E/M 2023—Starting Jan. 1, Streamlined Rules Apply Beyond the Office Setting

Jan. 1, 2023, saw big changes to E/M coding. In a range of settings, use of E/M codes has become much less of a headache.

Streamlined Requirements Are No Longer Just for the Office

In 2021, it started with the office-based E/M codes. In 2021, CMS streamlined its documentation guidelines for the office-based E/M codes (CPT codes 99202-99215). Before that year, you had to obtain and document a review of body systems *plus* a past medical history, family history, and social history, *plus* a chief complaint, *plus* elements of the history of the present illness. Additionally, examination elements were required for specific levels of E/M codes. Since 2021, documentation of office-based E/M services has required only a *medically relevant* patient history and examination. This means that the chart only needs to document the information that will be medically relevant for the physician, and this will vary depending on the nature of the patient encounter.

The streamlined rules now apply to more E/M services. The 2021 changes for office-based E/M services are now being applied to the following categories of E/M services and their related families of codes:

- Hospital inpatient and observation care services
- Consultations
- Emergency department (ED) services
- Nursing facility services
- Home or residence services

Determine the appropriate level of E/M code. As with the office-based E/M codes, when using E/M codes in the above places of service you should perform and document a medically appropriate history and examination. The appropriate level of E/M code is determined by the following:

- The level of medical decision making (MDM) or
- The total time that the physician spends caring for the patient—including before, during, and after the face-to-face encounter—on the date of the visit.

The ED exception. Levels of service for the ED E/M codes (CPT codes 99281-99285) cannot be determined by total physician time. This is because, according to the AMA, "emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time."[1]

99281—ED E/M Code Revised

Prior to 2023, CPT code 99281 *Emergency department visit for the evaluation of a patient* was selected when documentation supported a problem-focused history and exam and straightforward MDM. These requirements have now been removed and the descriptor updated to: *Emergency department visit for the evaluation of a patient that may not require the presence of a physician or other qualified health care professional.*

E/M code 99281 (like its office-based equivalent, 99211) is for a service provided by clinical staff under the supervision of a physician. For both codes, the concept of MDM does not apply. In an ED, 99281 will rarely—if ever—be used for ophthalmology.

MDM Table Updated for Extra Places of Service

The overall complexity level of MDM can be straightforward or of low, moderate, or high complexity. You determine the overall level of MDM by looking at three decision-making components: 1) problems, 2) data, and 3) risk. If at least two components point to the same level of MDM, then that would be the overall level of MDM. If the three components each point to a different level, then the middle one determines the overall level of MDM.

Since 2021, when practices have coded for an office-based encounter, they have used the Final Determination Table for MDM to determine which level of complexity those three components indicate. Now that MDM is to be used to determine E/M level in other places of service, there is a new Final Determination Table that includes examples from nonoffice settings. The Academy's

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2023 Final Determination Tables can be downloaded at aao.org/em for both office and hospital settings.

99418—New Add-On Code for Prolonged Services

Inpatient hospital care. When you are providing inpatient hospital care and using time as the factor for determining the level of E/M code, there could be scenarios that exceed the time designated for the highest level of service. If this is the case, prolonged services should be reported. As of Jan. 1, 2023, you can use CPT code 99418 to report for each additional 15 minutes. This code replaced codes 99354-99357, which were deleted on Dec. 31, 2022. It is an inpatient counterpart to 99417, which has been in use since 2021 for office-based E/M services.

When to use 99418. Only use this new add-on code if 1) time is the determining factor and 2) the total time is at least 15 minutes greater than the time allotted for the highest level of service in that setting. For example, if you are using time to determine the level of E/M for a subsequent hospital inpatient visit, you would need a time of at least 50 minutes to bill 99233, which is the highest level of E/M for that service. If the total time was 65-79 minutes, you could bill 99233 + 99418; if 80-94 minutes, bill 99233 + 99418 × 2; and for every additional 15 minutes, you can bill an extra 99418.

Note: Prolonged services of less than 15 minutes are not reported

Prolonged Service Codes

This table demonstrates how the prolonged service codes 99417 and 99418 can be used in the office and inpatient settings, respectively.

Established Patient Office Visit (Use of 99417 With 99215)		Subsequent Hospital Inpatient (Use of 99418 With 99233)	
Time: Total Duration (Minutes)	Code(s)	Time: Total Duration (Minutes)	Code(s)
Less than 55	99215	Less than 65	99233
55-69	99215 + 99417	65-79	99233 + 99418
70-84	99215 + 99417 × 2	80-94	99233 + 99418 × 2
85-99	99215 + 99417 × 3	95-119	99233 + 99418 × 3

If total time exceeds the durations shown above, you can bill for an additional prolonged service code for each additional 15 minutes.

Source: *2023 Fundamentals of Ophthalmic Coding (aao.org/store).*

2023 E/M Overview: Office Visits, Inpatient Hospital, and ED

When using time to determine level of E/M code, you must meet or exceed defined times, as shown below.

Encounter Type		MDM Level			
		Straight-forward	Low	Moderate	High
Office, New Patient	Code	99202	99203	99204	99205
	Minutes	15-29	30-44	45-59	60-74
Office, Established Patient	Code	99212	99213	99214	99215
	Minutes	10-19	20-29	30-39	40-54
Initial Hospital Inpatient	Code	99221		99222	99223
	Minutes	40		55	75
Subsequent Hospital Inpatient	Code	99231		99232	99233
	Minutes	25		35	50
Emergency Department	Code	99282	99283	99284	99285
	Minutes	Time not relevant.			

Source: *2023 Fundamentals of Ophthalmic Coding (aao.org/store).*

Office Consultations

Medicare Part B does not cover consultation codes. However, there are a few remaining commercial and/or Medicaid payers that do. If one of your payers does so, report CPT codes 99242-99245 for consultations performed in the office or other outpatient place of service. As of Jan. 1, 2023, this family of codes had descriptor changes and—as mentioned above—are now selected based on MDM or total physician time. Furthermore, CPT code 99241 was deleted on Jan. 1. The lowest level of MDM, straightforward, is designated as CPT code 99242.

Reminder—How to Code for Inpatient Consultations

Since 2010, you must report initial inpatient consultations with CPT codes 99221-99223 when submitting to Medicare Part B. For subsequent consultations, report CPT codes 99231-99233. These codes should be reported instead of CPT codes 99251-99255 for payers not recognizing consultations. As a result, multiple claims for inpatient hospital visits can occur on one date of service by different providers. To distinguish between the principal physician of record (the admitting physician) and consultants, the former should append modifier –AI to the appropriate level of E/M. All other physicians (consultants) should submit the E/M code without modifier –AI.

1 www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf. Accessed Nov. 3, 2022.

MORE ONLINE. For a coding example, see this article at aao.org/eyenet.