VENTRA Health

Medicare Final Rules Impact on the 2023 Evaluation and Management Changes

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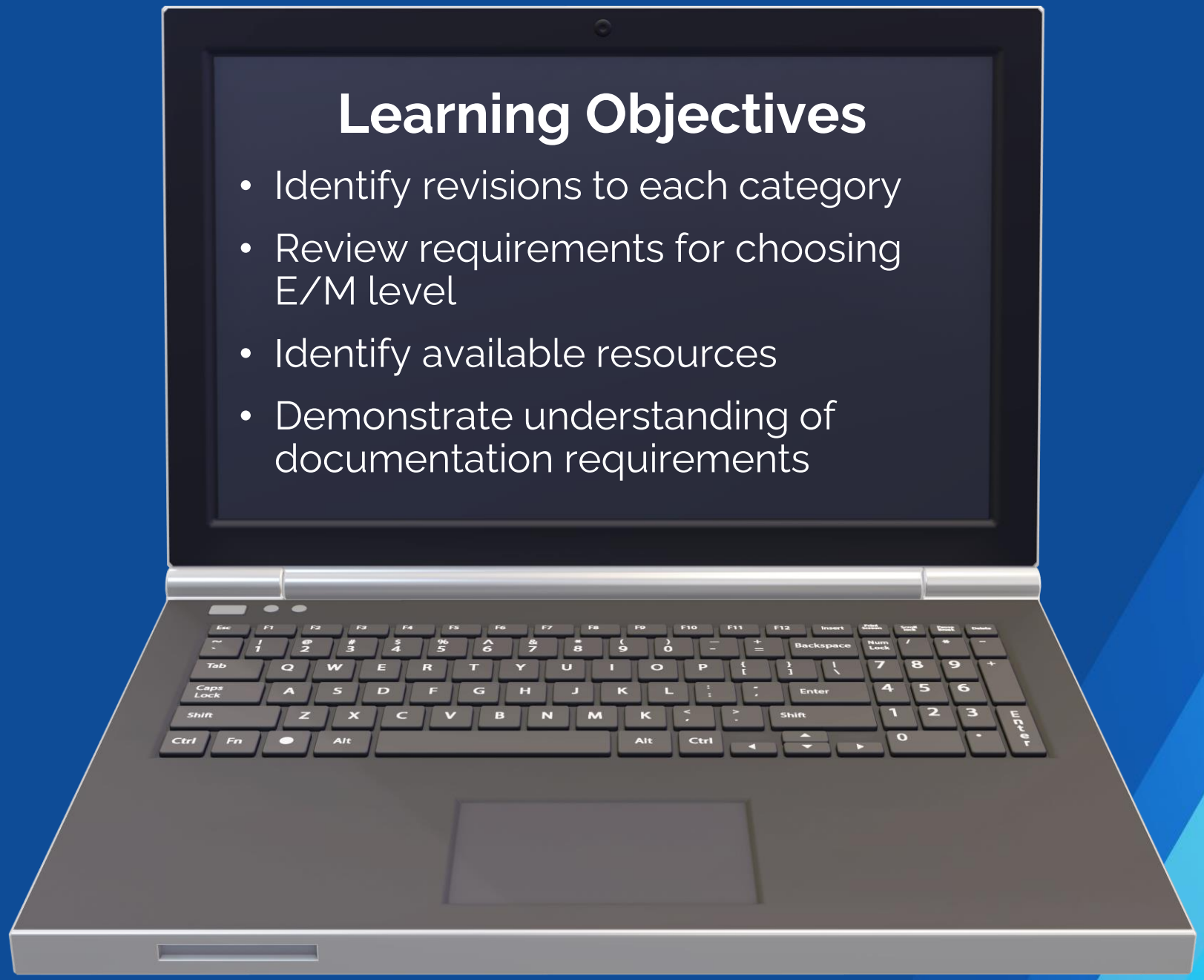
Disclaimer

This presentation is based upon the presenter's interpretation and is made in good faith with the information available at the time it was prepared. Views are subject to change as new guidance becomes available. This presentation is not intended to constitute and/or substitute for legal advice.

The content contained in this presentation is for educational purposes only. The limited references to any CPT® codes contained herein are not a substitute or replacement for the AMA's Current Procedural Terminology book and may not be used as such.

Learning Objectives

- Identify revisions to each category
- Review requirements for choosing E/M level
- Identify available resources
- Demonstrate understanding of documentation requirements



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High Level Overview

- Inpatient, Observation
- Consultations
- Emergency Services
- Nursing Facility
- Home Residence, Assisted Living, Domiciliary
- Critical Care
- Prolonged

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Inpatient and Observation Care Services

Observation code deleted and merged with Inpatient.

Place of Service (POS) will determine patient status.

