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2023 Evaluation and Management Code Updates

Part 1

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Agenda

- General Guideline Changes
- Inpatient and Observation Services
- Admit and Discharge on Same Day
- Prolonged Services

General Guideline Changes

Not Specific Section Guidelines

Overview of Updates

- **Evaluation and Management (E/M) Introductory Guidelines**
  - Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239
  - Consultations codes 99242-99245, 99252-99255,
  - Emergency Department Services codes 99281-99285,
  - Nursing Facility Services codes 99304-99310, 99315, 99316,
  - Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350

Overview of Updates

- Deletion of Hospital Observation Services E/M codes 99217-99220
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines
- Deletion of Consultations E/M codes 99241 and 99251
- Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines

Overview of Updates

- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines
  - Will not be time-based
- Deletion of Nursing Facility Services E/M code 99318
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340

Overview of Updates

- Deletion of Home or Residence Services E/M code 99343
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines
- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 99418 and guidelines

Why?

- To decrease administrative burden of documentation and coding
  - Align CPT® and the Centers for Medicare & Medicaid Services (CMS)
- Decrease the need for audits
- Decrease unnecessary documentation in the medical record
- To ensure that payment for E/M is resource-based and no direct goal for payment redistribution between specialties

General Guideline Changes

2022 vs 2023

Levels of E/M Services

- No longer based on examination
  - Medically appropriate history and/or physical examination, when performed
  - Extent of history & exam is not an element used in selection of E/M
- Levels of E/M selection
  - Based on the level of Medical Decision Making (MDM) OR
  - Total time for E/M services performed on the date of the encounter
- Concept of MDM does not apply to Current Procedural Terminology (CPT®) codes 99211, 99281
- Minimal Updates to MDM Table

Low Level MDM

- Addition to the Number and Complexity of Problems Addressed at the Encounter
- 1 stable or acute illness or
- 1 acute, uncomplicated illness or injury requiring hospital or observation level of care

High Level MDM

- Updates to the Risk of Complications and/or Morbidity or Mortality of Patient Management
- Revision: Decision regarding hospitalization or escalation of hospital-level care
- Addition: Parenteral controlled substances
- Expansion allows usage of MDM table across sections and subsections

E/M Guidelines Overview

- *The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver.*

Classification of E/M Services

- E/M Section is divided into broad categories
  - Office visits, hospital or observation care
- Categories further subdivided
  - New or established, initial or subsequent
- Basic format for E/M code based on MDM or time is the same
  - Unique code listed, Place and/or type of service specified, Content, Time
- Place of service and service type is defined as where face-to-face encounter occurs

New versus Established

- New patient has not received professional services from the physician or other qualified health care professional (QHP) or another physician or QHP in the exact same specialty and subspecialty who belongs to the same group practice for the past three years
- If provider is on call, the patient's encounter is classified as if the unavailable physician or QHP provided the visit
- When QHPs are working with physicians, they are considered as working in the exact same specialty and subspecialty

Initial and Subsequent Services

- Some categories may apply to both new or established patients (hospital inpatient or observation care)
- Initial service is when the patient has not received any professional services from the physician or QHP of the exact same specialty/subspecialty in the same group practice during the inpatient, observation or nursing facility admission and stay
- Subsequent service reported when the patient has received professional services from the physician or QHP of the exact same specialty/subspecialty in the same group practice during the inpatient, observation or nursing facility admission and stay

Initial and Subsequent Services

- If provider is on call, the patient's encounter is classified as if the unavailable physician or QHP provided the visit
- When QHPs are working with physicians, they are considered as working in the exact same specialty and subspecialty
- Single stay
  - Inpatient or observation services that transition to inpatient
  - Skilled nursing facility level of care transitions to nursing facility level of care

Services Reported Separately

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

History and/or Examination

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

Selecting Level of Service

- There are four types of MDM
  - Straightforward
  - Low
  - Moderate
  - High
- MDM is defined by three elements
  - Number and complexity of problems addressed
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications and/or morbidity or mortality of patient management

