
    - 99211- *no specified time*
    - 99212- 10-19 minutes
    - 99213- 20-29 minutes
    - 99214- 30-39 minutes
    - 99215- 40-54 minutes

E&M: New Versus Established Patients (per CPT)

- A new patent is one who has not received any face-to-face professional service from the physician/qualified healthcare professional **or**

  another physician/qualified healthcare professional of the exact same specialty/subspecialty who belongs to the same group practice within the past 3 years.

- Is "new patent" defined the same in all places of service? ***No!***

- RHC-patient seen by any provider in the past 3 years billed on RHC NPI

New Patient Office/Outpatient E&M Services

Code	Description
99202	Office or other outpatient 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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient 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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient 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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient 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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Established Patient Office/Outpatient E&M Services

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient 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 time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient 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 time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient 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 time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient 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 time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

CPT Code 99211

- 99211 “Nurse Visits”
  - Unique E&M code (no ”provider” presence required)
  - NEVER should be billed for MD, DO, PA, NP services
  - Any ancillary service provider is approved
  - Anytime a patient is evaluated in the office by anyone other than a “qualified” provider
- Does not qualify for FQHC/RHC encounter rate

Preventive Medicine Services (per CPT)

CPT code's 5th digit	Patient's age
1	< 1
2	1-4
3	5-11
4	12-17
5	18-39
6	40-64
7	65+

- 99381-99387 (new), 99391-99397 (established)
- Medicare DOES NOT pay for an "annual physical"
- According to CPT, modifier -25 may be used for "significant" E&M
- These codes do not require a "chief complaint"

For FQHCs and RHCs, Refer to CMS Preventive Service Charts

Federally Qualified Health Center (FQHC) Preventive Services Chart

Rural Health Clinic (RHC) Preventive Services Chart

“Routine” Physicals-Medicare

- “While I’m here, I’ve had some problems I’d like to talk about”
- “But Medicare pays for an annual physical”
- “Medicare/Medicaid pays for everything"
- “I don’t have to meet a deductible or coinsurance for any preventive service, including the Annual Wellness Visit”
- “I’ve never had to pay for this before”
- “I was never informed that I had a financial obligation”

Important! If your doctor or other health care provider performs additional tests or services during the same visit that Medicare doesn’t cover under this preventive benefit, you may have to pay **coinsurance**, and the Part B **deductible** may apply. If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

Medicare and You Handbook 2023 pg 54

Excellent Resource: Medicare Preventive Services Chart

Medicare Wellness Visits

mln
EDUCATIONAL TOOL
KNOWLEDGE • RESOURCES • TRAINING

Medicare Wellness Visits

Quick Start | IPPE | AWV | Know the Differences | FAQs | Resources

Early detection saves lives. Encourage patients to get their preventive services.

Medicare Physical Exams Coverage

Medicare Physical Exams Coverage

Initial Preventive Physical Exam (IPPE)	Annual Wellness Visit (AWV)	Routine Physical Exam
Review of medical and social health history and preventive services education.	Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA).	Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
✓ New Medicare patients within 12 months of first Part B coverage period	✓ Covered once every 12 months	✗ Medicare doesn't cover a routine physical (it's prohibited by statute), but the IPPE, AWV, or other Medicare benefits cover certain routine physical elements
✓ Patients pay nothing (if provider accepts assignment)	✓ Patients pay nothing (if provider accepts assignment)	✗ Patients pay 100% out-of-pocket

Initial Preventive Physical Exam (IPPE)

HCPCS & CPT Codes

G0402 — Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0403 — Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

G0404 — Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 — Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

G0468 — Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

Initial Preventive Physical Exam (IPPE)

Medicare Covers: Patients with Medicare Part B once within the first 12 months of their Medicare Part B coverage period

Frequency: Once per lifetime, must occur no later than 12 months after effective date of first Medicare Part B coverage period

Patient Pays:

- **G0402:** No copayment, coinsurance, or deductible
- **G0403, G0404, and G0405:** Copayment or coinsurance, and deductible apply

- **G0468(FQHC):** No copayment, coinsurance, or deductible
  - You must offer AWV or IPPE with a standard bundle of services to all patients to use this code; FAQs on Medicare FQHC PPS (pages 2, 5, & 6) fact sheet has more information

