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E/M Changes 2023 Coding for SNF/NF

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2023 – New (revised) options

Option 1 → Decision Making *Restructured

Option 2 → Time *Redefined

*AMA's Goal "*To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible….. To decrease unnecessary documentation in the medical record that is not needed for patient care."*

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History and/or exam

- Per CPT, the history and exam documentation requirements are now minimal, looking for, **"medically appropriate."**
  - Nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.
    - **HPI, ROS, PFSH, and exam not used in code selection**
- The history still has a considerable amount of influence on code selection. It's part of the diagnostic process.
  - **Sets the tone for the visit**

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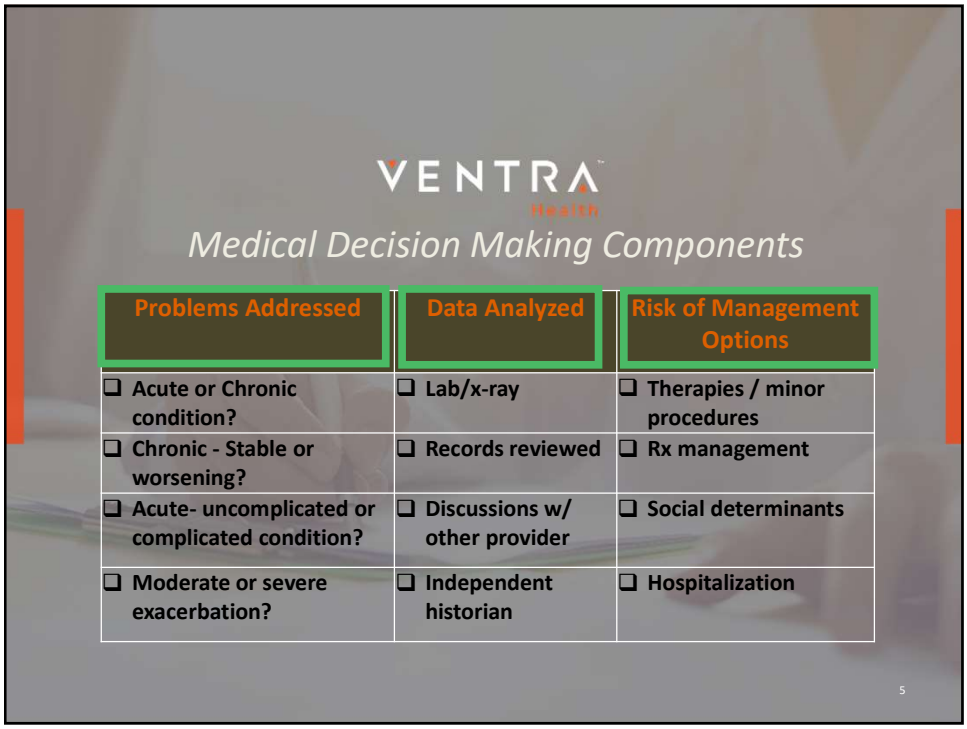

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Problems addressed at the encounter

- ***Problem addressed:*** A problem is addressed or managed when it is **evaluated or treated**.
  - ✓Updates within the history?
  - ✓Examined?
  - ✓Assessment and plan?

- Includes those conditions where further testing or treatment will not take place due to risk/benefit analysis or patient's (surrogate's) choice.
  - Patient has a possible malignant skin lesion. Based on its appearance, the provider recommends a dermatology consult/biopsy. Risks discussed. Patient declines.

❖ *Problems addressed is the closest to clinical examples we'll get from the AMA since they graduate in complexity.*
❖ *Typical scenarios were removed from the CPT E/M descriptors.*

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Guardrails removed- previously in CPT (95/97) we had:

99308 –usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

99309 –usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

99310 –the patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

Some MACs took it a step further with expectation of changes to the treatment plan.

