2023 DOCUMENTATION GUIDELINES
FROM THE EDPMA WEBINAR OCTOBER 2022

What has it been? – the 1995 Code Selection Guidelines require the following to assign the level of care

- A “quantifiable” History and Physical Exam
- MDM – medical decision making
    - Diagnosis & management options
    - Data
    - Risk

What is the change with the new 2023 Code Selection Guidelines?

- History and Exam no longer factor into determining the E&M Level
- However, “a medically appropriate” H&P still must be documented
    - Used to develop overall plan
    - Helps with monitoring the overall health of the patient
- *Billing* will be based solely on MDM documentation

E&M level selection will now be based only on MDM

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications, morbidity and/or mortality of patient management

Currently, coders assign risk based on:

- Presenting problem(s)
- Diagnostic procedure(s) ordered
- Management options selected

- NOTE: currently, risk counts for only one element of medical decision making

With the new guidelines, MDM now has different categories of risk

- Risk of the presenting problem(s)
- Risk of complications/morbidity/mortality of patient treatment and management
- Also, the amount and/or complexity of data reviewed and analyzed helps determine the level of risk

Coders use a table to track elements and determine **level of risk** of MDM

Level of Risk	Number and complexity of presenting problem(s) addressed	Amount and/or complexity of data reviewed/analyzed	Risk of complications, morbidity, and mortality of treatment & management
Minimal	1 self-limited or minor problem	Minimal or none	**Minimal** risk of morbidity from additional diagnostic testing or treatment
Low	• ≥ 2 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 admission or observation level of care	**Limited** – Must meet at least 1 of 2 categories **Category 1: Tests & documents (any combination of 2)** • Review prior external note(s) from unique source • Review result(s) of each unique test • Ordering each unique test **Category 2: Assessment requiring independent historian(s)**	**Low** risk of morbidity from additional diagnostic testing or treatment
Moderate	• ≥ 1 chronic illness w/exacerbation, progression, or side effects of treatment • ≥ 2 stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 acute complicated injury or acute illness with systemic symptoms	**Moderate** – Must meet at least 1 of 3 categories **Category 1: Tests, documents or independent historians (any combination of 3)** • Review prior external note(s) from unique source • Review result(s) of each unique test • Ordering each unique test • Assessment requiring independent historian(s) **Category 2: Independent interpretation of tests** • Not one separately reported **Category 3: Discussion of management or test interpretation** • Discuss with external health care professional or appropriate source (not separately reported)	**Moderate** risk of morbidity from additional diagnostic testing or treatment *Examples*: • 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	• ≥ 1 chronic illness with severe exacerbation, progression, or side effects of treatment • 1 acute or chronic illness/injury that poses a threat to life or bodily function	**Extensive** – Must meet at least 2 of 3 categories **Category 1: Tests, documents or independent historians (any combination of 3)** • Review prior external note(s) from unique source • Review result(s) of each unique test • Ordering each unique test • Assessment requiring independent historian(s) **Category 2: Independent interpretation of tests** • Not one separately reported **Category 3: Discussion of management or test interpretation** Discuss with external health care professional or appropriate source (not separately reported)	**High** risk of morbidity from additional diagnostic testing or treatment *Examples*: • Drug therapy requiring intensive monitoring (i.e. INR for warfarin. Glucose levels and electrolytes do not apply) • Decision regarding major elective 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 deescalate care due to poor prognosis • Parenteral controlled substances

To select a level of care, two out of three columns must meet or exceed that level

- Problem category 99281 or **Minimal**
  - With the new guidelines descriptor change, 99281 does not require the presence of a physician

- This code is highly unlikely to be used by emergency medicine going forward

- Problem category 99282 or **Straightforward**
  - Only 1 self-limited or minor problem addressed under the “number & complexity of problems addressed” category
  - Suture removal, repeat rabies vaccine, wound check are some examples