Initial Preventive Physical Examination (IPPE elements)

Documentation requirements:

- Past medical and history
  - Current medications and supplements
  - Family history
  - History related to alcohol, tobacco, illicit drugs
  - Diet and physical activities
- Risk for depression and mood disorders
  - Use a screening instrument to assess potential for depression (eg, PHQ-9)
- Review functional ability and level of safety
  - Hearing, ADLs, fall risk and home safety

Additional IPPE Documentation Elements

- Examination
  - Height, weight, body mass index, and blood pressure;
  - Visual acuity screen; and
  - Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards.
- End of life planning
  - Verbal or written and provided to the patient
  - Advance directive in case the beneficiary can't make health care decisions
- Educate, counsel and refer
  - Include written preventions plan ('checklist') for patient including (as deemed appropriate) a once in a lifetime screening EKG (G0403-G0405)

Annual Wellness Visit (AWV)

HCPCS & CPT Codes

G0438 — Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439 — Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0468 — Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV
99497 — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498 — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Annual Wellness Visit (AWV)

Medicare Covers: Patients with Medicare Part B who:

•Aren't within 12 months after effective date of their first Medicare Part B coverage period

•Haven't had an Initial Preventive Physical Exam (IPPE) or AWV within the past 12 months

Frequency:

•Once per lifetime G0438 (first AWV)

•Annually G0439 (subsequent AWV) and G0468 (AWV in FQHC)

•Annually optional 99497, 99498

Patient Pays:

G0438 and G0439:

•No copayment, coinsurance, or deductible

G0468 (FQHC):

•You must provide AWV or IPPE with a standard bundle of services available to all patients; get more information at section 60.2 of Medicare Claims Processing Manual, Chapter 9

•No copayment, coinsurance, or deductible

99497 and 99498:

•No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element

- Bill using modifier –33 (Preventive Service) on same AWV claim
- Must deliver on same day by same AWV provider

Annual Wellness Visits (AWV)

Documentation Requirements

- Includes patient's history
- Compiling a list of current providers
- Height and weight
- Reviewing the patient's risk factor for depression
- Identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions)
- Setting up a written patient screening schedule
- Compiling a list of risk factors
- Furnishing personalized health services and referrals, as necessary

Counseling to Prevent Tobacco Use

HCPCS & CPT Codes

99406 — Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 — Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Medicare Covers
Outpatient and hospitalized patients with Medicare Part B who meet these criteria:
- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert when counseling is delivered
- Counseling is provided by qualified physician or other Medicare-recognized practitioner

Frequency
- 2 cessation attempts per year
  - Each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year

Patient Pays
- No copayment, coinsurance, or deductible

Evaluation and Management 2023

Additions-1

Revisions-50

Deletions-26

New Evaluation and Management (E/M) Services Guidelines*

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

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

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Home and Residence Services

High Level Summary

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

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Home or Residence Services

Guidelines

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

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Home or Residence Services

Code Descriptor Example

▲**99341** **Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

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

*CMS requires G-codes for prolonged services

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Home or Residence Services

Code Descriptor Example

▲**99347** **Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99347	20
99348	30
99349	40
99350	60
Prolonged (99417)*	75 mins or longer

*CMS requires G-codes for prolonged services

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Consultations

High Level Summary

- Retain the consultation codes, with minor, editorial revision to the code descriptors.
- Deletion of confusing guidelines, including the definition of "transfer of care."
- Deletion of lowest level office (99241) and inpatient (99251) consultation codes to align with four levels of MDM.
- If payer considers consultation codes status "I", the inpatient /observation or office visit codes may be used for consults.
  - CPT® Editorial Panel correctly anticipated Medicare would not recognize Consultation codes.
  - For example, use "Initial Hospital or Observation" and CPT® now aligns with current practice with removal of *"by the admitting physician"* from "Initial" care.

