Reviewing 2023 E/M Guideline Changes

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Presenter's Bio

Chris Breithoff, CPC, CPCO, CDEO, CRC has over 35 years of dedication to coding compliance, quality education and health care auditing. Her focus has been on professional fee coding and documentation improvement. Chris has experience in various settings from small to large multispecialty providers groups and large teaching hospitals. Her areas of expertise include health care auditing, individual and group coding education to providers and professional fee coders and conducting prospective and retrospective audits. Currently, Chris is the Director of Physician Services at MRA. Chris has been a member of AAPC since 1999.

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Overview

- E/M Introductory Guidelines updated:
  - Hospital Inpatient and Observation Care Services
  - Consultation Codes
  - Emergency Department Services
  - Nursing Facility Services
  - Home or Residence Services
- Deletions and Revisions of Hospital Observation Services
- Deletions and Revision of Consultations

Overview (cont.)

- Revision of Emergency Department Services
- Deletion and Revisions of Nursing Facility Services
- Deletion of Domiciliary, Rest Home, or Custodial Care Services
- Deletion and Revisions of Home or Residence Services Code
- Deletions and Revision of Prolonged Service Codes
- Establishment of Prolonged Services 99418

E/M Guidelines Overview

- It is important to review instructions for each category and subcategory
- These guidelines are used to help select the appropriate level of service
- These guidelines do not establish documentation requirements or standards of care
- Documentation is to support care of the patient by current and future providers
- Guidelines are for services that require a face to face with the patient and/or family/caregiver
- The face-to-face services for 99211 and 99281 can be done by clinical staff

Overview

Deletions:					
Hosp OBS	Consultations	Nursing Facility	Domiciliary, Rest Home or Custodial Care	Home or Residence	Prolonged Services
99217-99220	99241 99251	99318	99324-99238 99334-99337 99339 99340	99343	99354-99357

Revisions:					
Hosp IP	Consultations	ED Services	Nursing Facility	Home or Residence	Services Prolonged
99221-99223 99231-99239	99242-99245 99252-99255	99281-99285	99304-99310 99315 99316	99341 99342 99344 99345 99347-99350	99358 99359 99415 994160

Overview of the 2023 EM Services

Level of service will be based on:

- MDM
- Time
- New prolonged service codes (CPT 99418 and CMS –G0316, G0317, G0318)

Components for the 2023 E/M Codes

All E/M categories will now align with the Office/ Other Outpatient E/M codes that were revised in 2021

Code selection will be based on:

- Level of MDM as defined for each service

OR

- Total physician or other qualified health care professional time on the ***date of the encounter***
  - Time spent with clinical staff is NOT included

Chief Complaint (CC)

A concise statement describing the symptom, problem, condition, diagnosis or the reason for the patient encounter.

The chief complaint is the patient's presenting problem and is normally documented as an opening statement in the HPI (History of Present Illness) or chief complaint section of the documentation.

- !*DG: The medical record should clearly reflect the chief complaint.*

Examples of good Chief Complaints:

- Patient here to establish care
- Patient has a sore throat
- Patient presents for follow up of ADHD

History and Exam

- Removing the History and Exam component for code selection does not remove them from being a necessary part of an E/M service
- ***These components should still be performed and documented as appropriate***
- The medical record should still include all services performed throughout the course of the encounter and providers should ensure that the record is true and accurate, as it is still a legal document and helps support the medical necessity of the visit

Definition of Time

- Beginning January 1, 2023, all E/M categories (except ED): **TOTAL** physician or other QHP time spent on the date of the encounter will be used to calculate time
- Time will include both face-to-face and non-face-to-face time on the date of the encounter
- Time must not overlap
- Total time must clearly be documented by the provider in order to determine the appropriate E/M level
- *NOTE*: Counseling/coordination of care is no longer a factor
- ED services will continue to not be reported based on time- these must be leveled based on MDM

Physician/Other QHP Time

Provider time will now include:

- Preparing to see the patient (review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam 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 patient/family/caregiver
- Care coordination (not separately reported)
- NOTE: Time should be documented within the note

What is Not Included in Time

- Time spent by clinical staff
- Time spent on separately reportable services/procedures
- Teaching with Residents/Medical Students
- Travel time
- Extended charting time due to user use – slow typing, new EMR system, system issues, etc.

