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ASCO Practice Leadership Series

2023 Evaluation and Management Changes

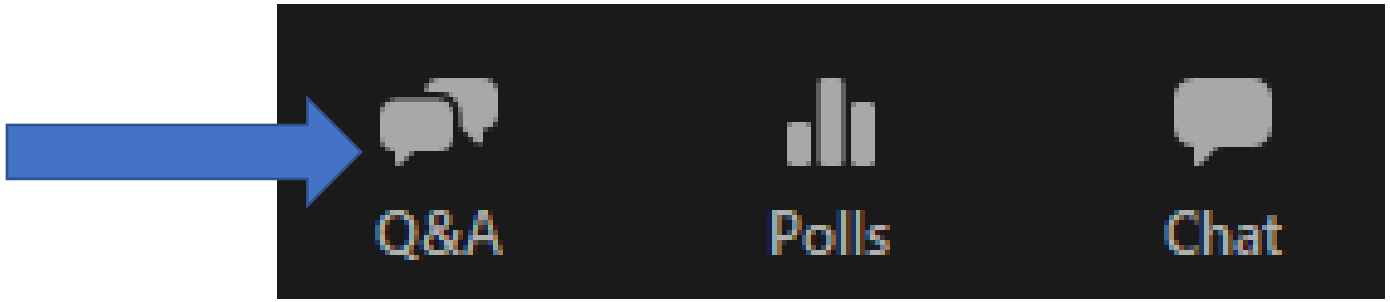
Thursday, October 20, 2022, 4:00pm ET

ASCO® PracticeNET

Networking for Education and Transformation

Welcome!

- Please mute your phones
- Q&A session at the end
  - Use the Q&A button in the bar at the bottom of your Zoom window
  - Type in your question
  - We will address questions in the order they are received



Speakers

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American Society of Clinical Oncology

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2023 Evaluation and Management Changes

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October 20th, 2022

Topics

- Inpatient and Observation Service Changes
- Prolonged Services
- Other changes
- Medical Decision Making
- Reimbursement

Background

In 2021, revisions were made to the office and outpatient evaluation and management services which included (but not limited to):

- Removal of history and examination as key components.
- Time and medical decision making as the criteria for code selection.
- New 15-minute prolonged service code.

However, these changes did **not** apply to inpatient, observation, discharge, or critical care services.

2023 Updates and Changes

History and exam removed as key components on ALL E/M codes.

Level of service is decided by Medical Decision Making (MDM) OR time for all E/M codes.

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Hospital Services

Code Selection

Inpatient, Observation, Discharge Services

Codes selected based on time or medical decision making. History and exam no longer apply to MDM.

Time is specifically defined rather than a “typical” time.

CPT® and HCPCS code for a prolonged service of 15 minutes in the inpatient/observation/discharge setting.

Code Family Combination

Inpatient and Observation Service Changes

Prior to 2023

- Initial, subsequent, and discharge codes were categorized into either observation or inpatient services.

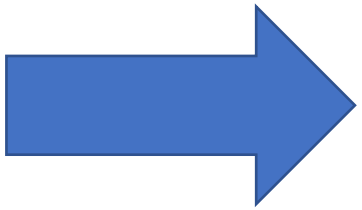
2023

- Codes combined into one code family to "hospital inpatient *and* observation care".

Inpatient and Observation Service Changes

Code Family Combination

2023: Observation codes deleted.



2023: Report instead “hospital inpatient *and* observation care” codes.

Inpatient and Observation Service Changes

Code Family Combination in 2023

Deleted Codes	Report Instead
• Discharge: 99217 • Initial: 99218-99220 • Subsequent: 99224-99226	• Initial: 99221-99223 • Subsequent: 99231-99233 • Same Day: 99234-99236 • Discharge: 99238-99239

Initial Versus Subsequent

Inpatient and Observation Service Changes

Initial

Prior to 2023

Report the *first hospital encounter* by admitting physician.

2023

Report when the patient has *not* received any professional services from physician/QHP in same specialty group during stay.

Subsequent

Prior to 2023

Report for services on days *after the date* of initial admission.

2023

Report when the patient has *previously* received *any* professional services from a physician/QHP in same specialty/group during stay.

