2023 Documentation Guidelines:

- Taken from ACEP lecture given by Dr. Michael Granovsky, July 2022

The Top 10 List – Key 2023 MDM Drivers:

1. Document appropriate consideration of admission or escalation of hospital level of care
    - Chest pain, COPD, asthma, hyperglycemia
2. Document discussion of management with other providers
    - Hospitalist or consultant, PCP
3. Document independent interpretations
    - ECGs, plain X-rays, CT scans, ultrasounds
4. Document review of external records
    - Inpatient hospital admission, office records, nursing home records, EMS run sheets
5. Document diagnostic tests appropriately considered, even if not ultimately performed
    - X-ray or CT scan.
    - Head injury PECARN criteria applied and discussed with parent
6. Document prescription medications were appropriately considered
    - Antibiotics, antivirals, pain medications, etc.
7. Document if history is obtained from an independent historian
    - Parent, caregiver, EMS, etc.
8. Chronic illnesses impacting care
    - Diabetes mellitus, hypertension, chemotherapy
9. Document if care is affected by social determinants of health
    - Homeless, illiterate, limited access to medical care or treatments
10. Document discussion of test interpretation with external physician/provider
    - Discussed with radiologist regarding abdominal CT, etc.

Why change?

- Change in Guidelines: "Patients over paperwork"
    - Stated goal is to reduce the documentation burdens on clinicians and to allow them more time to spend in direct patient care
    - Result: may see reductions in coding levels which will reduce our total RVU's generated, which will reduce our payment for services provided
- Currently 83% of typical ED doc RVU's are 99281-99285 (40% level 5, 30% level 4, 10% level 3), 8% from 99291 (critical care) and 9% from procedures
- E/M service

Level	2022 MDM	2023 MDM	2023 RVUs
99281	Straight forward	None	0.64
99282	Low	Straight Forward	1.24
99283	Moderate	Low	2.11
99284	Moderate	Moderate	3.56
99285	High	High	5.17
99291	Critical care	Critical Care	6.33

- Likely that the new guidelines will result in fewer level 3's and more level 4's
- Current guidelines are from 1995 (i.e. 4 HPI elements, 10 ROS, 8 PE, etc.)

- As of January 1, 2023, new guidelines take effect, similar to the changes recently in effect for outpatient office-based codes, which emphasize medical decision making (MDM) or time spent on that individual patient
- New guidelines were released July 1, 2022
    - History and physical exam is NOT an element used in choosing the correct office based codes
        - The history and PE will still be important for understanding the clinical presentation of the patient and for medical legal reasons
        - However, the H&P will no longer matter for billing and code selection
    - ACEP's representatives to the AMA's RUC and CPT process were instrumental in assuring that ***time*** is NOT a key determining factor for emergency department-based E/M levels of service
        - Successfully argued we are generally managing multiple patients at once, so keeping track of individual minutes spent on each patient is an unreasonable burden in the emergency department setting
        - This may not seem like a big deal…but this was/is HUGE and a great victory for EM!
        - Without time to determine E/M level of service, we are left with just our MDM to determine the E/M service
        - The following grid will not be something you need to memorize but you should understand that a coder will use something like the following grid to determine the correct code for your chart

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		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
99281	N/A	N/A	N/A	N/A
99282	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99283	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	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* or 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

	Component 1 – Problems	Need 2 Out of 3 Component 2 – Data	Component 3 – Risk
Level 4	Chronic illnesses with exacerbation Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	*(Must meet 1 of 3 categories)* **Category 1: Tests, documents, or independent historian** Three from the following: • Review of prior external notes • Ordering of each unique test • independent historian(s) D-dimer Troponin BNP Basic labs CXR EKG **Category 2: Independent interpretation of diagnostic test** **Category 3: Discussion of management or test interpretation with external provider**	Prescription drug management Decision regarding minor surgery with risk Diagnosis or treatment significantly limited by social determinants of health
Level 5	Chronic illnesses with severe exacerbation Acute or chronic illness or injury poses a threat to life or bodily function Cough Vague CP Wheeze Vomiting	(Must meet 2 of 3 categories) **Category 1: Tests, documents, or independent historian** Three from the following: • Review of prior external notes • Ordering of each unique test • independent historian(s) D-dimer Troponin BNP Basic labs CXR **Category 2: Independent interpretation of Diagnostic test** EKG Interp. **Category 3: Discussion of management or test interpretation with external provider**	Drug therapy requiring intensive monitoring for toxicity Decision regarding hospitalization Decision not to resuscitate or to de-escalate care

- Current guidelines use a risk table (as above) to help determine level of MDM, including 3 components:
  - Patient's presenting problem
    - For example, a chronic illness with exacerbation or an acute problem or multiple chronic illnesses with a severe exacerbation, etc.
  - Diagnostic Tests
    - Lab w/venipuncture, a CXR, etc.
  - Management Options
    - OTC medications, need for IVFs, or fracture reduction, or need for IV narcotic, etc.
- The new guidelines will make the patient's presenting problem and management options even bigger components when assessing MDM
  - For purposes of this scoring, you are not able to include independent interpretation of test if it is billed separately (i.e. ECG billed separately)
  - "Old record review" changed to require "review of ***external*** notes," which would not include review of your ED's prior notes but notes from external sites
    - Like nursing home records, EMS run sheet, previous discharge summary
  - Use of an independent historian
    - Parent, guardian, spouse, etc.
  - Independent interpretation of a test
    - Lab results, ECG, X-ray, etc.
  - **Our documentation will be key** to helping coders assign the appropriate code level
  - New to the assessment of risk:
    - Diagnosis/treatment limited by social determinants of health
      - Patient is homeless or does not have access to prescriptions
      - Low level literacy or illiterate, unemployment, psychosocial circumstances
    - **Consider** management becomes as important as doing it
      - "I considered ordering a CT scan but chose not to do so because…"
      - Considering inpatient hospitalization or observation

- Considering treatment options like antibiotics or no antibiotics

Examples:

- Teenager presents with productive cough and fever. COVID swab and Flu swab are negative. Diagnosis: Acute bronchitis
    - Is this a level 3 or level 4?
        - History gathered from patient and mother (**independent historian**)
        - **Consideration** of prescribing antibiotics or antiviral medications.
            - Tests were negative, patient appears non-toxic. Discussed with mother and prescriptions were not indicated
        - In current practice, probably a level 3
        - With new guidelines and proper documentation, this may be a level 4
- Male in his 50s w/hx of COPD presents with dyspnea. On exam, wheezing and tachypneic. Treated with multiple nebs, and tests include CBC, chem-7, and CXR. CXR negative for pneumonia. Patient improves and is discharged home.
    - Is this a level 4 or 5?
        - Patient presented with COPD exacerbation
        - **Independent interpretation of CXR** revealed no infiltrate and chronic changes seen
        - **External note reviewed**: prior admission reveals baseline O2 sat of 92%
        - **Consideration of admission**: On initial reassessment after treatment started, patient not improved enough and may require admission. Treatment continued and patient improved. Can be discharged home for outpatient follow up with his PCP
        - Could easily have been a level 4 based on old documentation guidelines but could easily be a level 5 with new guidelines if documented properly
- 39-year-old M presents with chest pain for 3 weeks and reports it is worse if he coughs. Patient appears comfortable on my examination. D-dimer and cardiac profile ordered, as well as other basic labs and a lipase due to some vomiting after coughing. Some expiratory wheezes auscultated. BNP added to tests. Treated with an inhaler treatment in ED. Rapid COVID-19 test sent and CXR obtained.
    - Is this a level 4 or a 5?
        - A lot of factors to consider. If you document your thought processes, will easily be a level 5. If not, could easily drop down to level 4

<u>"Silver linings" of new guidelines</u>:

- "***The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.***" 2023 CPT E/M Descriptors and Guidelines, released July 1, 2022
    - Big win by ACEP in the new guidelines: support for "prudent layperson standard" when evaluating a patient is not determined by the final diagnosis:
    - Many payers across the country have been attempting to decrease our E/M billing level based on the final diagnosis rather than the patient's presentation. For example, young patient presents with chest pain and it is determined to be GERD or costochondritis, versus older patient with a history of CAD/CABG, DM, HTN presenting with chest pain and final diagnosis determined to be GERD or costochondritis.
    - Payers have been trying to say the final diagnosis does not support a higher level of service, even if your work-up and concerns were the same as if the patient may have had acute coronary syndrome
    - ACEP has long argued, and Congress previously agreed, that the standard should be based on what a prudent layperson would believe was an emergency medical condition

- "***Multiple problems of a lower severity may, in the aggregate, create a higher risk due to interaction.***" 2023 CPT E/M Descriptors and Guidelines, released July 1, 2022
    - Patient has impetigo, BP is elevated, "I came in today because I twisted my ankle"
- "***Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.***" 2023 CPT E/M Descriptors and Guidelines, released July 1, 2022
    - Don't have to recopy and document every test
    - If you ordered it and reviewed it, you will get credit for it even if you don't enter the test into your record
- "***Ordering a test may include those considered, but not selected after shared decision making. A patient may request diagnostic imaging that is not necessary for their condition. Discussion of the lack of benefit may be required."***
    - Patient with headache for 1 hour and says, "I want a head CT scan."
    - It is the cognitive work, not the ordering of the study, that counts towards grading or scoring for MDM