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Spring 2025 Virtual Conference

Understanding Medicare Compliance for Part B Providers

Overview of Evaluation and Management Services

6/3/2025

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Today's Presenters

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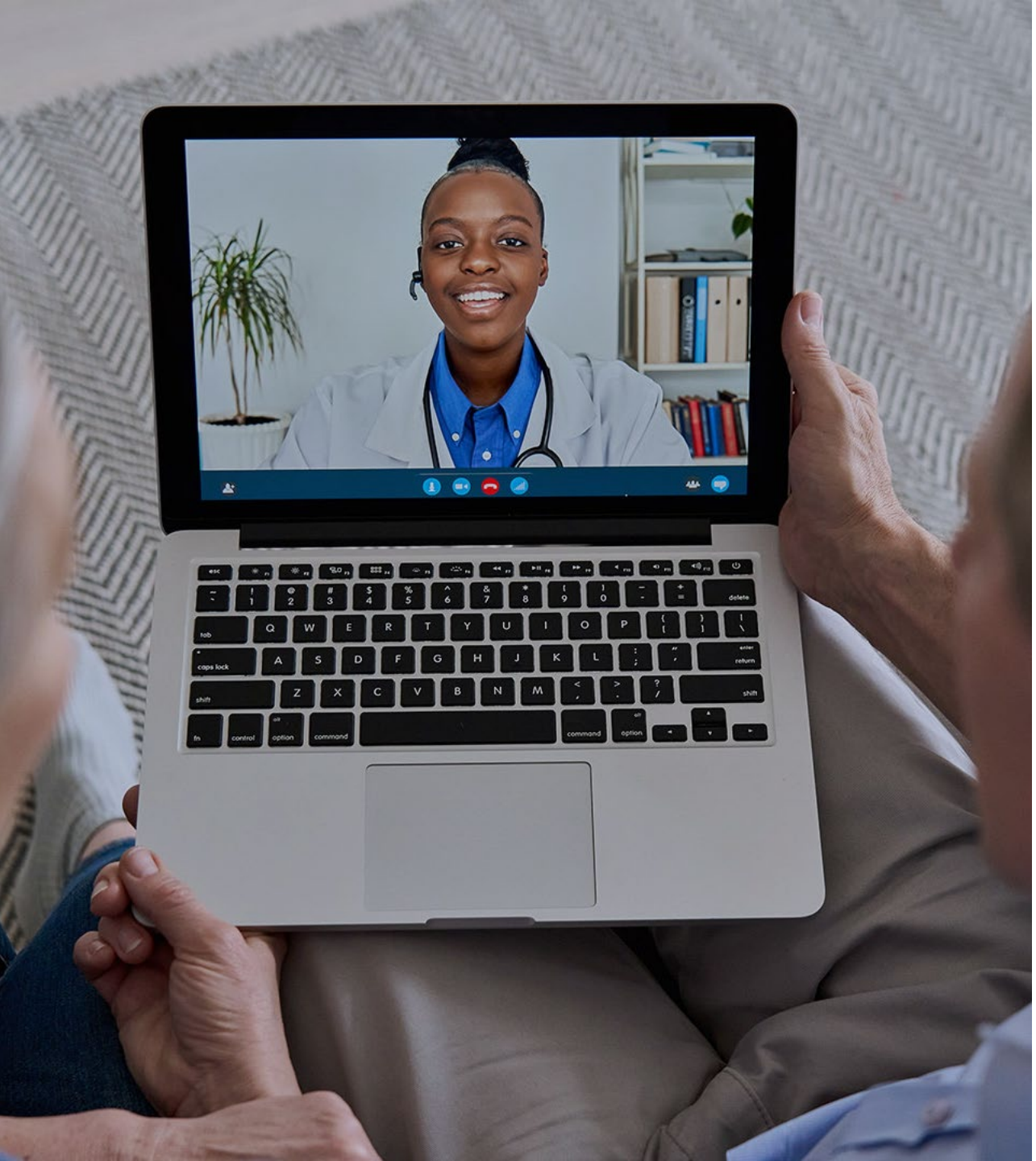

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Objective

Provide an overview of E/M services including changes for 2025. Discuss the changes and how they impact coding. Provide resources that will be useful going forward.