Inpatient/Observation Service codes	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below:		
99221 – Initial	40 mins	OR	Straightforward or Low	Limited	Low
99222 – Initial	55 mins		Moderate	Moderate	Moderate
99223 – Initial	75 mins		High	Extensive	High
99231 – Subsequent	25 mins		Straightforward or Low	Limited	Low
99232 – Subsequent	35 mins		Moderate	Extensive	Moderate
99233 – Subsequent	50 mins		High	High	High

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Inpatient and Observation, Admit/Discharge Same Date Discharge Day Management

"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."

Document time for discharge day management for **both** inpatient & observation services.

Inpatient/Observation Service codes	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below:		
99234 – Admit & Discharge	45 mins	OR	Straightforward/Low	Limited	Low
99235 – Admit & Discharge	70 mins		Moderate	Moderate	Moderate
99236 – Admit & Discharge	85 mins		High	Extensive	High
99238 – Discharge only	30 mins or less		Medicare requires a face-to-face interaction.		
99239 – Discharge only	31 mins or more		Medicare requires a face-to-face interaction.		

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Office or Other Outpatient Consultations

Deleted confusing guidance, including "transfer of care" and replaced with:

- *Services that* ***are provided for the management of the patient's entire care or for the care of a specific condition or problem, report office or other outpatient visits or home or residence services***.

Request for an opinion > **Render** the service > **Report** must be written with opinion back to the requesting provider

Office or Other Outpatient Consultations	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below.		
99242	20 mins	OR	Minimal	Minimal/none	Minimal
99243	30 mins		Low	Limited	Low
99244	40 mins		Moderate	Moderate	Moderate
99245	55 mins		High	Extensive	High

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Inpatient or Observation Consultations

Removed "by the admitting physician" from the guidelines and now states,

- *"Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation-level patients, . . ."*

Inpatient or Observation Consultations	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below.		
99252	35 mins	OR	Minimal	Minimal or none	Minimal
99253	45 mins		Low	Limited	Low
99254	60 mins		Moderate	Moderate	Moderate
99255	80 mins		High	Extensive	High

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Emergency Department Services

- Code definitions are now aligned with office and other outpatient services
  - 99281 is now comparable to 99211, which typically represents staff supervision
- May be reported by physicians and QHP's other than just ED staff
- Critical care may be reported after the completion of ED service
- **Time is not a factor for ED services**

Emergency Department	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
	MDM level is based on 2 out of 3 elements below.		
99281	Patient may not require the presence of a physician or other QHP.		
99282	Minimal	Minimal or none	Minimal
99283	Low	Limited	Low
99284	Moderate	Moderate	Moderate
99285	High	Extensive	High

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Nursing Facility Care

Nursing Facility	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below:		
99304 – Initial	25 mins		Straightforward or Low	Limited	Low
99305 – Initial	35 mins		Moderate	Moderate	Moderate
99306 – Initial	45 mins	OR	High	Extensive	High
99307 – Subsequent	10 mins		Straightforward	Minimal or none	Minimal
99308 – Subsequent	15 mins		Low	Limited	Low
99309 – Subsequent	30 mins		Moderate	Moderate	Moderate
99310 – Subsequent	45 mins		High	Extensive	High
99315 – Discharge	30 mins or less		MDM not applicable to discharge coding. Code selection is based on the total time on the date of the discharge management's face-to-face encounter.		
99316 – Discharge	31 mins or more				

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Home or Residence Services

Home or Residence Services	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below.		
99341 – New	15 mins		Straightforward	Minimal or none	Minimal
99342 – New	30 mins		Low	Limited	Low
99344 – New	60 mins	OR	Moderate	Moderate	Moderate
99345 – New	75 mins		High	Extensive	High
99347 – Established	20 mins		Straightforward	Minimal or none	Minimal
99348 – Established	30 mins		Low	Limited	Low
99349 - Established	40 mins		Moderate	Moderate	Moderate
99350 - Established	60 mins		High	Extensive	High

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E/M with Prolonged Care Code

Deleted direct patient contact codes 99354-99357.

Codes 99358, 99359 were retained for use on dates **other than the date of the encounter.**

Do not report 99417 with psychotherapy services.

E/M with Designated Prolonged Care Code	1 unit Prolonged	2 units Prolonged
99205 + 99417	75 mins	90 mins
99215 + 99417	55 mins	70 mins
99223 + 99418	90 mins	105 mins
99233 + 99418	65 mins	80 mins
99236 + 99418	100 mins	115 mins
99245 + 99417	70 mins	85 mins
99255 + 99418	95 mins	110 mins
99306 + 99418	60 mins	75 mins
99310 + 99418	60 mins	75 mins
99345 + 99417	90 mins	105 mins
99350 + 99417	75 mins	90 mins

Medicare Differences

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CMS Final Rule vs. MAC's

- Medicare Administrative Contractors (MAC) do not automatically update once the Final Rule is released.
- Medicare issues Change Requests giving the MAC's instructions on what needs to be added, updated or deleted.
- Even with instructions from Medicare, MAC's do not always interpret the instructions the same way.