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Consultations

Guidelines—All previously existing concepts

- A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.
- A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
- A "consultation" initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (e.g., non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes.
- The consultant's opinion and any services that were ordered or performed must also be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

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Office or Other Outpatient Consultations
Code Descriptor Example

★▲**99242** **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99242	20
99243	30
99244	40
99245	55
Prolonged (99417)	70 mins or longer

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Inpatient or Observation Consultations

Code Descriptor Example

★▲**99252** **Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99252	35
99253	45
99254	60
99255	80
Prolonged (99418)	95 mins or longer

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Nursing Facility Services

High Level Summary

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

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Nursing Facility Services

Guidelines

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

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Nursing Facility Services

Guidelines

- When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a high-level MDM-type specific to initial nursing facility care by the principal physician or other qualified health care professional is recognized. This type is:
    - ***Multiple morbidities requiring intensive management:*** A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

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Initial Nursing Facility Care

Code Descriptor Example

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

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

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

*CMS requires G-codes for prolonged services

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Subsequent Nursing Facility Care

Code Descriptor Example

★▲**99307** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99307	10
99308	15
99309	30
99310	45
Prolonged (99418)*	60 mins or longer

*CMS requires G-codes for prolonged services

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Nursing Facility Discharge Services

Code Descriptor Example

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

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

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

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

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Update to Medical Decision Making Table-Hospital

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

2023 Revised MDM Grid

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Update to Medical Decision Making Table-Hospital

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**

High	**High**
	• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following**:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

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Inpatient and Observation Care Services

High Level Summary

- Deletion of observation CPT® codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99223, 99221- 99233, 99238-99239).
- Editorial revisions to the code descriptors to reflect the structure of total time on the date of the encounter or level of medical decision making when selecting code level. Specifically, the replacement of the three-key-components requirement with increasing level of MDM, along with changes in the time element to be used for each code when time is the basis for code selection.
- Retention of revised Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236).
- Revision of guidelines.

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Inpatient and Observation Care Services

Guidelines

- *An initial service may be reported when the patient has not received any professional services from the physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.*
    - Consistent for all inpatient services and new section in E/M introductory guidelines
    - Similar to "new" and "established" patient definitions except related to the stay vs last 3 years
- A transition from observation level to inpatient does not constitute a new stay.

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Inpatient and Observation Care Services

Guidelines

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

***CMS retains their policy of only reporting ONE E/M service per calendar date

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Inpatient and Observation Care Services

Guidelines

If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or other qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233). This instruction applies whether the consultation occurred on the date of the admission or a date prior to the admission. It also applies for inpatient consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

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Initial Hospital Inpatient or Observation Care

Code Descriptor Example

▲**99221** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99221	40
99222	55
99223	75
Prolonged (99418)*	90 mins or longer

*CMS requires its own prolonged service G codes:.

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Subsequent Hospital Inpatient or Observation Care
Code Descriptor Example

★▲**99231** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

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

CPT®	Time (in minutes) *(Must be met or exceeded)*
99231	25
99232	35
99233	50
Prolonged (99418)*	65 mins or longer

*CMS requires its own prolonged service G codes:.

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

Code Descriptor Example

▲**99234** **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99234	45
99235	70
99236	85
Prolonged (99418)*	100 mins or longer

*CMS requires its own prolonged service G codes:.

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

Guidelines

- Used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.
- Codes 99234, 99235, 99236 require *two or more encounters* on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter. For a patient admitted and discharged at the same encounter (i.e., one encounter), see 99221, 99222, 99223.

*CMS retains the term "calendar date" as the same as "per day", with retention of special rules for these codes:

- If less than 8-hour stay only use 99221-99223, not 99234-99236
- If 8 or more, but less than 24 hours, even if two dates, use only 99234-99236

NGS Admission and Discharge Services

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Hospital Inpatient or Observation Discharge Services

Code Descriptor Example and Guideline Revisions

▲**99238** **Hospital inpatient or observation discharge day management**; 30 minutes or less on the date of the encounter

▲**99239** More than 30 minutes on the date of the encounter

(For hospital inpatient or observation care including the admission and discharge of the patient on the same date, see 99234, 99235, 99236)

Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family/caregiver and coordination of post-discharge services may be reported with 99231, 99232, 99233.

