CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11842	**Date: February 9, 2023**
	Change Request 13064

SUBJECT: Internet-Only Manual (IOM) Updates to Pub. 100-04, Chapter 12 for the New Hospital Inpatient or Observation Care Code Family, Nursing Facility Visits Code Family, Billing the Substantive Portion of a Split (or Shared) Visit, Changes for Prolonged Services, and Updates to the IOM with Policies Finalized for Office/Outpatient E/M Visits in the CY2020 and CY2021 Final Rules

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet-Only Manual with billing instructions for the new Hospital Inpatient or Observation Care code family to align with the Hospital Inpatient or Observation Care policy published in the CY 2023 Final Rule (CMS-1770-F), titled: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023.

An additional purpose of this Change Request is to update the Internet-Only Manual with billing instructions for the Nursing Facility Visits code family to align with the Nursing Facility Visits policy published in the CY 2023 Final Rule (CMS-1770-F), titled: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023.

The last purpose of this Change Request is to update the Internet-Only Manual with billing instructions for billing the substantive portion of a split (or shared) visit. Given the delayed implementation of our substantive portion policy until CY 2024, our current policy remains in place. As such, when an E/M visit requires a medically appropriate history and/or physical exam, in accordance with its code descriptor, these service element(s) can qualify as the substantive portion, when performed.

In addition, we are updating the IOM with policies finalized for office/outpatient E/M visits in the CY2020 (CMS-1715-F) and CY2021 Final Rules (CMS-1734-F).

We are also updating changes for prolonged services.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 9, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30/30.6/Evaluation and Management Service Codes - General (Codes 99202 - 99499)
R	12/30/30.6.7/Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215)
R	12/30/30.6.8/Payment for Hospital Observation Services
R	12/30/30.6.9/Payment for Inpatient Hospital Visits - General
R	12/30/30.6.9.1/Payment for Initial Hospital Inpatient or Observation Care Services and Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)
R	12/30/30.6.9.2/Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management (Codes 99231 99239)
R	12/30/30.6.13/Nursing Facility Services
R	12/30/30.6.15/Prolonged Services, Standby Services, and Evaluation and Management Service for Power Mobility Devices (PMDs) (G0372)
R	12/30/30.6.15.1/Prolonged Services – General Rules
R	12/30/30.6.15.2/Prolonged Office/Outpatient E/M Visits
R	12/30/30.6.15.3/Prolonged Other E/M Visits
R	12/30/30.6.18/Split (or Shared) Visits

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11842	Date: February 9, 2023	Change Request: 13064

SUBJECT: Internet-Only Manual (IOM) Updates to Pub. 100-04, Chapter 12 for the New Hospital Inpatient or Observation Care Code Family, Nursing Facility Visits Code Family, Billing the Substantive Portion of a Split (or Shared) Visit, Changes for Prolonged Services, and Updates to the IOM with Policies Finalized for Office/Outpatient E/M Visits in the CY2020 and CY2021 Final Rules

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 9, 2023

I. GENERAL INFORMATION

A. Background: Beginning in 2023, the two Evaluation and Management (E/M) visit families that were titled "Inpatient", or "Observation" have been merged into one E/M code family. The new family is titled "Hospital Inpatient or Observation Care," and the codes in this family will be used to report E/M services provided to a patient. There are no changes to the included care settings from each respective family, rather the current care settings for each of the current families are being included within the new, merged family.

Beginning January 1, 2023, the CPT code, Other Nursing Facility Service (99318), has been deleted and is no longer used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. Effective for dates of service on and after 1-1-2023, for Medicare Part B payment policy, the regular code set for Nursing Facility Services shall be used. This incorporates CPT coding updates and updates to the CPT E/M Guidelines.

Additionally, beginning in 2023, we finalized our proposed policy to delay implementation of our definition of the substantive portion as more than half of the total practitioner time until January 1, 2024. There are no changes to the current split (or shared) visit policy other than the definition of 'substantive portion'.

Material is also being added to update the office/outpatient sections of the manual that were effective in CY 2021 and changes for prolonged services.

B. Policy: This CR updates the Internet-Only Manual with billing instructions for the new Hospital Inpatient or Observation Care code family to align with the Hospital Inpatient or Observation Care policy published in the CY 2023 Final Rule (CMS-1770-F), titled: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023.