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Problems addressed at the encounter

- If chronic vs. acute is not clearly described- (example, back pain)
  1. Coder should default to the lesser. **FEEDBACK TO PROVIDERS IS CRUCIAL!**
  2. - or - Query
- For chronic conditions, the **status must be categorized** as stable (at goal) or with exacerbation (not at goal)
  - *HTN: Blood pressures continue to trend upwards the past two weeks despite increasing Lisinopril from 10mg to 20mg.(MODERATE)*
  - *HTN: Blood pressures well controlled with Lisinopril. (LOW)*
  1. If not documented, coders should default to the lesser. **FEEDBACK TO PROVIDERS IS CRUCIAL!**
  2. - or - Query
- Comorbidities and underlying diseases are not used in the MDM calculation unless they are addressed, or there is a **direct impact** on the amount of data or **(documented) patient-specific risks** for management (e.g. immunocompromised patient, ESRD, etc.)
  - *Patient w/ diabetes cut her foot. Coders cannot jump from an "uncomplicated" to a "complicated" injury on their own. Looking for the provider to document reason.*

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Problems addressed - Definitions

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient.

"**Stable**" for the purposes of MDM is defined by the **specific treatment goals** for an individual patient. **When not at goal, the condition is not stable**, even if no change and there is no short-term threat to life or function. E.g., persistently poorly controlled BP, where better control is a goal, is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity. There is little to no risk of mortality with treatment. Full recovery w/o functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity. Little to no risk of mortality with treatment. Full recovery w/o functional impairment is expected. Treatment delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent where treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable.

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Problems addressed - Definitions

Chronic illness with exacerbation, progression, or side effects of treatment: Chronic illness is acutely worsening, poorly controlled, or progressing with intent to control progression. Requires additional supportive care or treatment for side effects. Not at goal.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness causing systemic symptoms. **High risk of morbidity without treatment**. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for-*Self-limited or minor problem* or *acute, uncomplicated illness or injury.*

. Systemic symptoms may not be general but may be single system.

Acute, complicated injury: requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity

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Problems addressed - Definitions

- ***Chronic illness with severe exacerbation, progression, or side effects of treatment:*** 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.
- ***Acute or chronic illness or injury that poses a threat to life or bodily function:*** 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.

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Problems addressed – **unique to INITIAL NF visits**

CPT Added this to initial Nursing Facility coding-

Multiple morbidities requiring intensive management:

- *"A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations.*
- *The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital."*
  - Encourage providers to document patient-specifics.
  - They should not simply copy the language.
- This aligns with high-complexity, but still need 2 of 3 (data/risk)

Ventra Health believes this is reserved for the initial comprehensive evaluation (awaiting clarification from CMS)

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Amount and/or complexity of data to be reviewed and analyzed

Analyzed:

- Tests are imaging, laboratory, psychometric, or physiologic data. **Count the order or the review, but not both**. Adopt a policy to only count the orders.
- Tests ordered outside the encounter (such as phone call from nursing staff), are counted at the subsequent encounter when reviewed and analyzed.

Unique:

- A unique test is defined by CPT coding. (BMP = 1 unique test)
- A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity.
  - Provider reviews his/her partner's H&P from two days ago. Does NOT count.
  - Provider reviews a discharge summary done by his/her partner from the last stay. Does NOT count.
- Review of all materials from any unique source counts as one item towards data.
  - Review the preceding inpatient H&P, CT results, culture report and discharge summary will count as **ONE** unique source.

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Documentation challenges - Data

Summary of acute stay, Cedar Creek Medical center:
90 yo female who was admitted 9/4/22 for weakness/multiple falls. She had 4 falls in a 7 hr period while in assisted living. CT head neg for acute process. Neuro consulted-signed off. UA was neg for UTI. CXR showed mild patch infiltrate to LLL. She was initially started on azithromycin IV but transitioned to PO after she pulled out her line. Pt noted to be agitated during inpatient stay; required Seroquel. Also during stay c/o chest pain- ECG wnl. Hyponatremia (resolved with IVF) hyperthyroidism (CT head/neck +thyromegaly and nodules- will need FNA as outpatient) On 9/12, she was transferred to ___for rehab.