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Observation Provider Visits - CMS

All other physicians billing
Observation care codes are billed only by the admitting physician. All other practitioners providing care to patients receiving observation services bill office and other outpatient visits, codes 99202-99205 or 99211-99215. New vs. established patient rules apply.

"Per day" defined
CPT defines evaluation and management services as “per day” which means the codes include all work performed in all sites on the date of service.

Place of service
Observation care is an outpatient service. Although the code range includes inpatient and outpatient services, the place of service code should identify the patient's location for the service billed. All claims for observation care are billed with place of service code -22.

Observation admission and discharge, same day
The codes for observation admission and discharge on the same day are 99234-99236. The medical record must also include documentation stating the stay for observation care involves 8 hours, but less than 24 hours.

Observation to inpatient, same day
If admitted as an inpatient by the same physician on the same day as the observation admission, bill only one initial hospital inpatient or observation care code 99221-99223 as the code represents all work performed in all sites on the date of service. The place of service code should identify the patient's location for the service billed.

Observation to inpatient, next/subsequent day
If admitted as an inpatient the next/subsequent day following an observation care day, bill initial hospital inpatient or observation care code 99221-99223 for the hospital admission. The place of service code should identify the patient's location for the service billed. Do not bill observation discharge management code or an office and other outpatient visit for services provided on the date of admission as an inpatient. Novitas Part B Fact Sheet: Observation Services CMS Transmittal 11842

CMS and CPT Rules for Admission and Discharge Same Calendar Date

CMS and CPT rules for admission and discharge, same calendar date with application of CMS 8 hour rule			
Hospital Length of Stay	**Discharged On**	**Code(s) to Bill CMS**	**Code(s) to Bill CPT**
< 8 hours	**Same calendar date** as admission or start of observation	Initial hospital services only 99221-99223	Adm/Discharge 99234-99236
8 or more hours	**Same calendar date** as admission or start of observation	Adm/Discharge 99234-99236	Adm/Discharge 99234-99236
< 8 hours	**Different calendar date** than admission or start of observation	Initial hospital services only 99221-99223	Initial and discharge, 99221-99223 on adm. 99238-99239 on d/c
8 or more hours	**Different calendar date** than admission or start of observation	Initial and discharge, 99221-99223 on adm. 99238-99239 on d/c	Initial and discharge, 99221-99223 on adm. 99238-99239 on d/c

CPT vs CMS Table-Codingintel.com

Modifier AI – "Principal Physician of Record

- Modifier "-AI," defined as "Principal Physician of Record," shall be used by the admitting or attending physician who oversees the patient's care, as distinct from other physicians who may be furnishing specialty care.
- The principal physician of record shall append modifier "-AI" in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed
- The primary purpose of this modifier is to identify the principal physician of record on the **initial** hospital and nursing home visit codes.

- Example: Noridian Modifier AI

Practice Examples

Case #1 Office (Established patient)

Assessment:

1. Essential hypertension (I10), controlled on current prescription regimen (Lisinopril, 10mg, once orally per day). Refill rx order sent to CVS pharmacy for 60-day supply. Current BP 128/76. Patient to continue checking BP at home. Follow up 3 months.

2. Neuropathy (G62.9), currently under good control. Refill Gabapentin, 100mg, 3x orally per day.

Evaluation and Management Code (E&M Level)	**Number and Complexity of Problems Addressed**	Complexity/Level of Medical Decision Making (MDM)
99202 99212	• 1 self-limited issue • 1 minor problem	Straightforward
99203 99213	• 2+ self-limited problems • 2+ minor problems • 1 stable chronic illness • 1 acute uncomplicated illness/injury	Low
99204 99214	• 1 or more chronic issues with exacerbation • 2+ stable chronic illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 Acute illness with systemic symptoms • 1 Acute complicated illness	Moderate
99205 99215	• 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment • 1 acute or chronic illness or injury posing threat to life/function	High