This CR also updates the Internet-Only Manual with billing instructions for the Nursing Facility Visits code family to align with the Nursing Facility Visits policy published in the CY 2023 Final Rule (CMS-1770-F), titled: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023.

Additionally, this CR will update the Internet-Only Manual with billing instructions for billing the substantive portion of a split (or shared) visit. Given the delayed implementation of our substantive portion policy until CY 2024, our current policy remains in place. As such, when an E/M visit requires a medically appropriate history and/or physical exam, in accordance with its code descriptor, these service element(s) can qualify as the substantive portion, when performed.

Lastly, CMS is updating the IOM with policies finalized for office/outpatient E/M visits in the CY2020 (CMS-1715-F) and CY2021 Final Rules (CMS-1734-F).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13064.1	Contractors shall be aware of the updates listed in this CR for Chapter 12 of Pub. 100-04.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13064.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ann Marshall, 410-786-3059 or Ann.Marshall@cms.hhs.gov , Patrick Sartini, 410-786-9252 or Patrick.Sartini@cms.hhs.gov , Kris Corwin, 410-786-8864 or Kristopher.Corwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev.11842)

Transmittals for Chapter 12

30.6 - Evaluation and Management Service Codes - General (Codes 9920*2* - 99499)
(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

30.6.1 - Selection of Level of Evaluation and Management Service
Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. General Rules

Advise physicians to *generally* use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management *(E/M)* services. *Medicare has created Medicare-specific codes that must be used to report prolonged E/M services and E/M visit complexity add-on services.*

Medicare will pay for E/M services for specific, non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS), and certified nurse midwife (CNM)), whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service; however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary, and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level of Evaluation and Management Service

As of January 1, 2023, for most E/M visit families, practitioners will select visit level based on the level of medical decision making (MDM) or the amount of time spent by the physician or non-physician practitioner. For some types of visits (such as emergency department visits and critical care), in accordance with their CPT codes, practitioners do not have this choice and will use only MDM or only time to bill. The CPT E/M Guidelines for MDM apply. For all E/M visits, history and physical exam must be performed in accordance with code descriptors, but history and exam no longer impact visit level selection. When practitioner time is used to select visit level, the full time must be completed; the general CPT rule regarding the midpoint for certain timed services does not apply.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of an E/M visit code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the Medicare Administrative Contractor (MAC) at the appropriate physician fee schedule amount based on the rendering national provider identifier (NPI) number.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

See section 30.6.18 for rules regarding billing of E/M visits that are split (or shared).

30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 9920*2* - 99215)

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Definition of New Patient for Selection of E/M Visit Code

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

B. Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, the Medicare Administrative Contractors (MACs) may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility

MACs may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician *(see section on Nursing Facility Services below).*

D. Drug Administration Services and E/M Visits Billed on Same Day of Service

MACs must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

E. Prolonged Office/Outpatient E/M Visits

When the practitioner selects office/outpatient E/M visit level using time, the practitioner reports prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). See Prolonged Services section for additional information.

F. Add-On Code for Office/Outpatient E/M Visit Complexity

Beginning January 1, 2021, Medicare established HCPCS add-on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition.

HCPCS code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).

The Consolidated Appropriations Act, 2021 delayed PFS payment for this code until January 1, CY 2024 or later. Practitioners may report this code for qualifying visits furnished on or after January 1, 2021, although we assigned a PFS payment status indicator of "B" (Bundled) until 2024.

• HCPCS code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

• Reporting is not restricted based on specialty, but certain specialties will likely furnish these types of visits more than other specialties. HCPCS code G2211 may be reported with any visit level.

• Example 1: In the context of primary care, HCPCS code G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team.

• Example 2: In the context of specialty care, HCPCS code G2211 could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill, and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals.

• Example 3: We do not expect reporting of HCPCS code G2211 when the office/outpatient E/M visit is reported with payment modifiers such as a modifier -24, -25, or -53.

G. Medical Review When Practitioners Use Time to Select Visit Level

Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.

30.6.8 - Payment for Hospital Observation Services

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Who May Bill Observation Care Codes

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital

following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

A/B MACs (B) pay for initial observation care billed by only the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care. A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.