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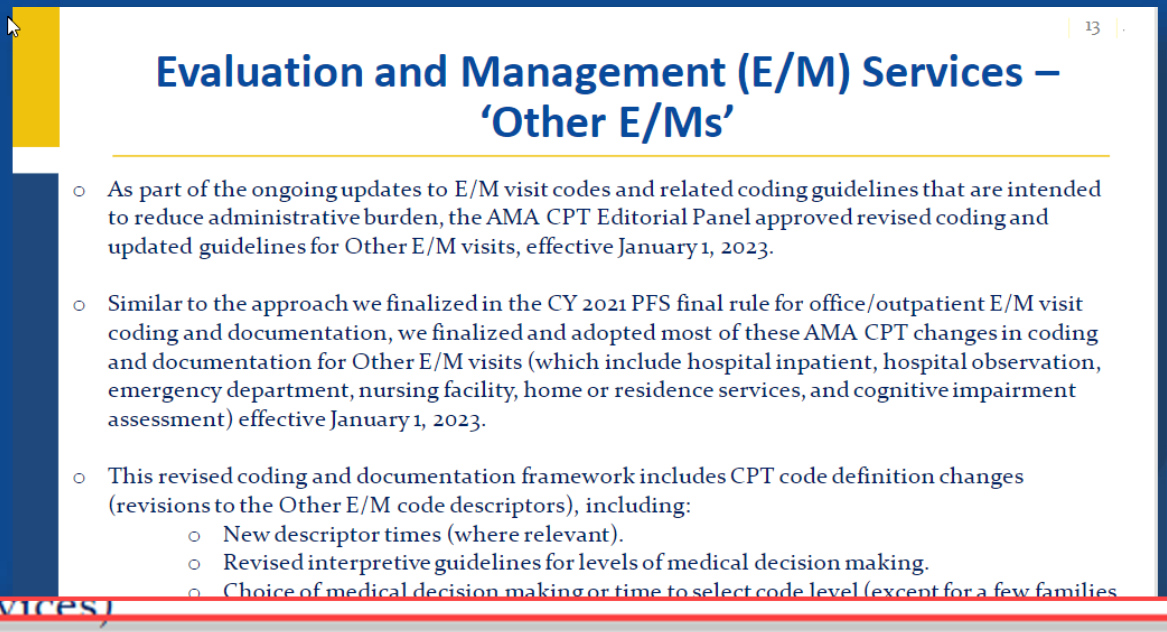
Medicare and AMA Agree, but . . .

The E/M guidelines state, "include a medically appropriate history and/or physical examination, when performed."

Medicare has slipped in the word 'required' into their education, which is also in the final rule.



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Evaluation and Management (E/M) Services – 'Other E/Ms'

- As part of the ongoing updates to E/M visit codes and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023.
- Similar to the approach we finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation, we finalized and adopted most of these AMA CPT changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023.
- This revised coding and documentation framework includes CPT code definition changes (revisions to the Other E/M code descriptors), including:
  - New descriptor times (where relevant).
  - Revised interpretive guidelines for levels of medical decision making.
  - Choice of medical decision making or time to select code level (except for a few families

timed services)

- Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

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AMA and Medicare Agree to Disagree

AMA allows two E/M services on same date of service, with a few exceptions:

- Transfers from outpatient to inpatient or skilled nursing facility to nursing facility do not constitute a new stay.

CMS did not accept the change, with two notable exceptions:

- ED service prior to critical care by the same provider or provider group is allowed.
- Hospital discharge with admission to another facility is allowed.

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Medicare Observation Services

- No POS changes
- No changes to using modifier AI
- Only the physician or QHP who orders observation care may bill (code) for observation care services.
- Other physicians or QHP's that provide services will use office and other outpatient E/M service codes.
  - FYI – The MAC's that have held webinars on the changes do not agree.

Medicare Change Request 13064

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Inpatient and Observation, Admit and Discharge Same Date

CMS final policy for the "8 to 24 hour" rule-

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

Hospital Length of Stay	Discharge On	Codes to Bill
< 8 hours	Same calendar date as admission or start of observation	99221-99223
8 hours or more	Same calendar date as admission or start of observation	99234-99236
< 8 hours	Different calendar date as admission or start of observation	99221-99223
8 hours or more	Different calendar date as admission or start of observation	99221-99223 and 99238,99239