Agenda

- E/M Big Picture
- Office or Other Outpatient Services
- Inpatient/Observation E/M
- Nursing Facility E/M
- Home and Residence Services E/M
- Emergency Department E/M
- 2025 E/M Updates
- Prolonged Services

E/M Big Picture

E/M Services Big Picture

- Codes determined based on **MDM** or **total time** on the date of the encounter
  - **Exception**: Time still does not apply in the emergency department
- Inpatient and observation services included in one category
- Nursing facility services in one category
- Home and residence services in one category
- CMS does not allow reporting of more than one E/M service when patient changes sites for Medicare

E/M Services Big Picture

- Prolonged services codes align with total time on the date of the encounter
- Split/shared services: facility setting, between physicians and qualified NPPs
- Incident To: office or other outpatient settings

E/M Services Guidelines

- **Classification of E/M Services**
- The basic format of codes with the levels of E/M services based on MDM or time is the same for most categories
  - First, a unique code number is listed
  - Second, the place and/or type of service is specified (e.g., office or other outpatient visit), consultation
  - Third, the content of the service is defined
  - Fourth, time is now specified, no longer a suggested timeframe
  - The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs
- **Note, Exception**: outpatient services for designated inpatients (e.g., hospital or SNF) are reported with the CPT and POS relative to the patient's inpatient setting

E/M Services Guidelines
Initial and Subsequent

- Concept includes
  - Same physician or qualified health care professional
  - Same specialty and/or subspecialty and NPP group members performing same-specialty services (basically, same care team members)
- **Note**: Definition for “new” now varies based on site of service – see slide 13

E/M Services Guidelines

- Professional Service Definition: face-to-face service rendered by physician and/or qualified NPP
- Excludes prior non-F2F services (e.g., diagnostic interpretations)

Initial Service Guidelines

- Office/outpatient setting
  - Initial service is defined as care rendered to a patient who has not received any professional service(s) by a physician or same specialty group member during the **prior three years**
- Observation, Inpatient or SNF setting
  - Initial service is defined as care rendered to a patient who has not received any professional service(s) by a physician or same specialty or NPP group member **during the current stay**

E/M Services Guidelines

- A Subsequent Observation or Hospital service
  - The patient has received professional service(s) from the physician or qualified NPP group member of the exact same specialty and subspecialty during the admission and stay
- **Note**: When a physician or qualified NPP is on call for or covering for another physician or qualified NPP, encounter is classified as performed by the unavailable provider
- **Reminder**: NPs and PAs working with physicians are considered as working in the exact same specialty and subspecialty as the physician

E/M Services Guidelines

- Single Stay
  - Hospital inpatient or observation care services
    - **includes** a transition from observation to inpatient
  - Nursing facility services
    - **includes** a transition from skilled nursing facility to nursing facility level of care
  - **Key**: transition does not represent a new stay

Office or Other Outpatient Services

Overview

- Office or other outpatient visits
  - New Patient (99202–99205)
  - Established Patient (99211–99215)

Medical Decision Making

- Page nine–ten of 2025 CPT
- CMS follows the AMA CPT Medical Decision Making table as printed in CPT
- Level of MDM determined based on two out of three elements of MDM
  - Wherever the MDM matches at least two levels is the level at which you may bill the service

New Patient Visits

Code	MDM Level	Time
99202	Straightforward	15 minutes
99203	Low	30 minutes
99204	Moderate	45 minutes
99205	High	60 minutes

Established Patient Visits

Code	MDM Level	Time
99211	N/A	N/A
99212	Straightforward	10 minutes
99213	Low	20 minutes
99214	Moderate	30 minutes
99215	High	40 minutes

Inpatient/Observation E/M

Hospital Observation Services Deleted Codes

- Observation Care Discharge Services
  - 99217 **has been deleted** (Use 99238, 99239)
- Initial Observation Care
  - **99218, 99219, 99220 have been deleted** (Use 99221, 99222, 99223)
- Subsequent Observation Care
  - **99224, 99225, 99226 have been deleted** (Use 99231, 99232, 99233)