Initial Hospital Inpatient or Observation Care Services

- Observation codes deleted and consolidated into the new category: Initial Hospital Inpatient or Observation Care
- When patient is admitted from another site (i.e. office, ED) both services may be reported separately, with modifier 25 added to the other service
- If a consultation is performed in anticipation of, or related to an admission by another provider, if the same consultant performs an encounter once the patient is admitted by the other provider, the consultants inpatient encounter should be reported with code form the subsequent category, even if the consultation occurred on the date of admission or the date previous to the admission

Initial vs Subsequent Services

Initial Service: Has not received any professional services (face to face) from the physician or another from the same specialty/sub-specialty of the same group during the stay

Subsequent Service: Has received professional services (face to face) from the provider or another from the same specialty/ sub-specialty of the same group during the stay

Initial vs Subsequent Services

- If a physician or Other Qualified Healthcare Professional is on call for another provider, the patient's encounter should be reported as it would have been for the provider who is not available

- If a transition from OBS to IP is done during a stay, it should be considered a single stay

- If a transition between skilled nursing facility and nursing facility is done, it should be considered a single stay

IP/OBS Changes for 2023

Initial Inpatient and OBS EM Codes:

- 99217-99220: Deleted 1/1/2023
- 99221: 40 minutes **or** straightforward or low medical decision making
- 99222: 55 minutes **or** moderate medical decision making
- 99223: 75 minutes **or** high medical decision making

Comparison on Time for 2022 vs 2023 per CPT

Initial IP/ OBS EM Code	Typical Time (2022)	Total Time (2023)
99221	30 minutes	40 minutes
99222	50 minutes	55 minutes
99223	70 minutes	75 minutes

IP/OBS Changes for 2023

Subsequent Inpatient and OBS EM Codes:

- 99231: 25 minutes **or** straightforward or low medical decision making
- 99232: 35 minutes **or** moderate medical decision making
- 99233: 50 minutes **or** high medical decision making

Comparison on Time for 2022 vs 2023 per CPT

Subsequent IP/OBS EM Code	Typical Time (2022)	Total Time (2023)
99231	15 minutes	25 minutes
99232	25 minutes	35 minutes
99233	35 minutes	50 minutes

Hospital Inpatient or Observation Care Services (Including Admission and DC)

- Report for patients admitted and discharged to IP or OBS status on the same date using E/M codes 99234-99236
- Requires 2 or more encounters on the same date
  - One encounter should be an initial admission encounter
  - One encounter should be a discharge encounter
- If the patient is admitted and discharged at the same encounter, see initial hospital IP or OBS category, 99221-99223
- Do not report DC services (99238, 99239) with initial hospital IP or OBS codes (99221-99223) for the same date
- For newborns admitted and discharged on the same date, use 99463

Comparison on Time for 2022 vs 2023 per CPT

IP/OBS Admit and D/C EM Code	Typical Time (2022)	Total Time (2023)
99234	40 minutes	45 minutes
99235	50 minutes	70 minutes
99236	55 minutes	85 minutes

Hospital Inpatient or Observation Discharge Services

- Used to report services provided to the patient on the date of discharge (if other than the date of admission)
- Should be reported by the provider responsible for discharge services
- Other providers should report an IP/OBS subsequent care code (99231-99233)

99238- IP or OBS discharge services- 30 minutes or less

99239- IP or OBS discharge services- more than 30 minutes

Consultations
Office/Other Outpatient

- Changed to match office/other OP services
- Deletion of 99241 due to four MDM levels
- No longer includes OBS consults
- Transfer of care should be reported with a new or established Office/Other OP, home or residence E/M code
- Consultations requested by patient and/or the patient's family member **should not** be reported with a consultation code. Instead, another appropriate E/M code should be reported
- Subsequent visits after a consultation is provided should be reported with an established patient code, depending on the site (i.e. office, home or residence)

Comparison on Time for 2022 vs 2023 per CPT

Office or Other Outpatient EM Consultation Code	Typical Time (2022)	Total Time (2023)
99242	30 minutes	20 minutes
99243	40 minutes	30 minutes
99244	60 minutes	40 minutes
99244	80 minutes	55 minutes