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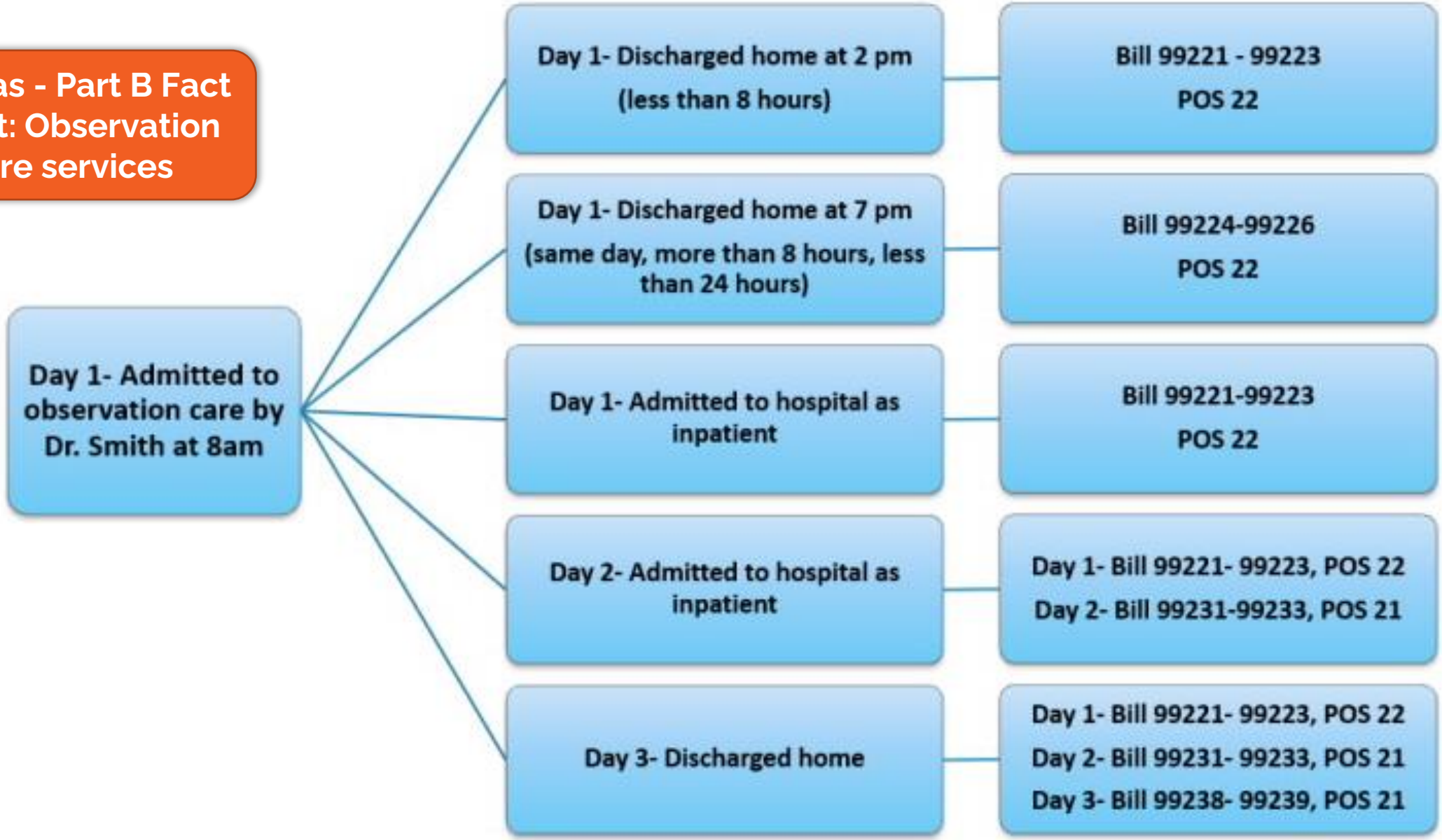
Observation billing, same provider

Novitas - Part B Fact Sheet: Observation care services



Medicare and E/M Time

Medicare does not interpret the CPT E/M Guidelines as adopting this general CPT regarding the midpoint of time.

2023 Medicare PFS Final Rule, Page 69587

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Prolonged Services - Medicare

Per the CMS Final Rule, prolonged services cannot be billed with discharge day management codes nor emergency department codes

Codes 99358,99359 NOT PAID BY MEDICARE

Medicare created new G-codes for prolonged services delivered in other settings:

- G0316 - Prolonged 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)
- G0317 – Prolonged evaluation and management service(s) **nursing facility**; each additional 15 minutes
- G0318 - Prolonged valuation and management service(s) **home & residence**; each additional 15 minutes

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TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	*G0316*	*90 minutes*	*Date of visit*
Subsequent IP/Obs. Visit (99233)	*G0316*	*65 minutes*	*Date of visit*
IP/Obs. Same-Day Admission/Discharge (99236)	*G0316*	*110 minutes*	*Date of visit to 3 days after*
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe, and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

Federal Register Correction

Published March 13, 2023

are corrected to read:

Primary E/M service	Prolonged code *	Time threshold to report prolonged (minutes)	Count physician/NPP time spent within this timeframe (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90	Date of visit.
Subsequent IP/Obs. Visit (99233)	G0316	65	Date of visit.
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	110	Date of visit to 3 days after.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 69413, in the entry "(6) Equipment Cost per Minute," we made a typographical error in the equipment cost per minute formula.