Elements of Medical Decision Making

Level of MDM (Based on 2 out of 3 Elements of MDM)	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
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing
Low	Low • 2 or more self-limited or minor problems; • 1 stable, chronic illness; • 1 acute, uncomplicated illness or injury; • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 out of 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*; 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
Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; • 2 or more stable, chronic illnesses; • 1 undiagnosed new problem with uncertain prognosis; • 1 acute illness with systemic symptoms; • 1 acute, complicated injury	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* Category 1: Tests and documents • 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*; • Assessment requiring an independent historian Or Category 2: Independent interpretation of tests	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

Definitions or Clarifying Terms

- *Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).*
- Emergency Department visits are in Part II
- Still need to meet "incident to" requirements

Definitions or Clarifying Terms

- *Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.*

Definitions or Clarifying Terms

- *Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.*

Chronic illness with exacerbation, progression, or side effects of treatment

- 2023 A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

- 2022 A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects ~~but that does not require consideration of hospital level of care~~

Chronic illness with severe exacerbation, progression, or side effects of treatment

•2023 The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

•2022 The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require ~~hospital~~ level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function

•2023 An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

•2022 An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

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

- **Independent historian(s):** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information

Independent Interpretation

•2023 The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

•2022 The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional ~~is reporting the service or has previously reported the service for the patient~~. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Drug therapy requiring intensive monitoring for toxicity

•2023 An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

•2022 Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles ~~or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.~~ Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

- Certain categories of time-based E/M codes that do not use MDM and use time differently
  - Critical care services
- Be sure to review instructions for each category
- Emergency Department services not included in the move to time-based services
- Time defined in the description is used for code selection
- Requires a face-to-face encounter with the physician or QHP

Guidelines for Selecting Level of Service Based on Time

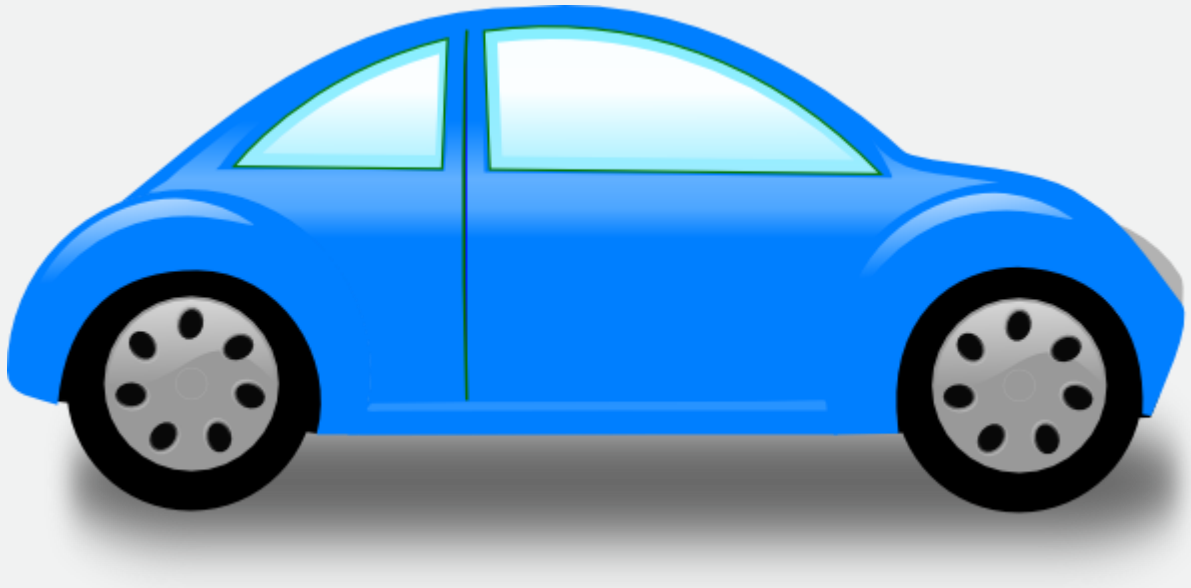
- Time is the total time on the date of the encounter
- Includes both face-to-face and non-face-to-face time personally spent by the physician or QHP
  - Includes time in activities that require the physician or QHP
  - Does not include activities performed by clinical staff
- Does not include time spent in performance of other separately reported service(s)
  - Not separately reported (NSR)
- Prolonged services based on the total time on the date of the encounter spent caring for the patient

