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CME

The 2023 Hospital and Nursing Home E/M Visit Coding Changes

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A step-by-step approach that saves time coding E/M office visits can now be tailored to hospital and nursing home E/M visits as well.

Following the major revisions to coding evaluation and management (E/M) office visits in 2021,[1] a similar revamp has been made for coding E/M visits in other settings. Effective Jan. 1, 2023, the history and physical examination requirements have been eliminated for coding hospital and nursing home visits.[2] As with office visits, hospital and nursing home coding is now based solely on medical decision making (MDM) or total time (except for emergency department visits, which must be coded based on MDM, and hospital discharge visits, which must be coded based on time). This further streamlines E/M coding, creating one unified set of rules for office, nursing home, and hospital visits.

Hospital and nursing home E/M visits are divided into three groups: initial services (i.e., admissions), subsequent services, and discharge services. According to the American Medical Association

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(AMA), initial visits are "when the patient has not received any professional 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."[2] After the patient has received care from that group once, all other visits are subsequent until the discharge service. When the patient transitions from inpatient to observation, or vice versa, that does not begin a new stay eligible for an initial services visit.

CPT codes 99234-99236 are for patients admitted to the hospital and discharged on the same date. For patients with multi-day stays, use 99221-99223 for initial services, 99231-99233 for subsequent visits, and 99238-99239 for discharge services.

Initial nursing home visits are coded with 99304-99306. CPT is deleting the code for nursing home annual exams (99318), which will instead be coded as subsequent nursing home visits (99307-99310).

Two sets of observation care codes (99217-99220 and 99224-99226) should no longer be used as of Jan. 1. Observation services have instead been merged into the corresponding initial service, subsequent service, and discharge codes.

These changes open the door to a simpler, quicker coding process. Many of the principles that already apply to E/M office visit coding now apply to hospital and nursing home E/M coding, but there are some differences in the details. This short guide can help physicians navigate the changes.

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MEDICAL DECISION MAKING

Determining the level of MDM for hospital and nursing home visits is now much like doing so for office visits.[3] The four MDM levels are straightforward, low, moderate, and high. They are determined by three factors: the number and complexity of problems addressed, the amount and complexity of data reviewed, and the patient's risk of complications, morbidity, or mortality.

If you feel confident coding office visits based on MDM, you can use that knowledge to code hospital and nursing home visits based on MDM as follows:

- A level 1 initial or subsequent hospital visit requires the same MDM components as a level 3 office visit,

UNIVERSAL CODING TEMPLATE

Follow these steps to quickly code E/M visits in the office, hospital, or nursing home.

Step 1: Total time	Straightforward-level visit	Low-level visit	Moderate-level visit	High-level visit
Office (established)	99212: 10-19 min	99213: 20-29 min	99214: 30-39 min	99215: 40-54 min
Office (new)	99202: 15-29 min	99203: 30-44 min	99204: 45-59 min	99205: 60-74 min
Hospital (initial, i.e., admits)		99221: 40 min or more	99222: 55 min or more	99223: 75 min or more
Hospital (admit/discharge same day)		99234: 45 min or more	99235: 70 min or more	99236: 85 min or more
Hospital (subsequent)		99231: 25 min or more	99232: 35 min or more	99233: 50 min or more
Hospital (discharge)		99238: 30 min or less	99239: 31 min or more	
Nursing home (initial)		99304: 25 min or more	99305: 35 min or more	99306: 45 min or more
Nursing home (subsequent)	99307: 10-14 min	99308: 15 min or more	99309: 30 min or more	99310: 45 min or more