Review external notes

Before her acute stay, the patient saw her cardiologist. According to the office notes, her echo results were…

Unique test

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Amount and/or complexity of data to be reviewed and analyzed

- ***External:*** Records, communications and/or test results from an external source, such as a physician, other qualified health care professional (QHCP), facility, or health care organization. *"A review of the records from General Hospital stay reveals…."*
- ***External physician, QHCP, or Facility:*** Someone not in the same group practice or who is in a different specialty or subspecialty. This includes licensed professionals who are practicing independently, or it could be a facility or organizational provider such as a hospital, nursing facility, or home health agency. PT/OT/ST - *"I spoke with the physical therapist today (yesterday). Patient is progressing quicker than anticipated, able to ambulate w/ minimal assistance. Gait much improved. Will consider discharging Monday…"*
- ***Discussion:*** Requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two). An example is using a HIPAA secure messaging app, etc.

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Amount and/or complexity of data to be reviewed and analyzed

Independent historian(s):

- An individual (eg, guardian, surrogate, spouse, witness) who provides or supplements the patient's history. (Patient is unable to provide or is unreliable [dementia, psychosis etc] or confirmation is needed.)
- Does not include translation services.
- Information does not have to obtained in person but must be garnered directly from the historian. *"Due to cognitive deficits, secondary to CVA, the patient is unreliable with his history. I spoke with his wife who contributed the following…"*

Independent interpretation:

- Personally interpreting a test, when not billing for the interpretation. (x-ray/EKG).
- Test must be associated with a CPT code.
- Provider must document his/her interpretation, yet not to the level of detail needed for billing the interpretation. (a brief summary suffices).

Appropriate source: For "**discussion of management"** an appropriate source includes professionals not in health care but who are involved in managing the patient (lawyer, parole officer, case manager). NOT family or informal caregivers.

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Risk of complications and/or morbidity or mortality of patient management

Risk:

- The probability and/or consequences of an event.
- Risk criteria applies to management decisions made during the day of the encounter.
- Risk is based upon the usual behavior and thought processes of a physician or QHCP in the same specialty.
- Risk is based upon consequences of the problem(s) addressed when appropriately treated.
- Risk also includes diagnostics or management options (hospitalization) when not carried out (due to contraindications, or patient choice, etc.).

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Risk of complications and/or morbidity or mortality of patient management

- ***Social determinants of health:*** Economic and social conditions that impact health or ability to obtain care (homeless, unable to affords meds/food, etc.)
  - Provider must document what they are and how they impact the decision-making process/plan.
  - *"The patient's sister, his primary care giver who he was living with, died two weeks ago. He is unsure about his living situation when discharged. Says he has no transportation now and is concerned about the ability to keep up with his doctor's appointments. Without continued OP therapy he is at risk…."*
- ***Drug therapy requiring intensive monitoring for toxicity:*** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
- ***Surgery (minor or major, elective, emergency, procedure or patient risk):***
  - ***Risk Factors, Patient or Procedure:*** those relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

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Risk of complications and/or morbidity or mortality of patient management

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.

- Monitor to assess for adverse effects not primarily for therapeutic efficacy.
- Use a method that generally accepted for the agent- though could be patient-specific.
- Intensive monitoring can be short- or long-term.
- Includes but is not limited to, lab, physiologic testing, or imaging. Monitoring by history or exam does not qualify.
- Risk (high) for this type of monitoring is credited whenever management (of the med) takes place.
- Example, monitoring for cytopenia when using antineoplastic agent between cycles.
- Monitoring glucose levels during insulin therapy, when the the primary reason is to evaluate the therapeutic effect (unless severe hypoglycemia is a current, significant concern) does **NOT** qualify.