Hospital Inpatient Services Revisions

- Guidelines revised to include both observation and inpatient services
- Sections and subsections renamed to include observation care
- Codes 99221–99223, 99231–99233 restructured to model outpatient office codes
- Time expectations revised and are now required

Hospital Inpatient and Observation Care

- Key Facts
  - Hospital inpatient or observation care codes are also used to report partial hospitalization services
  - Observation services may be provided in any hospital location, including the ED, a designated observation area or elsewhere in the hospital
  - Codes 99234, 99235 and 99236 – for admission and discharge from hospital inpatient or observation status on the same date
  - Total time on the date of the encounter is by calendar date
    - A service that spans the transition of two calendar dates is a single service and is reported on the calendar date on which it was initiated, with all time reported on a single claim

Observation vs. Inpatient

- **Same code sets: 99221–99223, 99231–99233, only POS varies**
  - Observation services are outpatient services, payable in outpatient **POS 19 and 23**
  - Inpatient services are payable in **POS 21**

Initial Services: Observation vs. Inpatient

- **Initial observation** codes (99221–99223) are billed **only by the attending** physician, with Modifier AI to denote that status
- **Initial inpatient** services (99221–99223) may be **billed by both** attending physicians and consultants; attending physician adds Modifier AI

Consultation: Billing Depends on POS

- **Emergency Department (POS 23)**
  - Consultation services billed with ED code set 99282–99285
- **Observation (POS 19 or 23)**
  - Consultation services in observation are billed with outpatient code sets 99202–99205, 99212–99215
- **Inpatient (POS 21)**
  - Consultation services for inpatients are billed with inpatient code sets 99221–99223, 99231–99233

Hospital Inpatient or Observation Care Services (Including Admission and Discharge)

- Admission and discharge on **different DOS**
  - 99221–99223 (initial), 99231–99233 (subsequent), 99238–99239
- Admission and discharge on **same DOS**
  - 99234, 99235, 99236

Hospital Inpatient or Observation Care Services (Including Admission and Discharge)

- Note
  - These codes require **two or more** encounters on the same date, one of which must represent an initial **admission** visit and another representing a **discharge** visit
  - These encounters must be completed by the attending physician or a member of the group
  - A resident's service does not meet this requirement
  - Do not report 99238 or 99239 in conjunction with same date admission and discharge services

Hospital Inpatient or Observation Discharge Different Dates

- 99238–99239: When admission and discharge occur on different dates
  - Performed and billed only by the **attending physician**
  - Include cumulative time spent on the date of the discharge
  - Codes include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms
  - Discharge date services by other providers are billed with 99231–99233 as appropriate

Same Date Admission and Discharge

- 99234–99236
  - Apply to services on which admission and discharge to either observation or inpatient status have been completed on the same date
  - Performed and billed **only by the attending physician**
  - Include cumulative time spent on the date of care
  - Require a **minimum of two encounters** by the attending physician, one of which must be an admission visit and the other a discharge visit
  - Bill for stays of **eight or more** hours
  - Stays of less than eight hours: use 99221–99223

Nursing Facility E/M

Nursing Facility Services

- Changed initial nursing facility care and subsequent nursing facility care code descriptors to use MDM or total time on the date of the encounter
- Removed regulatory language related to comprehensive assessments
- Matched place of services to CMS manuals
- Revised the initial nursing facility care codes
- Created new “problem addressed” type specific to nursing facility services not in the MDM table
- Clarified the reporting of discharge services

Guideline Revisions Overview

- Nursing facility services guideline revisions
  - Initial nursing facility care (99304–99306)
  - Subsequent nursing facility care (99307–99310)
  - Nursing facility discharge services (99315–99316)
  - Other nursing facility services (99318)

Nursing Facility Services

- Two major subcategories of nursing facility services, both of which apply to new or established patients
  - Initial nursing facility care
  - Subsequent nursing facility
- Same codes apply to SNF and nursing facility settings
- POS reflect type of facility and care provided

Nursing Facility Services

- Since 2023: The codes are used to report evaluation and management services
  - For patients in **nursing facilities and skilled nursing** facilities
  - For patients in **psychiatric residential** treatment centers
  - For patients in **intermediate care facilities** for individuals with intellectual disabilities
  - Codes represent services by the **principal physician(s), consultative providers** and other qualified health care professional(s) overseeing the care of the patient in the facility