Initial CPT® Codes

Inpatient and Observation Service Changes

Patient has not received any professional services from a physician/QHP in same specialty group during stay.

99221	99222	99223
• *Initial* hospital inpatient or observation care, per day • *Straightforward or low* level of MDM • *40 minutes* or more	• *Initial* hospital inpatient or observation care, per day • *Moderate* level of MDM • *55 minutes* or more	• *Initial* hospital inpatient or observation care, per day • *High* level of MDM • *75 minutes* or more

Subsequent CPT® Codes

Inpatient and Observation Service Changes

Report when the patient has *previously* received *any* professional services from a physician/QHP in same specialty/group during stay.

99231	99232	99233
• *Subsequent* hospital inpatient or observation care, per day • *Straightforward or low* level of MDM • *25 minutes* or more	• *Initial* hospital inpatient or observation care, per day • *Moderate* level of MDM • *35 minutes* or more	• *Initial* hospital inpatient or observation care, per day • *High* level of MDM • *50 minutes* or more

Discharge CPT® Codes

Inpatient and Observation Service Changes

Total time spent by physician or qualified healthcare professional for discharge of a patient

99238	99239
• Hospital inpatient or observation discharge day management • *30 minutes or less*	• Hospital inpatient or observation discharge day management • More than 30 minutes

Discharge Only CPT® Codes

Inpatient and Observation Service Changes

Activities

- Final exam
- Discussion of stay
- Coordination of continuity of care
- Document preparation for discharge
- All services provided on date of discharge

Reporting

- Used by physician/QHP responsible for discharge
- For Same day admin and discharge, see appropriate codes
- Other providers use subsequent service codes

Same Day Admission and Discharge CPT® Codes

Inpatient and Observation Service Changes

99234	99235	99236
• Hospital inpatient or observation care for admission and discharge on same day • *Straightforward or low* level of MDM • *45 minutes* or more	• Hospital inpatient or observation care for admission and discharge on same day • *Moderate* level of MDM • *70 minutes* or more	• Hospital inpatient or observation care for admission and discharge on same day • *High* level of MDM • *85 minutes* or more

Consultation CPT® Codes Updates

Deleted codes: 99241 and 99251

- Matches 2021 format changes, four levels of MDM for services.

Definition of "transfer of care"

- Services for management of patient's entire care or for a specific condition/problem.

Split/Shared Services
Inpatient and Observation Services

2023 Medicare Physician Fee Schedule Proposed Rule

CMS is considering delays regarding the definition of "substantive portion" of a service until 2024.

CMS Definition of Substantive Portion	
2022	**2023**
•Two options (select one): 1.<u>One</u> of the three key components (history, exam, or MDM). The component must be performed in its entirety by the billing practitioner. **OR** 2.More than half of the total time spent by the physician and NPP performing the split (or shared) visit. •One practitioner must have face-to-face contact with the patient (does not have to be the billing practitioner).	•More than half of the total time spent by the physician and NPP performing t split (or sh d) visit. •One pra -to-face contact wit not have to be the billi). •The subst be entir w t patient co ace to non face to face a tivities).

Time

Inpatient and Observation Service Changes

Prior to 2023	2023
• Code based on time if face-to-face activities (counseling and coordination of care) account for more than 50% of encounter.	• Includes face-to-face and non-face-to-face activities. • 50% rule no longer applies.

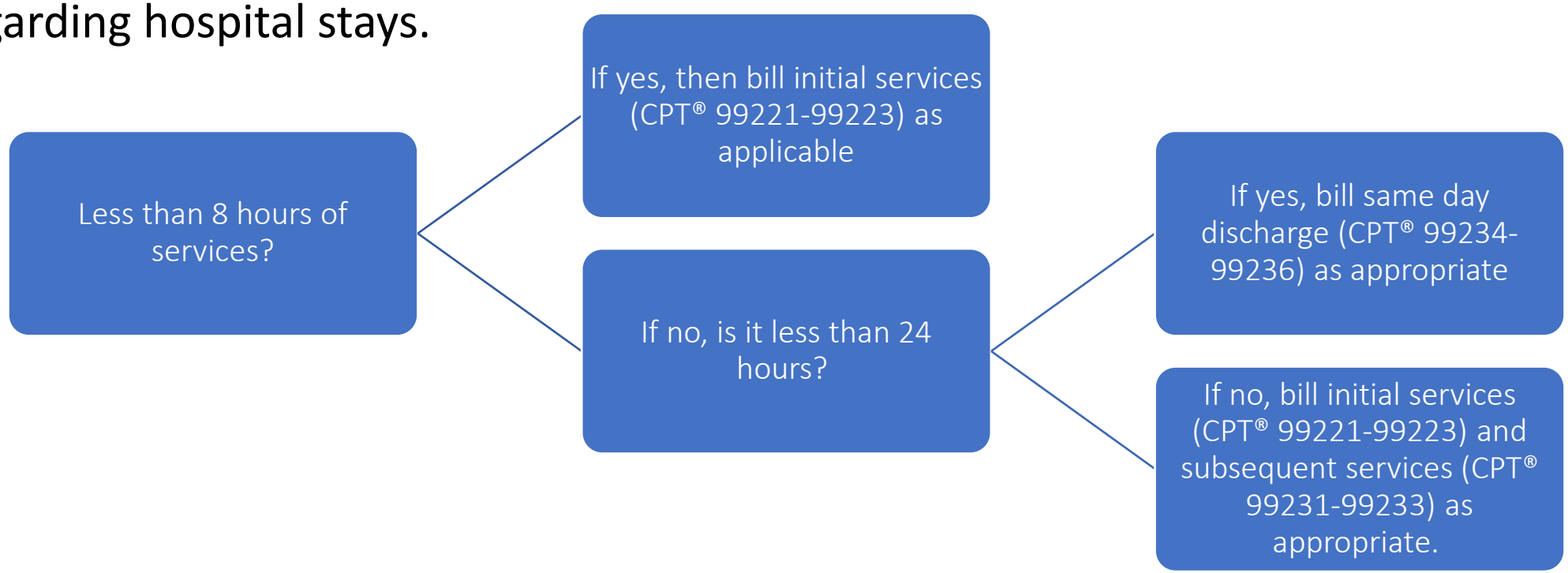
Inpatient and Observation Service Changes: Time

If a service is continuous before and after midnight, all the time attributed services must be applied to only one date of service.

Example: A patient admitted to observation at 20:00 hours on August 30th and discharged at 03:00 hours on August 31st, for a total of five hours. The provider selects August 31st as the date of service. If provider totaled an hour and 20 minutes of care during this time, CPT® 99235 should be reported as the minimum time of 70 minutes was met.

Centers for Medicare and Medicaid Services 8-to-24-Hour Rule

Because admissions can be done around the clock, CMS requires 8 to 24 hours for a "day" regarding hospital stays.



"Proposed 8-to-24-hour rule" for Hospital Inpatient or Observation Care, CMS CY 2023 Proposed Rule

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Centers for Medicare and Medicaid Services 8-to-24-Hour Rule

Reporting Scenarios – one hour of care by physician:

- Patient admitted at 11pm, discharged at 4am (less than 8 hours): Report 99222. No discharge services would be reported.
- Patient admitted at 11pm, discharged at noon (more than 8 hours, less than 24 hours): Report 99234.
- Patient admitted at 11pm Monday, discharged on Wednesday (more than 24 hours): Report 99222 and discharge CPT on date of discharge.

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Prolonged Services

Prolonged Services: Office and Outpatient

CPT ® Code 99417	HCPCS Code G2212
▪ Prolonged office or other outpatient evaluation and management service(s) beyond the **minimum** total time of the primary procedure (either CPT® code 99205 or 99215).	▪ Prolonged office or other outpatient evaluation and management service(s) beyond the **maximum** required time of the primary procedure.
▪ Primary service selected based on time only (not medical decision making.	▪ Selected based on time (either CPT® code 99205 or 99215) only.
▪ With or without direct patient contact.	▪ With or without direct patient contact.
▪ Reported for each 15-minute unit of service.	▪ Reported for each 15-minute unit of service.
▪ May not be reported with Psychotherapy Services, Prolonged Services With Direct Patient Contact, Prolonged Services Without Direct Patient Contact, or Prolonged Clinical Staff Services.	▪ May not be reported with Prolonged Services With Direct Patient Contact, Prolonged Services Without Direct Patient Contact, or Prolonged Clinical Staff Services.
▪ Reportable to **private payers only**, unless directed to use HCPCS code G2212.	▪ **Reportable to CMS only**, unless otherwise advised by a private payer.
	▪ Included in the Medicare Telehealth list.