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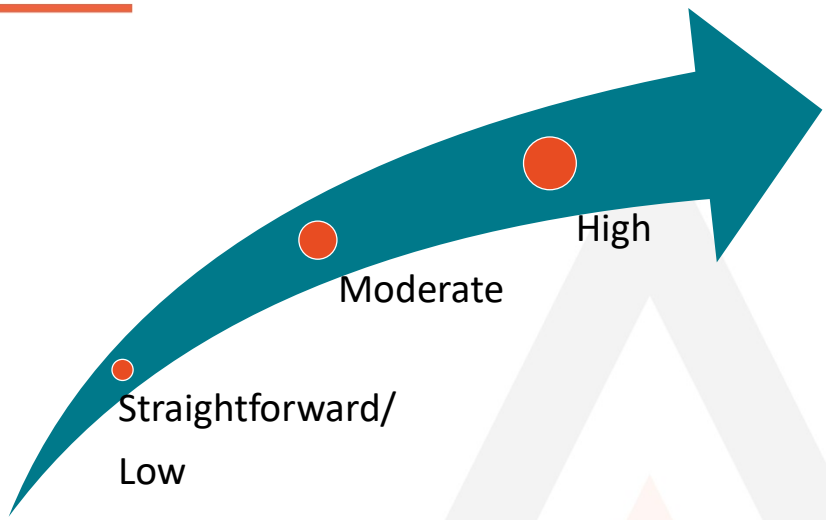
Code Selection



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Calculating the code – Straightforward (99304/99307) Need 2 of 3

Problems Addressed	Data	Risk
self-limited or minor problem	Minimal or none	Minimal or none Minimal risk of morbidity from Additional diagnostic testing or treatment

A self-limited or minor problem is one "that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management/compliance."

- Dry skin – use lotion, monitor
- Skin tag (w/o irritation) – cosmetic?
- Small abrasion from bumping against the table at lunch - monitor
- Runny nose – will monitor

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Calculating the code – Low (99304/99308)

Problems Addressed	Data	Risk
2 or more self-limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** acute, uncomplicated illness or injury; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury requiring Hospital inpatient or Observation level of care	*(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*; ● Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from Additional diagnostic testing or treatment** *Rx management – see "moderate risk"

Assessment/Plan:

1. Paroxysmal atrial fibrillation Compensated, continue metoprolol amiodarone and Xarelto.
2. Nausea over the last week better. Continue Zofran 4 mg po q 6 hrs prn N/V

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Calculating the code – Low (99304/99308)
Need 2 of 3

Problem Addressed	Data	Risk	Code
Minimal	Min/None	Min/None	99307
Low	Limited	Low	99304/99308
Moderate	Moderate	Moderate	99305/99309
High	Extensive	High	99306/99310

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Calculating the code – Moderate (99305/99309)

Problems Addressed	Data	Risk
1 or more chronic illnesses with **exacerbation**, progression, or side effects of treatment; **or** ■ **2 or more stable, chronic illnesses;** **Or** ■ **1** Undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	*(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** ● Review of prior **external note(s)** from each unique source*; ● Review of the result(s) of each unique test*; ● Ordering of each unique test*; **UA, culture, sensitivity, cbc** ● Assessment requiring an **independent historian**(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ **Discussion of management** or test interpretation w/ external physician/other QHCP/ appropriate source (not separately reported)	***Examples only***: ■ **Prescription drug Management** ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery Without identified patient or procedure risk factors ■ Diagnosis or treatment Significantly limited by **Social determinants** of health

1. UTI w/ fever. UA, C&S, cbc. Start Bactrim. Pyridium for pain.
(flank pain, spasms, frequency, typical of UTI are not counted separately)

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Calculating the code – Moderate (99305/99309)
Need 2 of 3

Problem Addressed	Data	Risk	Code
Minimal	Min/None	Min/None	99307
Low	Limited	Low	99304/99308
Moderate	Moderate	Moderate	99305/99309
High	Extensive	High	99306/99310

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Calculating the code – Moderate (99305/99309)

Problems Addressed	Data	Risk
1 or more chronic illnesses with **exacerbation**, progression, or side effects of treatment; **or** ■ **2 or more stable, chronic illnesses;** **Or** ■ **1** Undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	*(Must meet the requirements of at least 1 out of 3 categories)* Category 1: **Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** ● Review of prior **external note(s)** from each unique source*; ● Review of the result(s) of each unique test*; ● Ordering of each unique test*; **INR** ● Assessment requiring an **independent historian**(s) **or** Category 2: **Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** Category 3: **Discussion of management or test interpretation** ■ **Discussion of management** or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	*Examples only*: ■ **Prescription drug Management** ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery Without identified patient or procedure risk factors ■ Diagnosis or treatment Significantly limited by **Social determinants** of health