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Step 2: MDM problems plus

Straightforward problems	Low-level problems	Moderate-level problems	High-level problems
1 minor or self-limited problem (e.g., simple rash)	2 or more minor or self-limited problems	New problem with uncertain prognosis (e.g., breast lump)	
	1 stable chronic illness (e.g., hypertension, diabetes, asthma, COPD, chronic kidney disease, coronary artery disease)	2 stable chronic illnesses or 1 unstable chronic illness	Life-threatening unstable chronic illness (e.g., severe COPD, asthma)
	Acute illness – uncomplicated (e.g., sinusitis, sore throat, UTI)	Acute illness – systemic symptoms (e.g., pneumonia, colitis, pyelonephritis)	Life-threatening acute illness (e.g., heart attack, pulmonary embolism, acute kidney injury, stroke, depression w/ suicidal ideation)
	Injury – uncomplicated (e.g., simple ankle sprain)	Injury – complicated (e.g., head injury w/ brief loss of consciousness)	Life-threatening injury
PLUS			
	Recommending an over-the-counter medication or prescription drug management (deciding to prescribe, alter, or continue a prescription medication)	Prescription drug management (If moderate-level problem PLUS simple data, see Step 3.) (If moderate-level problem PLUS counting data points, see Step 4.)	Decision to: • Hospitalize an office or nursing home patient • Escalate hospital care (e.g., transfer to ICU) • Deescalate care/DNR due to poor prognosis • Use IV narcotics or other drugs requiring intensive monitoring • Recommend emergency surgery (all patients) or non-emergency surgery for patients w/ risk factors OR: Interpret study (e.g., "I personally looked at the x-ray, and it shows …") *plus* review/order three tests (If high-level problem PLUS counting data points, see Step 4.)
EQUALS*			
Straightforward visit (level 2 in office, no hospital equivalent): • 99212: Office (established) • 99202: Office (new) • 99307: Nursing home (subsequent)	Low-level visit (level 3 in office, level 1 hospital/nursing home): • 99213: Office (established) • 99203: Office (new) • 99221: Hospital (initial) • 99234: Hospital (admit/discharge same day) • 99231: Hospital (subsequent) • 99304: Nursing home (initial) • 99308: Nursing home (subsequent)	Moderate-level visit (level 4 in office, level 2 hospital/nursing home): • 99214: Office (established) • 99204: Office (new) • 99222: Hospital (initial) • 99235: Hospital (admit/discharge same day) • 99232 Hospital (subsequent) • 99305: Nursing home (initial) • 99309: Nursing home (subsequent)	High-level visit (level 5 in office, level 3 hospital/nursing home): • 99215: Office (established) • 99205: Office (new) • 99223: Hospital (initial) • 99236: Hospital (admit/discharge same day) • 99233 Hospital (subsequent) • 99306: Nursing home (initial) • 99310: Nursing home (subsequent)

* Codes 99238 and 99239 for hospital discharge are based on time only. They cannot be reported using medical decision making.

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Step 3: MDM with simple data

Moderate-level problem PLUS one of the following:

- Interpret one study (e.g., "I personally looked at the x-ray, and it shows …"),
- Discuss patient management or a study with an external physician (one who is not in the same group practice as you or is in a different specialty or subspecialty),
- Modify workup or treatment because of social determinants of health.

EQUALS moderate-level visit, even without medication management (see codes in Step 2).

Step 4: MDM counting data points

Moderate-level problem PLUS at least three points from data counting (below).

EQUALS moderate-level visit (see codes in Step 2).

High-level problem PLUS at least two of these three:

- Interpret one study (e.g., "I personally looked at the x-ray, and it shows …"),
- Discuss patient management or a study with an external physician,
- At least three points from data counting (below).

EQUALS high-level visit (see codes in Step 2).

Data counting:

- Review/order unique test/study: 1 point for each,
- Review external notes: 1 point for each unique source,
- Assessment requiring use of an independent historian (family member or other person who can provide a reliable history for a patient who is unable to): 1 point max.

• A level 2 initial or subsequent hospital visit requires the same MDM components as a level 4 office visit,

• A level 3 initial or subsequent hospital visit requires the same MDM components as a level 5 office visit.

Several medical decisions that are more common in hospitals than office settings carry enough risk that, when paired with high-level problems, they call for the top visit level. These include the decision to escalate hospital care (e.g., transfer to the intensive care unit), the decision to deescalate care or discuss do-not-resuscitate orders due to poor prognosis, the decision to use IV narcotics or other drugs that require intensive monitoring, and decisions regarding emergency surgery for patients with or without risk factors or non-emergency surgery for patients with risk factors.

TOTAL TIME

There are new time thresholds for each level of service for initial hospital visits, subsequent hospital visits, and nursing home visits to use when you are coding by total time. Instead of offering a time range like office visits (e.g., a 99214 office visit requires 30-39 minutes), nursing home and hospital care visits require that you meet or exceed specific times (e.g., a 99232 subsequent hospital visit requires 35 *or more* minutes).