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Prolonged Services

Inpatient and Observation Services

Prior to 2023

- Could only be reported for a service of 31 minutes to 1 hour beyond the primary procedure (inpatient or observation E/M) with CPT® codes 99356, 99357.

2023

- **New CPT®** code 99418 created for 15-minute service beyond the time of a level 5 inpatient or observation E/M.

Prolonged Services: Inpatient Hospital and Observation

CPT ® Code 99418	HCPCS Code GXXX1
▪ Prolonged inpatient or observation evaluation and management service(s) of 15 minutes beyond the **reported** time of the primary service (CPT® code 99223, 99233, 99236, 99255, 99306, 99310).	▪ Prolonged hospital inpatient or observation care evaluation and management service(s) with or without direct patient contact to **start** when 15 minutes beyond the **total** time for the primary service (either CPT® code 99223, 99233, 99236) is reached.
▪ Primary service selected based on time only (not medical decision making).	▪ Primary service selected based on time only (not medical decision making).
▪ With or without direct patient contact	▪ Reported for each 15-minute unit of service.
▪ Reported for each 15-minute unit of service.	▪ Total time is based on the CMS Physician Time File.
▪ May not be reported with Psychotherapy Services (90833, 90836, 90838), Prolonged Services before/after direct patient care (99358, 99359).	▪ May not be reported with other prolonged services for evaluation and management (99358, 99359, 99418, 99415, 99416).
▪ Reportable to **private payers only**, unless directed to use HCPCS code G2212.	▪ **Reportable to CMS only**, unless otherwise advised by a private payer.

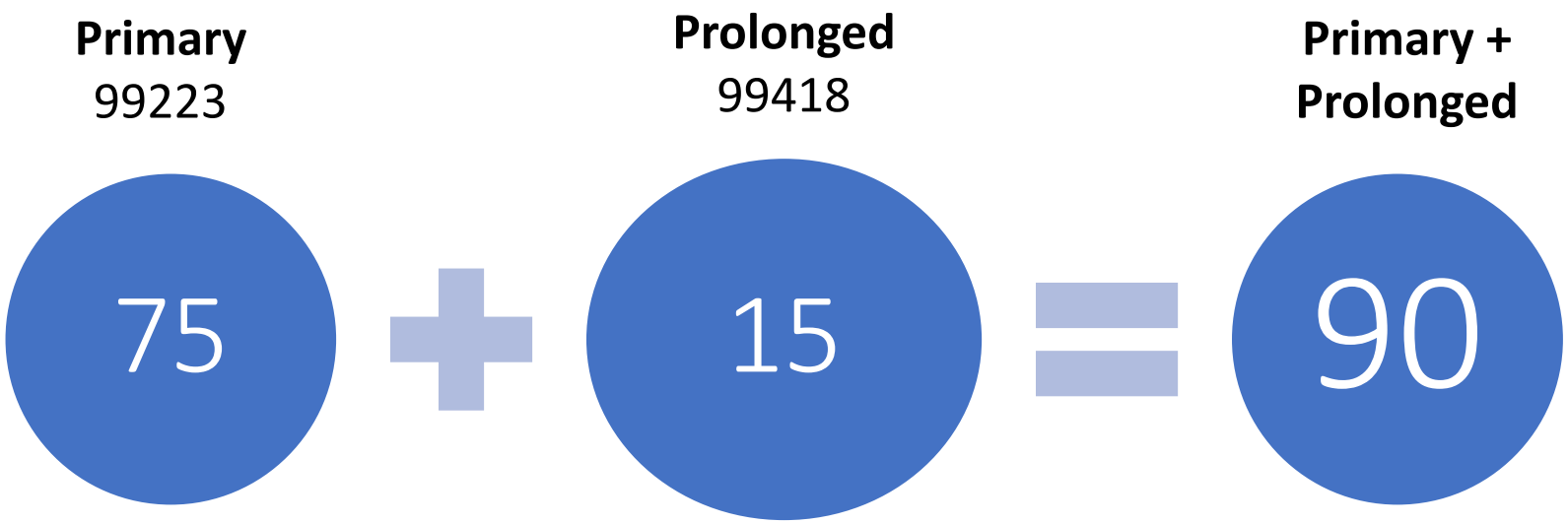
Prolonged Services Reporting Examples CPT vs. CMS

Primary Service

99223-Initial hospital inpatient or observation 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, **75 minutes** must be met or exceeded.