1. CHF Stable. **Continue** Carvedilol 12.5 mg p.o. every 12 hours.
2. Paroxysmal atrial fibrillation. **Rate controlled with Digoxin** 125 µg p.o. daily. **Spoke w/ cardiologist.** **Needs INR** (for the Rx, no action but efficacy assessed)

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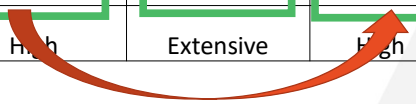
Calculating the code – Moderate (99305/99309) Need 2 of 3

Problem Addressed	Data	Risk	Code
Minimal	Min/None	Min/None	99307
Low	Limited	Low	99304/99308
Moderate	Moderate	Moderate	99305/99309
High	Extensive	High	99306/99310



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NGS Medicare – Rx Management

10. Please define prescription drug management relative to MDM.

- **Answer:** In order to count prescription drug management there must be:

1. A prescription drug that the practitioner is evaluating the appropriateness of using for the patient; and/or continuing to prescribe for the patient.
2. Documentation on the prescription drug(s) that are being considered and the reason why they are being considered.
3. 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.
4. 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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Rx Management - Caution

Assessing risk associated with medications cannot be automatically be assigned a level. Remember, in the table appear the words "Examples only"

- According to WPS Medicare's (YouTube video) stance on Rx management:
- "Not all patients with prescription drugs will be a moderate risk"…. "You could order a prescription drug but the risk to the patient is not moderate." Example used, a minor problem, Rx an antibiotic the patient has take before with no issues.
- Over the counter could pose a moderate risk. "Asking the patient to take this in a way different from the manufacturer's instructions" was used as an example.

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Calculating the code – High (99306/99310)

Problems Addressed	Data	Risk
■**1** or more chronic illnesses with Severe exacerbation, progression, or side effects of treatment; ■ **1** acute or chronic illness or injury that poses a threat to life or bodily function ■ *Conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations.* *The patient is at significant risk of worsening / (re)admission to a hospital."*	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ■ **Any combination of 3 from the following:** ●Review of prior external note(s) from each unique source*; ● Review of the result(s) of each unique test*; ● Ordering of each unique test*; ● Assessment requiring an Independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Or Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from Additional diagnostic testing or treatment** ***Examples only***: ■ Drug therapy requiring Intensive monitoring for toxicity ■ Decision regarding elective major surgery with Identified patient or procedure risk factors ■ Decision regarding Emergency major surgery ■ Decision regarding Hospitalization or escalation of hospital level care ???? ■ Decision not to resuscitate or to deescalate care because of poor prognosis

Provider called – Fever returned, tachycardiac, AMS – likely relapse of sepsis – to the ER. Likely admit.

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Calculating the code – Moderate (99306/99310)
Need 2 of 3

Let's talk about this decision to hospitalize.....

Problem Addressed	Data	Risk	Code
Minimal	Min/None	Min/None	99307
Low	Limited	Low	99304/99308
Moderate	Moderate	Moderate	99305/99309
High	Extensive	High	99306/99310

CPT: *For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.*

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Documentation Goal - Greater Detail (status & plan)

- I50.20: HFrEF (heart failure with reduced ejection fraction). Remains clinically and hemodynamically stable on hydralazine, carvedelol and Isosorbide. With effectiveness, will continue present management
- N18.4: Chronic kidney disease, stage 4 (severe) Acute kidney injury with CKD stage III-IV at baseline. Suspected multifactorial etiology, given ongoing issues with volume depletion, NSAID usage as well as diuretics. Renal function tests gradually improving, appears closer to baseline; will avoid nephrotoxic medications.
- E11.69: Type 2 diabetes mellitus with other specified complication Blood sugars are reasonably controlled on present regimen, we will continue to monitor Accu-Cheks, continue with Farxiga 10mg qd, Insulin aspart sliding scale Insulin detemir 15unit qhs. We will consider stopping long-acting sulfonylureas.
- F41.0: Panic anxiety syndrome. Psychiatry consulted, will continue with mood stabilizers. Discussed at length with patient's niece who is a physician as well.
- R06.00: Dyspnea Patient remains on supplemental oxygenation, however oxygen saturation essentially stable, empirically will continue bronchodilators for Symptom management. Otherwise remains clinically and hemodynamically stable

