Office of Integrity & Compliance

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2023 Home or Residence E&M Guidelines

Home or Residence

Home or Residence level of service is based on either: **Time** or **Complexity of Medical Decision Making**

New Patient Code	MDM	Time
99341	Straightforward	15-29 minutes
99342	Low Level	30-59 minutes
99344	Moderate	60-74 minutes
99345	High	75–89 minutes
Established Patient Code	**MDM**	**Time**
99347	Straightforward	20-29 minutes
99348	Low Level	30-39 minutes
99349	Moderate	40-59 minutes
99350	High	60-74 minutes

Time personally spent on the calendar date of the encounter: *"I personally spent ____ minutes on the calendar day of the encounter, including pre and post visit work."* Activities include:

- Preparing to see the patient (e.g., 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
- Documenting clinical information in the electronic or other health record
- Care coordination (not separately reported)

Home or Residence Prolonged Services

As of 1/1/2023, the following codes may be used to represent fully completed 15-minute segments of prolonged care, only when the primary service highest-level time has been exceeded by 15-minutes.

New Patient Home/Residence Visit Code + Prolonged Services			
Code	**99345**	**99345 + 99417 x1**	**99345 + 99417 x2**
Time (minutes)	75–89 No Prolonged code < 90 min	90-105	106-121

Established Patient Home/Residence Visit Code + Prolonged Services			
Code	**99350**	**99350 + 99417 x1**	**99350 + 99417 x2**
Time (minutes)	60-74 No Prolonged code < 75 min	75-90	91-106

CMS has developed its own HCPCS codes to report prolonged services to Medicare when those conditions are met, Prolonged Service code 99417 will convert in eRecord to G0318.

Medicare New & Established Patient Home/Residence Visit Code + Prolonged Services			
Code	**CMS Prolonged Service Codes**	**CMS Threshold**	**Count time spent within this time period**
99345 + 99417 x5	= G0318	140 mins.	3 days before visit + date of visit + 7 days after
99350 + 99417 x4	= G0318	110 mins.	3 days before visit + date of visit + 7 days after

Medical Decision-Making Documentation Details

Medical Decision Making (MDM) 3 elements to be included in documentation:

1. Number and complexity of problems addressed during encounter
2. Amount and/or complexity of data reviewed and analyzed
3. The risk of complications or morbidity or mortality of patient management

- Capture complexity of each problem addressed during visit
  - Be specific (acute, chronic, stable, worsening, etc.)
- Itemize data ordered, reviewed, discussed, or personally interpreted
  - Each independent test ordered or reviewed
  - Specify when personally interpreting images -
    "I personally reviewed the head CT which showed …"
  - Note discussions with other healthcare professionals
  - Identify any independent historians
- Specify treatment plan for each problem addressed during visit
  - Document how you addressed **each problem**

2023 CPT E&M Inpatient & Outpatient Level of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low	**Low**
	• 2 or more self-limited or minor problems
	• 1 stable chronic illness
	• 1 acute, uncomplicated illness or injury
	• 1 stable, acute illness
	• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high).
			Low risk of morbidity from additional diagnostic testing or treatment

Moderate	**Moderate**
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
	• 2 or more stable chronic illnesses
	• 1 undiagnosed new problem with uncertain prognosis
	• 1 acute illness with systemic symptoms
	• 1 acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported).
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	**High**
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).
			High risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances