2023 E/M Code & Guideline Changes

Effective January 1, 2023...

E/M Services & Guidelines are being overhauled to align with the 2021 E/M changes for the 99202-99215 Office/ Outpatient Services. With these updates, the 1995 & 1997 E/M Guidelines will be retired and E/M levels of service will be based on documented medical decision making or total time. A medically appropriate history and exam should still be documented, but will no longer be required to determine the level of service. Significant changes will impact the following E/M code sets:

- ◊ Emergency Department
- ◊ Observation Care
- ◊ Hospital Inpatient
- ◊ Consultation Services
- ◊ Nursing Facility
- ◊ Domiciliary or Rest Home
- ◊ Home or Residence
- ◊ Prolonged Services

For the AMA CPT® E/M Code and Guideline Changes — Ctrl+Click here (PDF) (also attached).

This is the comprehensive "how to' guide for E/M services which includes detailed definitions, descriptions and instructions needed to facilitate understanding and correct coding.

Table 1: This chart identifies levels of MDM or time associated with the revised code sets.

Type of Service	Level of Medical Decision Making (MDM) & Associated Time			
	Straightforward	Low	Moderate	High
Office (established)	99212 10-19 min	99213 20-29 min	99214 30-39 min	99215 40-54 min
Office (new)	99202 15-29 min	99203 30-44 min	99204 45-59 min	99205 60-74 min
Consult (office/outpatient)	99242 20+ min	99243 30+ min	99244 40+ min	99245 55+ min
Consult (inpatient)	99252 35+ min	99253 45+ min	99254 60+ min	99255 80+ min
Hospital (initial)		99221 40+ min	99222 55+ min	99223 75+ min
Hospital (admit/discharge same day)		99234 45+ min	99235 70+ min	99236 85+ min
Hospital (subsequent)		99231 25+ min	99232 35+ min	99233 50+ min
Nursing Facility (initial)		99304 25+ min	99305 35+ min	99306 45+ min
Nursing Facility (subsequent)	99307 10+ min	99308 15+ min	99309 30+ min	99310 45+ min
Home Services (new)	99341 15+ min	99342 30+ min	99344 60+ min	99345 75+ min
Home Services (established)	99347 20+ min	99348 30+ min	99349 40+ min	99350 60+ min
Emergency Dept (MDM only)	99282	99283	99284	99285

Emergency Department Services

- Use MDM to determine level of service for ED visits **99282-99285,** time is not a factor in ED coding.
- **99281** code descriptor (below) was revised and is now the "99211, Nurse visit" of the ED. Additional guidance on payer acceptance may follow in the new year.

⇒ Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional

- When an ED visit is for the convenience of the physician, an office/outpatient code should be used instead.

Hospital Observation and Hospital Inpatient Services

- Observation Care codes (99217-99220, 99224-99226) are deleted and combined with existing hospitals services into a single code family "Hospital Inpatient or Observation Care" (99221-99223, 99231-99233, 99238, 99239)
- Hospital inpatient or observation status admit & discharge, same day codes 99234-99236 have new guidelines which require the patient be seen twice at separate encounters (admission & discharge) on the same date to support billing.

Table 2

Observation Code Crosswalk			
Service	2022		2023
Initial	99218-99220	→	99221-99223
Subsequent	99224-99226	→	99231-99233
Discharge	99217	→	99238-99239

Table 3: CPT & CMS Admit/Discharge Same Day Coding Rule Comparison

CMS and CPT rules for admission and discharge, same calendar date with application of CMS 8 hour rule			
Hospital Length of Stay	**Discharged On**	**Code(s) to Bill CMS**	**Code(s) to Bill CPT**
< 8 hours	**Same calendar date** as admission or start of observation	Initial hospital services only 99221–99223	Adm/Discharge 99234–99236
8 or more hours	**Same calendar date** as admission or start of observation	Adm/Discharge 99234–99236	Adm/Discharge 99234–99236
< 8 hours	**Different calendar date** than admission or start of observation	Initial hospital services only 99221–99223	Initial and discharge, 99221–99223 on adm. 99238-99239 on d/c
8 or more hours	**Different calendar date** than admission or start of observation	Initial and discharge, 99221–99223 on adm. 99238-99239 on d/c	Initial and discharge, 99221–99223 on adm. 99238-99239 on d/c

Consultations

- Low level consults 99241 (outpatient) and 99251 (inpatient) are deleted.
- CPT updated editorial comments reinforce the longstanding rule that consultations are provided at the request of another physician or qualified health care professional and require a written report back to requesting provider.
- Medicare has not changed their policies on consults, they do not recognize them.