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Time Based Coding
option 2 for E/M selection

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Time-based E/M

- **Greater than 50% counseling/coordination of care has been removed!**
- Requires a **face-to-face** encounter between the provider and the patient at some point during the date of service.
- Count the **total time** on the date of the encounter. Does not have to be continuous.
- Include both the face-to-face time with the patient and/or family/caregiver **and non-face-to-face time** personally spent by the provide on the day of the encounter
- Encompasses all time **regardless of the location of the provider** (eg, whether on or off the unit).
- **Exclude time spent on separately billable services**, such as Advance Care Planning (99497) or smoking cessation counseling (99406).
  - **When E/M is time-based, then the other time-based service must demonstrate there's no overlapping** *"20 minutes were spent with the patient counseling on smoking cessation. This was in addition to any time spent or work related to other billable services."*

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Time-based E/M

Provider's time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, therapies or procedures
- referring to or communicating w/ other health care professionals
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately billed)
- explaining results to the patient/family/caregiver
- care coordination

Do NOT count time spent on the following:

- time spent performing separately billable services
- travel
- general teaching of clinical staff

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Initial visits - No changes

- **99304** Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- **99305** Initial nursing facility 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.
- **99306** Initial nursing facility 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, 45 minutes must be met or exceeded.

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Subsequent visits – Two Increases

- **99307** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- **99308** Subsequent nursing facility care, per day, for the evaluation and management of a 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, 15 minutes must be met or exceeded.
- **99309** Subsequent nursing facility 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, 30 minutes must be met or exceeded.
- **99310** Subsequent nursing facility 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, 45 minutes must be met or exceeded.

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Prolonged services for NON-Medicare According to CPT:

- 99418 Prolonged inpatient, observation or nursing facility 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)

- For SNF/NF, 99418 can only be used in addition to 99306 or 99310.
- The extended time does not have to be continuous but **must be on the day of the face-to-face encounter** with the patient.
- Document the activities that commanded the extra time.

Time	Initial Visit	Subsequent Visit
60-74 minutes	99306, 99418 x 1	99310, 99418 x 1
75-89 minutes	99306, 99418 x 2	99310, 99418 x 2
90-104 minutes	99306, 99418 x 3	99310, 99418 x 3

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CMS (Medicare) Final Rule – G0317

"The long descriptor would be 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).

We proposed that prolonged nursing facility services by a physician or NPP would be reportable using prolonged service HCPCS code G0317, which would be used to account for additional time spent when the total time for the NF service (**specified in the time file**) is exceeded by 15 or more minutes.

We proposed that the practitioner would include any prolonged service time spent within the surveyed timeframe, which includes the **day before the visit, the day of the visit, and up to and including 3 days after the visit** (please see summary Table 18 in our proposed rule)." (see page 69606, **Federal Register** / Vol. 87, No. 222 / Friday, November 18, 2022 / Rules and Regulations)

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CMS (Medicare) – 2023 Final Rule
New Code G0317 = 0.61 work RVU

CMS-1770-F 667

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	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
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.

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Documentation for Prolonged

- For services that qualify and take place on a different day than the face-to-face E/M, Ventra suggests documenting the day they took place.

SUMMARY:

- ❑To prepare for today's visit, I spent 35 minutes reviewing the prior hospital stay, records from the wound care specialist, and reconciling medications. 01/01/23.
- ❑I spent 50 minutes examining the patient, discussing treatment options with him and his wife, spoke with the social worker, and wrote orders, 01/02/23.
- ❑Addendum? Or a separate note? I spent 10 minutes on the phone with nursing staff discussing lab results and putting in orders. Patient also with a notable cough that started this morning. Will get chest x-ray. 01/03/23.

Difficult to capture & manage

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Discharge services

The nursing facility discharge management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous.

Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. These services require a face-to-face encounter with the patient and/or family/caregiver that may be performed on a date prior to the date the patient leaves the facility. Code selection is based on the total time on the date of the discharge management face-to-face encounter.