Activities Included in Time Calculation

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (NSR)
- Documenting clinical information in the medical record
- Independently interpreting results (NSR) and communicating results to patient/family/caregiver
- Care coordination (NSR)

Not Included in Time Calculation

- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient



Inpatient and Observation

Consolidation of Codes

Hospital Inpatient and Observation Care Services

- Initial and subsequent E/M services
  - Hospital inpatient
  - Hospital outpatient in observation status
  - May be used to report partial hospitalization psychiatric (PHP) services
- Observation status patients aren’t necessarily located in an observation area
- Specific codes for admitted and discharged on the same date

Hospital Inpatient and Observation Care Services

- Total time on the date of encounter
- Continuous service that spans two dates is a single service
  - Report on one calendar date
  - Continuous before and through midnight, all time may be applied to the reported date of service
- Observation codes deleted and merged into the existing hospital care codes

Initial Versus Subsequent

- *An initial service may be reported when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the 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.*
- Similar to new vs established except related to the stay
- Transition from observation level to inpatient is not a new stay

Guidelines

- CPT® says: 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 says: Only ONE E/M service per calendar date

Revised CPT® Codes 99221-99223

- 99221 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99222 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- 99223 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

Revised CPT® Codes 99231-99233

- 99231 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99232 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99233 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

Coding Scenarios

- Doctor sees patient who is in observation status. Moderate level of MDM and spends 60 minutes in total time in the initial service.
- How would this be coded if doctor’s service began at 11:50 pm and lasted until 12:50 am?
- Patient is an inpatient, and doctor has done rounds each day. What would a low level MDM visit be coded on inpatient day 3?

Revised CPT® Codes 99238-99239

- 99238 Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
- 99239 Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
- Only used by physician or QHP responsible for discharge services
  - Other providers may use 99231-99233 when provider gives post-discharge instructions but is not provider responsible for discharge

Revised CPT® Codes 99234-99236

- 99234 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99235 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
- 99236 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.

Admit/Discharge on Same Day

- 99234-99236 require two or more services
  - One for the initial admission encounter
  - One for the discharge encounter
- Admit/discharge during initial encounter, report 99221-99223
- CMS “8 to 24-Hour Rule” Clarification
  - Less than 8-hour stay, use 99221-99223
  - 8-hour stay and discharged on the same calendar date, use 99234-99236

Table 22 Summary of Final Policy for the "8 to 24-Hour" Rule

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only (may use prolonged services)
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge (may use prolonged services)
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only (may use prolonged services)
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services, plus discharge day management (may use prolonged 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 previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

Consultations

- Consultation provided prior to admission, then patient admitted
- Same consulting physician then reports subsequent hospital codes (99231-99233) during patient's stay
- It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation)

Revised Inpatient/Observation Consultation Codes 99252-99255

- 99252 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99253 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

Revised Inpatient/Observation Consultation Codes 99252-99255

- 99254 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99255 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.