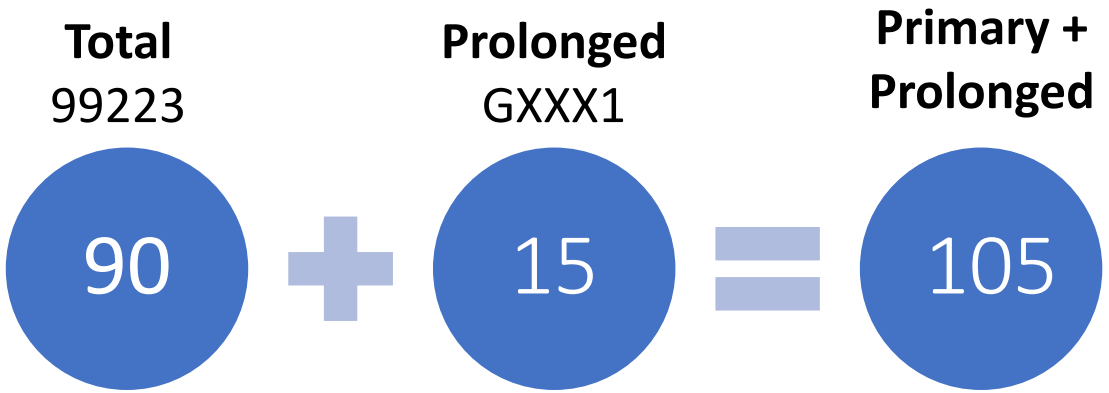
Prolonged Services
CPT® Guidelines

Prolonged service may begin when the required time for the primary service has been reached.



Prolonged Services
CMS Guidelines

Prolonged services starts when 15 minutes beyond the total time is reached.



*This is not final and requires additional clarification from CMS.

Reporting Prolonged Services Office and Outpatient

Report 99417, G2212 for prolonged office and outpatient services on date of the encounter.

Report 99415-99416 for prolonged clinical staff services.

Report 99358, 99359 for prolonged services related to professional services (including E/M) on a date other than the face-to-face encounter to which it is related

Prolonged Services: Deleted Codes

- Prolonged Services with Direct Patient Contact (99354-99357) have been deleted.

- CMS proposed to change status indicator of 99358, 99359 to inactive, making these codes invalid for Medicare purposes.

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Medical Decision Making

Elements of Medical Decision Making

Number and complexity of problems addressed.

Amount and complexity of data to be reviewed and analyzed.

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

To select the appropriate E/M code, **two** of the three elements of medical decision making must be met or exceeded.

CPT Codes	Level of MDM	Number and Complexity of Problems Addressed	Amount and Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202, 99212 99221, 99231, 99234 99242, 99252	Straightforward	Minimal	Minimal or None	Minimal risk
99203, 99213 99221, 99231, 99234 99243, 99253	Low	Low	Limited	Low risk
99204, 99214 99222, 99232, 99235 99244, 99254	Moderate	Moderate	Moderate	Moderate risk
99205, 99215 99223, 99233, 99236 99245, 99255	High	High	Extensive	High risk

Selecting a Code Based on MDM

Important Reminders:

- Code selection is based on TWO of the three elements of MDM.
- Selection must point back to the criteria as outlined on the MDM table.

Code Selection

Step 1 – Problem: Select the applicable number and complexity of problems addressed at the encounter.

- The number and complexity of complexity of problems addressed at the encounter is divided into four levels: minimal, low, moderate, and high.
- Each level has specific criteria for the conditions addressed.
- To correctly identify the appropriate level, it is important to understand the “problem” definitions.

New – Presenting Problem

Added -

Stable, acute illness: A problem that is new or recent and for which treatment has been initiated. Patient may be improved and stable, but resolution is not yet complete.