- Problem category 99283 (or 4) or **Low**
  - Acute uncomplicated illness or injury
    - Does not likely require testing or imaging
    - Treated with OTC meds
  - Stable, acute illness already undergoing treatment*
    - Stable is defined by patient-specific goals of treatment
    - A patient who isn’t at their treatment goal is not stable
    - *Note: these examples are for all providers across all service lines*
      - *A patient presenting to the ED for evaluation generally would not meet the definition of stable*
  - Stable, chronic illness like HTN, COPD, asthma, DM
    - The provider must either treat or document they addressed the problem in the MDM in order to count the condition in the problem category.
      - <u>Examples</u>: for patients with hypertension, the provider would comment whether lab results are normal or abnormal for things like electrolytes, creatinine, BUN and relate it to th epatient’s HTN condition
      - A patient with hypertension who presents with elevated blood pressure and is compliant with their medication (name the medication and dosage) and the provider does not feel additional intervention is necessary today
      - For diabetic patients, document the blood sugar level obtained during the encounter. Is it normal or abnormal, and are additional treatment steps necessary?

- Problem category 99284 or **Moderate**
  - ≥ 1 chronic illness w/exacerbation, progression, or side effects of treatment
    - Worsening or poorly controlled condition requiring care or adjustments to care or creates side effects as a result of care
      - Asthma, COPD, ulcerative colitis, MS
  - ≥ 2 stable chronic illnesses
  - 1 undiagnosed new problem with uncertain prognosis
    - Examples: Abdominal pain, chest pain, undifferentiated mass
    - These could end up as level 99285 depending on the work up, findings and your documentation
  - 1 acute complicated injury or acute illness with systemic symptoms

        - Multiple injuries, not life-threatening
        - Fracture requiring evaluation of cardiovascular or neuro vascular structures
        - Patient has symptoms in other body areas slash organ systems other than condition, like pyelonephritis, pneumonitis, allergic reaction

- Problem category 99285 or **High**
    - One or more chronic illnesses with **severe** exacerbation, progression, or side effects of treatment
        - This is a worsening or poorly controlled chronic illness which will require additional care or adjustments to care, or one which creates side effects as a result of care (may or may not require hospitalization. Or observation)
        - Some examples include Asthma, COPD, CHF
    - One acute or chronic illness or injury that poses a threat to life or bodily function
        - Some examples include myocardial infarction, Pulmonary embolus., severe respiratory distress, acute renal failure., abrupt change in neurologic status
    - The presenting problems in these categories are high risk presentations, with significant risk of morbidity or poses a threat to life or bodily function.
    - These are patients with symptoms that potentially represent a highly morbid condition and, therefore, support high MDM, even when the final diagnosis is not highly morbid
    - The final diagnosis for a condition does not, in and of itself, determine the complexity of the MDM.
    - Your differential diagnosis can help the coder determine if the category is moderate or high complexity

- Problem category key points
    - Review all complaints and reasons for the patient's presentation.
    - Remember all the things you need to take into consideration In treating and managing the patient, Including:
        - Presenting problem(s)
        - Comorbidities
        - Addictions (an unstable, chronic condition)
        - Social determinants of health
    - Documenting a differential diagnosis is very important
    - Documentation that the provider used a risk calculator or score to determine the need for additional treatment or testing is also an indicator of the complexity of the problem being addressed
        - HEART score
        - PECARN head injury rule
        - NEXUS C-spine rule
        - PORT score

Data category

- **Limited** – Must meet at least 1 of 2 categories
    - **Category 1: Tests & documents (any combination of 2)**
        - Review prior external note(s) from unique source
            - Nursing home record
            - Urgent care note
            - EMS note
        - Review result(s) of each unique test
            - Test not ordered by the provider during that encounter
                - A prior CT done a month ago
                - Labs from last admission
        - Ordering each unique test (without overlapping elements)
            - An example is a lab test panel like CMP or CBC
            - X-rays
                - You would not get credit for ordering a 1-view chest X-ray and a two-view chest X-ray since they have overlapping elements
    - **Category 2: Assessment requiring independent historian(s)**
        - A parent, a guardian, a spouse, a witness

