

# CPT® Evaluation and Management

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## E/M revisions to code descriptors & guidelines 2021-2023

On Nov. 1, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to the Evaluation and Management (E/M) office visit CPT® codes (99201-99215) code descriptors and documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country.

After these revisions were implemented, the CPT Editorial Panel approved, for 2023, [additional revisions](#) (PDF) to the rest of the E/M code section. These revisions seek to provide continuity across all the E/M sections allowing for the revisions implemented in the E/M office visit section in 2021 to extend to all other E/M sections.

### **E/M code descriptors and guidelines**

Review and download the E/M code descriptors and guidelines for 2023.

[Download Now](#)

### **Expert insights on E/M 2023**

[Watch the recorded webinar](#) for guidance from CPT experts: "E/M 2023: Advancing Landmark Revisions Across More Settings of Care" (aired Aug. 9, 2022).

[Download the corresponding FAQs](#) (PDF) for the webinar, which include questions submitted by webinar attendees.

# 2023 summary of revisions to the E/M code descriptors and guidelines

## Inpatient and observation care services

- Deletion of observation CPT codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221, 99222, 99223, 99221-99233, 99238-99239).
- Editorial revisions to the code descriptors to reflect the structure of total time on the date of the encounter or level of medical decision-making when selecting code level.
- Retention of revised Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236).
- Revision of guidelines.

## Consultations

- Retention of the consultation codes, with minor, editorial revision to the code descriptors.
- Deletion of confusing guidelines, including the definition of “transfer of care.”
- Deletion of lowest level office (99241) and inpatient (99251) consultation codes to align with four levels of MDM.

## Emergency department services

- Maintained the existing principle that time cannot be used as a key criterion for code level selection.
- Editorial revisions to the code descriptors to reflect the code structure approved in the office visit revisions.
- Modified MDM levels to align with office visits and maintain unique MDM levels for each visit.
- Existing CPT code numbers maintained (analogous to office visit revisions).
- Articulated current practice that was not explicit in the CPT code set.
  - May be used by physicians and QHPs other than just the ED staff.
- Critical care may be reported in addition to ED service for clinical change.

## Nursing facility services

- Editorial revisions to the code descriptors to reflect the new standard E/M code structure.
- Revision to nursing facility guidelines with new “problem addressed” definition of “multiple morbidities requiring intensive management,” to be considered at the high level for initial nursing facility care.
- Deletion of code 99318 (annual nursing facility assessment). This existing service will be reported through the subsequent nursing facility care services (99307-99310) or Medicare G codes.
- Not all “initial care” codes are the mandated comprehensive “admission assessment” and may be used by consultants.
- Use subsequent visit when the principal physician’s team member performs care before the required comprehensive assessment.

## Home and residence services

- Editorial revisions to the code descriptors to reflect the new standard E/M code structure.
- The domiciliary or rest home CPT codes (99334-99340) were deleted and merged with the existing home visit CPT codes (99341-99350).
- Elimination of duplicate MDM Level New Patient code (99343).

## Prolonged services

- Deletion of direct patient contact prolonged service codes (99354-99357). These services will now be reported through either the code created in 2021, office prolonged service code (99417) or the new inpatient or observation or nursing facility service code (993X0).
  - 99417 is also used for Home or Residence prolonged services.
- Creation of a new code (993X0) to be analogous to the office visit prolonged services code (99417). This new code is to be used with the inpatient or observation or nursing facility services.
- Retention of 99358, 99359 for use on dates other than the date of any reported “total time on the date of the encounter” service.

## E/M CPT learning module

This educational module provides an overview of the evaluation and management (E/M) code revisions and shows how it differs from current coding requirements and terminology.

[Access the Module](#)

With these landmark changes, as approved by the CPT Editorial Panel, documentation for E/M services will now be centered around how physicians think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes.

Visit the "[Implementing CPT® Evaluation and Management \(E/M\) revisions](#)" page for videos, webinars and other resources to help you implement the changes.

## E/M historical background

For decades, the physician community has struggled with burdensome reporting guidelines for reporting office visits and other E/M codes. With the proliferation of electronic health records (EHRs) into physician practices, documentation requirements for office visits have moved towards increased “note bloat” within the patient record due to the largely check-box nature of meeting the current documentation requirements.

To address this, beginning in 2021 through the current revisions posted in the 2023 CPT code set, the AMA-convened CPT Editorial Panel approved revisions to the CPT E/M guidelines and code descriptors. These revisions were in direct response to the leadership demonstrated by former CMS Administrator, Seema Verma, to take on the challenge of revising the (E/M) office visit reporting guidelines.

## Administrative burden

The AMA's proposal to reduce administrative burden achieves a shared goal with CMS, truly putting patients over paperwork and improving the health system. These revisions work in lock step with the already established administrative burden relief initiatives established by CMS for 2019:

- Elimination of the requirement to document medical necessity of furnishing visits in the home rather than office.
- Elimination of the requirements for clinicians to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
  - Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

Additional burden reduction will be seen through:

- Simplifying code selection criteria and making them more clinically relevant and intuitive
- Creating consistency across payers by adding detail within the CPT E/M Guidelines
- Alignment with current documentation guidelines from Medicare and the CPT code set to ensure minimal disruption to practices.

In 2018, CMS estimated that physicians spent an average of 4.2 minutes documenting an office visit and flexibility in documentation requirements would lead to a 2.5% reduction in documentation time (.11 minute/6.6 seconds). The AMA contends implementation of the E/M changes in 2021 and 2023 will lead to additional administrative burden relief and supports studies to measure the change in documentation time as physicians incorporate these changes into their practice.

## 2021 summary of revisions to the E/M office visits

### Eliminate history and physical as elements for code selection

While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level.

- The workgroup revised the code descriptors to state providers should perform a "medically appropriate history and/or examination"

### Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time

- **MDM:** The workgroup did not materially change the three current MDM sub-components, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines. (See below for additional discussion.)
- **Time:** The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better

recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and **not** MDM.

## **Modifications to the criteria for MDM**

The Panel used the current CMS Table of Risk as a foundation for designing the revised required elements for MDM. Current CMS Contractor audit tools were also consulted to minimize disruption in MDM level criteria.

### **Creation of a shorter prolonged services code**

- The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

## **Primary objectives of the CPT Editorial Panel revisions**

The CPT Editorial Panel took seriously the charge to create revisions to the E/M code descriptors and guidelines and outlined four primary objectives to this important work:

1. To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible.
2. To decrease the need for audits, through the addition and expansion of key definitions and guidelines.
3. To decrease unnecessary documentation in the medical record that is not needed for patient care.
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

## **History of code set revisions**

The AMA led a consensus-driven, open and transparent workgroup process to ensure the reimagined approach to office visits represented input from the broad array of medical specialties that perform these visits. The workgroup was created with members who had both CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) experience. In addition, the process engaged participants with diverse medical specialty backgrounds including primary care, several surgical specialties (e.g., general surgery, cardiology and vascular surgery), private payers and qualified healthcare professionals (i.e., physician assistants).

The workgroup held numerous open conference calls, where on average, more than 300 individuals participated to provide direct input. Many of the major decisions made by the workgroup, including the definition of time and key definitions of MDM criteria, were based on targeted stakeholder survey results.

The workgroup brought their proposal to the CPT Editorial Panel as consensus recommendations and only minor modifications were made by the Panel prior to approving them.