2023 Evaluation and Management (E/M) Coding Changes- Part 2

November 9, 2022
Webinar FAQ Document

1. **Question** –Does pre-operative clearance qualify as a consultation?

   Answer – 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. [1] If the surgeon makes a formal request for another physician to evaluate the patient to advise whether the patient is medically stable to undergo surgery and then the consulted physician provides a written summary of his/her findings and recommendations, the pre-operative clearance will qualify as a consultation. Keep in mind that not all payers recognize consultation codes.

2. **Question** – Would place of service still stay the same for Observation (POS 22-23) and Inpatient (POS 21)?

   Answer – Yes, the place of service would stay the same for observation and inpatient because the guidelines for place of service have not changed for calendar year 2023.

3. **Question** –Are the providers billing by time only now or can they bill based on MDM or time?

   Answer – Providers still have the choice to make code selection based on medical decision making (MDM) or time in 2023. This affects the E/M codes that used to be based on history, exam, and MDM or time. This does not affect all E/M codes, care management or critical care services.

4. **Question** –For subsequent consultations, does it have to be the same provider or a provider in the same practice in order to use 99231 – 99233?

   Answer – Yes, to use a subsequent care code, it must be the same provider or another provider or qualified healthcare professional (QHP) within the same practice as the physician or QHP who provided the initial consultation encounter.

5. **Question** –Are the prolonged service codes allowed with all the consultation codes or are they only allowed with 99245 & 99255?

[1] CPT® Evaluation and Management (E/M) Code and Guideline Changes, "Hospital Inpatient or Observation Discharge Services," Page 26. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Answer – Prolonged service codes are only allowed when the time requirements on the highest-level consultation codes (99245 & 99255) are exceeded by 15 minutes. It would not be appropriate to use the prolonged service codes on the other consultation codes.[2]

6. **Question** – In part one of the presentation, on slide 63, it shows prolonged care code 99418 as 90 mins or longer. In part 2 of the presentation, it shows the prolonged care code 99418 as 95 mins or longer. Please clarify.

   Answer – In part one of the presentation, slide 63 references initial hospital inpatient or observation care codes (99221-99223). Prolonged care code 99418 may be used with the highest-level initial inpatient or observation code, 99223, if the encounter goes 15 minutes beyond the time required for this code (75 minutes). So, in order to use the prolonged care code 99418 with the initial hospital inpatient or observation code 99223, 90 minutes must be met or exceeded.

   In part two of the presentation, slide 14 references inpatient and observation consultation codes (99252-99255). In order to use the prolonged care code 99418, the encounter must last 15 minutes beyond the time required for the highest-level inpatient or observation consultation code (80 minutes). So, in order to use the prolonged care code 99418 with the inpatient or observation consultation codes, 95 minutes must be met or exceeded.[3]

7. **Question** - Is the Emergency Department E/M information provided in the presentation provided for facility billing?

   Answer – No, facilities will continue to assign ER E/M codes based on internal criteria.

8. **Question** -Will CMS now accept 99281 for a left without being seen patient in the ED since 99281 no longer requires a physician or QHP?

   Answer- No. These guidelines have not changed for 2023. While the description for the service says that a physician's presence may not be necessary, there is no change to the regulations that hospital services are integral, although incidental to a physician's service and the clinician performing the service would need to be following a physician's order or plan of care. Examples provided by the CPT® Editorial Panel for this service include the removal of stitches or staples.

9. **Question** -If a patient stays in the Emergency Department for 3 days waiting for a bed to open outside of the facility, can the physician report Emergency Department E/M levels for each service date while patient is in the ED?

   Answer- According to the Centers for Medicare & Medicaid Services (CMS), providers may only report an Emergency Department E/M level for the service date in which the patient entered the Emergency

[2] CPT® Evaluation and Management (E/M) Code and Guideline Changes, "Prolonged Services," Page 37. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

[3] CPT® Evaluation and Management (E/M) Code and Guideline Changes, "Prolonged Services," Page 37. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Department and services were rendered, even if the patient's encounter spans multiple service dates. [4] Other payers may have different policies regarding this situation.

10. **Question** -If patient comes into the Emergency Department due to motor vehicle accident (MVA) and hurt their back, then they are transferred to Labor & Delivery because they are pregnant, would you charge an Emergency Department E/M and a clinic visit E/M ?

    Answer- If the patient is not being examined by the physician and treated in the Emergency Department, it would not be appropriate to charge an ED E/M level. If the patient is evaluated and treated in the Emergency Department prior to transfer, it would be appropriate to change an E/M level based on the facility's internal criteria.

11. **Question** -Can a nurse practitioner (NP) or a physician assistant (PA) do the initial visit at a nursing home?