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

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

Time must be documented (expect variances)

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Advance Care Planning (ACP)

- Voluntary Advance Care Planning (ACP) is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient and/or family member(s), and/or surrogate to discuss the patient's health care wishes if they become unable to make decisions about their care.
- **Codes**
  - 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
  - 99498; each additional 30 minutes (List separately in addition to code 99497)
- **Time**
  - **Time must be documented. The threshold for billing is 16 minutes.** **Be precise** when recording the time.
  - The minutes that are allocated towards ACP **must exclude time spent in other services**, such as a separately billable E/M (99304-99306, 99307-99310, 99315-99316), or smoking cessation, 99406/99407.

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Advance Care Planning (ACP)

- **Documentation**
  - According to CMS, "*Voluntary ACP can be offered upon agreement with the patient, family member or surrogate. That **agreement must be documented** in the medical record*." WPS Medicare further explains that the consent must be specific to the service being rendered. A consent to treat (signed) at the time of admission (new patient paperwork) or a blanket financial form will not suffice.
  - If a patient is unable to be present, ACP documentation must reflect why the patient is unable to participate.
  - **Document the content of the discussions.** According to the CMS billing article for ACP, "*At a minimum, and as noted above, appropriate documentation must include the content and the medical necessity of the ACP related discussion, the voluntary nature of the encounter, the content of any advance directives (along with completion of advance directive forms, when performed), the names of participants in the discussion; and the time spent in the face-to-face encounter. **Best practice** for the time documentation is to include the **start and end time** of the face-to-face conversation*."

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Advance Care Planning (ACP)

- If a time-based E/M service is billed on the same day as ACP, create a documentation template that delineates how time was spent. For example, if billing 99305 and 99497, **both of the following should be documented:**

1. 99305
   - *"**40** minutes were spent with the patient, with his family and with nursing staff as described above. This excludes any time spent in separately billable services."*

2. 99497
   - *"I personally spent **18** minutes dedicated to Advance Care Planning, as detailed above."*
     -Consider using start/stop times instead.

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DIAGNOSIS, ASSESSMENT AND PLAN **Well written A/P. For the problems addressed, each has a status and a clearly stated treatment plan.**
CPT Codes: 99310
Z00.00: **Annual physical exam** Mid January CBC, CMP, and TSH within normal limits. We will collect hemoglobin A1c, lipid panel, Vitamin D level. Audiologist & ophthalmologist referral.
•Here, the data is limited to the orders for A1c, lipid panel and vit D level. The mid January labs were already reviewed by another provider within the group during the 01/25/23 visit. Credit cannot be given again.
.
I73.9: PAD (peripheral artery disease) Pulses 2+. No signs of ischemia. No new wounds. Cont. to monitor
R29.6: Recurrent falls No recent falls since admission. Patient on trazodone but no other high fall risk drugs.
D64.9: Chronic anemia We will collect CBC. Patient is asymptomatic.
•The new cbc order can be counted towards data points for today. Of note, when result is reviewed, cannot count again. Credit is only given for either the order or the review, not both, even when on a different day, or when done by another provider (within the same group)

N40.0: BPH (benign prostatic hyperplasia) Voiding without difficulty. Continue Flomax
•Credit is given for Rx management. Condition is assessed and the decision to continue w/ Flomax was made.
M48.02: Cervical stenosis of spine No numbness, tingling, or complaints of pain. Patient on Tylenol for pain.
G89.29: Chronic pain Pain well controlled with Tylenol
G20: Parkinsons disease No increased gait ataxia/tremors/falls. Pt. continues on ropinirole, and amantadine
•Is the provider's intent for the patient to continue, (by his/her order) the meds? "Continues on" doesn't clearly communicate that there is an action on the provider's part by the way it's worded. Credit is given for problem addressed, but Rx management could be challenged under audit if that is what took place.
G47.00: Insomnia Patient continues on trazodone. He refuses to discontinue
•Like above, is the provider agreeing to continue the drug? Creating an order? Not clear if that was the intent (action). Keep in mind, if there was any discussion with the patient about discontinuing, even if he refuses, that counts as Rx management. Credit is given for decisions regarding diagnostics and treatments even when not carried out. Document the reasons, rationales, risks, and outcome. For example, "The patient was cautioned again about increased fall risks with trazodone. He was encouraged to try alternatives, but he refuses. Will continue the trazadone at the current dose."