On pages 69596 and 69597, due to technical errors in the calculations of the time thresholds, there were errors in the description of times for reporting prolonged inpatient/observation services for code G0316.

On page 69614, in Table 24: Required Time Thresholds to Report Other E/M Prolonged Services, due to technical errors in the calculations of the time thresholds, there were errors in the description of times for reporting prolonged inpatient/observation services for code G0316.

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Prolonged Services Are Add-on Codes

- For prolonged services where the time spans multiple days, the prolonged code is still reported on the date of the face-to-face service.
- If used, workflow will need to be in place to hold the E/M until the time span is complete.
- **BEWARE** – There are specialty societies that have provided education that is not in line with Medicare, stating that the prolonged service is billed on the last date of the time span.

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Final Rule Technical Correction – Critical Care

CPT	Medicare & Medicare Advantage
30-74 min 99291	30-103 min 99291
75-104 min 99291, 99292x1	104-133 min 99291, 99292x1
105-134 min 99291, 99292x2	134-163 min 99291, 99292x2
135-164 min 99291, 99292x3	164-193 min 99291, 99292x3

Medicare now requires that a **minimum of 104 minutes** be met before using the add on code 99292

Must exclude time spent performing billable services

Count any time spent performing bundled service (next slide)

Update Split or Shared Service for Medicare

2023 Medicare PFS Final Rule delayed the implementation of time but only until 01/01/2024.

“for visits other than critical care visits furnished in calendar year 2022 and 2023, **substantive portion means one of the three key components (history, exam or MDM) or more than half of the total time spent** by the physician and NPP performing the split (or shared) visit. “

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Split or Shared: E/M Components

- Visits (other than critical care) furnished in calendar year 2022 and 2023 - "substantive portion" is defined as one of the three key components:
  - History
  - Exam
  - Medical decision making
- Record must identify both the physician and the APP
- Documentation clearly reflects both individual's work
- One provider must have face-to-face contact with the patient
- The provider with the substantive portion signs and bills the service
- Modifier –FS is appended to the E/M

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Best, Better, Bare Minimum

BEST

"*I performed the substantive portion of the visit. I performed the (Hx, Exam, MDM…)*", adding patient-specific documentation to individualize the note and further support the substantive portion

> I saw and evaluated the patient alongside Smith, PA and performed the substantive portion, the exam, as documented above. Patient will be admitted to the floor for further evaluation and management.
> Signed: Hospitalist, MD

BETTER

"*I performed the substantive portion of the visit, I performed the (Hx, Exam, MDM…).*"

BARE MINIMUM

"*I performed the substantive portion of the visit*."

- **Remember:** Medicare reviewers will be charged with identifying the "substantive portion" and what parts of the documentation was provided by the physician and the APP.
- If you are still using an old attestation macro, you may not be meeting the requirements for billing a shared or split service.

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Split or Shared: Time

- Both the physician and APP need to document their time.
- One provider must have face-to-face contact with the patient.
- Any time spent together, only one provider can claim the time.
- Provider with more than half the total time is the billing provider.
- Append modifier FS to the E/M service.
- Providers must carve out time spent performing separately billable services from E/M time.
- Time is the only component for Critical Care, rules above apply.
- Remember, time is not a component for selecting the level of service in the ED.

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Shared/Split Critical Care Example

Same Group Specialty:

- Hospitalist A – 25 mins
- Hospitalist B – 10 mins
- NPP – 30 min

35 mins
+
30 mins
=
65 mins

Medicare will now allow you to aggregate time. The provider with the most time, reports shared/split service. Add time together of 'like' providers.

Hospitalist reports the 99291 – FS

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Medicare Change Request 13064

We summarize these policies in the following table.

Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	*2022*-2023		2024
	If Substantive Portion is a Key Component…	**If Substantive Portion is Time…**	**Substantive Portion Must Be Time**
Other Outpatient*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*
Inpatient/Observation/Hospital/SNF*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)
*Office visits *and Nursing Facility visits* are not billable as split (or shared) services.

NGS Critical Care FAQ

6. The billing providers in our critical care service may be an attending physician, NP or PA. They all bill under the same group/tax ID number. How do you report critical care services when both an NP and attending physician contribute to critical care service 99291?

Answer: Effective 1/1/2022, critical care services may be performed on a split/shared basis by physician and NPP members of the same group. Time spent by each practitioner individually may be aggregated toward total critical care time and the total time spent supports the billed service. **Each provider must individually document his/her contribution to the critical care service and the service is to be billed by the provider who performed and documented the greater component of critical care time.**

Episodes of continuing/subsequent critical care, represented by CPT code 99292 may be performed and billed by other group members, including NPPs.