ArchProCoding
RURAL & COMMUNITY HEALTH

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	Straightforward
99203 99213	**Limited** (Must meet at least 1 of the following 2 categories) • **Category 1: <u>Tests and Documents</u>** • <u>Any 2 of the following</u>: • **1.** review prior external notes, **2.** review resul[illegible] **3.** order of EACH unique test • **Category 2: <u>Assessment requiring "Inde</u>**[illegible]	Low
99204 99214	**Moderate (**Must meet at least 1 of the [illegible]ies) • **Category 1: <u>Tests, Documents and</u>** [illegible] **<u>endent</u>** [illegible] • <u>Any combination of 3 of the follo</u>[illegible] • **1.** review of prior external note(s) [illegible] each unique so[illegible]iew resul[illegible]ach unique test, **3.** order of each unique test, **4.** Assessment re[illegible] independent his[illegible] • **Category 2: <u>Independent interpreta</u>** [illegible] **<u>est performed by a</u>** [illegible] **<u>(not billed)</u>** • **Category 3: <u>Discussion of Manageme</u>** [illegible] **<u>terpretation wit</u>** [illegible] **<u>ovider (not billed)</u>**	Moderate
99205 99215	**Extensive** • **Category 1**: **<u>Tests, documents, or independent historian(s)</u>** • Any combination of 3 from the following: **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test*; **4.** Assessment requiring an independent historian(s) ***<u>or</u>*** • **Category 2: <u>Independent interpretation of tests</u>** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); ***<u>or</u>*** • **Category 3**: **<u>Discussion of management or test interpretation</u>** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed)	High ArchProCoding RURAL & COMMUNITY HEALTH

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • OTC	Low
99204 **99214**	**Moderate risk of morbidity from additional diagnostic testing or treatment** • **Prescription drug management (rx)** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • Diagnosis or treatment significantly limited by *social determinants of health (SDoH)*	**Moderate**
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis	High

ArchProCoding
RURAL & COMMUNITY HEALTH

Case #1: DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by 2 of the 3 elements from the table below:

Number and Complexity of Problems Addressed			2 Stable Chronic Conditions	
Amount and/or Complexity of Data to be Reviewed and Analyzed				
Risk of Complications and/or Morbidity or Mortality of Patient Management			Prescription Drug Management	
LEVEL OF DECISION MAKING	Straight Forward	Low Complexity	Moderate Complexity	High Complexity

MODERATE COMPLEXTY FOR EST PATIENT = 99214

Case #2 Office (New patient)

CC: URI symptoms

History:

16-year-old new patient presents with 2-day history of coughing and shortness of breath. Patient denies chest pain.

Examination:

General: WDWN 16-year-old male in NAD. BMI 20.27, Pulse 82, Temp 99.3, Height 5' 8", Weight 158 lbs.

Eyes: PERRLA.

Ears: No pain, inflammation, TMs wnl. No lymphadenopathy.

Heart: RRR, no murmur.

Lungs: CTA, no wheezing.

Assessment/Plan:

1. Acute Respiratory Infection (URI) (J06.9)
   - Rx: ProAir HFA Aerosol Solution, 30 days, 1 refill, 2 puffs per day as needed
   - Rx: Zithromax 200 mg/5ml, orally once/day for 5 days
   - Follow up prn

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	• 1 self-limited issue • 1 minor problem	Straightforward
99203 99213	• 2+ self-limited problems • 2+ minor problems • 1 stable chronic illness • **1 acute uncomplicated illness/injury**	**Low**
99204 99214	• 1 or more chronic issues with exacerbation • 2+ stable chronic illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 Acute illness with systemic symptoms • 1 Acute complicated illness	Moderate
99205 99215	• 1+ chronic illnesses with sever exacerbation/progression or side effect of treatment • 1 acute or chronic illness or injury posing threat to life/function	High

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	Straightforward
99203 99213	**Limited** (Must meet at least 1 of the following 2 categories) • **Category 1: Tests and Documents** • Any 2 of the following: • **1.** review prior externa ... order of EACH unique test • **Category 2: Assess**	Low
99204 99214	**Moderate** (Must r ... ing 3 categories) • **Category 1: T ... men ... ent Historian(s)** • Any combin ... of the follo • **1.** review o ... ernal note(s) fr ... source, **2.** Review resu ... n unique test, **3.** order of each uniqu ... Assessment requir ... historian(s) • **Category 2 ... dent interpretation of ... by another pro ... billed)** • **Category 3: ... n of Management or test ... ith outsid ... r (not billed)**	Moderate
99205 99215	**Extensive** • **Category 1**: **Tests ... independent historian(s)** ... of 3 from the following: **1.** Review of prior exte ... result(s) of each unique test*; **3.** Ordering of each uniqu ... historian(s) ***or*** • **Category 2: Independent i** ... erpretation of a test performed by another physician/other qualified health ca ...), ***or*** • **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed)	High ArchProCoding RURAL & COMMUNITY HEALTH