For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

For information regarding hospital billing of observation services, see Chapter 4, §290.

B. Physician Billing for Observation Care Following Initiation of Observation Services

Starting in CY 2023, hospital inpatient and observation care by practitioners will be billed using the same CPT codes, CPT codes 99221 through 99223, 99231 through 99233, and 99238 and 99239. (CPT 99234 through 99236 are already used for billing hospital inpatient or observation care (including admission or discharge.) Although observation care codes (CPT codes 99218 through 99220 and 99224 through 99226) are being deleted, practitioners will still be able to furnish and bill for observation services using the revised Hospital Inpatient or Observation Care Services code set. Where noted, the term "observation care code" applies to Hospital Inpatient or Observation Care Services codes (CPT codes 99221-99223, 99231-99239.)

The time counted toward the Hospital Inpatient or Observation Care codes is "per day." "Per day," also referred to as "date of encounter," means the "calendar date." When using MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous, before and through midnight, all the time may be applied to the reported date of the service (that is, the calendar date the encounter began).

A billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The practitioner selects a code that reflects all of the practitioner's services provided during the date of the service. The definitions of "initial visit" and "subsequent visit" for the purposes of billing observation care using the Hospital Inpatient or Observation Care Services codes can be found in section 30.6.9.E. Note also, that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; refer to section 30.6.9.F.)

Observation care codes are billed by the treating practitioner. All other *practitioners* who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For additional guidance for billing observation care using the Hospital Inpatient or Observation Care Services code set, CPT codes 99221-99223, 99231-99239, refer to sections 30.6.9.1 and 30.6.9.2, where specified.

For additional guidance for billing prolonged Hospital Inpatient or Observation Care, refer to section 30.6.9.15.

C. Documentation Requirements for Billing *Hospital Inpatient or Observation* Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for *medically appropriate history and/or examination,* and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

D. Admission to Inpatient Status Following Observation Care

For the purposes of reporting an initial hospital inpatient or observation care service, a transition from observation status to inpatient status does not constitute a new stay.

If the same physician who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial or subsequent observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from hospital outpatient observation care subsequent to the date of initiation of observation services, the physician must bill a *subsequent hospital inpatient or observation care code* for the services provided on that date. The physician may not bill the hospital *inpatient or* observation discharge management code (*CPT codes 99238-99239*) or an outpatient/office visit for the care provided while the patient received hospital outpatient observation services on the date of admission to inpatient status.
Note that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; time spent by the same practitioner on the same day for the same patient in multiple settings (or for a patient who transitions between outpatient and inpatient status) may be counted toward the Hospital Inpatient or Observation Care Services base code and, if applicable, a prolonged code. Refer to section 30.6.9.F.)

E. Hospital Observation Services During Global Surgical Period

The global surgical fee includes payment for hospital observation *care* services unless the criteria for use of CPT modifiers "-24," "-25," or "-57" are met. A/B MACs (B) must pay for these services in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with CPT modifiers "-24," "-25," or "-57" (decision for major surgery); and

- The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

Examples of the decision for surgery during a hospital observation period are:

- An emergency department physician orders hospital outpatient observation services for a patient with a head injury. A neurosurgeon is called in to evaluate the need for surgery while the patient is receiving observation services and decides that the patient requires surgery. The surgeon would bill a new or established office or other outpatient visit code as appropriate with the "-57" modifier to indicate that the decision for surgery was made during the evaluation. The surgeon must bill the office or other outpatient visit code because the patient receiving hospital outpatient observation services is not an inpatient of the hospital. Only the physician who ordered hospital outpatient observation services may bill for observation care.

- A neurosurgeon orders hospital outpatient observation services for a patient with a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation code with the "-57" modifier to indicate that the decision for surgery was made while the surgeon was providing hospital observation care.

Examples of hospital observation services during the postoperative period of a surgery are:

- A surgeon orders hospital outpatient observation services for a patient with abdominal pain from a kidney stone on the 80th day following a TURP (performed by that surgeon). The surgeon decides that the patient does not require surgery. The surgeon would bill the observation code with CPT modifier "-24" and documentation to support that the observation services are unrelated to the surgery.