Answer- There are regulations outside of CMS policies that govern who is allowed to perform the initial comprehensive visit at a nursing home. CMS does allow an initial visit to be reported when an advanced practice nurse or physician assistant is working with a physician and performs the initial visit in a nursing home. [5]

12. **Question**- Do "incident to" guidelines apply to the Emergency Department setting?

Answer- No, in a true sense of the statement, "incident to" applies to the clinic setting only. Hospital services are inherently integral to a physician's or QHP's service, and clinical staff operate under the orders of the physician/QHP and under the appropriate level of supervision.[6]

13. **Question** -Is HCPCS code G0318 or G2212 used for prolonged care for Medicare patients?

Answer- HCPCS code G0318 is the Medicare prolonged care code to be used for home and residence services. This code is effective January 1, 2023. Code G2212 is the Medicare prolonged care code to be used for office or other outpatient services and has been effective since January 1, 2021.

14. **Question** -Can prolonged care codes be used with nursing home visits?

Answer- Yes, prolonged care codes may be used with nursing home visits. For Medicare patients, G0317, *Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15*

[4] "Emergency Room Services That Span Multiple Service Dates." https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1151CP.pdf

[5] CPT® Evaluation and Management (E/M) Code and Guideline Changes, "Nursing Facility Services," Page 31. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

[6] CMS IOM, Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Subsection 60 'Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service, B, Institutional Setting', page 82, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

minutes by the physician or qualified healthcare professional, with or without direct patient contact, should be used.

For an initial nursing facility (NF) visit, G0317 should only be used with the primary E/M 99306 and the time threshold that should be met or exceeded is 95 minutes. The time to meet this threshold can be counted the day before, day of, and up to three days after the date of the visit.

For a subsequent NF visit, G0317 should only be used with primary E/M 99310 and the time threshold that should be met or exceeded is 85 minutes. The time to meet this threshold can be counted the day before, day of, and up to three days after the date of the visit.

For other payers, CPT® guidelines instruct that code 99418, *Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time,* should be used.

For an initial NF visit, 99418 should only be used with primary E/M 99306 and should not be used until the time threshold reaches 60 minutes.

For a subsequent NF visit, 99418 should only be used with primary E/M 99310 and should not be used until the time threshold reaches 60 minutes.

15. **Question** -When coding prolonged visits, do you use time that is over the minimum for the base code, or the max?

    Answer- To use a prolonged visit code, the time would have to exceed the time threshold for the highest-level E/M. The amount of time that must be exceeded past the highest-level E/M differs depending on if you are using a Medicare prolonged service code (G Code) or a CPT® prolonged service code.

    CMS instructs that a prolonged service code (G Code) may be used 15 minutes past the maximum time on the highest-level E/M. For example, E/M code 99223 has a time period of 75 minutes through 89 minutes. CMS says 99223 lasts until minute 90, then there is a 15-minute gap, then prolonged services G0316 can be used.

    CPT® instructs that a prolonged service code may be used a minute past the highest-level E/M time. For example, E/M code 99223 has a time period of 75 minutes through 89 minutes. CPT® says that the prolonged service code can be used at minute 90.

16. **Question** -If the consultant does an outpatient consult, but doesn't know that the patient will be admitted, does the consultant still have to use subsequent care the first time the consultant sees the patient in the hospital? If the second encounter is performed by a provider who belongs to same practice, do the same rules apply?

Answer- Yes, effective January 1, 2023, if the consultant provides a consultation for an outpatient encounter and then that patient gets admitted, the consultant must use a subsequent consultation code for the second visit even though it is the first time that the consultant sees the patient since admission. The only exception to this would be if the encounter after admission is for a different problem than was addressed in the initial consultation.

Yes, if the second encounter after admission is performed by a different physician in the same specialty practice as the initial consultant, this provider would also report the subsequent care code.

17. **Question** -When referring to addressed problems, can a problem be used by two different providers? For example, if a medical provider addresses alcohol dependence with treatment and orders treatment and a psychiatrist also addresses the alcohol dependence but does not order treatment, could Alcohol dependence be used for both services?

    Answer- Yes, two providers may document and address the same problems, specifically in cases where there are multiple aspects of treatment such as with addiction or dependence. Some facilities may have medical staff rules and regulations or bylaws regarding this matter.

18. **Question** -If a patient is admitted to a skilled nursing facility (SNF) on a Wednesday and the admitting provider cannot see the patient until Thursday to complete the history and physical but the Certified Registered Nurse Practitioner (CRNP) is called in Wednesday evening to address one acute issue can the admitting provider still bill the initial visit on Thursday?

    Answer -Skilled nursing facility initial comprehensive visits must be performed by a physician. Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310). [7]

[7] CPT® Evaluation and Management (E/M) Code and Guideline Changes, "Initial Nursing Facility Care," Page 32