Nursing Facility Services

- CMS **allows** both hospital discharge and initial nursing facility services by the attending provider to be reported on the same calendar date
- CMS **does not allow** both nursing facility and emergency department services to be reported on the same calendar date
  - 2023 CMS Final Rule allows these to be billed by different physicians/qualified healthcare providers

Initial Nursing Facility Care

- Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay
- They may be used for
  - The initial comprehensive visit performed by the principal physician or other qualified health care professional (add modifier AI)
  - Consultative providers in the nursing facility setting

Initial Nursing Facility Care

- Initial service requirements vary
  - **Attending physician**: patient has not received any F2F services from the physician or qualified group member **during the stay – may be billed after a hospital discharge**
  - **Consulting physician: patient has not received any F2F service by the same physician/group, including care during the prior hospital stay**
- Requirements apply to services provided by attending or consulting group members, including NPPs

Initial Nursing Facility Care

- Skilled nursing facility initial comprehensive visits must be performed by a physician
- Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation

Initial Nursing Facility Care

- The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide timely care to the patient- add modifier AI to initial principal physician service
- Medically necessary assessments conducted prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310)

Level of Care Changes Not a New Stay

- When a patient is transitioned between skilled nursing facility care and nursing facility care, this **does not** constitute a new stay
- Transition services between these two levels may be represented by **subsequent** nursing facility care codes

Initial Nursing Facility Care Codes

Code	MDM Level	Time
99304	Straightforward or Low	25
99305	Moderate	35
99306	High	50

Subsequent Nursing Facility Care Codes

Code	MDM Level	Time
99307	Straightforward	10
99308	Low	20
99309	Moderate	30
99310	High	45

Nursing Facility Discharge Services

- These services require a face-to-face encounter with the patient and/or the patient's family or caregiver
- Services may be performed on a date other than the date of the physical discharge
- Code selection is based on total time on the date of the discharge management encounter

Discharge: Nursing Facility Care Codes

Code	Time
99315	30 or less
99316	More than 30

Nursing Facility Discharge Services

- 99315–99316: 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

Other Nursing Facility Services Summary

- Annual nursing facility assessment code 99318 was **deleted 12/31/2022**
- Services may be reported with an appropriate code from subsequent nursing facility services codes (99307, 99308, 99309, or 99310)
- These services are commonly reported as annual wellness visits (G0438–G0439)

Home and Residence Services E/M

Home and Residence Services

- **Deleted**: New patient codes: 99324, 99325, 99326, 99327, 99328: Domiciliary, Rest Home (e.g., Boarding Home), or custodial care
- **Deleted**: Established patient codes (99334, 99335, 99336, 99337)
- **Deleted**: Domiciliary, Rest Home (e.g., Assisted Living Facility), or home care plan oversight services (99339, 99340)
- **Now in Use**: Home or Residence Services (99341–99345 (new patient) and 99347–99350 (established)

Home or Residence Service Overview

- CPT guidelines were revised in 2023
- Home or residence now includes
  - Domiciliary, rest home (e.g., boarding home or assisted living), custodial care
- Home care plan oversight subsections have been incorporated into a single section and renamed “Home or Residence Services”
- Sections and subsections have been renamed to include observation care
- New and established patient codes 99341–99342, 99344–99345, 99347–99350 have been restructured to model the office or other outpatient services codes
- Code 99343 has been deleted

Home or Residence Services Guidelines

- Codes are used to report E/M services provided in a home or residence
- Home may be defined as a private residence, temporary lodging, or short -term accommodation (e.g., hotel, campground, hostel or cruise ship)
  - For Medicare purposes the cruise ship must be within USA territorial waters
- Codes also apply when the residence is
  - An assisted living facility
  - Group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities)
  - Custodial care facility
  - Residential substance abuse treatment facility

Home or Residence Services Guidelines

- Use nursing facility service codes (99304–99306 or 99307–99310, 99315–99316) for services in a **licensed intermediate care facility** for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center
- When selecting code level using time, do not count any travel time
- When a patient is admitted to hospital inpatient, observation status, or to a nursing facility, as a result of care in a home or residence, refer to codes for initial hospital inpatient and observation care or initial nursing facility care