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Given the Z00.00 for annual physical (first diagnosis), it leads the reviewer to think that this was a complete inventory of chronic conditions. A considerable amount of time may have been spent (?). In 2023, ALL the time spent the case, including the non-face-to-face time, can be counted. Include minutes reviewing records (preparing to see patient), discussions with others, entering orders, med reconciliation, taking phone calls, and documenting the note.

Code 99310 requires 45 minutes if time-based

If coding based on decision making, 2 of 3 components must be met:
•type/severity of problems addressed (99310 is severe exacerbation/life threatening)
•data (99310 is extensive)
•and/or risk (99310 is high risk)

For this patient, all three aligned with moderate. See the table below for illustration.

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	Problems Addressed	Data	Risk
99307	STRAIGHTFORWARD VISIT – 10 minutes 1 self-limited or minor problem	Minimal/none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low 99304 25 min 99308 15 min	■2 or more self-limited or minor problems; or ■ 1 stable, chronic illness; or ■ 1 acute, uncomplicated illness or injury; or ■ 1 stable, acute illness	Limited (Must meet the requirements of at least 1 out of 2 categories) Category 1: Any combination of 2 from the following: ● Review of prior external note(s) from each unique source*; ● Review of result(s) of each unique test*; ● Order of each unique test* or Category 2: Assessment requiring independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment
Moderate 99305 35 min 99309 30 min	■1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or ■ 2 or more stable chronic illnesses; or ■ 1 undiagnosed new problem with uncertain prognosis; or ■ 1 acute illness with systemic symptoms; or ■ 1 acute, complicated injury	Moderate (Must meet requirements of at least 1 of 3 categories) Category 1: Tests, documents, or independent historian(s). ■Any combination of 3 from the following: ● Review prior external note(s) from each unique source*; ● Review result(s) of each unique test*; ● Order of each unique test*; ● Assessment requiring an independent historian(s) or Category 2: ■ Independent interpretation of test (not separately reported) Category 3: ■ Discuss mgmt or test interpretation w/ external physician/ other QHCP/or appropriate source (not separately billed)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ■ Prescription drug management ■ Decision for minor surgery w/ identified patient or procedure-specific risk factors ■ Decision for elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health
High 99306 45 min 99310 45 min	■1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or ■ 1 acute or chronic illness or injury that poses a threat to life or bodily function ■ (this applies to initial NF code only) Multiple morbidities requiring intensive management: a set of conditions, syndromes, or functional impairments likely to require frequent med changes or other treatment changes and/or re-evaluations. Patient at significant risk of worsening medical (behavioral) status and risk for (re)admission to a hospital.	Extensive (Must meet requirements of at least 2 of 3 categories) Category 1: Tests, documents, or independent historian(s). ■Any combination of 3 from the following: ● Review prior external note(s) from each unique source*; ● Review result(s) of each unique test*; ● Order of each unique test*; ● Assessment requiring an independent historian(s) or Category 2: Independent interpretation of a test (not separately reported); or Category 3: Discuss management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately billed)	High risk of morbidity from additional diagnostic testing or treatment. Examples only: ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision for elective major surgery w/ identified patient or procedure-specific risk factors ■ Decision for emergency major surgery ■ Decision for hospitalization or escalation of hospital level care ■ Decision not to resuscitate or to deescalate care because of poor prognosis

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In Summary

- Identify all E/M qualifiers, **regardless of its location within the note**:
  - Problems addressed
    - Count all that were managed, evaluated, assessed, treated (or refusal of treatment)
  - Data
    - Diagnostics, records reviewed, discussions, independent historian(s)
  - Risk
    - Include treatments even if not carried out
- Develop an effective way to communicate/query for CDI
- Time-based services, no overlapping when attributing minutes to codes
- Watch for documentation shortcuts – templates and copy/paste functions that may lead the reader to assume the information (work) applies to the current date of service coding

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AMA Documents

- Google search – ama cpt 2023 guidelines
- https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

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Thank you for attending

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