When coding initial hospital visits by total time, you can count all the time you spend caring for the patient on admission even if some of it extends after midnight on the calendar day of the admission. According to the AMA, "a continuous service that spans the transition of two calendar dates is a single service and is reported on one calendar date. If the service is continuous before and through midnight, all the time may be applied to the reported date of service."[3] This differs from office visits, for which you may count only the time on the date of the visit. Otherwise, the definition of total time for hospital and nursing home E/M visits is similar to that of office visits. It includes the time you personally spend on E/M for that patient before, during, and after the face-to-face services. It does not include staff time,

KEY POINTS

- Coding for evaluation and management (E/M) visits in hospitals and nursing homes is now much like coding E/M office visits.
- This unified set of coding rules allows physicians to quickly code nearly all visits using a template that starts with total time.
- There are a few key differences to be aware of, such as total time spent past midnight on the date of service can be counted for hospital E/M visits, but not for office E/M visits.

time spent on separately reportable procedures, travel time, or teaching time.

A SIMPLER WAY TO CODE

Like the 2021 changes to office visit E/M coding, the 2023 changes should make coding hospital and nursing home E/M visits simpler and quicker.

The universal coding template (see pages 9-11 or download as a PDF at https://www.aafp.org/pubs/fpm/issues/2023/0100/hospital-em-coding.html) suggests coding by time first if that will appropriately credit you for the work you did. It's the most straightforward and easy method. But if you believe MDM will credit you for a higher level of work, then step 2 is to determine what level of problems (low, moderate, or high) you addressed and whether you managed (prescribed, adjusted, or decided to keep the same) a prescription medication. Answering those two questions allows you to code most visits quickly using MDM. For the few visits that remain, you will need to proceed to steps 3 or 4, which may require you to tally data points and are therefore more time-consuming.

The template was adapted from a prior *FPM* article on office E/M coding[4] by adding nursing home and hospital visit times and relabeling office-visit level 3, 4, and 5 problems as low-, moderate-, and high-level problems.

Documentation to support your coding should also be easier going forward. While documenting a medically appropriate history and physical exam is still certainly important for good patient care, it's no longer required for coding; therefore, you should be able to determine the code level from only a few lines of documentation. The quiz below provides some examples to pair with the coding template for practice.

Hopefully, using this step-by-step approach to the 2023 E/M coding changes will allow you to code many types of visits more quickly and accurately so you can spend more time with your patients and less time on the computer. FPM

1. Millette KW. Countdown to the E/M coding changes. *Fam Pract Manag*. 2020;27(5):29-36.

2. CPT evaluation and management (E/M) code and guideline changes. American Medical Association. Accessed Nov. 2, 2022. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

3. Table 2 - CPT E/M office revisions level of medical decision making (MDM). American Medical Association. Accessed Nov. 2, 2022. https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

4. Millette KW. A step-by-step time-saving approach to coding office visits. *Fam Pract Manag*. 2021;28(4):21-26.

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DOCUMENTATION AND CODING QUIZ

Assessment/plan documentation	Answer choices (circle correct code)
1. Nursing home subsequent visit: "Dementia worsening, start donepezil."	99307, 99308, 99309, 99310
2. Nursing home subsequent visit: "Acute pneumonia … Total time spent caring for the patient today was 45 minutes. Total time includes time spent reviewing the chart, speaking to the nurse, talking to the family, seeing the patient, and documenting care."	99307, 99308, 99309, 99310
3. Nursing home admission (initial visit): "Total time spent admitting the patient today was 40 minutes."	99304, 99305, 99306
4. Hospital admission (initial visit): "Acute MI … I personally looked at the chest x-ray and it shows no cardiomegaly, effusions, or infiltrates … K 3.2, Troponin I 3.4, Hgb 11."	99221, 99222, 99223
5. Hospital subsequent visit: "New-onset acute respiratory failure, transfer to ICU."	99231, 99232, 99233
6. Hospital subsequent visit: "Diabetes worsening, increase insulin."	99231, 99232, 99233
7. Hospital observation (admit/discharge on the same day): "ACS ruled out. Total time spent caring for the patient today was 90 minutes."	99234, 99235, 99236

Answer key:

1. 99309 (Unstable chronic illness + medication management = moderate-level nursing home visit)
2. 99310 (45 minutes or more of total time = high-level nursing home visit)
3. 99305 (35 minutes or more of total time spent = moderate-level nursing home admission)
4. 99223 (Acute life-threatening illness + interpretation of study and order/review 3 tests = high-level hospital admission)
5. 99233 (Acute life-threatening illness with decision to escalate care = high-level hospital subsequent visit)
6. 99232 (Chronic illness worsening + medication management = moderate-level hospital subsequent visit)
7. 99236 (85 or more minutes spent on hospital admit/discharge same day = high-level hospital same-day admit/discharge)