Table 4: For payers that don't accept consultation codes, the grid below can be used to guide alternate code selection according to updated E/M guidelines for MDM or time based level of service. Code selection by MDM is a direct crosswalk while time based coding must meet the minimum time requirements for the alternate code selected.

2023 Consultation to Alternate Code Crosswalks

MDM Based Consult ► Inpatient			
Consult	(MDM)	Initial	Subsequent
99252	Straightforward	99221	99231
99253	Low	99221	99231
99254	Moderate	99222	99232
99255	High	99223	99233

Time Based Consult ► Inpatient					
Consult	(Time)	Initial	(Time)	Subsequent	(Time)
99252	35-44 min			99232	35-49 min
99253	45-59 min	99221	40-49 min	99232	35-49 min
99254	60-79 min	99222	55-74 min	99233	50+ min
99255	80+ min	99223	75+ min		

MDM Based Consult ► Office/Outpatient			
Consult	(MDM)	New	Established
99242	Straightforward	99202	99212
99243	Low	99203	99213
99244	Moderate	99204	99214
99245	High	99205	99215

Time Based Consult ► Office/Outpatient					
Consult	(Time)	New	(Tiime)	Established	(Time)
99242	20-29 min	99202	15-29 min	99213	20-29 min
99243	30-39 min	99203	30-44 min	99214	30-39 min
99244	40-54 min	99204	45-59 min	99215	40+ min
99245	55+ min	99205	60+ min		

Nursing Facility Services

- **99318** Annual nursing facility assessment has been deleted.
- **99304-99310, 99315, 99316** code descriptors revised. Guidelines were also revised to include the following:

⇒ CPT describes the principal physician as the admitting physician, and indicates that modifiers may be required to differentiate between the principal physician and other practitioners (Modifier is not specified, but it may be AI which is already in use for inpatient initial services.)

⇒ CPT provides a new definition of high-level MDM — multiple morbidities requiring intensive management. The new description applies to initial nursing facility care

⇒ SNF initial visits must be provided by a physician while subsequent visits can be furnished by a physician or other qualified healthcare professional

Domiciliary, Home or Residence Services

- Domiciliary (99324-99328), rest home (99334-99337) and custodial care services (99339, 99340) are deleted. Home or residence service codes will be used to report visits for patients in those facilities.
- Home or residence code **99343** has been deleted. Use 99344 instead when the MDM is moderate.
- Home codes **99341, 99342, 99344, 99345, 99347-99350** have been revised to include domiciliary and custodial care services

Table 5: Deleted Code crosswalk: Nursing Facility, Domiciliary, Home or Residence Services

2022 Service Types	2022 Codes	2023 Replacement Codes
Annual Nursing Facility Assessment	99318	99307 - 99310 (Subsequent Nursing Facility Care)
Domiciliary or Rest Home Visit, New Patient	99324 - 99328	99341 - 99342, 99344 - 99345 (Home Visit, New Patient)
Domiciliary or Rest Home Visit, Established Patient	99334 - 99337	99347 - 99350 (Home Visit, Established Patient)
Assisted Living Facility or Home Care Plan Oversight Services	99339 - 99340	99437, 99491 (Chronic Care Management), **or** 99424, 99425 (Principal Care Management)
Home Visit, New Patient	99343	99341 - 99342, 99344 - 99345 (Home Visit, New Patient)

Prolonged Services (add-on codes)

CPT 2023 updates include new, revised, and deleted prolonged service codes as well as new or revised guidelines. CMS adopted most CPT E/M coding changes for 2023, but still does not recognize prolonged service coding updates and have created new HCPCS codes for reporting of prolonged services for Medicare patients.