Consultation Pointers

- Type of E/M service provided at the request of another physician, QHP, or other appropriate source
  - Recommend care for a specific condition or problem
- The consulting physician or QHP may initiate diagnostic and/or therapeutic services at the same or subsequent visit
- Consultation initiated by patient, family, not requested by physician or QHP, or other appropriate source, is not reported using consultation codes

Consultation Pointers

- Consultant's opinion and services ordered or performed must be communicated by written report to the requesting physician, QHP or other appropriate source
- If payer doesn't cover consultation codes, other appropriate codes may be used
  - Anticipated CMS would not recognize the codes

Prolonged Services

On the Date of E/M Service

Prolonged Services

Deleted 2023	Suggested CPT® Replacement
99354, 99355 Prolonged service(s) in the outpatient setting	99417 Prolonged outpatient E/M service (effective 2021)
99356, 99357 Prolonged service in the inpatient or observation setting	99418* Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)

- 99418 replacement for placeholder 993X0
- 99358, 99359 retained

Prolonged Services Guidelines

- 99417 is used for office or other outpatient services
- 99418 is used to report prolonged total time provided on the date of an inpatient or observation E/M service
  - Combined time with and without direct patient contact
- Initial time unit of 15 minutes may be added once the time of the primary E/M code has been surpassed by 15 minutes
  - Minimal time for the high level E/M
- Time spent performing separately reported services is not counted

Prolonged Service on Date Other Than The Face-to-Face E/M

- Codes 99358, 99359 used when a prolonged service is provided on a date other than the date of a face-to-face E/M
- Not dependent upon time being used to select the face-to-face service
- *Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient which (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.*
- Extensive list of “do not report”

CMS Coding – GXXX1

- G0316 Prolonged hospital inpatient or observation care 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 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (Do not report G0316 for any time unit less than 15 minutes)

CMS Coding – GXXX2

- 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 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (Do not report G0317 for any time unit less than 15 minutes)

CMS Coding – GXXX3

- G0318 (Prolonged home or residence 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 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)

CMS Rationale

- CPT® 99223 time period is 75 minutes through 89 minutes, and Prolonged Services Time can start at minute 90
- CMS says 99223 lasts until minute 90, then there is a 15-minute gap, then prolonged services G0316
- Time spent for code selection may expand beyond services on the day of service
- Don’t report 99358,99359 with G0316.

Initial Hospital Inpatient or Observation Care

CPT®	Time (In minutes) Must meet or exceeded
99221	40
99222	55
99223	75
99418	90 minutes or longer
G0316	105 minutes or longer

Subsequent Hospital Inpatient or Observation Care

CPT®	Time (in minutes) Must meet or exceeded
99231	25
99232	35
99233	50
99418	65 minutes or longer
G0316	80 minutes or longer

Admit/Discharge Same Day

CPT® Code	Time (in minutes) Must meet or exceed
99234	45
99235	70
99236	85
99418	100 minutes or longer
G0316	125 minutes or longer

Inpatient or Observation Consultations

CPT® Code	Time (in minutes) Must meet or exceed
99252	35
99253	45
99254	60
99255	80
99418	95 minutes or longer
No Code	CMS doesn’t cover

CMS Proposed Rule Codes – Table 18 Proposed Time Thresholds

Primary E/M	Prolonged Code	Time Threshold	Time Spent Threshold
Initial IP/OBS (99223)	G0316	105 minutes	Date of visit
Subsequent IP/OBS (99233)	G0316	80 minutes	Date of visit
Admit/Discharge Same Day (99236)	G0316	125 minutes	Date of visit to 3 days after
Initial NF Visit (99306)	G0317	95 minutes	Day before, day of, up to 3 days after

CMS Proposed Rule Codes – Table 18 Proposed Time Thresholds

Primary E/M	Prolonged Code	Time Threshold	Time Spent Threshold
Subsequent NF Visit (99310)	G0317	85 minutes	Day before, day of, up to 3 days after
Home/Residence Visit New Pt (99345)	G0317	141 minutes	3 days before, day of, 7 days after
Home/Residence Visit Est Pt (99350)	G0318	112 minutes	3 days before, day of, 7 days after

Questions?

References

- AMA CPT® Evaluation and Management site
- https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- CY 2023 MPFS Final Rule
- https://www.federalregister.gov/public-inspection/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

Thank you!