Each line of service must clearly indicate the rendering provider's identifying information, especially given the variation between MD and NPP reimbursement. This information would need to be provided in Item 24 or the electronic equivalent.

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Documentation Tips & Resources

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AMA Q&A – E/M 2023: Advancing . . .

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.

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AMA Q&A – E/M 2023: Advancing . . .

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.

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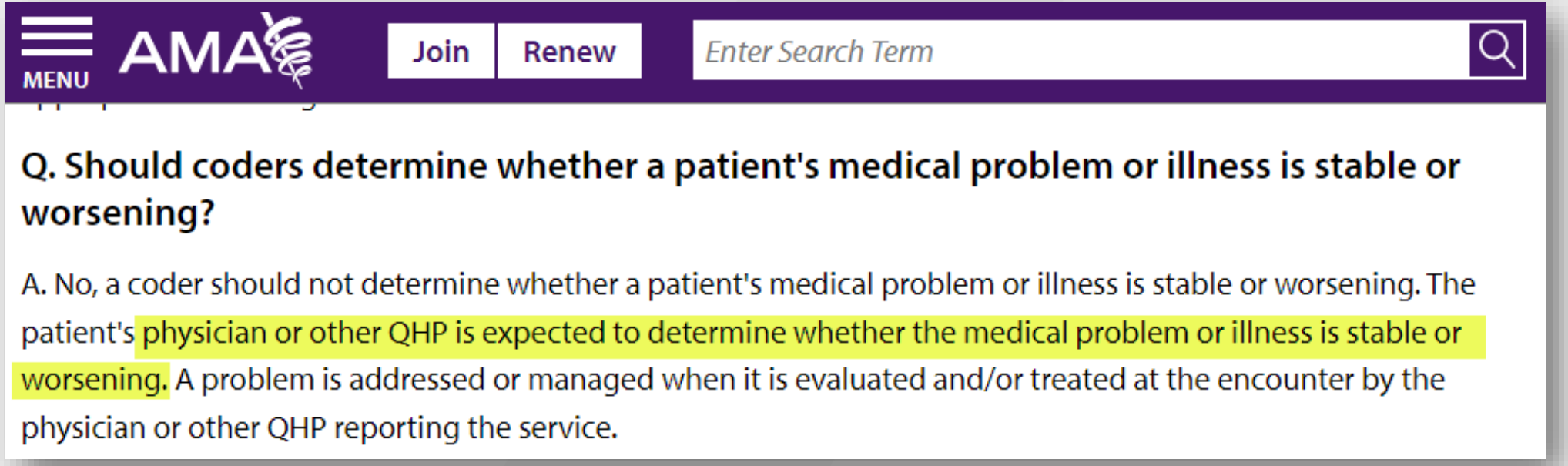
Column 1 - Complexity of Problems Addressed, (COPA)

- Acute, Chronic, Acute on Chronic
- Improving, failing to progress, not responding, worsening, not at goal
- Exacerbation, moderate or severe
- Complicated, uncomplicated
- Differential diagnoses
- Life threatening

AMA - (E/M) revisions FAQs



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Column 2 – Data Review and Analyzed

- **External records** – Where records are from, need brief summary of review.
- **Review of results** – Review of lab reports or other diagnostic testing not ordered by you or a provider in your group, of same specialty.
- **Tests ordered** – Credit given for each unique test ordered. "Labs ordered" cannot be counted, unable to identify each unique test.
- **Independent interpretation of tests** – Test images, scans, tracings are reviewed, brief interpretation of images is needed.
- **Independent historian** – Document who is providing the information and the information they contributed.
- **Discussion of management or test with external provider, QHP, appropriate source** – Document who you spoke with and briefly summarize the discussion.

Tests that are **CONSIDERED** but not selected after shared decision making will still receive credit in this category.

"Images of the left wrist consider, on exam no pain noted, full ROM."

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Errata and Technical Corrections – CPT® 2023, Date: March 1, 2023

Evaluation and Management (E/M) Services Guidelines **Levels of E/M Services** **Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Independent interpretation:*** The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test. A test that is ordered and independently interpreted may count both as a test ordered and interpreted. ***Appropriate source:*** For the purpose of the **discussion of management** data element (see Table 1, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers. For the purpose of ***documents reviewed***, documents from an appropriate source may be counted. **Revise definition of "Independent interpretation" to add: "A test that is ordered and independently interpreted may count as both a test ordered and interpreted"; and definition of "Appropriate source" to add: "For the purpose of documents reviewed, documents from an appropriate source may be counted" in the Amount and/or Complexity of Data to Be Reviewed and Analyzed subsection.**	**Posted** **3/01/23** **T**

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CPT Assistant FAQ's or Q&A's