New Patient: Home or Residence Services

CPT Code	Medical Decision Making	Time Thresholds
99341	Straightforward	15 minutes
99342	Low	30 minutes
99344	Moderate	60 minutes
99345	High	75 minutes

Established Patient: Home or Residence Service

CPT Code	Medical Decision Making	Time Thresholds
99347	Straightforward	20 minutes
99348	Low	30 minutes
99349	Moderate	40 minutes
99350	High	60 minutes

Prolonged Service: Home or Residence

- G0318 – only added when **CMS timeframe** for
  - 99345 (140 minutes) code based 75 minutes completed and an **additional 65 minutes** of care has been provided
  - 99350 (110 minutes) code based 60 minutes completed and an **additional 50 minutes** of care has been provided
- Service time includes a **timespan of eleven days** (three-day pre-DOS, DOS, seven days post-DOS= eleven days)
- G0318 is only billed upon completion of the CMS-required timeframe, and billed on the DOS on which it was performed and completed

Emergency Department E/M

Emergency Department E/M

- Revised codes: 99281, 99282, 99283, 99284, 99285
- Alignment of codes 99211 and 99281 – neither require participation by a physician
- Guidelines for selecting level of service based on MDM
- New and revised guidelines

Emergency Department Services

- Codes for emergency department services have been revised and are now reported based on level of MDM to conform with office E/M revisions
  - Concept of MDM does not apply to 99281
  - Four types of MDM
    - Straightforward
    - Low
    - Moderate
    - High

Alignment of Codes 99211, 99281

- Level of service decreased for code 99281 to align with code 99211
- Code 99281 and code 99211 reported for minimal services in their respective setting
- Code 99281 and code 99211 require supervision by clinical staff

Emergency Department Services and Time

- Time is not a descriptive component for ED levels of E/M services because ED services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time
- CPT® 2024 Professional Edition (p 26)
- In the ED setting, only MDM is the basis for level-setting a service

ED and Critical Care Guidelines

- For critical care services provided in the ED, see critical care guidelines for 99291, 99292
- Critical care and ED services may both be reported on the same day by the same provider or group, when after completion of the ED service, the condition of the patient changes and critical care services are medically necessary

Emergency Department Coding

CPT Code	Medical Decision Making
99281	N/A
99282	Straightforward
99283	Low
99284	Moderate
99285	High

2025 E/M Updates

Office/Outpatient (O/O) Evaluation and Management (E/M) Visits

- G2211 (O/O E/M visit complexity add-on code) is allowable when CPT codes 99202-99205, 99211-99215 (O/O E/M base code) are billed by the same practitioner on the same day as an approved Medicare Part B preventive service to which Modifier 25 is added
- When Modifier 25 is added to non-preventive service claims, G2211 is not payable and will be denied
- Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211

Evaluation and Management Visit

- G2211 is not restricted to medical professionals based on a particular specialty
  - Should be used by medical professionals, regardless of specialty
- G2211 would not be considered duplicative of care management services since the inherent complexity better recognizes the professional work within the visit, while the care management codes recognize services that happen outside of the visit
- Coinsurance and deductible apply

Documentation Requirements

- Document the **medically necessary reason** for the O/O E/M visit
- No additional documentation is currently required for G2211
- Medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and accuracy of the documentation of the time spent
- Supporting documentation for billing code G2211 may include
  - Information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses
  - Practitioner's assessment and plan for the visit
  - Other service codes billed

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-On for Infectious Diseases

- New HCPCS add-on code (G0545) established to describe the intensity and complexity inherent to I/O care, associated with a confirmed or suspected infectious disease reported by physicians with specialized infectious disease training
  - This is intended to recognize the inherent complexity for all infectious diseases, and not just emerging infectious diseases with epidemic potential
- G0545 description: Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases' specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and/or complex antimicrobial therapy counseling and treatment. (add-on code, list separately in addition to **hospital inpatient** or **observation** evaluation and management visit, initial, **same day discharge**, **subsequent** or **discharge**