- A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 80th day following a TURP (performed by that surgeon). While the patient is receiving hospital outpatient observation services, the surgeon decides that the patient requires kidney surgery. The surgeon would bill the observation code with HCPCS modifier "-57" to indicate that the decision for surgery was made while the patient was receiving hospital outpatient observation services. The subsequent surgical procedure would be reported with modifier "-79."

- A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 20th day following a resection of the colon (performed by that surgeon). The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

An example of a billable hospital observation service on the same day as a procedure is when a physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient. The physician would bill the observation code with a CPT modifier 25 and the procedure code.

30.6.9 - Payment for Inpatient Hospital Visits - General

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Starting in CY 2023, hospital inpatient and observation care by practitioners will be billed using the same CPT codes, CPT codes 99221 through 99223, 99231 through 99233, and 99238 and 99239. (CPT 99234 through 99236 are already used for billing hospital inpatient or observation care (including admission or discharge.) Where they appear, references such as "hospital care," "hospital E/M" or "hospital inpatient care services" in this section apply to Hospital Inpatient or Observation Care Services codes (CPT codes 99221-99223, 99231-99239.)

A. Hospital Visit and Critical Care on Same Day

Hospital evaluation and management (E/M) visits may be billed the same day as critical care services in certain circumstances discussed in section 30.6.12. Documentation must support the claims as indicated in that section.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231 - 99233.

Both Initial Hospital Care (CPT codes 99221 - 99223) and Subsequent Hospital Care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

B. Two Hospital Visits Same Day

The time counted toward the Hospital Inpatient or Observation Care codes is "per day." "Per day," also referred to as "date of encounter," means the "calendar date." When using MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous, before and through midnight, all the time may be applied to the reported date of the service (that is, the calendar date the encounter began).
A billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The practitioner selects a code that reflects all of the practitioner's services provided during the date of the service. The definitions of "initial visit" and "subsequent visit" for the purposes of billing observation care using the Hospital Inpatient or Observation Care Services codes can be found in section 30.6.9.E.

A/B MACs (B) pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not.

Note that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; time spent by the same practitioner on the same day for the same patient in multiple settings (or for a patient who transitions between outpatient and inpatient status) may be counted toward the Hospital Inpatient or Observation Care Services base code and, if applicable, a prolonged code. Refer to section 30.6.9.F.)

C. Hospital Visits Same Day But by Different Physicians

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, A/B MACs (B) do not pay physician B for the second visit. The hospital visit descriptors include the phrase "per day" meaning care for the day.

If the physicians are each responsible for a different aspect of the patient's care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D. Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.

E. Definition of Initial and Subsequent Visit

An initial service is one that occurs when the patient has not received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay.

A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay.

F. Prolonged Hospital Inpatient or Observation Care Services

Beginning January 1, 2023, prolonged services are reported for certain hospital inpatient or observation care visits using G0316. Prolonged services can be reported when time is used to select visit level, and the total practitioner time for the highest-level visit is exceeded by 15 or more minutes for services that are medically reasonable and necessary. See Prolonged Services section below for detailed reporting instructions.

30.6.9.1 - Payment for Initial Hospital *Inpatient or Observation* Care Services and *Hospital Inpatient or* Observation Care Services (Including Admission and Discharge Services)

Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Initial Hospital *Inpatient or Observation* Care From Emergency *Department*

A/B MACs (B) pay for an initial hospital *inpatient or observation* care service if a *practitioner* sees a patient in the emergency *department* and decides to admit the person to the *hospital or place the patient in observation care*. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same *practitioner* on the same date of service. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the *practitioner* in conjunction with that admission are considered part of the initial hospital *inpatient or observation* care when performed on the same date as the admission.

B. Initial Hospital *Inpatient or Observation* Care on Day Following Visit

A/B MACs (B) pay both visits if a patient is seen in the office on one date and admitted to the hospital *as an inpatient or receives observation care* on the next date, even if fewer than 24 hours has elapsed between the visit and the admission *for hospital inpatient or placement in observation care*.

C. Initial Hospital *Inpatient or Observation* Care and Discharge on Same Day

Both hospital inpatient and observation care coding should be billed as follows:

When the patient is admitted to inpatient hospital care *or is in observation care* for less than 8 hours on the same date, then Initial Hospital *Inpatient or Observation* Care, from CPT code range 99221 - 99223, shall be reported by the physician. The Hospital *Inpatient or Observation* Discharge Day Management service, CPT codes 99238 or 99239, shall not be reported for this scenario.

