

Breaking: AMA unveils anticipated E/M changes for facility-based services

by: [DecisionHealth Staff](#) Jul 5, 2022

The AMA set off its own fireworks during the Independence Day weekend with the early release of [new E/M guidelines](#) that will be included in the 2023 CPT manual and take effect Jan. 1, 2023.

Beginning on that date, the format for office and other outpatient visits (**99202-99215**) will apply to hospital inpatient and observation visits, consults, and services in the emergency department, nursing facility, home and residence. As a result, history and physical examination will no longer contribute to the level for these visits. Instead, for most visits practices will select codes based on medical decision-making (MDM) or time. The only exception will be emergency department visits, which will be MDM-only because the codes do not have a time component.

Among the most radical changes, the AMA plans to delete all observation care codes (**99217-99220, 99224-99226**) and merge observation services with initial and subsequent hospital care codes (**99221-99223, 99231-99233, and 99238-99239**).

For example, the description for code 99221 will state: "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 straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded."

In place of the observation discharge code (**99217**), coders will use hospital or observation discharge service codes (**99238-99239**) or codes **99234-99236** when admission and discharge of the patient occur on the same date.

More service guidelines and MDM updates

The guidelines include a revised definition of "New and Established Patients" that includes this addition: "In the instance where a physician or other qualified health care professional is on call for or covering for another physician or qualified health care professional, the patient's encounter will be classified as it would have been by the physician or qualified health care professional who is not available."

You'll also find a new definition of "Initial and Subsequent Services" for patients who have been admitted to hospital inpatient, observation or nursing facilities. In effect, the initial care codes apply when the patient has received no face-to-face services "from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay," the guidelines state.

The update includes revisions to the MDM chart. Under low complexity of problems addressed, "1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care," will be added to the list. In addition, there are two revisions to the examples for high risk of morbidity. Parenteral controlled substances will be added to the list of examples and "Decision regarding hospitalization" will be revised to "Decision regarding hospitalization or escalation of hospital-level care."

Practices should note that the AMA did not use time ranges for codes that do have a time component. Under the new guidelines a specific number of minutes "must be met or exceeded."

The update also means that the CPT definition of split/shared services will apply to services that are coded based on time. It remains to be seen whether CMS will update its rules for billing split (or shared) services to match up with the CPT guidelines.

The general guidelines provide more clarity on when a decision to hospitalize a patient applies. According to the update, "the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient."

Other changes of note include:

- Level 1 consultations (**99241** and **99251**) will be deleted so the codes align with the four levels of MDM. The AMA also cleaned up the guidelines for consult codes, for example, getting rid of "confusing guidelines, including the definition of 'transfer of care,'" according to a notice on the AMA website.
- Domiciliary, rest home and custodial care codes (**99234-99340**) will be deleted. Instead, these services will be reported with the home visit codes (**99341-99350**), which will be revised to describe services in the home or other residences.
- Annual nursing facility assessment code **99318** will be deleted. Instead, the service will be reported with the subsequent nursing facility care service codes (**99307-99310**). Code descriptors for the nursing facility codes will be revised throughout to reflect the code structure of the office visit codes.
- The guidelines add a new prolonged service code for total face-to-face and non-face-to-face time "provided by the physician or other qualified health care professional on the date of an inpatient evaluation and management service," such as hospital inpatient or observation care and nursing facility services.

- Prolonged service codes for outpatient services (**99354-99355**) and inpatient services (**99356-99357**) will be deleted. When appropriate, practices will report prolonged service code 99417 with outpatient codes and the new prolonged service code with inpatient codes.

Editor's note: This is a breaking news story. Stay tuned to Part B News for additional coverage and analysis.