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-On for Infectious Diseases

- G0545 will include the following service elements (used for one, or any combination, of the three service elements)
  1. Disease transmission risk assessment and mitigation
  2. Public health investigation, analysis and testing
  3. Complex antimicrobial therapy counseling and treatment
- Use in addition to CPT codes
  - 99221–99223
  - 99231–99233
  - 99234–99235
  - 99238–99239
- HCPCS code G0545 is not intended to be a time-based code
  - For time-based reporting of additional incremental time, see prolonged hospital I/O E/M codes
- May be reported by practitioners who have specialized infectious disease training, including but not limited to physicians, nurse practitioners, physician assistants and certified nurse specialists

Strategies for Improving Global Surgery Payment Accuracy

- Beginning with services furnished in CY 2025, modifier 54 will be required for **all** 90-day global surgical packages in any case when a practitioner plans to furnish only the surgical procedure portion of the global package (including both formal and other transfers of care)
  - Will improve payment accuracy
  - Inform CMS about how global package services are typically furnished
- For CY 2025, there will be no changes regarding the use of modifier 55 and modifier 56
  - Continue to bill exclusively in cases where there is a documented formal transfer of care

Strategies for Improving Global Surgery Payment Accuracy

- Add-on HCPCS code G0559 will be used for practitioners who did **not** furnish the surgical procedure and does not have the benefit of a formal transfer of care
  - List separately in addition to O/O E/M visit, new or established patient
  - Billed only once per practitioner during the 90-day global period (additional resource costs would be incurred upon the first visit)
  - Should **not** be billed by another practitioner in the same group practice as the surgeon or the same specialty
  - Will reflect the time and resources involved in post-op follow-up visits by practitioners not involved in furnishing the surgical procedure

Strategies for Improving Global Surgery Payment Accuracy

- Required elements for G0559, when possible and applicable
  - Reading available surgical note to understand the relative success of the procedure
  - Research the procedure to determine expected post-operative course and potential complications
  - Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately
  - Communicate with the practitioner who performed the procedure
- Documentation should indicate the relevant surgical procedure, to the extent the billing practitioner can readily identify it

Split/Shared Services

Split (or shared) E/M Visits

- Visits provided in part by a physician and in part by other nonphysician practitioners
- Provided in a hospital or other institutional settings
  - Split/shared E/M visit is defined as a **medically necessary encounter** provided in a facility setting where the physician and a qualified NPP in the same group each personally perform a portion of the service on the same date
- Expanded definition
  - May be the practitioner who spent more than 50 percent of the time or who made or approved the MDM
    - Except for critical care visits which do not use MDM and only use time

Split (or shared) E/M Visits

- Substantive portion means more than half of the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making
- Used for new or established patients
- Initial or subsequent visits, as well as prolonged services
- Face-to-face and non-face-to-face activities
- Modifier FS (Split or shared E/M) is required for reporting purposes
- Documentation must include
  - Physician and practitioner who performed the service
  - Who provided the substantive portion must sign and date the medical record

Prolonged Services

Prolonged Service – CMS Concept

- **CMS RVU Update Committee (RUC) time requirements vary from those in CPT for the following services**
  - Same-day inpatient/observation admission and discharge (99236)
  - SNF visits, initial and subsequent (99306/99310)
  - Home and residence visits (99345/99350)
  - Cognitive assessment and planning visits (99483)

Prolonged Services: Code Summary

- As of 1/1/2023, the following codes may be used to represent **fully completed** segments of 15-minute units of prolonged care
  - **G0316** – prolonged service in the inpatient/observation setting, when also billing 99223 or 99233 or 99236
  - **G0317** – prolonged service in the nursing facility setting, when also billing 99306 or 99310
  - **G0318** – prolonged service in the home or residence setting, when also billing 99345 or 99350
  - **G2212** – continues to be used for prolonged services in the office/outpatient setting and for prolonged cognitive impairment assessment services

