

E/M 2023: Advancing landmark updates across more settings of care

Recorded on Aug. 9, 2022



Attendee Questions and Presenter Answers

The following questions were submitted by attendees during the Current Procedural Terminology (CPT®) Webinar, “E/M 2023: Advancing Landmark Revisions Across More Settings of Care,” on Aug. 9, 2022. Answers have been provided by the American Medical Association’s (AMA) CPT Content Management & Development team and reviewed by webinar presenters Peter Hollmann, MD, AMA/Specialty Society Relative Value Scale Update Committee (RUC) member, and Barbara Levy, MD, CPT Editorial Panel member.

PLACE OF SERVICE WITH INPATIENT/OBSERVATION CODES

Q Patients in Observation are typically considered Outpatients for many billing purposes. With the consolidation of Inpatient and Observation E/M codes, when we are reporting 99221, do we change the Place of Service (POS) designation to reflect the patient’s status? IE 99221 POS 21 for IP and 99221 POS 22 for OP?

Yes, when reporting 99221, change the Place of Service (POS) designation to reflect the patient’s status (e.g., for 99221 POS 21 and for 99221 POS 22 for OP). Per the [CPT E/M guidelines](#): “The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.”

INPATIENT/OBSERVATION STATUS TRANSITION

Q If a patient’s status is changed from Observation to Inpatient, would the first E/M encounter as inpatient be considered a subsequent visit, or would that encounter be considered an initial visit? Is the reporting the same for a Critical Access Hospital, where observation and inpatient encounters are not combined?

If a patient’s status is changed from Observation to Inpatient, it would be considered as Inpatient subsequent visit because per the guidelines: “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.”

Critical Access Hospitals are designated by CMS; please follow CMS/payer rules as they may have additional information and requirements for reporting these services.

INPATIENT E/M—TIME REPORTING

- Q In prior guidance when counting time for inpatient services, unit/floor time was necessary. With the 2023 changes to the Inpatient codes, will we now be able to count time off the unit/floor? If the provider is completing documentation or reviewing medical records in his/her office and not on the unit/floor, can this time now be counted?**

For coding purposes in 2023, time for these services is the total time on the date of the encounter. It includes **both** the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

INPATIENT/OBSERVATION AND DATA: INITIAL VERSUS SUBSEQUENT VISIT LEVELS

- Q In regards to subsequent hospital visits, how will labs and imaging studies be counted for E/M in terms of Amount and/or Complexity of Data to be Reviewed/Analyzed for daily/Standing orders pertinent to their hospital stay?**

A similar question: Does the addition of parenteral controlled substances count as High complexity only on the day of the encounter where they are initiated? Or will it also count on the subsequent days the patient continues to be on those on these controlled substances?

The code descriptors for subsequent hospital inpatient or observation care codes (99231-99233) have been revised to include MDM levels. For each subsequent day, the patient's condition and any standing orders may be considered when selecting the appropriate level of MDM required in order to support a given code. The MDM table that is current for E/M Services code selection is the best place to review this information. In the example raised regarding parenteral medications, MDM occurs on the day the medication(s) are ordered or initiated. If the physician/QHP is overseeing and monitoring this medication and determining whether or not to continue, it may be counted on subsequent days as well, except if another physician/QHP is managing this aspect of the patient's care. As each patient's condition(s) and the individual clinician's judgement providing treatment will vary, this must be resolved on a case-by-case basis, for each subsequent day that the patient is an inpatient or under observation.

CONSULTATIONS

- Q If my provider is asked to consult on an Observation patient, should the office or other outpatient E/M codes be used to report this activity?**

No, the office or other outpatient services (99202-99205, 99211-99215) would not be reported. Instead, the inpatient or observation consultations services (99252-99255) should be reported, depending on the time threshold specified in the code descriptor. Subsequent consultation services during the same admission are reported using subsequent inpatient or observation hospital care codes (99231-99233).