When a patient is admitted to inpatient hospital care *or is in observation care* and then discharged on a different calendar date, the physician shall report an Initial Hospital *Inpatient or Observation* Care from CPT code range 99221 - 99223 and a Hospital *Inpatient or Observation* Discharge Day Management service, CPT code 99238 or 99239.

When a patient has been admitted to inpatient hospital care *or is in observation care* for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date, Hospital *Inpatient or Observation* Care Services (Including Admission and Discharge Services), from CPT code range 99234 - 99236, shall be reported.

The following table summarizes the above, based on hospital length of stay and discharge date:

Hospital Length of Stay	***Discharged On***	***Code(s) to Bill***
< 8 hours	*Same calendar date as admission or start of observation*	*Initial hospital services only**
8 or more hours	*Same calendar date as admission or start of observation*	*Same-day admission/discharge**
< 8 hours	*Different calendar date than admission or start of observation*	*Initial hospital services only**
8 or more hours	*Different calendar date than admission or start of observation*	*Initial hospital services* + discharge day management*

**Plus prolonged inpatient/observation services, if applicable.*

D. Documentation Requirements for Billing *Hospital Inpatient or* Observation Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. In addition to meeting the documentation requirements for *medically appropriate history and/or examination,* and medical decision making documentation in the medical record shall include:

- Documentation stating the stay for hospital treatment or observation care status involves 8 hours but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the admission and discharge notes were written by the billing physician.

E. Physician Services Involving Transfer From One Hospital to Another; Transfer Within Facility to Prospective Payment System (PPS) Exempt Unit of Hospital; Transfer From One Facility to Another

Separate Entity Under Same Ownership and/or Part of Same Complex; or Transfer From One Department to Another Within Single Facility

Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between:

- Different hospitals;
- Different facilities under common ownership which do not have merged records; or
- Between the acute care hospital and a PPS exempt unit within the same hospital when there are no merged records.

In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

F. Initial Hospital Care Service *Requirements*

Per the CPT code descriptors for Initial Hospital Inpatient or Observation Care Services, a medically appropriate history and/or examination will be required, but will no longer be used to select visit level. Practitioners working in hospitals should continue to be aware of the documentation needed to meet requirements for other payment systems or Conditions of Participation, in addition to the documentation required to bill Hospital Inpatient or Observation Care codes under the PFS.

Physicians who provide an initial visit to a patient during inpatient hospital care that meets the *code descriptor* requirements shall report an initial hospital care code (99221-99223). The principal physician of record shall append modifier "-AI" (Principal Physician of Record) to the claim for the initial hospital care code. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care.

Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 - 99255) prior to January 1, 2010, when the furnished service and documentation meet the *Initial Hospital Inpatient or Observation Care code descriptor* requirements. Physicians must meet all the requirements of the initial hospital care codes, to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.

Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting CPT code 99499 requires submission of medical records and A/B MAC (B) manual medical review of the service prior to payment. A/B MACs (B) shall expect reporting under these circumstances to be unusual.

G. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission

In the inpatient hospital setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 - 99223) or nursing facility care codes (99304 - 99306). A/B MACs (B) consider only one M.D. or D.O. to be the principal physician of record (sometimes referred to as the admitting physician.) The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Only the principal physician of record shall append modifier "-AI" (Principal Physician of Record) in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

30.6.9.2 - Subsequent Hospital *Inpatient or Observation Care* Visit and Hospital *Inpatient or Observation* Discharge Day Management (Codes 99231 - 99239)

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Subsequent Hospital *Inpatient or Observation Care* Visits During the Global Surgery Period

(Refer to §§40-40.4 on global surgery)

The Medicare physician fee schedule payment amount for surgical procedures includes all services (e.g., evaluation and management visits) that are part of the global surgery payment; therefore, A/B MACs (B) shall not pay more than that amount when a bill is fragmented for staged procedures.