September 2022 page 17

Evaluation and Management (E/M) Services Guidelines

Question: *A physician or other qualified health care professional (QHP) reviews an electronic medical record (EMR) that contains a computed tomography (CT) scan report, an operative note, and a pathology report that came from three different specialties within the same hospital. Is this EMR considered a single unique source because all documents are from the same entity (the hospital) or three independent unique sources of data because they came from three different specialties?*

Answer: Review of outside records from a single source, in this case, hospital records, is counted as one element. A unique source is defined as a physician or other QHP in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward medical decision making (MDM). Note that if it were medically necessary for the physician or QHP to independently review the CT images, then this could qualify as meeting Category 2, Independent Interpretation of Tests, under the MDM element of "amount and/or complexity of data to be reviewed and analyzed."

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AMA - (E/M) revisions FAQs

MENU AMA Join Renew Enter Search Term

Q. A family practice physician received records from a new patient's cardiologist, which includes electrocardiogram (EKG) and chest x ray (CXR). Would it be appropriate for the physician to receive credit for reviewing the cardiologist's notes (one unique source) and the EKG and CXR?

Yes. Based on the presented scenario, the records reviewed (cardiologist notes, EKG and CXR) may be reported as a unique source when selecting the Medical Decision Making (MDM) level. Review of all materials from any unique source counts as one element toward MDM. Per the E/M 2021 Errata and Technical Corrections, CPT 2021, a "Unique" source is defined as follows:

> Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

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AMA Q&A – E/M 2023: Advancing . . .

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.

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Column 3 – Risk of Patient Management

Moderate Risk Examples

- Prescription drug management
- Decision regarding minor surgery
- Diagnosis or treatment significantly limited by social determinants of health

High Risk Examples

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding emergency major surgery
- Decision regarding hospitalization
- Decision not to resuscitate or to de-escalate care because of poor prognosis
- Parenteral controlled substance

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AMA Q&A – E/M 2023: Advancing . . .

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 that 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.

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Novitas - Prescription Drug Mgmt

4. When can prescription drug management be credited in the medical decision-making risk of complications chart?

Credit is given for prescription drug management when documentation indicates medical management of the prescription drug by the physician who is rendering the service. **Medical management includes a new drug being prescribed, a change to an existing prescription or simply refilling a current medication. The drug and dosage should be documented as well as the drug management**.

If medications are just listed in patient's medical record, credit is given for past history.

Reference

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

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NGS – Prescription Drug Mgmt

10. Please define prescription drug management relative to MDM.

Answer: In order to count prescription drug management there must be documentation of at least one of the following factors:

- **A prescription drug that the practitioner is evaluating the appropriateness of using for the patient; and/or continuing to prescribe for the patient.**
- **Documentation on the prescription drug(s) that are being considered and the reason why they are being considered.**
- **Documentation of a decision to initiate a new prescription drug(s).**
- **Documentation of a practitioner's decision to discontinue a prescription drug or to adjust the current dosage relative to changes in a patient's condition.**
- **The patient condition, possible adverse effects, potential benefits, etc. of the patient using this prescription drug.**

Prescription drug management is based on the documented evidence that the provider has evaluated medications during the E/M service as it relates to the patient's current condition**. Simply listing medications that patient takes is not prescription drug management**. Credit will be provided for prescription drug management as long as the documentation clearly shows decision-making took place in regard to those medications.

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First Coast – Prescription Drug Mgmt

E/M FAQ -- What constitutes prescription drug management?

Q. During an evaluation and management visit, what constitutes "prescription drug management?"

A. "Prescription drug management" is based on documented evidence that the provider has evaluated the patient's medications as part of a service. **This may be a prescription being written or discontinued, or a decision to maintain a current medication or dosage.**

Note: Simply listing current medications is not considered "prescription drug management."

"Prescription drug management" does differ from "drug therapy requiring intensive monitoring for toxicity".

Per the CPT definitions, "drug therapy requiring intensive monitoring for toxicity" is for a drug requiring intensive monitoring which is a therapeutic agent with the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a 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 does not qualify includes 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.

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Noridian – Prescription Drug Mgmt

Q7. What are the guidelines regarding prescription drug management in the MDM?