Example: Respiratory infection under treatment and monitored for resolution

– Presenting Problem

Added -

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: Short-term problem with low risk of morbidity with required treatment taking place in a hospital inpatient or observation level setting

Example: uncomplicated appendicitis

– Presenting Problem

REVISED

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.

Example: malignant pleural effusion requiring indwelling pleural catheter

– Presenting Problem

REVISED

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/injury with exacerbation/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.

Example: anaphylaxis, pulmonary embolism

Code Selection

Step 2 – Data: Select the amount and/or complexity of data to be reviewed or analyzed.

- Calculate the amount and complexity of data to be reviewed and analyzed.

- “Data” is defined as certain data elements that are ordered, reviewed, analyzed, or independently interpreted.

Code Selection: Calculating Data

- A unique test is defined by the CPT® set.
- Multiple results of the same test count as one unique test.
- Tests that have overlapping elements are not unique, even if they have distinct CPT codes.

Code Selection

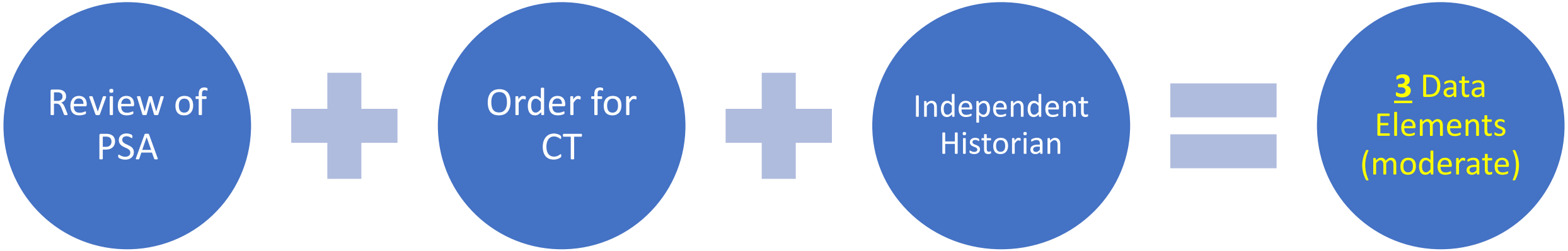
Combining and Counting Data Elements

- A combination of different data elements allows these elements to be summed.

- Does **not** require each item type or category to be represented.

Code Selection:
Combining and Counting Data Elements

Example: A patient with prostate cancer is seen. The physician reviews the latest PSA. At the visit, the patient states that he has no complaints. However, the patient's wife reports the patient is experiencing considerable pain in the hip. Considering this, the doctor orders a CT of the abdomen & pelvis to check for progression.



Code Selection

Step 3: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Risk associated with appropriate treatment rather than the condition itself.
- High risk of morbidity may include decisions regarding escalation of hospital-level care and parenteral controlled substances.

Let’s put it all together

- After the level of each of the categories is determined, the level of service for the evaluation and management code can be selected.

- Don’t forget: **Two** of the three elements must be met or exceeded to report the applicable E/M code

Let’s put it all together

Example 1: A moderate E/M code (99214) would be reported if:

1. A patient presented with a new progression of bone metastasis while under treatment for breast cancer (moderate problems addressed).
2. The physician reviewed the most recent CT scan (low level of data reviewed).
3. It is determined the patient will have a change in chemotherapy due to the progression. (moderate/high level of risk dependent on the chemotherapy plan).

Let’s put it all together

Example 2: A low-level E/M code (99203, 99213) would be reported if:

1. A patient presented with a stable history of breast cancer no longer on treatment (low level of problems addressed).
2. The physician conducted a review of tumor marker, CBC, CMP (moderate level of data reviewed).
3. A CT scan was ordered for the next visit (low level of risk of morbidity/mortality).

Are patients with cancer undergoing chemotherapy considered high risk?

A patient with cancer undergoing chemotherapy is not always considered high risk (“Drug therapy requiring intensive monitoring for toxicity”).

- Monitoring should not be for therapeutic levels but to assess side effects from treatment.
- A drug requiring monitoring for toxicity may have the potential to cause serious morbidity or death.
- Long-term monitoring should be performed at least on a quarterly basis.
- Monitoring is included in the MDM when it is considered as part of management of the patient.

