2023 EVALUATION AND MANAGEMENT SERVICE GUIDELINES – EMERGENCY MEDICINE CODER TRAINING – PART 1 OF 4

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TOPICS

- 2023 E/M Services Guidelines – Summary
- Code Revisions
- E/M Code Descriptors
- General Principals of Medical Record Documentation
- Medical Decision Making

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (1)

- Effective January 1, 2023
- Replacement for the 1995 and 1997 DGs
- Adopted by the AMA and CMS
- Intended to reduce administrative burden on providers
- AMA Table of Risk and CMS tools used to create the new MDM grid

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (2)

- History and exam no longer elements in selection of E/M codes
- Revision to Emergency Department services E/M codes 99281 – 99285 and accompanying guidelines
- Time is not a descriptive component for the ED E/M codes

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (3)

- Observation service codes deleted for 2023, but the concept of observation care has not been eliminated
- Observation codes combined with Inpatient Care codes to form one code family
  - Initial: 99221 - 99223
  - Subsequent: 99231- 99233
  - Discharge: 99238 or 99239
  - Admission and Discharge on the same date 99234 - 99236

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (4)

- Selection of code based on either time or MDM level.
- Time is not a component in the ED so MDM will be used for final E/M code choice for emergency medicine services.
- Time for shared or split visit is now a sum of the provider and/or QHPs (Qualified Healthcare Providers) providing the service - change from previous “substantive care” language

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (5)

- No distinction between new and established patients in the ED. Exists for other specialties.
- New vs. established patient definitions remain unchanged
- Focused on a physician or other QHP of the exact same specialty or subspecialty who belongs to the same group practice, within the past three years.

NEW 2023 CPT E/M SERVICES GUIDELINES – SUMMARY (6*)

- Advanced registered nurse practitioner (ARNP) and physician assistants (PAs) are considered as working in the same specialty or subspecialty as the physician.
- Critical care services are not impacted since these are time-based codes without an MDM component in their code descriptors

CODE REVISIONS

DELETED E/M CODES (1)

- 99217: Obs Discharge – Replaced with 99238, 99239
- 99218-99220: Initial Obs – Replaced with 99221-99223
- 99224-99226: Subsequent Obs – Replaced with 99231-99233

REVISED CODES – EMERGENCY DEPARTMENT

ED	HX & EX	MDM
99281	Evaluation and management of a patient that may not require the presence of a physician or other qualified healthcare provider	-
99282	Medical appropriate history and/or examination	Straightforward
99283	Medical appropriate history and/or examination	Low
99284	Medical appropriate history and/or examination	Moderate
99285	Medical appropriate history and/or examination	High

2023: E/M code 99283 is now low complexity instead of moderate. Some criteria for moderate complexity type cases will move from 99283 to 99284.

EMERGENCY MEDICINE E/M CODE DESCRIPTORS

EM E/M CODE DESCRIPTORS (1)

- 99281 - Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified healthcare professional.
- 99282 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and examination, and straightforward medical decision making.
- 99283 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and examination, and low level of medical decision making.

EM E/M CODE DESCRIPTORS (2*)

- 99284 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and examination, and moderate level of medical decision making.
- 99285 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and examination, and high level of medical decision making.

GENERAL PRINCIPALS OF MEDICAL RECORD DOCUMENTATION

GENERAL PRINCIPALS OF MEDICAL RECORD DOCUMENTATION (1)

Each patient encounter should include:

- Reason for visit
- Relevant History & Exam
- Review pertinent prior diagnostic tests and past history
- Studies ordered with pertinent results listed
- Treatment provided
- Diagnosis or diagnoses
- Plan of care and disposition

GENERAL PRINCIPALS OF MEDICAL RECORD DOCUMENTATION (2*)

Each patient encounter should include (cont.):

- "…if rational for ordering diagnostic/ancillary services not documented, it should be easily inferred"
- Past and present diagnoses should be accessible
- Appropriate health risks identified
- Patient's process, response to care, and any revisions of diagnosis

DOCUMENTATION THAT HELPS DRIVE MDM LEVEL

- Document order and review of laboratory, x-ray, and special studies.
- Document review of old records. Document how they are related to the current visit, what was discovered during record review, and how it is pertinent to the current visit.
- Document conversations with persons other than the patient. This includes conversations with parents, grandparents, and siblings who represent younger children, or the elderly who may be unable to provide a reliable history.

ITEMS NOT INCLUDED IN DETERMINATION OF MDM LEVEL

- Some studies, primarily EKG and Ultrasound interpretations, should NOT count towards MDM if they are coded and billed separately.