A7. Credit is given for prescription drug management when documentation indicates medical decision making for the management of a prescription drug by the physician who is rendering the service. **Medical management could include a new drug being prescribed, a change to an existing prescription, verification of any side effects or problems with the drug, or simply refilling a current medication. The drug and dosage must be documented as well as the drug management.**

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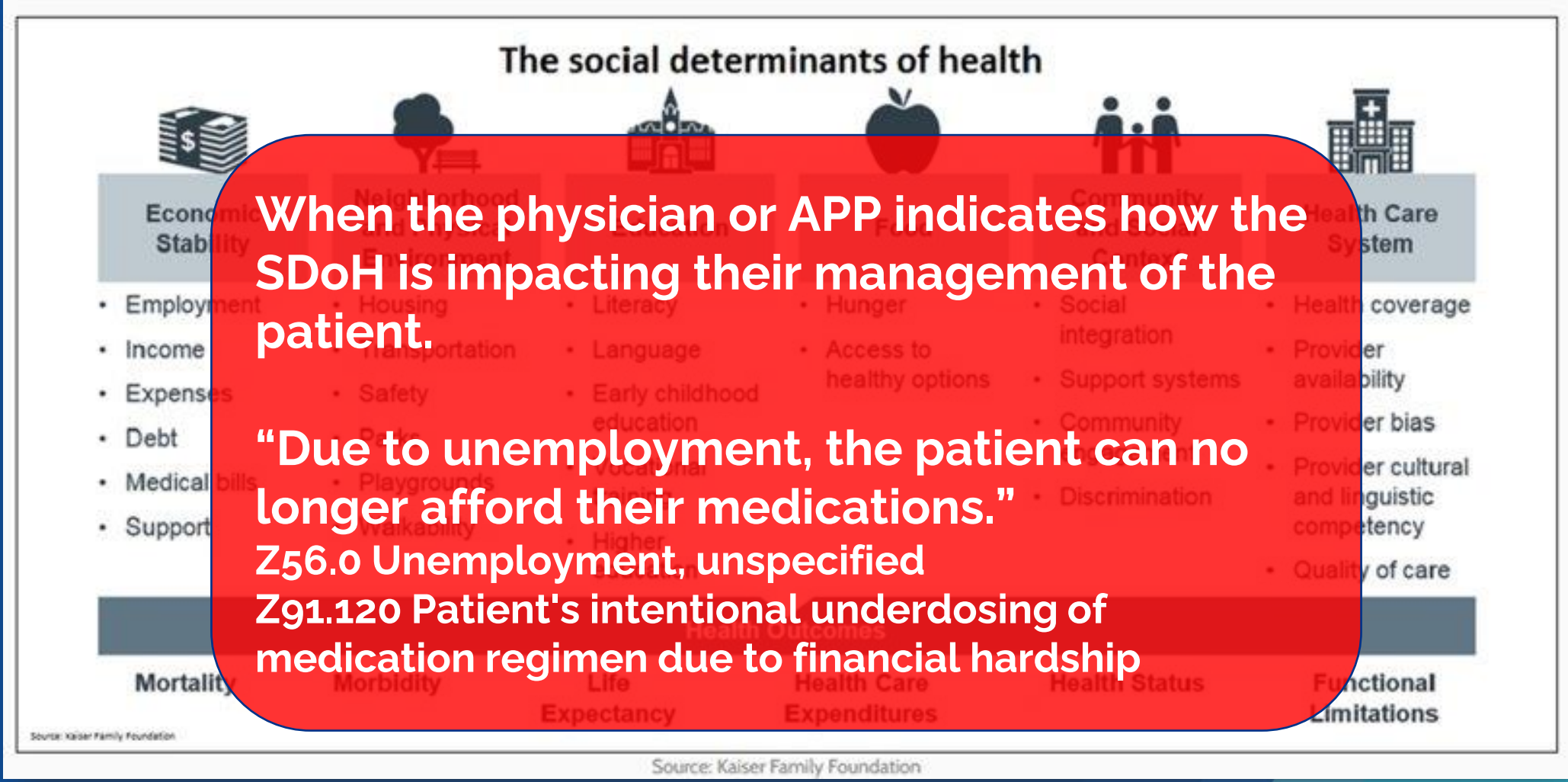
SDOH – When does it apply to Risk?



Official Resources

Article, July 7, 2023
https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

CPT® Evaluation and Management (E/M) Code and Guideline Changes
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

2023 Medicare PFS Final Rule
https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

ACEP 2023 Emergency Department Evaluation and Management Guidelines
https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs/

Novitas Part B E/M FAQ's
https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00005056

NGS Part B E/M FAQ's
https://www.ngsmedicare.com/web/ngs/evaluation-and-management?lob=96664&state=96736&rgion=93624&selectedArticleId=400695

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https://medicare.fcso.com/em/index.asp

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About...

Ventra Health Advisory Solutions Speakers

Each of our speakers have at least 25 years' experience in health care ranging from practice management to audit and compliance. We are in a unique position to bring to you the expertise of physicians, nurses, coders and compliance professionals.

We aid physician groups who are at odds with payers, including large-scale appeals, or those working through Medicare's many monitoring programs that can be difficult to navigate without an experienced partner.

Ventra Health assists practices with meeting their corporate integrity agreement obligations, helps those who have been accused of wasteful billing practices, and we assist defense teams in criminal investigations.

Our speakers are featured at physician specialty society symposiums, as well as a conference presenters for compliance and coding associations.

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Thank you!

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