NGS' Prolonged Services Timetable 2025

CPT Code	Prolonged Code	Base Time	CMS-Extra Minutes Needed	CMS Prolonged Time	Date Span
99205	G2212	60	15	75	DOS
99215	G2212	40	15	55	DOS
99223- Hosp/Obs.	G0316	75	+15 (same as CPT)	90	DOS
99223- Hosp/Obs.	G0316	50	+15 (same as CPT)	65	DOS
99236- Same-Day Admit/Disch.	G0316	85	+25	110	DOS + post 3 days = 4 days
99306- NF Initial	G0317	50	+45	95	1 pre, DOS, 3 post =5 days
99310- NF Subsequent	G0317	45	+40	85	1 pre, DOS, 3 post =5 days
99345- Home/Residence Initial	G0318	75	+65	140	3 pre, DOS, 7 post =11 days
99350- Home/Residence Subsequent	G0318	60	+50	110	3 pre, DOS, 7 post =11 days
99483- Cognitive Behavior Assess.	G2212	60	+40	100	3 pre, DOS, 7 post =11 days

Prolonged Services

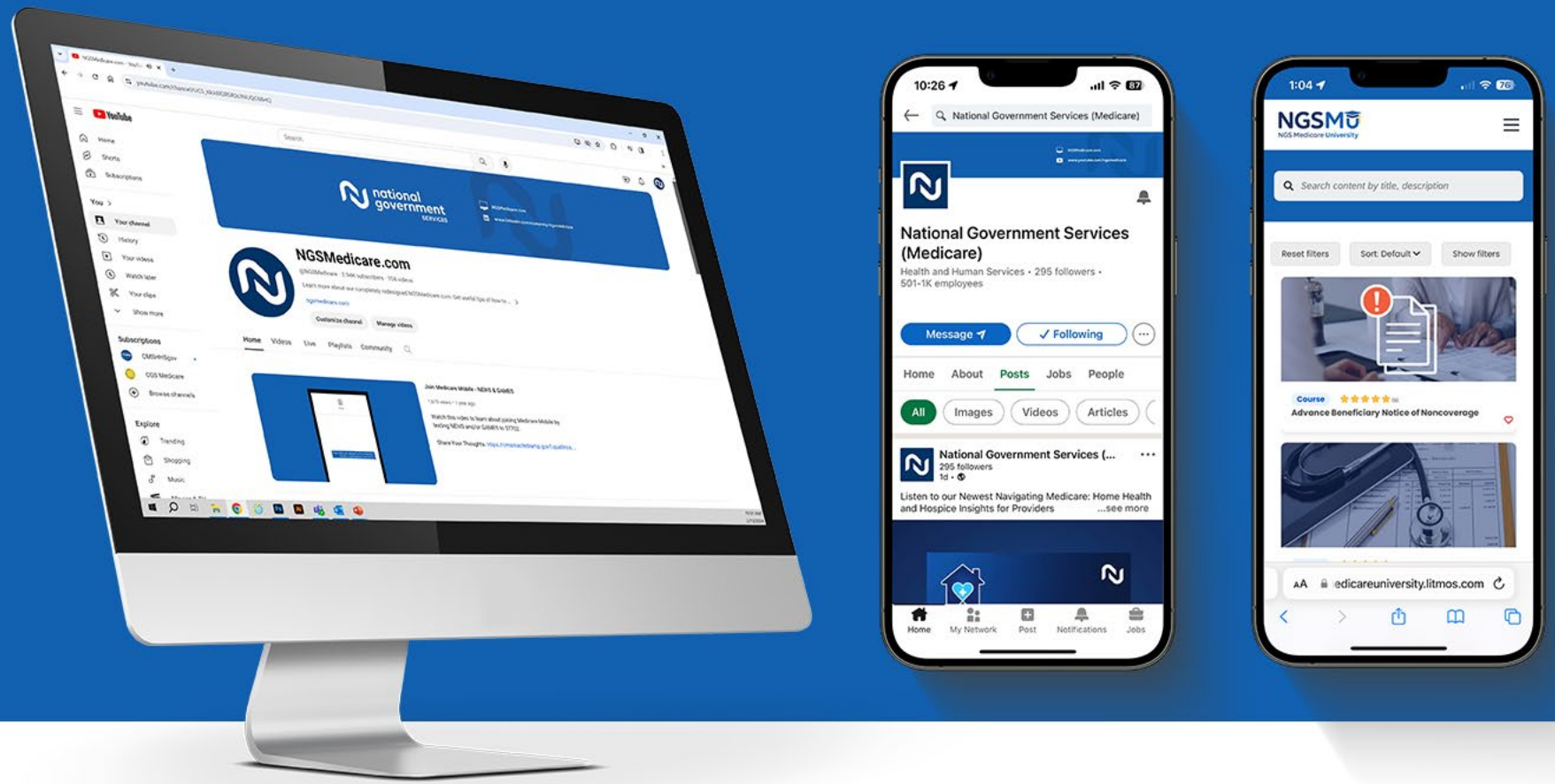
- Prolonged service codes are not applicable to the following services
  - ED services: 99281–99285
  - Critical care services: 99291–99292
  - Discharge services: 99238–99239 and 99315–99316