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Time

Time: Face- to- Face and Non-Face to Face Activities

Preparing to see the patient (e.g., review of tests).
Obtaining and/or reviewing separately obtained history.
Ordering medications, tests, procedures.
Referring and communicating with other health care professionals (when not separately reported).
Documenting clinical information in the electronic or other health record.
Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
Care coordination (not separately reported).

Time: Activities <u>Not</u> Included

The performance of other services that are reported separately.

Travel.

Teaching that is general and not limited to discussion that is required for the management of a specific patient.

Activities not done on the date of the encounter.

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Reimbursement

Medicare Reimbursement: Overview

- Factors affecting 2023 E/M Reimbursement Rates
  - Conversation Factor decreasing by proposed 4.4% from $34.6062 to $33.0775.
  - Proposed updated RVUs and their components in 2023 resulting from CMS' adoption of the AMA CPT Editorial Panel's work on E/Ms
- 2023 values reflect the PROPOSED rule values and are subject to change. The final rule is expected this fall which will contact the final 2023 values.

Medicare RVU: Changes

Code Set	% Change	Average RVU Change
Office/Outpatient (99202-99215)	+.17%	0.00
Prolonged Services	+13.74%	.44
Hospital Services (99221-99239)		
• Inpatient	+3.07%	.19
• Observation	11.07%	.30
• Same Day	-5.66%	-.28

Medicare Reimbursement: Changes

Code Set	% Change	Average $ Change
Office/Outpatient (99202-99215)	-4.2%	-$3.85
Prolonged Services	+8.7%	+$2.39
Hospital Services (99221-99239)		
• *Inpatient*	-1.5%	-$1.53
• *Observation*	+6.1%	+$5.81
• *Same Day*	-9.8%	-$16.63

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Resources

Resources

American Medical Association

- E/M revisions to code descriptors and guidelines 2021-2023
- *Errata and Technical Corrections - CPT® 2021, September 3 2021.*
- 2022 and 2023 CPT® Professional Edition

CMS

- 2023 CMS Medicare Physician Fee Schedule Proposed Rule

Resources

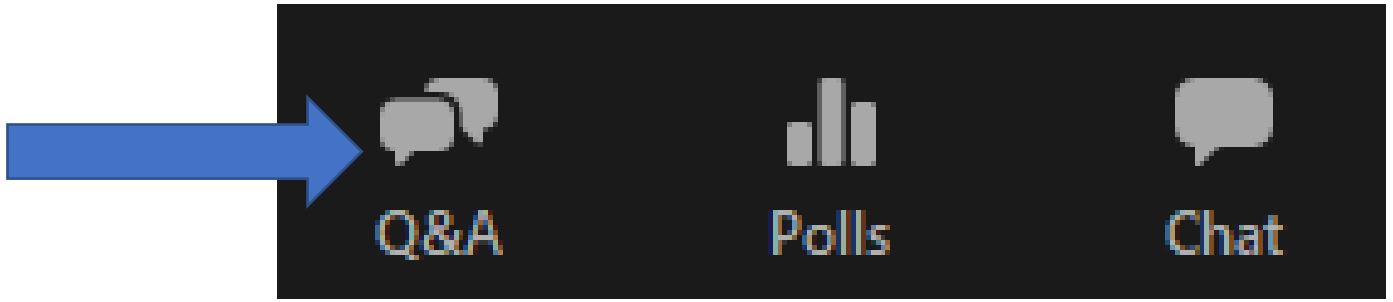
American Society of Clinical Oncology

ASCO Practice Central (practice.asco.org)

- ASCO's resources for the 2023 Changes:
  - Important Updates to Evaluation and Management Services in 2023
  - Selecting a Code Based on Time
  - Medical Decision Making Simplified
  - Inpatient, Observation, and Discharge
  - Consultations
  - Guideline Updates, Clarifications, and Corrections
  - Prolonged Services
  - Practice Tips
- ASCO’s Guide to the 2021 Evaluation and Management Changes

Feel free to submit questions

Use the Q&A button in the bar at the bottom of your Zoom window



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Next Calls

- 3rd Thursday of each month, 4:00 – 5:00pm ET
- November 17
  - The Medicare Physician Fee Schedule Final Rule & Outpatient Prospective Payment System

https://practice.asco.org/calendar