Consultations
Inpatient/Observation

- Used to report consults for hospital inpatients, observation-level patients, residents in nursing facility, or patient in a partial hospital setting
- Patient should not have received any face-to-face professional services by the consultant during the current stay
- When an NPP is working with physician, they are considered the exact same specialty/sub-specialty as the physician
- For subsequent IP consultations performed during the stay, subsequent E/M codes should be reported (99231-99233)
- For subsequent nursing facility consultations performed, subsequent E/M codes should be reported (99307-99310)
- Deletion of 99251 due to four MDM levels

Comparison on Time for 2022 vs 2023 per CPT

Inpatient or Observation Consultation E/M Code	Typical Time (2022)	Total Time (2023)
99252	40 minutes	35 minutes
99253	55 minutes	45 minutes
99254	80 minutes	60 minutes
99255	110 minutes	80 minutes

Emergency Department Services

- Structure and the criteria of code selection changed to match other E/M categories
- Four MDM levels (SF, Low, Moderate, High)
- Revision of 99281 to align with the office/outpatient code 99211
  - Concept of MDM doesn't apply to 99281
  - Doesn't require the presence of a physician or other QHP
  - Not reported if patient leaves after triage. There should be some type of service provided
- No distinction between new and established patients in the ED
- Time **may not** be used to select ED E/M services
- ED and critical care services can both be reported on the same day, if the condition of the patient changes after the initial ED service and critical care is required and provided
- Consultations in the ED should be reported with the office/outpatient consultation codes 99241-99245
- For CMS and other payers that do not accept consultation codes, for consults in the ER, consultants should report an ER code

Emergency Department Services

- Guidelines now include a statement regarding modifiers. When a reportable procedure is performed, a modifier may need to be reported regarding the extent of the services provided in a surgical package.
  - Many procedures performed in the ED are not followed-up in the ED; therefore, a modifier should be reported to show the reduction in service
  - Examples of modifiers that may need to be reported:
    - 52, Reduces services
    - 53, Discontinued procedure
    - 54, Surgical care only
    - 55, Postoperative management only
    - 56, Preoperative management only
- For patient's seen in the ED as a convenience of a provider, office/other outpatient codes should be reported (99202,99215)
- A medically appropriate History and Exam should still be performed and documented

Comparison on Time for 2022 vs 2023 per CPT

ED E/M Code	MDM (2022)	MDM (2023)
99281	SF	N/A
99282	Low	SF
99283	Moderate	Low
99284	Moderate	Moderate
99285	High	High

Nursing Facility

- History and Exam are no longer considered when leveling the visit, but a medically appropriate history and exam should still be performed and documented as appropriate.
- These codes should be reported for E/M services provided to patients in nursing facilities and skilled nursing facilities, psychiatric residential treatment centers and immediate care facilities for individuals with intellectual disabilities
- POS codes should be reported to specify the type of facility
- For the initial NF E/M codes, the MDM level nor the time associated with the codes changed
- There is a new high-level MDM-type specifically for the initial nursing facility care:
  - Multiple morbidities requiring intensive monitoring
- Annual nursing facility assessment code 99318 has been deleted
  - To report, see 99307, 99308, 99309, 99310

Comparison on Time for 2022 vs 2023 per CPT

Subsequent Nursing Facility EM Code	Typical Time (2022)	Total Time (2023)
99307- SF MDM	10 minutes	10 minutes
99308- Low MDM	15 minutes	15 minutes
99309- Moderate MDM	25 minutes	30 minutes
99310- High MDM	35 minutes	45 minutes

Home or Residence Services

- Domiciliary, Rest Home, or Home Care Plan Oversight Services category was deleted
  - These encounters should now be reported with care management services codes 99437, 99491 or principle care management codes 99424, 99425

- Used for residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility

- 99343 was deleted. Prior to 2023, 99343 and 99344 were both moderate MDM. Without History and Exam being a component when leveling a visit, 99343 was unnecessary

Comparison on Time for 2022 vs 2023 per CPT

New Patient Home or Residence EM Code	Typical Time (2022)	Total Time (2023)
99341- SF MDM	20 minutes	15 minutes
99342- Low MDM	30 minutes	30 minutes
99344- Moderate MDM	60 minutes	60 minutes
99345- High MDM	75 minutes	75 minutes

Comparison on Time for 2022 vs 2023 per CPT

Established Patient Home or Residence EM Code	Typical Time (2022)	Total Time (2023)
99347- SF MDM	15 minutes	20 minutes
99348- Low MDM	25 minutes	30 minutes
99349- Moderate MDM	40 minutes	40 minutes
99350- High MDM	60 minutes	60 minutes