- Q Please help us better understand the appropriate use of consultation codes when a patient is subsequently admitted, as in the following scenario: A patient is seen by a cardiologist in the office. Two weeks later, the patient is admitted by a physician other than the cardiologist. The cardiologist is contacted for a consult; what would be the appropriate code(s) to report?**

In this scenario, the cardiologist would report the appropriate consultation code (99242-99245), while the admitting physician would report the appropriate inpatient/observation care code (99221-99223). If the patient remains hospitalized, then an appropriate subsequent hospital inpatient/observation care code (99231-99233) may be reported.

PRESCRIPTION DRUG MANAGEMENT

- Q Related to MDM: It was discussed and understand that it was intended for clinical judgment by clinicians. problem is, coders/auditors/coding educators are trying to use the tool for consistency. We need a way to insightfully apply the guidelines. Please elaborate on what constitutes Prescription Drug Management—is it enough to simply review a medication list, does there need to be management of the condition, etc.? Also, does a provider stating “there is a moderate risk for an over-the-counter medication” enough to justify a moderate level of risk re: patient management?**

There is no “blanket” guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a specific patient’s risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management. The E/M workgroup will continue to monitor questions and consider clarifications and education to refine the guidance.

PROLONGED SERVICES

- Q Are there prolonged services codes to be used with the telephone visit code 99443?**

None of the new prolonged services codes (99417, 993X0) may be used with a telephone call. Code 99443, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion*, was created before most payers allowed telephone calls to be paid and it was felt that calls over 30 minutes should be addressed with an in-person visit. With the Public Health Emergency (PHE), Medicare treats 99441-99443 as substitutes for office visits, so some of the original logic does not apply. Code 99358 is 30 minutes on a single date for non-face-to-face services. It may be allowed instead of 99443 for longer calls. We would be reluctant to suggest it should be used as a prolonged services code for additional time of 30 minutes beyond the 30 minutes of 99443 given the allowed use of 99443 during the PHE and the history of the creation of the telephone codes.

GUIDELINES

- Q With the 2023 changes, will the Preventive Medicine Codes use 95/97 guidelines as they are not time-based?**

No, for the 2023 code set, the Preventive Medicine codes (99381-99397) will be reported based upon previous criteria as there were no changes made. The “comprehensive” nature of the preventive medicine services codes 99381-99397 reflects an age- and gender-appropriate history/exam and is not synonymous with the 95/97 guidelines previously required for evaluation and management codes 99202-99350.

95/97 GUIDELINE APPLICABILITY

- Q Do the 2023 guidelines also impact the Transitional Care Management codes, 99495–99496? These codes currently require moderate or high MDM, and we have to use 95/97 guidelines to get that for these codes. Will we now determine MDM for these codes with the new 2023 guidelines instead?**

Yes. The 2023 guidelines rather than the 95/97 guidelines will be used to select the service level for Transitional Care Management codes. The guidelines have been revised and code selection will be determined as follows: *“Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date of discharge and there must be a high level of medical decision making. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and there must be at least a moderate level of medical decision making. Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM. Documentation includes the timing of the initial post-discharge communication with the patient or caregivers, date of the face-to-face visit, and the level of medical decision making.”*

EMERGENCY DEPARTMENT

- Q Please elaborate on who would be reporting CPT code 99281; who is performing the service in this case? It would seem that anyone besides the physician or QHP treating the patient would belong to the facility.**

For 2023, code 99281 is defined as an “Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional.” However, similar to Office or Other Outpatient code 99211, code 99281 requires physician supervision. The tasks of code 99281 (e.g., suture removal) may be performed by clinical staff, but the work RVUs of the service are that of the supervision. 99281 has no direct practice expense inputs as the staff are those of the facility. This is unlike 99211, where the staff are those of the physician or qualified health care professional. Only physicians or other QHPs are able to report the service.



FOR MORE INFORMATION

Review and download the [E/M code descriptors and guidelines for 2023](#), and view the [recorded webinar](#).

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