Baptist Health Medical Group
BAPTIST HEALTH SOUTH FLORIDA

The Clinician Edition

BHMG Physician Practice E&M Audit and Coding Education Department — November 2022

E&M Coding Education Questions?
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SPECIAL PROVIDER EDUCATION SERIES
Part 3

New Rules for Inpatient E&M Visits
Effective January 1, 2023

The new 2023 CMS Final Rule has established new documentation and coding rules for the inpatient E&M setting. These new rules affect both the documentation and the code category that a provider will utilize. The new changes will be effective on January 1, 2023 and will dictate the context and quality of the inpatient encounter.

CMS states that inpatient visits will follow the same guidelines as 2021 Office. In addition, the some of the traditional inpatient code categories will be deleted and consolidated under one. If you have been providing services to office patients, then adopting these current guidelines to your hospital patient will be easy.

How to Document your Inpatient E&M Visits: effective Jan 1, 2023.

A ***Comprehensive*** History or Exam is no longer needed for any of the inpatient initial admission codes. The only requirement for this category of service is a "medically appropriate" history and exam. These CMS new rules do not state that a history and exam is no longer needed, but the necessity to document unrelated elements is no longer needed. The level of the documentation will be determined by the provider based on the presenting problem.

Remember, a patient's note supports your cognitive labor and medical necessity of the service **you** provided, therefore Medical Decision Making (MDM), aka Assessment and Plan, or TIME will be the only determining factors for E&M services. MDM documentation will now support additional elements, supportive actions, and risk for your documented treatment plan.

For An Inpatient Shared Visit

For a "shared visit", ~~then~~ one clinician would perform and document the history and exam (medically appropriate) and the other provider would perform and document the MDM (Assessment and Plan), either low, straightforward, moderate, or high.

- **The substantive portion of a shared visit MUST be met by the billing provider. For Baptist Health South Florida, we have decided that MDM (Assessment/Plan) would be the component that our providers will utilize for all shared visits (Inpatient or Outpatient status)**
- **The provider that performs the MDM DOES NOT need to perform this key component in person!**
  - **Only 1 of the 2 providers are required to perform the face-to-face portion of the visit**
- If the Shared Visit is based on TIME:
  - **Each clinician MUST document their time separately within the body of the note and the provider with at least the most time would be the billing provider.**

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Inpatient Admission/Observation Codes- Only based on MDM or Time

Initial Inpatient Code	Previous History/Exam	New 2023 Guidelines History and Exam	Medical Decision Making	New Time Factor
99221	Detailed	Medically Appropriate	Straightforward/ Low	40 minutes
99222	Comprehensive	Medically Appropriate	Moderate	55 minutes
99223	Comprehensive	Medically Appropriate	High	75 minutes

What else is new?... Deleted Codes:

- Observation Discharge (E&M code 99217)
- Hospital Initial Observation Services (E&M codes: 99218—99220)
- Subsequent Observation Codes (E&M codes: 99224-99226)
- Consultation E&M codes (99241 and 99251)
- Prolonged Services E&M codes (99354-99357)

Stay tuned for additional details regarding the CMS 2023 E&M changes and educational opportunities from the BHMG Coding Education Team!

IMPORTANT CHANGE

Initial Observation E&M (99218-99220) services as of January 1, 2023, will be coded under the Initial Admission codes (99221—99223).

Additional CMS changes that will be implemented in CY2023 include:

New Activities for TIME (Face-to-Face and Non-Face-to-Face)

The following bulleted points can be performed and documented as the reason for total time spent on date of encounter as face-to-face or non-face-to-face):

1. Reviewing patient's record prior to visit
2. Obtaining/reviewing separately obtained history from someone other than patient
3. Performing a medically appropriate history and examination
4. Counseling/educating the patient/family/caregiver
5. Ordering prescription medications, tests, or procedures
6. Referring and communicating with another healthcare provider(s) when not separately reported during the visit
7. Documenting clinical information in the patient's electronic health record
8. Independently interpreting results
9. Communicating results to the patient/family/caregiver
10. Coordination of care for the patient

Stay tuned for additional details and educational opportunities from the BHMG Coding Education Team!