EXAMPLE – GREAT ED PROVIDER DOCUMENTATION

“This is a 35-year-old male with a history of nausea and vomiting for the last two days. Patient complaining of weakness and some intermittent abdominal cramping. The patient is not experiencing ongoing chest or abdominal pain. On exam, the patient has dry mucous membranes, a tachycardia of 104, and a BP of 110/70. The patient’s lungs are clear, there is no murmur, and there is no focal abdominal tenderness. The plan is to order a CBC, a BMP, a liver profile and lipase, and at least one liter of lactated ringer’s solution, and IV Zofran™ 4 mg and reassess. On reassessment, lab studies revealed normal results, and the urinalysis shows a specific gravity of 1.020 with no ketones and no WBCs or RBCs. The patient is feeling better and is discharged on clear liquids and Zofran 4 mg orally q 4-6 h prn nausea.”

MDM – WHERE THE RUBBER HITS THE ROAD

HISTORY AND EXAM

- No longer elements in the selection of E/M codes
- Nature and extent are determined by the treating provider performing the services
  - "Only as appropriate"
- Primary purpose is now to support care of the patient
- Descriptive history and exam are still important as they help coders determine the complexity of a patient's problem(s)

MEDICAL DECISION MAKING IN 2023

Marshfield Clinic Scoring Tool will become obsolete in 2023!

E/M CODE SELECTION

- Selection of an E/M level is based on the following:
  1. The level of the MDM as defined for each service, or
  2. The total time for E/M services performed on the date of the encounter BUT. . .
- "Time is not a descriptive component for the emergency department levels of E/M services (99281-99285) because emergency department services are typically provided on a variable intensity basis, involving multiple encounters with several patients over an extended period of time."*

ED must be coded using MDM.

2023 TABLE 1: LEVELS OF MEDICAL DECISION MAKING (MDM) (1)

- **Multiple pages of guidelines and definitions addressing among other items:**
  - What does “problems addressed” mean?
  - What does “analyzed” mean as it pertains to the data column?
  - Single vs. multiple tests?
  - What qualifies as a “unique” test?
  - Who qualifies as an “independent historian”?

2023 TABLE 1: LEVELS OF MEDICAL DECISION MAKING (MDM) (2)

- **Multiple pages of guidelines and definitions addressing among other items (cont.):**
  - What does “external” mean as it applies to medical records, physicians, or QHPs?
  - How do coders count a test that has been “considered” but not ordered?
  - Who qualifies as an external physician or “appropriate source”?
  - What is a social determinant of health (SDOH)?

2023 TABLE 1: LEVELS OF MEDICAL DECISION MAKING (MDM) (3*)

- Examples in the grid applicable to specific settings of care
  - Example: The decision to hospitalize applies to the outpatient (e.g. ED, offices or nursing facility encounters), whereas the decision to escalate hospital level of care (e.g., transfer to ICU) applies to inpatient hospital or patients placed in observation.

2023 MDM COMPONENTS

MDM still consists of three components and is still scored by the highest two of three:

1. Number and Complexity of Problems Addressed (COPA)
   - Previously Number of Diagnoses and Management Options
2. Amount and/or Complexity of Data to be Reviewed and Analyzed (DATA)
   - Qualitative
3. Risk of Complication and/or Morbidity or Mortality of Patient Management (RISK)
   - Incorporates elements of the Risk Table
   - Can use objective criteria used in past for level of risk

MDM LEVELING

- Four types of MDM are recognized: straightforward, low, moderate, and high.
- MDM includes establishing a diagnoses, assessing the status of a condition, and/or selecting a management option.
- MDM does not apply to 99211 or 99281.

THE OLD WAY VS. THE NEW WAY

2022 1995 Documentation Guidelines				
Level	HPI	ROS	PFSHX	PE
1	1	0	0	1
2	1	1	0	2
3	1	1	0	2-7
4	4	2	1	2-7
5	4	10	2	8

2023 Emergency Medicine MDM Requirements by E/M Level		
Level	2022 MDM	2023 MDM
99281	Straightforward	None
99282	Low	Straightforward
99283	Moderate	Low
99284	Moderate	Moderate
99285	High	High

MDM LEVELING: BIGGEST CHANGES (1)

- Previously Number of Diagnoses and Management Options now COPA
- Additional work-up planned is no longer a major factor
  - Gone is “new problem to the examiner” and the 3 vs. 4 points
- More qualitative in nature now:
  - Self-limited or minor problem
  - Acute, uncomplicated illness or injury
  - Acute illness with systemic symptoms
  - Chronic illness with severe exacerbation

MDM LEVELING: BIGGEST CHANGES (2)

- Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

MDM LEVELING: BIGGEST CHANGES (3)

- "The final diagnosis for a condition does not, in and of 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. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid."

MDM LEVELING: BIGGEST CHANGES (4*)

- The evaluation and/or treatment should be consistent with the likely nature of the condition.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.
- The term “risk” as used in these definitions relates to risk from the condition.

MDM LEVELING: POTENTIAL ISSUES

- Management of multiple new or established conditions could impact MDM
  - Example: Diabetes with a new urinary tract infection
- Must document co-morbidities that could impact treatment
  - Examples: Hypertension, diabetes

QUESTIONS:

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REFERENCES

- AMA *CPT® Evaluation and Management (E/M) Code and Guideline Changes.* July 1, 2022. American Medical Association.