B. Hospital *Inpatient or Observation* Discharge Day Management Service

Hospital *Inpatient or Observation* Discharge Day Management Services, CPT code 99238 or 99239 is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital *inpatient or observation* discharge day management service is payable per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (CPT code range 99231 - 99233) for a final *inpatient hospital visit*; *practitioners furnishing additional observation care services bill the appropriate office/outpatient code, per section 30.6.8.B.*

C. Subsequent Hospital *Inpatient or Observation* Visit and Discharge Management on Same Day

Pay only the hospital *inpatient or observation* discharge management code on the day of discharge (unless it is also the day of admission, in which case, refer to §30.6.9.1 C for the policy on *Hospital Inpatient or* Observation Care Services (Including Admission and Discharge Services CPT Codes 99234 - 99236). A/B MACs (B) do not pay both a subsequent hospital *inpatient or observation care* visit in addition to hospital *inpatient or observation* discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital *inpatient or observation care* visit and hospital *inpatient or observation* discharge management for the same date of service.

D. Hospital *Inpatient or Observation* Discharge Management (CPT Codes 99238 and 99239) and Nursing Facility Admission Code When Patient Is Discharged From Hospital and Admitted to Nursing Facility on Same Day

A/B MACs (B) pay the hospital *inpatient or observation* discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service.

If a surgeon is admitting the patient to the nursing facility due to a condition that is not as a result of the surgery during the postoperative period of a service with the global surgical period, he/she bills for the nursing facility admission and care with a modifier "-24" and provides documentation that the service is unrelated to the surgery (e.g., return of an elderly patient to the nursing facility in which he/she has resided for five years following discharge from the hospital for cholecystectomy).

A/B MACs (B) do not pay for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient's admission to the nursing facility is to receive post operative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy

following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately.

E. Hospital *Inpatient or Observation* Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital *Inpatient or Observation* Discharge Day Management Service, CPT code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date.

30.6.13 - Nursing Facility Services

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Definition of Initial and Subsequent Visits

An initial service is one that occurs when the patient has not received any professional services from the physician or other NPP of the same specialty who belongs to the same group practice during the stay. A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP of the same specialty who belongs to the same group practice during the stay.

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to the Medicare Learning Network article SE0418 at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo

The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier "-AI", (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C-04-08 (see http://www.cms.gov/site-search/search-results.html?q=S%26C-04-08) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), in a SNF the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial federally mandated comprehensive visit in a SNF.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS)), who is not employed by the facility, may perform the initial visit when the State law permits. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A

qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure, and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/*Individuals with Intellectual Disabilities*) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301- 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

For Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility see section 30.6.7.C above.

A given practitioner cannot bill an initial NF visit and another E/M visit (such as an O/O visit or ED visit) on the same date of service, for the same patient. However, the time the practitioner spends furnishing a visit in another setting can be counted toward reporting prolonged NF services, if requirements for reporting prolonged NF services are met.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311- 99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

A/B MACs (B) shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a "per day" service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2023, the CPT code, Other Nursing Facility Service (99318), *has been deleted and is no longer* used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. *Effective for dates of service on and after 1-1-2023, f*or Medicare Part B payment policy, *the regular code set for Nursing Facility Services shall be used.*

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

C. Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

D. Medically Complex Care

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier "-AI" (Principal Physician of Record), to the initial nursing facility care code when billed to identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed as subsequent nursing facility care visits.

E. Incident to Services

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office. "Incident to" E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated "office" area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

F. Prolonged *NF* Services

Beginning January 1, 20*23*, *prolonged NF services are reported using Medicare-specific coding (HCPCS code G0317). Prolonged Services can be reported when time is used to select visit level, and the total time for the highest-level visit is exceeded by 15 or more minutes for services that are reasonable and medically necessary. See Prolonged Services section below for detailed reporting instructions on prolonged NF visits. Prolonged services are not reportable in conjunction with codes for NF discharge day management.*

G. Multiple Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a "per day" service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

H. Split (or Shared) SNF/NF E/M Visit

SNF E/M visits may be billed as split (or shared) visits if they meet the rules for split (or shared) visit billing, discussed in our other manual sections, except for SNF E/M visits that are required to be performed in their entirety by a physician. NF visits do not meet the definition of split (or shared) services, and therefore, are not billable as such. See section 30.6.18 for additional information.