Prolonged Services- Clinical Staff

- CPTs 99415–99416 represent prolonged **clinical staff** time
  - Added only after a F2F service by a physician or NPP
  - Require a full 30 minutes of additional time after completion of either 99205 or 99215 by the physician or NPP
  - Cannot be used to represent time spent awaiting test results or elsewhere in the office suite

Prolonged Services (Without Direct Patient Contact)

- Prolonged service codes G0316–G0318 and G2212 encompass **all provider time** spent on the DOS, including both with and without the patient being present
- 99417–99418: AMA codes, invalid for Medicare



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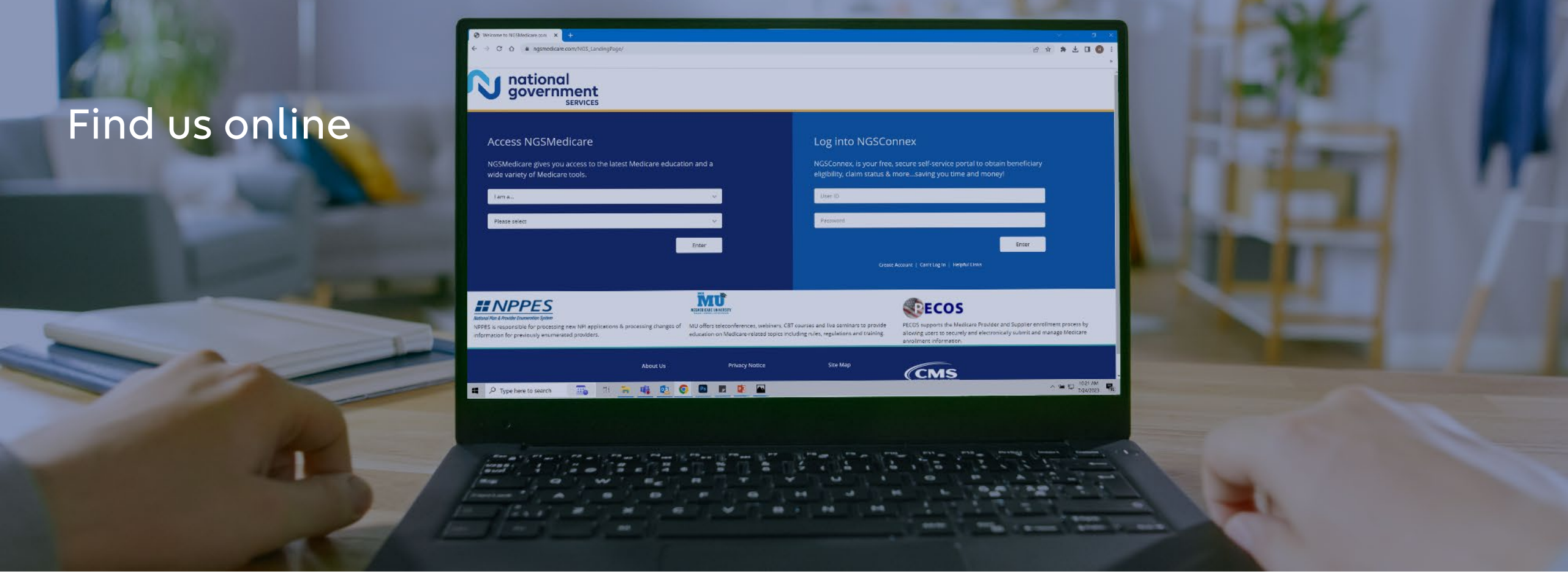

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