- Office/Outpatient & Inpatient/Observation prolonged service codes **99354-99357** are deleted
- Existing prolonged care **99417**, currently valid with 99205 and 99215, is revised to allow reporting with outpatient consult 99245, home visits 99345 and 99350, and cognitive assessment code 99483 in 2023
- **99418** is added for prolonged service in the hospital or nursing facility

⇒ Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310

⇒ Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359

⇒ Do not report 99418 for any time unit less than 15 minutes

- Medicare adds HCPCS code **G0316** for prolonged hospital service (inpatient or observation care)

⇒ Use G0316 in conjunction with 99223, 99233, and 99236

⇒ Do not report G0316 on the same DOS as other prolonged services for E/M 99358, 99359, 99418).

⇒ (Do not report G0316 for any time unit less than 15 minutes)

- Medicare also adds new prolonged services codes G0317 for nursing facility and G0318 for home or residence.
- Non face-to-face prolonged service codes 99358, 99359 are still active CPT codes, but will no longer be reimbursed by Medicare as they have been assigned a status indicator of Invalid for 2023

Table 6: Minimum time requirements for reporting prolonged services

Minimum Time Threshold Required To Report (CPT or CMS) Prolonged Service in Addition to Primary E/M Code						
Primary E/M Service (Must be time based)		**CPT**		**MEDICARE**		**Provider time limited to:**
Office/Outpt, New	99205	+99417	75 min	G2212	89 min	Date of visit
Office/Outpt, Established	99215	+99417	55 min	G2212	69 min	Date of visit
Hospital, Initial Inpt/Obs	99223	+99418	90 min	G0316	105 min	Date of visit
Hospital, Subsequent Inpt/Obs	99233	+99418	65 min	G0316	80 min	Date of visit
Inpt/Obs Same Day Admit/Discharge	99236	+99418	100 min	G0316	125 min	Date of visit + 3 days after
Consult, Office/Outpt	99245	+99417	70 min	N/A	N/A	Consults are non-covered
Consult, Inpatient	99255	+99418	95 min	N/A	N/A	Consults are non-covered
Nursing Facility, Initial	99306	+99418	60 min	G0317	95 min	1 day before visit + date of visit +3 days after
Nursing Facility, Subsequent	99310	+99418	60 min.	G0317	85 min	1 day before visit + date of visit +3 days after
Home/Residence, New	99345	+99417	90 min	G0318	140 min	3 days before visit + date of visit + 7 days after
Home/Residence, Established	99350	+99417	75 min	G0318	110 min	3 days before visit + date of visit + 7 days after
Cognitive Assessment & Care Planning	99483	+99417	50 min	G2212	100 min	3 days before visit + date of visit + 7 days after

Split/Shared Services

CMS delays the implementation of a policy finalized in CY 2022 for the definition of substantive portion, as more than half of the total time and only time being used to determine the billing practitioner for split or shared services. For 2023, Medicare advises to continue following 2022 substantive portion guidelines.

Medicare Split/Shared Services *(effective 1/1/22)*

2023 CMS FINAL RULE UPDATE
Continue following 2022 Substantive portion guidelines, the proposal to use time only has been delayed for one year.

E/M services performed jointly in a facility setting (outpatient department, inpatient, emergency department) by a physician and non-physician practitioner from the same group.

Applicable Split-Shared Services: Initial & Subsequent Hospital Visits, Discharge Management Services, Emergency Department Visits, Observation Care, Critical Care, Prolonged Service; and SNF visits, except for those mandated to be done by a physician

- Cannot be used in office setting where Incident To rules apply instead

Required Modifier: **-**FS appended to the E/M code for split or shared service between a physician & APP in the same group

Billing Provider: Charges **cannot** automatically be billed under the physician's NPI.

- **For 2022**, Charges are to be submitted by clinician who performs & documents a substantive portion of the visit. CMS defines substantive as the practitioner who:
  A. performs & documents more than half of the total distinct (non-duplicated) time spent on the E/M visit (*when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)*
  B. performs & documents one of the three key components in its entirety (history, exam or medical decision-making)
- Billing provider must sign & date the record. Documentation should also identify the physician and NPP sharing the visit
- ~~**In 2023**, only time will be used to determine the billing practitioner~~ DELAYED UNTIL 2024