I. SNF/NF Discharge Day Management Service

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 - 99316 shall be reported for this visit. The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

30.6.15 Prolonged Services, Standby Services, and Evaluation and Management Service for Power Mobility Devices (PMDs) (G0372)

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

30.6.15.1 - Prolonged Services – General Rules

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Prolonged E/M services may be reported for certain E/M visit families, when the total visit time spent by the practitioner exceeds a certain time threshold. Prolonged E/M services are reported using Medicare-specific coding.

See section 30.6.18 for rules regarding billing of E/M visits that are split (or shared) and involve prolonged service time.

30.6.15.2 Prolonged Office/Outpatient E/M Visits

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

When the practitioner selects visit level using time, the practitioner may report prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). The following table provides reporting examples.

HCPCS Code(s)	***Total Time Required for Reporting****
99205	*60-74 minutes*
99205 x 1 and G2212 x 1	*89-103 minutes*
99205 x 1 and G2212 x 2	*104-118 minutes*
99215	*40-54 minutes*
99215 x 1 and G2212 x 1	*69-83 minutes*

99215 x 1 and G2212 x 2	*84-98 minutes*
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	*99 or more*

**Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.*

HCPCS code G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services). (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).

Qualifying activities are listed in the CPT Codebook's E/M Service Guidelines (Guidelines for Selecting Level of Service Based on Time). These activities may be counted when time is used to select visit level, when performed and medically reasonable and necessary.

30.6.15.3 Prolonged Other E/M Visits
(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Beginning January 1, 2023, prolonged Other E/M visit services are reported as discussed in this section. Other E/M visits include inpatient/observation visits, nursing facility visits, home/residence visits, and cognitive impairment assessment and care planning. Prolonged Other E/M services may be reported with the highest visit level, for timed visits, when the total visit time spent by the practitioner exceeds a certain time threshold.

Prolonged services are not reported in conjunction with emergency department visits or critical care services.

Prolonged services are created to provide payment for additional practitioner time that is not already accounted for in the valuation of the primary service. Accordingly, practitioner time spent in qualifying activities can be counted when performed on any date within the surveyed timeframe for the visit, and when the total time (in the physician time file) is exceeded by 15 or more minutes. We show this in the following table.

Primary E/M Service	***Prolonged Code****	***Time Threshold to Report Prolonged***	***Count physician/NPP time spent within this time period (surveyed timeframe)***
Initial IP/Obs. Visit (99223)	*G0316*	*90 minutes*	*Date of visit*
Subsequent IP/Obs. Visit (99233)	*G0316*	*65 minutes*	*Date of visit*
IP/Obs. Same-Day Admission/Discharge (99236)	*G0316*	*110 minutes*	*Date of visit to 3 days after*
IP/Obs. Discharge Day Management (99238-9)	*n/a*	*n/a*	*n/a*
Emergency Department Visits	*n/a*	*n/a*	*n/a*
Initial NF Visit (99306)	*G0317*	*95 minutes*	*1 day before visit + date of visit + 3 days after*
Subsequent NF Visit (99310)	*G0317*	*85 minutes*	*1 day before visit + date of visit + 3 days after*

NF Discharge Day Management	*n/a*	*n/a*	*n/a*
Home/Residence Visit New Pt (99345)	*G0318*	*140 minutes*	*3 days before visit + date of visit + 7 days after*
Home/Residence Visit Estab. Pt (99350)	*G0318*	*110 minutes*	*3 days before visit + date of visit + 7 days after*
Cognitive Assessment and Care Planning (99483)	*G2212*	*100 minutes*	*3 days before visit + date of visit + 7 days after*
Consults	*n/a*	*n/a*	*n/a*

** Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.*

Qualifying activities are listed in the CPT Codebook's E/M Service Guidelines (Guidelines for Selecting Level of Service Based on Time). These activities may be counted when time is used to select visit level, when performed and medically reasonable and necessary.

30.6.18 - Split (or Shared) Visits

(Rev.11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Definition of Split (or Shared) Visit

A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.

Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.