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99202 99212	Minimal risk of morbidity from additional diagnostic testing or treatment • Rest, gargles and bandages	Straightforward
99203 99213	Low risk of morbidity from additional diagnostic testing or treatment • OTC	Low
99204 99214	Moderate risk of morbidity from additional diagnostic testing or treatment • **Prescription drug management (rx)** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • Diagnosis or treatment significantly limited by *social determinants of health (SDoH)*	**Moderate**
99205 99215	High risk of morbidity from additional diagnostic testing or treatment • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis	High

ArchProCoding
RURAL & COMMUNITY HEALTH

Case #2: DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by 2 of the 3 elements from the table below:

Number and Complexity of Problems Addressed	⃠	**1 acute uncomplicated illness/injury**	⃠	⃠
Amount and/or Complexity of Data to be Reviewed and Analyzed	⃠	⃠	⃠	⃠
Risk of Complications and/or Morbidity or Mortality of Patient Management	⃠	⃠	RX MGT	⃠
LEVEL OF DECISION MAKING	Straight Forward	Low Complexity	Moderate Complexity	High Complexity

LOW COMPLEXTY FOR NEW PATIENT = 99203

Case #3 Initial Hospital Inpatient

Assessment:

1. Type 2 diabetes mellitus with hyperglycemia (E11.65) uncontrolled, blood glucose level = 650. Patient newly diagnosed, begin sliding scale insulin with blood glucose checks every 4 hours. CMP and Hemoglobin A1C now. Diabetic diet.

2. Chronic systolic (congestive) heart failure (I50.2), stable. EKG and BNP now. Furosemide 20mg tablet twice daily.

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed at the Encounter	Level of Medical Decision Making (MDM)
99221	• 2 or more self-li… …ms; or • 1 stable, c… • 1 acut… …d illness or i… • 1 st… …; or • 1 … …illness or injury requ… …pital or ob… …n level …	**Low**
99222	•1 … …e chronic issues … …bation •2… …chronic illnesses •1 U… …sed problem with un… •1 Acu… …ith systemic sympto… •1 Acute …	**Moderate**
99223 ArchProCoding RURAL & COMMUNITY HEALTH	•1+ chronic illnesses … …bation/progression or side effect of treatment •1 acute or chronic illness or injury posing threat to life/function	**High**

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed	Level of Medical Decision Making (MDM)
99221 99231 99234	*(Must meet the requirements of <u>at least 1 of the 2 categories</u>)* **Category 1: Tests and Documents** •Any 2 of the following: •1. review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test **Category 2: Assessment requiring "Independent Historian(s)"**	Low
99222 99232 99235	*(Must meet the requirements of <u>at least 1 of the 3 categories</u>)* **(Category 1: Tests, Documents, or independent historian(s)** •Any combination of 3 from the following: •1.review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test, 4. assessment requiring and independent historian(s) **Category 2: Independent interpretation of test performed by another provider (not billed)** **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	Moderate
99223 99233 99236	*(Must meet the requirements of <u>at least 2 of the 3 categories</u>)* **(Category 1: Tests, Documents, or independent historian(s)** •Any combination of 3 from the following: •1.review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test, 4. assessment requiring and independent historian(s) **Category 2: Independent interpretation of test performed by another provider (not billed)** **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	High

