What's New in Coding for 2023?

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Did the E/M guidelines change again? Yes. However, the changes that the American Medical Association (AMA) made to their E/M Guidelines for 2023 have minimal impact in the office/urgent care setting.

The purpose of these changes is to roll out the new guidelines implemented in 2021 for all categories of E/M.

With these changes, the 1995/1997 guidelines will be completely retired. To view the published changes for 2023, visit www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

Problem Addressed

Two new options were added to the *Low* category of *Problem Addressed*:

- **1 stable, acute illness**
  "Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to the condition."
  This could be a patient that is coming in for a follow-up visit on an existing condition.

- **1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care**
  "Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting."
  This second option is for the hospital setting only.
  In addition to these new definitions, condition examples were removed from all definitions for *Problem Addressed*.

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Documentation

History and/or Examination

"E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service."

The words "when performed" are included in the guidelines for all categories of codes. This indicates that if a history or examination is not necessary, it does not need to be documented.

Keep in mind this history/exam information may be necessary to support the level of Problem Addressed or the medical necessity of tests counted towards Data Reviewed.

Time

When leveling based on time, the total time needs to appear in the actual medical record. The Centers for Medicare and Medicaid Services has suggested that the record also state that the level was selected based on time.

Independent Historian

The AMA clarified that a translator should not be counted as an independent historian. As the translator does not have a history or is involved in management of the patient, use of a translator does not count in the *Data Reviewed* section. However, the need for a translator could be a *Social Determinant of Health (SDoH)* in some instances. This could be a *Moderate* level of *Risk of Management*.

Shared/Split Visits

The AMA has the following definition for shared visits.

"A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified healthcare professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time.

Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)."

This definition does not align with the guidelines from the CMS on shared/split visits. Medicare policy is that shared visits are for the hospital setting only.

Changes By Category Of Codes

Consultations

The lowest level, 99241, was deleted in 2023.

Code	MDM	Time (Met or Exceeded)
99242	Straightforward	20 minutes
99243	Low	30 minutes
99244	Moderate	40 minutes
99245	High	55 minutes

Consultations are rarely performed in the urgent care setting. Most payers follow Medicare guidelines and do not reimburse for consultations.

Home Visits

The categories for domiciliary, rest home, and custodial care were deleted in 2023. Included is this deletion were codes 99324-99328, 99334-99337, 99339, and 99340. Services in these settings should be reported with the home visit codes. The Place of Service (POS) will identify the type of facility that the patient was located in.

Code 99343 will be deleted in 2023.

Code	Patient Type	MDM	Time (Met or Exceeded)
99341	New	Straightforward	15 minutes
99342	New	Low	30 minutes
99344	New	Moderate	60 minutes
99345	New	High	75 minutes
99347	Established	Straightforward	20 minutes
99348	Established	Low	30 minutes
99349	Established	Moderate	40 minutes
99350	Established	High	60 minutes

"Two add-on codes, meant to capture additional practice expense related to suture or staple removal not inherent to the E/M, were added for reporting suture removal not requiring anesthesia or sedation in the office or other outpatient site outside of the global period."

Nursing Facility Services

These codes are used by both the admitting physician and specialists. HCPCS modifier "AI" is required on the admitting physician claim to identify their role in the care of the patient.

Code 99318 will be deleted in 2023.

Code	Visit Type	MDM	Time (Met or Exceeded)
99304	Initial	Straightforward or Low	25 minutes
99305	Initial	Moderate	35 minutes
99306	Initial	High	45 minutes
99307	Subsequent	Straightforward	10 minutes
99308	Subsequent	Low	15 minutes
99309	Subsequent	Moderate	30 minutes
99310	Subsequent	High	45 minutes
99315	Discharge	N/A	30 minutes or less
99316	Discharge	N/A	More than 30 minutes

These codes are also used for skilled nursing facilities. The POS is used to report the type of facility where the service was performed. Nursing facility is POS 32; skilled nursing facility is POS 31.

The following definition was added for Problem Addressed; it is unique to nursing facilities:

"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."

This definition was added to identify a high-level Problem Addressed category that is specific to initial nursing facility care by the principal provider.

Prolonged Services

Existing face-to-face prolonged services codes 99354-

99357 were deleted for 2023.

Two options remain for reporting prolonged services in the office or home setting:

- 99417 – each 15-minute increment of time beyond the *minimum* time for 99205, 99215, 99345, or 99350
- G2212 (Medicare only) – each 15-minute increment of time beyond the *maximum* time for 99205, 99215, 99345, or 99350

A new prolonged services code, CPT 99418, was added for the inpatient, observation, or nursing facility setting.

Other prolonged services codes:

- 99358, +99359 – non-face-to-face service on a date other than the date of the E/M
- 99415, +99416 – prolonged clinical staff time under direct supervision of the physician or non-physician practitioner (NPP)

Suture Removal

Two add-on codes were added for reporting suture removal not requiring anesthesia or sedation in the office or other outpatient site outside of the global period.

These codes are meant to capture the additional practice expense related to suture or staple removal not inherent to the E/M code.

- +15853 Removal of sutures *or* staples not requiring anesthesia (List separately in addition to E/M code)
- +15854 Removal of sutures *and* staples not requiring anesthesia (List separately in addition to E/M code)

In 2022, when the only reason for the visit is a straightforward suture removal, the service is reported with a lower-level E/M (eg, 99212). If the visit includes evaluation beyond what is required for the suture removal, this would be reported with a higher-level E/M. Nothing would be reported additionally for the suture removal.

In 2023, practices should continue to report a lower-level E/M as you do today. However, if the patient is seen for another reason or the office visit is extensive (eg, the patient has an infection), add-on codes 15853 or 15854 should be reported in addition to the E/M.

These two new codes are always reported with an E/M. Codes 15853 or 15854 should not be reported by themselves.

Here's to a successful 2023. ■