New Prolonged Service Codes

- Non-Medicare: 99418– for prolonged in IP/OBS, IP/OBS admitted and DC on the same date, IP/OBS, consultations, and nursing facility visits when time is used for code level selection, including face-to-face and non-face-to-face provider time of **at least** 15 additional minutes beyond the required time on the same date of service for highest level for IP, OBS or nursing facility visits (99223, 99233, 99236, 99255, 99306, 99310)
- Medicare: for these prolonged codes in IP/OBS, IP/OBS admitted and DC on the same date, and nursing facility when time is used for code level selection, including face-to-face and non-face-to-face provider time on the same date of service for highest level visits, CMS considers the first 15 minutes beyond the code time to be included in the base code. In order to report these add-on prolonged services codes, and additional 15 minutes must be completed (30 minutes total beyond the base code time)
  - G0316- IP/OBS services (99223, 99233, 99236)
  - G0317- Nursing facility services (99306, 99310)
  - G0318- Home/Residence services (99345, 99350)
- ***NOTE: The entire 15 minutes must be done in order to report 99418/G0316/G0317/G0318***

Prolonged Service Time Grid

TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

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	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 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.

Prolonged Service 99418/G0316, G0317, G0318

Parenthetical notes give instructions regarding reporting:

- Use with 99223, 99233, 99236, 99255, 99306, 99310 **only**
- Do not use with 90833, 90836, 90838, 99358, 99359
- Do not use for time less than 15 minutes
- Cannot count time performing testing that is being billed separately

Shared Services

- Allows payment to a physician for a split/shared visit when a physician and a NPP provider the service together (this does not need to be concurrent)
- The physician personally performs a substantive portion of the office visit
- Substantive portion is defined as: history, or exam, or MDM or more than half of total time

Shared or Split Time

- The 2021-time guidelines are rolled into all E/M categories for 2023
- This is a new CPT rule: 2 providers can share time
- Sum up the total time spent by the physician and other QHP to get a total time
- Time CANNOT overlap
- Time the providers spend together is only counted once (you will only be counting the time of one individual)
- ***Applies to non-Medicare patients and insurance carriers that DO NOT follow Medicare incident-to guidelines***

Recap on Time Based Coding

- The new guidelines state time should be documented in the chart
- Providing time for each task performed for the patient visit would be best practice
- Be careful when two providers are seeing the patient during the visit – CMS has different guidelines versus CPT guidelines
- Prolonged service codes CPT - 99418 or CMS – G0316, G0317 or G0318 can only be added to 99223, 99233, 99236, 99255, 99306 or 99310 codes
- Prolonged time must be reported in 15 minutes increments
- Can only count time spent on date of the patient encounter
- Every note should not have a time statement documented
- Procedure time needs to be excluded from the total time if billing for the procedure as well

Reason for 2023 MDM Revisions

- Reduce administrative burden
- Improve coding/payment accuracy
- More streamlined MDM table
- Help alleviate the guesswork when determining the appropriate level of complexity
- All components to level the MDM will be on one chart

Medical Decision Making (MDM)

- Proper MDM documentation outlines all the work the provider performed/considered during an E/M visit
- Includes Nature of Presenting Problem, test results that were reviewed and/or new tests ordered and all the other factors they consider in order to formulate the treatment plan
- MDM helps justify the medical necessity of the visit
- MDM also helps support the reasons for the visit (Chief Complaint)

MDM

The Medial Decision-Making table is broken down into 3 columns

- MDM Elements:
  - Number and complexity of problems addressed at the encounter
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications, morbidity and/or mortality of patient management

2 out of the 3 columns need to meet or exceed in order to level the visit

Components of MDM

Number and complexity of problems *addressed* at the encounter

A problem is considered addressed when it is:

- Evaluated and treated

or

- Further testing not carried out due to risk or patient choice, but was considered by the provider

NOTE: with these new revisions it will no longer matter if the condition is new or if additional work-up is planned

Components of MDM

Number and complexity of problems *addressed* at the encounter

A problem **isn't considered** addressed:

- If another provider is managing a problem, unless additional assessment or care coordination is documented
- Referral to another provider without evaluation

Components of MDM

Number and complexity of problems *addressed* at the encounter

- Self-limited or minor problem
- Stable chronic illness
- Acute, uncomplicated illness or injury
- Stable acute illness
- Acute uncomplicated illness or injury requiring hospital IP or OBS level of care
- Chronic illnesses with exacerbation, progression, or side effects of treatment
- Undiagnosed new problem with uncertain prognosis
- Acute illness with systemic symptoms
- Acute complicated injury
- 1+ Chronic illness with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illness or injury that poses a threat to life or bodily function
- Multiple morbidities requiring intensive monitoring (nursing facility only)

4 Levels of Problems Addressed per the 2023 MDM Grid

Self-limited or minor problem:

- This is a problem that "runs a defined prescribed course and most likely won't change the patient's permanent condition (rash, teething)"

Low number/complexity of problems:

- Two or more self-limited or minor problems
- One stable chronic illness (per CPT guidelines a stable chronic illness is one in which the patient is meeting treatment goals)
- One acute, uncomplicated illness or injury (this is a new problem with a low risk of morbidity or mortality – allergic rhinitis or simple sprain)
- One stable, acute illness (a problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition)
- One acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care (recent or new short-term problem with low risk of morbidity for which treatment is required)

4 Levels of Problems Addressed per the 2023 MDM cont.

Moderate level problems addressed:

- One or more chronic illness with exacerbation. Per the AMA “this is a chronic illness that has become acutely worse or is uncontrolled or progressing. The problem may require additional supportive care or require treatment for side effects, but the provider does not expect the patient needs hospitalization” – Example: Asthma exacerbation
- Two or more stable chronic illnesses
- One undiagnosed new problem with uncertain prognosis. Signs/symptoms point to a possible high risk of morbidity if the condition goes untreated

4 Levels of Problems Addressed per the 2023 MDM cont.

Moderate level problems addressed cont.

- One acute illness with systemic symptoms. Illness with systemic symptoms and has a high risk of, morbidity without treatment. General symptoms in a minor illness, see self-limited or minor problem or acute, uncomplicated illness/injury
- One acute complicated injury. This illness may be extensive and require evaluation of body systems unconnected to the injured organ. Treatment options may have a high risk of injury: Head injury with brief loss of consciousness

4 Levels of Problems Addressed per the 2023 MDM cont.

High numbers and complexity of problems addressed:

- One or more chronic illness with severe exacerbation, progression or side effect of treatment. The problem may pose significant health risk and require the patient to be admitted
- One or more chronic illness or injury that poses a threat to life or bodily function. This may include an acute illness causing systemic symptoms, an acute, complicated injury, side effects of treatment, a chronic illness or injury that has become severely worsened or progressed to the point where the patient's life or bodily function are in danger without treatment. Example: Pulmonary Emboli, Stroke
- Multiple morbidities requiring intensive monitoring (nursing facility only)

Definitions of Acute vs Chronic Problems

Stable; Acute Illness	• New or Recent • Improved but may not be completed resolved • Patients condition is stable
Stable: Chronic Illness	• Expected to last a year or until the death of the patient • Treated as chronic • “Stable” is defined by treatment goals of the patient: If not a treatment goal condition is not stable • Risk of morbidity without treatment is significant
Chronic Illness with Exacerbation/progression or side effect of treatment	• Chronic illness is getting worse, progressing and/or poorly controlled • Not responding to treatment • Requiring additional supportive care, treatment. This requires hospitalization

Components of MDM

Amount and/or complexity of data to be reviewed and analyzed

Category 1: Tests and documents

- Any combination of 2 or 3 (depending on the level) from the following:
  - Review of prior external note(s) from each unique source;
  - Review of the results(s) of each unique test;
  - Ordering of each unique test

Category 2: Assessment requiring an independent historian(s)

- *This category is only listed in the limited level. In the higher levels (moderate and high) this point is included in Category 1*

Components of MDM

Amount and/or complexity of data to be reviewed and analyzed

Category 2: Independent Interpretation of Tests

- Performed by another physician/ other QHP

Category 3: Discussion of Management or Test Interpretation

- External physician/ other QHP/ Appropriate source

Definition of Independent Historian

- In the past we have not given credit for a parent providing history for a child.
- The AMA has defined Independent Historian as: “An individual (parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (i.e.. due to **development stage,** dementia or psychosis) or because a confirmatory history is judged to be necessary.”
- The independent history does not need to be obtained in person but does need to be obtained directly from the person providing the independent information.

4 Levels of Complexity of Data to be Reviewed and Analyzed

Straightforward – minimal or none

Low – One category required

- 2 tests/documents or independent historian

Moderate – One category required

- 3 tests, documents and/or independent historian *or*
- Independent interpretation of a test *or*
- Discussion of management or test interpretation

High – Two categories required

- 3 items between tests and independent historian *or*
- Independent interpretation of a test *or*
- Discussion of management or test interpretation with external provider

Closer Look at the Various Categories

Category I: Test and documents – select any 2

- Review of prior external notes (s) from each unique source. The provider reviews medical records, test results from another provider. Example: Orthopedic PA reviews the Urgent Care note from the UC provider on this patient from 3 days ago
- Review of result(s) of each unique test. This may include imaging, lab, psychometric or physiological test data. Example: Ortho in the example above also reviews the Xray from Urgent Care
- Ordering of each unique test. Example: Family provider thinks the patient may have diabetes and orders labs

Closer Look at the Various Categories (cont.)

Category 2: Assessment requiring independent historian(s)

- This could be a parent, spouse, witness etc. who is able to explain the patient's history when the patient is unable to because patient has dementia or mentally impaired etc.
- Example: The husband describes the activities of daily living and how the patient is doing because the patient had a stroke and cannot communicate

NOTE:

- Using a family member or surrogate for translation does not count
- Multiple historians would not add additional points, the max credit is 1
- History obtained from another healthcare provider does not apply to this category

Closer Look at the Various Categories (cont.)

Category 2: Independent interpretation of tests by the provider

- Example: Provider reviews an outside x-ray and documents findings

NOTE:

- If the diagnostic test interpretation is billed by the office, then you cannot count it here
- If the diagnostic test interpretation isn't being billed by the office, then credit can be given for an independent interpretation, but the details should be documented in the medical record.

Closer Look at the Various Categories (cont.)

Category 3: Discussion of management or test interpretation. The provider discusses the case with an external provider

- Discussion requires direct interactive exchange and not through staff or trainees.
- Discussion cannot be within progress notes.
- External physician or other qualified healthcare professional is defined as an individual who is not in the same group practice or is a different specialty or sub-specialty. Therefore, it includes providers who are within the same multi-specialty group, but who have a different specialty.

Per CPT Amount and/or Complexity of Data to be Reviewed

At the CPT 2020 Symposium they stated: "Unless using time, the data reviewed does not need to occur on the date of the encounter, but it does have to be part of the analysis that is within the encounter. We also believe it is appropriate to count discussion of management or test interpretation as a data element, even if it occurs on a separate date when it is part of the MDM of the encounter. Presumably, this would be on the date of the encounter or very shortly thereafter, as a practical matter to be part of the MDM of the encounter."

Documentation is key!!

Components of MDM
Risk of Complications and/or Morbidity or Mortality of Patient Management

- Possible management options selected
- Management options considered but not chosen
  - Example: Patient with advanced cancer develops an acute condition that normally would warrant hospitalization, but the family chooses not to move forward with treatment and decides to go with palliative care or hospice

Review of the 4 Levels of MDM Risk

Minimal – Minimal risk of morbidity or need for additional testing or treatment. Management option in table of risk: rest, gargle, band aids, superficial dressing

Low: Low risk of morbidity and management options: OTC, Occupation/Physical Therapy, IV fluids with no additives

Moderate: Moderate risk of morbidity from testing or treatment. Management options: prescription drug, decision for major surgery w/o identified risk factors, minor surgery with identified risk factors, diagnosis or treatment significantly limited by social determinants of health

High: High risk of morbidity from additional testing or treatment. Management options: Drug therapy requiring intensive monitoring, Major surgery with identified risk factors, DNR, decision regarding emergency major surgery, decision regarding hospitalization or escalation of hospital-level service, parenteral controlled substances (intended for the initiation of parenteral controlled substance)

Definition of Social Determinants of Health (SDOH)

- Social determinants of health – economic and social conditions that influence the health of people and communities. Examples may include housing and food insecurity.
- Social determinants fall under moderate complexity – this includes diagnosis or treatment significantly limited by social determinants of health. – homelessness, food insecurity, lack of housing that would not allow for frequent dressing changes, no refrigeration for insulin.
- Documentation will be key by the providers!!!
- *Smoking or alcohol use are part of social history and not considered social determinants*

CPT Definition of Drug Therapy Requiring Intensive Monitoring for Toxicity

Per CPT they have given a definition of what drug therapy requiring intensive monitoring for toxicity is:

"A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or exam does not qualify. The monitoring affects the level of medical decision making an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Annual labs does not qualify"

Medical Decision Making

	Elements of MDM		
Level of MDM (2 of 3)	**Number of Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
N/A	N/A	N/A	N/A
SF	Minimal 1 self-limited or minor	Minimal or None	Minimal Risk

Medical Decision Making

	Elements of MDM		
Level of MDM (2 of 3)	**Number of Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Low	Low 2 or more self-limited or minor or 1 stable chronic illness OR 1 acute, uncomplicated illness or injury OR 1 stable, acute illness OR 1 acute, uncomplicated illness or injury requiring hospital inpatient or OBS level of care	Limited (meet at least 1 of 2 categories) **Category 1: Tests and documents** Any combination of 2: • Review prior external notes from each unique source • Review results of each unique test • Ordering of each unique test OR **Category 2:** Assessment requiring independent historian(s)	Low Risk

Medical Decision Making

	Elements of MDM		
Level of MDM (2 of 3)	**Number of Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Moderate	Moderate 1 or more chronic illness w/ exacerbation, progression or side effects of treatment OR 2 or more stable chronic illnesses OR 1 acute illness with systemic symptoms OR 1 acute complicated injury	Moderate (meet at least 1 of 3 categories) **Category 1: Tests and documents or independent historian(s)** Any combination of 3: • Review prior external notes from each unique source • Review results of each unique test • Ordering of each unique test • Assessment requiring an independent historian (s) OR **Category 2:** Independent interpretation of tests • Performed by another provider (not separately reported) OR **Category 3**: Discussion of management or test interpretation • Discussion with external provider/source (not separately reported)	Moderate Risk Examples only: Prescription drug management Decision regarding minor surgery with identified patient or procedure risk Decision regarding elective major surgery without identified patient or procedure risk factors Dx or Txt significantly limited by social determinants of health

Medical Decision Making

	Elements of MDM		
Level of MDM (2 of 3)	**Number of Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
High	High 1 or more chronic illness w/ severe exacerbation, progression or side effects of treatment OR 1 acute or chronic illness or injury that poses a threat to life or bodily function Multiple morbidities requiring intensive monitoring (nursing facility only)	Moderate (meet at least 2 of 3 categories) **Category 1:** Tests and documents or independent historian(s) Any combination of 3: • Review prior external notes from each unique source • Review results of each unique test • Ordering of each unique test • Assessment requiring an independent historian (s) OR **Category 2**: Independent interpretation of tests • Performed by another provider (not separately reported) OR **Category 3**: Discussion of management or test interpretation • Discussion with external provider/source (not separately reported)	Moderate Risk 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 care Decision not to resuscitate or to de-escalate care because of poor prognosis Parenteral controlled substances

Critical Care

- Per CMS, critical care ad-on code 99292 should be reported in complete 30-minute increments
- The first unit of the add-on code isn't reported until at least 104 minutes are spent (74 minutes (represented with parent code 99291 + 30 minutes)
- Per CPT, the add-on code can be reported at minute 75 minutes

Recap - Assessment and Plan

- Make sure your A/P reflects the conditions you are treating
- Tie the conditions to a treatment plan
- How are they responding to treatment
- Is the condition acute, chronic, stable, resolved, worsening etc.

Recap on E/M Services

- Visits will be leveled based on total time or MDM
  - Whichever is more advantageous to the provider
  - Reminder- Time does not apply in the ED setting
- When separately reportable services are reported, performed or interpreted they are NOT to be included when leveling the E/M
- History and Exam should still be performed and documented
- New CPT prolonged service code for prolonged services in the IP/OBS setting
- For teaching facilities, be sure to know the requirements for medical students/resident-involved visits, as there are specific guidelines that should be followed

Thank you!

References

- 2023 AMA CPT Profession Edition
- 2023 CMS Final Rule
- MM12982 - Medicare Physician Fee Schedule Final Rule Summary: CY 2023 (cms.gov)
- Medicare Claims Processing Manual (cms.gov)