- **Moderate** – Must meet at least 1 of 3 categories – could be 99283 or 99284
    - **Category 1: Tests, documents or independent historians (any combination of 3)**
        - Review prior external note(s) from unique source
        - Review result(s) of each unique test
        - Ordering each unique test
        - Assessment requiring independent historian(s)
    - **Category 2: Independent interpretation of tests**
        - Not one separately reported
        - A test for which there is a CPT and an interpretation or report is customary
            - For example, an X-ray, EKG, ultrasound
            - If you are billing out an independent interpretation (i.e., EKG), the order for that test cannot be counted separately, nor can the interpretation be billed separately.
    - **Category 3: Discussion of management or test interpretation**
        - Discuss with external health care professional or appropriate source (not separately reported)
            - Discuss images with a radiologist, or discuss admission with a hospitalist, or discuss patient’s condition with a consultant, or discuss issues with case management

- **Extensive** – Must meet at least 2 of 3 categories - 99285
    - **Category 1: Tests, documents or independent historians (any combination of 3)**

        - Review prior external note(s) from unique source
        - Review result(s) of each unique test
        - Ordering each unique test
        - Assessment requiring independent historian(s)
    - **Category 2: Independent interpretation of tests**
        - Not one separately reported
    - **Category 3: Discussion of management or test interpretation**
        - Discuss with external health care professional or appropriate source (not separately reported)

    - Since you must meet at least 2 of the 3 categories to reach the extensive or high complexity for 99285 E&M Level, this puts extra emphasis on the need for either independent interpretation of a test or discussion of management or test interpretation with another health care professional or appropriate source

Key points for the Data Category:

- If a test is repeated, it only counts once.
    - For instance, repeat blood glucose levels.
- Credit is given for the review of tests done outside of the encounter.
- Interpretations (EKG, X-rays, US, etc.) are not separately billable if using towards data category points
    - However, documentation does not need to meet the requirements of a billable interpretation if used for data category points
- Remember there are points for conversations with other health care providers, police, nursing homes, etc.

Risk Category

- Limited risk 99283
    - Low risk of morbidity from additional diagnostic testing or treatment.
    - This is probably the baseline for most patients, so you would only need to meet the criteria in one other category to be able to code a 99283.

- Moderate risk 99284
    - Moderate risk of morbidity from additional diagnostic testing or treatment.
    - Examples:
        - Prescription drug management
            - The provider administered, prescribed, or evaluated current medications during the ED visit
            - Continuing, discontinuation or modification of patient's existing medication dosages
        - Decision regarding minor surgery with identified patient or procedure risk factors.
            - Might include wound repairs, foreign body removal, or I&D

        - Decision regarding elective major surgery without identified patient or procedure risk factors
            - Displaced fracture care, reduction of an intermediate or major joint dislocation, insertion of a chest tube, cardioversion, intubation
        - Diagnosis or treatment significantly limited by social determinants of health
            - Economic or social conditions, such as food or housing insecurity that may significantly limit the diagnosis or treatment of a patient's condition
            - The inability to afford prescribed meds or the inaccessibility of subsequent healthcare
            - Homelessness, unemployed, alcohol or substance abuse

- High risk 99285
    - High risk of morbidity from additional diagnostic testing or treatment.
        - Drug therapy requiring intensive monitoring for toxicity. (i.e. INR for warfarin)
            - Glucose levels and electrolytes do not qualify
        - 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
            - Both the decision to admit or to consider admission but then not to admit count
                - "I feel this patient will do well as an outpatient"
                - Documenting a HEART score of three or less suggests this was considered for decision to admit or not admit
        - Decision not to resuscitate or to deescalate care because of poor prognosis
        - Parenteral controlled substances
            - Any controlled substance given IM or IV, like Morphine, Demerol, Dilaudid, Versed, Ketamine, Ativan, Valium, Narcan

Key Points for Risk Category

- Documentation of any conversations with the patient regarding transfer or admission, even if just to discuss why it is not necessary
- Documentation of scores or decision tools
- Documentation of any I am or IV. Administration of controlled substances
- Documentations of decisions to deescalate care due to poor prognosis