ArchProCoding
RURAL & COMMUNITY HEALTH

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99221 99231 99234	**Low risk of morbidity from additional diagnostic testing or treatment**	Low
99222 99232 99235	**Moderate risk of morbidity from additional diagnostic testing or treatment** •**Prescription drug management (rx)** •Decision for minor surgery with identified patient or procedure risk factors •Decision for elective major surgery without identified patient or procedure risk factors •Diagnosis or treatment significantly limited by social determinants of health (SDoH)	Moderate
99223 99233 99236	**[illegible]h risk of morbidity from additional diagnostic testing or treatment** •Drug therapy requiring intensive monitoring for toxicity •Decision regarding elective major surgery with identified patient or procedure risk factors •Decision regarding emergency major surgery •Decision regarding hospitalization or escalation of hospital level of care •Decision not to resuscitate or to de-escalate care because of poor prognosis •Parenteral controlled substances	**High**

Case #3 DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by **2 of the 3 elements** from the table below:

Number and Complexity of Problems Addressed			
Amount and/or Complexity of Data to be Reviewed and Analyzed		**3+ unique tests**	
Risk of Complications and/or Morbidity or Mortality of Patient Management		**Prescription drug management**	
LEVEL OF DECISION MAKING	Low Complexity	Moderate Complexity	High Complexity

MODERATE COMPLEXTY – INITIAL HOSPITAL PATIENT VISIT = 99222

Case #4 Subsequent Hospital Observation

ASSESSMENT AND PLAN:

1. Anemia. Patient received 2 units of packed red blood cells, improving her HGB to 9.8 and HCT to 33 today: Lactic acid elevated at 2.6. CBC: WBC was 8.2. Plan: Repeat H&H at 2pm. If stable, discharge home.

2. Urinary tract infection. She was also found to have a trace nitrite on her UA, it was negative for ketones and glucose, positive for small leukocytes and positive nitrates, protein 30. Plan: Patient is on Levaquin IV, change to oral dosage upon discharge to complete a full 7-day course.

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed at the Encounter	Level of Medical Decision Making (MDM)
99221	• 2 or more self … ; or • 1 stable, c… • 1 acut… …ted illness or inj… • 1 st… ; or • 1 a… …co… …llness or injury requ… …pital or ob… …n level c…	**Low**
99222	•1 … e chronic issu… …erbation •2 … chronic illnesse… •1 U… …osed problem with … …rogn… •1 Ac… …s with systemic sym… •1 Acu… …ed illness	**Moderate**
99223	•1+ chron… …ogression or side effect of treat… •1 acute or chronic ill… …posing threat to life/function	**High**

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed	Level of Medical Decision Making (MDM)
99221 99231 99234	*(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and Documents** •Any 2 of the following: •1. review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test **Category 2: Assessment requiring "Independent Historian(s)"**	Low
99222 99232 99235	*(Must meet the requirements of at least 1 of the 3 categories)* **(Category 1: Tests, Documents, or independent historian(s)** •Any combination of 3 from the following: •1.review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test, 4. assessment requiring and independent historian(s) **Category 2: Independent interpretation of test performed by another provider (not billed)** **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	Moderate
99223 99233 99236	*(Must meet the requirements of at least 2 of the 3 categories)* **(Category 1: Tests, Documents, or independent historian(s)** •Any combination of 3 from the following: •1.review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test, 4. assessment requiring and independent historian(s) **Category 2: Independent interpretation of test performed by another provider (not billed)** **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	High

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99221 99231 99234	Low risk of morbidity from additional diagnostic testing or treatment	Low
99222 99232 99235	Moderate risk of morbidity from additional diagnostic testing or treatment •Prescription drug management (rx) •Decision for minor surgery with identified patient or procedure risk factors •Decision for elective major surgery without identified patient or procedure risk factors •Diagnosis or treatment significantly limited by social determinants of health (SDoH)	Moderate
99223 99233 99236	High risk of morbidity from additional diagnostic testing or treatment •Drug therapy requiring intensive monitoring for toxicity •Decision regarding elective major surgery with identified patient or procedure risk factors •Decision regarding emergency major surgery •Decision regarding hospitalization or escalation of hospital level of care •Decision not to resuscitate or to de-escalate care because of poor prognosis •Parenteral controlled substances	High

Case #4 DETERMINE THE FINAL LEVEL OF MEDICAL DECISION MAKING

Final MDM is determined by 2 of the 3 elements from the table below:

Number and Complexity of Problems Addressed	⊘	⊘	⊘
Amount and/or Complexity of Data to be Reviewed and Analyzed	⊘	**3+ unique tests**	⊘
Risk of Complications and/or Morbidity or Mortality of Patient Management	⊘	**Prescription drug management**	⊘
LEVEL OF DECISION MAKING	Low Complexity	Moderate Complexity	High Complexity

MODERATE COMPLEXTY – Subsequent Hospital Observation PATIENT VISIT = 99232

E&M Utilization Patterns

Utilization

Code	Value
99211:	0
99212:	0
99213:	144
99214:	290
99215:	641

Update Worksheet

Table 2 - Established Office Visits

Utilization

Percentage

100%

50%

0%

99211 99212 99213 99214 99215

Click series name to hide/show

National GPCI State Provider

Variance

Percentage

100%

0%

-100%

99211 99212 99213 99214 99215

Click series name to hide/show

National GPCI State

View Data

Source: Doctors Metrics

[AAPC E/M Utilization Benchmarking Tool]

Telehealth vs. Virtual
Communication
Services

Telehealth vs. Virtual Communication Services (VCS)

- Telehealth and Virtual Communication Services (VCS) both use emerging technologies to deliver care.

- ***Telehealth services are usually pre-scheduled*** and can be audio only under certain circumstances, such as some mental health visits. What about "distant" and "originating" site telehealth.

- ***VCS are "virtual check-in services" that are usually patient-initiated*** and can include phone or other electronic means, such as an online patient portal where patients are reaching out to see if they need to come in for an immediate visit or can be taken care of virtually.

RHC/FQHC Considerations- Medicare

Payment for Telehealth Services

- CMS has extended the uniform RHC telehealth payment rate for independent or provider-based RHCs for any Medicare – approved telehealth **distant site** services furnished effective through **December 31, 2024**. RHCs must continue to report HCPCS code **G2025** on their telehealth claims.
- To bill for these services, a physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian.
- You can't bill for these services if they start from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Virtual Communication Services

- When the COVID-19 PHE ends, the payment for virtual communication services (**G0071**) will no longer include online digital evaluation and management services (99421, 99422, 99423) . Only the average for G2012 and G2010.
- These services may only be provided to **established patients**..
- Additionally, **consent for services** will require **direct supervision**.

Cost Sharing

- Do not report CS modifier for patients for E/M services related to COVID-19 testing. after May 11, 2023 . RHCs may collect 20% coinsurance after May 11, 2023, for these visit types..
- For preventive services provided via telehealth that have cost sharing waived, RHCs must report **G2025** on claims with the **CG and CS modifiers**, and FQHCs must report G2025 with the CS modifier on or after July 1, 2020, **through December 31, 2024.**

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

SE20016 - New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

RHC/FQHC Considerations
Telehealth for Mental Health Visits

MENTAL HEALTH SERVICES – For Medicare patients, RHC/FQHC are instructed to report a code on the CMS approved services list as if performed in-person and billing should add an appropriate modifier in order to receive your AIR/PPS payments

- Audio-video visits: Use modifier 95 (Synchronous Telemedicine Service Rendered via Real Time Interactive Audio and Video Telecommunications System).
- Audio-only visits: Use new service-level modifier FQ or 93

Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

Private Payer Telehealth Flexibilities

Private Health Insurance and Telehealth.

"As is currently the case during the COVID-19 PHE, coverage for telehealth and other remote care services will vary by private insurance plan after the end of the COVID-19 PHE. When it covers telehealth and other remote care services, private insurers may impose cost-sharing, prior authorization, or other forms of medical management on such services. For additional information on an insurer's approach to telehealth, patients should contact their insurer's customer service number located on the back of their insurance card."

HHS Fact Sheet: Telehealth Flexibilities and Resources and the COVID-19 PHE -May 10, 2023

Reference Links

- AMA 2023 Revised Hospital MDM Grid
- AMA 2021 Revised Office MDM Grid
- AMA CPT® Evaluation and Management (E/M) Code and Guideline Changes 1.1.2023
- CMS Evaluation and Management Services Guide
- Calendar Year 2023 Medicare Physician Fee Schedule Final Rule
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

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