B. Definition of Substantive Portion

(1) More Than Half of the Total Time

Beginning January 1, 202*4*, substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

During *the* transitional year from January 1, 202*3* through December 31, 202*3*, except for critical care visits, the substantive portion can be one of the three key E/M visit components (*a medically appropriate* history *or* exam, or medical decision-making (MDM)), or more than half of the total time spent by the physician and NPP performing the split (or shared) visit. In other words, for calendar year 202*3*, the practitioner who spends more than half of the total time, or performs the *medically appropriate* history *or* exam *described in the code descriptor*, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit. When one of the three key components is used as the substantive portion in 202*3*, the practitioner who bills the visit must perform that component in its entirety in order to bill. For example, if history is used as the substantive portion, the billing practitioner must perform the history *as described in the code descriptor in order to bill*. If physical exam is used as the substantive portion, the billing practitioner must perform the exam *as described in the code descriptor in order to bill*. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed.

For critical care visits, starting for services furnished in CY 2022, the substantive portion will be more than half of the total time. A unique listing of qualifying activities for purposes of determining the substantive portion of critical care visits applies (see below).

We summarize these policies in the following table.

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022-*2023* Definition of Substantive Portion	202*4* Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/ Hospital/SNF*	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making), SNF (Skilled Nursing Facility)
*Office visits *and Nursing Facility visits* are not billable as split (or shared) services.

(2) Distinct Time

In accordance with the CPT E/M Guidelines, only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

Example: If the NPP first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit, since they spent more than half of the total time (15 of 25 total minutes). If, in the same situation, the physician and NPP met together for five additional minutes (beyond the 25 minutes) to discuss the patient's treatment plan, that overlapping time could only be counted once for purposes of establishing total time and who provided the substantive portion of the visit. The total time would be 30 minutes, and the physician would bill for the visit, since they spent more than half of the total time (20 of 30 total minutes).

(3) Qualifying Time

Drawing on the CPT E/M Guidelines, except for critical care visits, the following listing of activities can be counted toward total time for purposes of determining the substantive portion, when performed and whether or not the activities involve direct patient contact:

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or 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).

Practitioners cannot count time spent on the following:

- 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.

See section 30.6.12 for a listing of qualifying activities for purposes of determining the substantive portion of critical care services.

For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

(4) Application to Prolonged Services

For 2022 and 2023 transitional years, the billing practitioner reports the codes for the primary service and the prolonged services, regardless of the amount of time the billing practitioner spent.

*Starting in 2024, since the substantive portion is more than half of the practitioners' total time, t*he physician or practitioner who spent more than half the total time (the substantive portion starting in 202*4*) will bill for the primary E/M visit and the prolonged service code(s) when the service is furnished as a split (or shared) visit, if all other requirements to bill for split (or shared) services are met. The physician and NPP will add their time together, and whomever furnished more than half of the total time, including prolonged time, (that is, the substantive portion) will report both the primary service code and the prolonged services add-on code(s), assuming the time threshold for reporting prolonged services is met *(see Prolonged Services section above)*.

- During the transitional calendar year*s* 2022-*2023*, when practitioners use a key component as the substantive portion, Emergency department and critical care visits are not reported as prolonged services.

We summarize these policies in the following table.

Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	***2022*-2023**		**2024**
	If Substantive Portion is a Key Component…	**If Substantive Portion is Time…**	**Substantive Portion Must Be Time**
Other Outpatient*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*
Inpatient/Observation/Hospital/SNF*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting *prolonged services*	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)
*Office visits *and Nursing Facility visits* are not billable as split (or shared) services.

C. New and Established Patients, and Initial and Subsequent Visits

Split (or shared) visits may be billed for new and established patients, as well as for initial and subsequent visits, that otherwise meet the requirements for split (or shared) visit payment.

D. Settings of Care

Split (or shared) visits are furnished only in the facility setting, meaning institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations at 42 CFR § 410.26.

Accordingly, split (or shared) visits are billable for E/M visits furnished in hospital and skilled nursing facility (SNF) settings. Visits in these settings that are required by our regulations to be performed in their entirety by a physician are not billable as split (or shared) services. For example, our Conditions of Participation require certain SNF visits to be performed directly and solely by a physician; accordingly, those SNF visits cannot be billed as a split (or shared) visit (see Section 30.6.13).

E. Medical Record Documentation

Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

F. Claim Identification

Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.

The modifier identified by CPT for purposes of reporting partial services (modifier -52 (reduced services)) cannot be used to report partial E/M visits, including any partial services furnished as split (or shared) visits. Medicare does not pay for partial E/M visits.