E/M Documentation Challenges and 2023 Changes

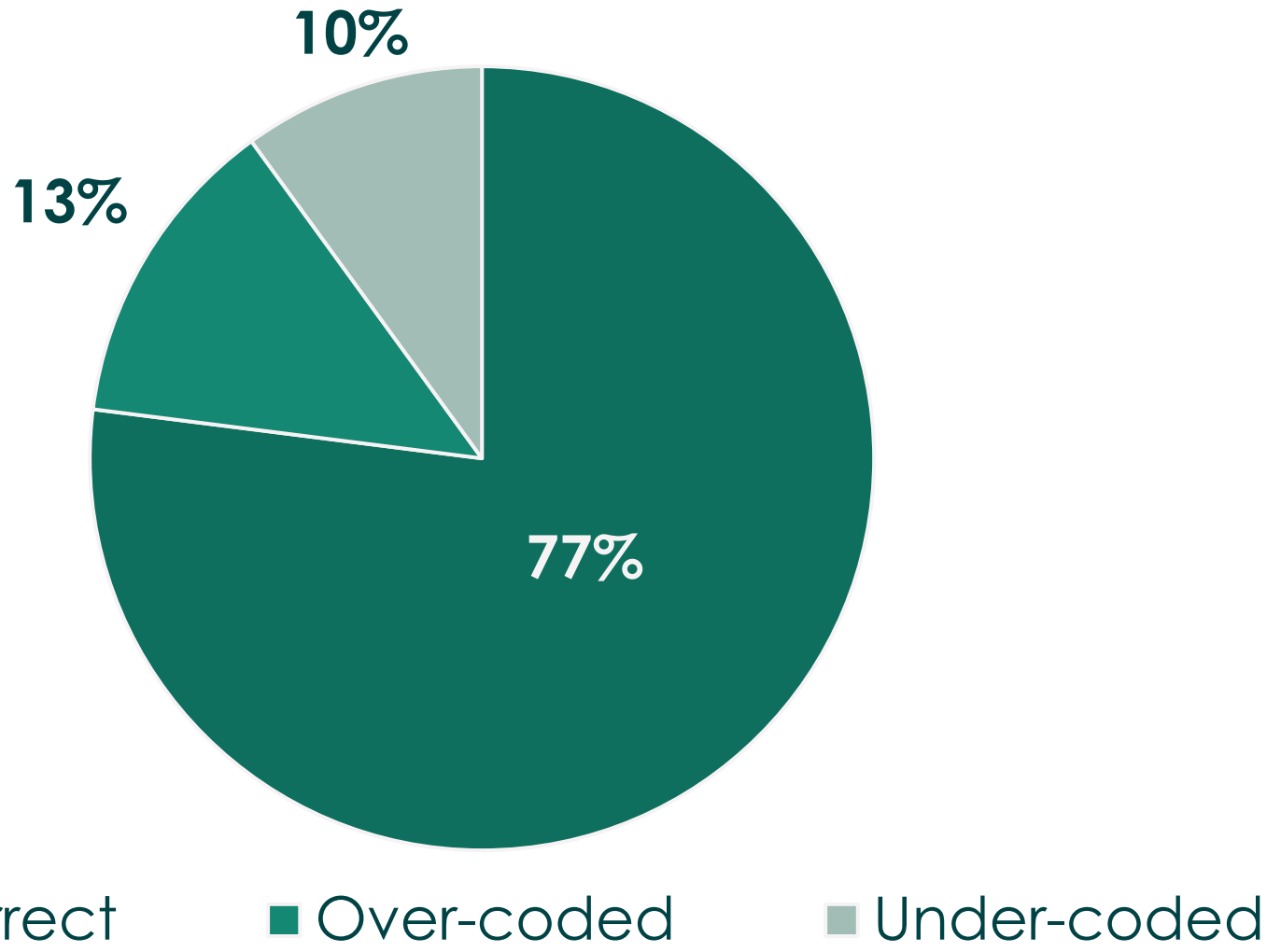
Agenda

- Review what we learned implementing 2021 E/M guideline changes
- Overview of the 2023 E/M guideline changes

What Have We Learned?

- Fear of upcoding
- Reluctance to code with the new guidelines
- Challenges with new guidelines
- Not counting time correctly
- Applying CPT guidelines to CMS regulations/guidance
- Documentation review followed by education works

AAPC Audit Services Case Study



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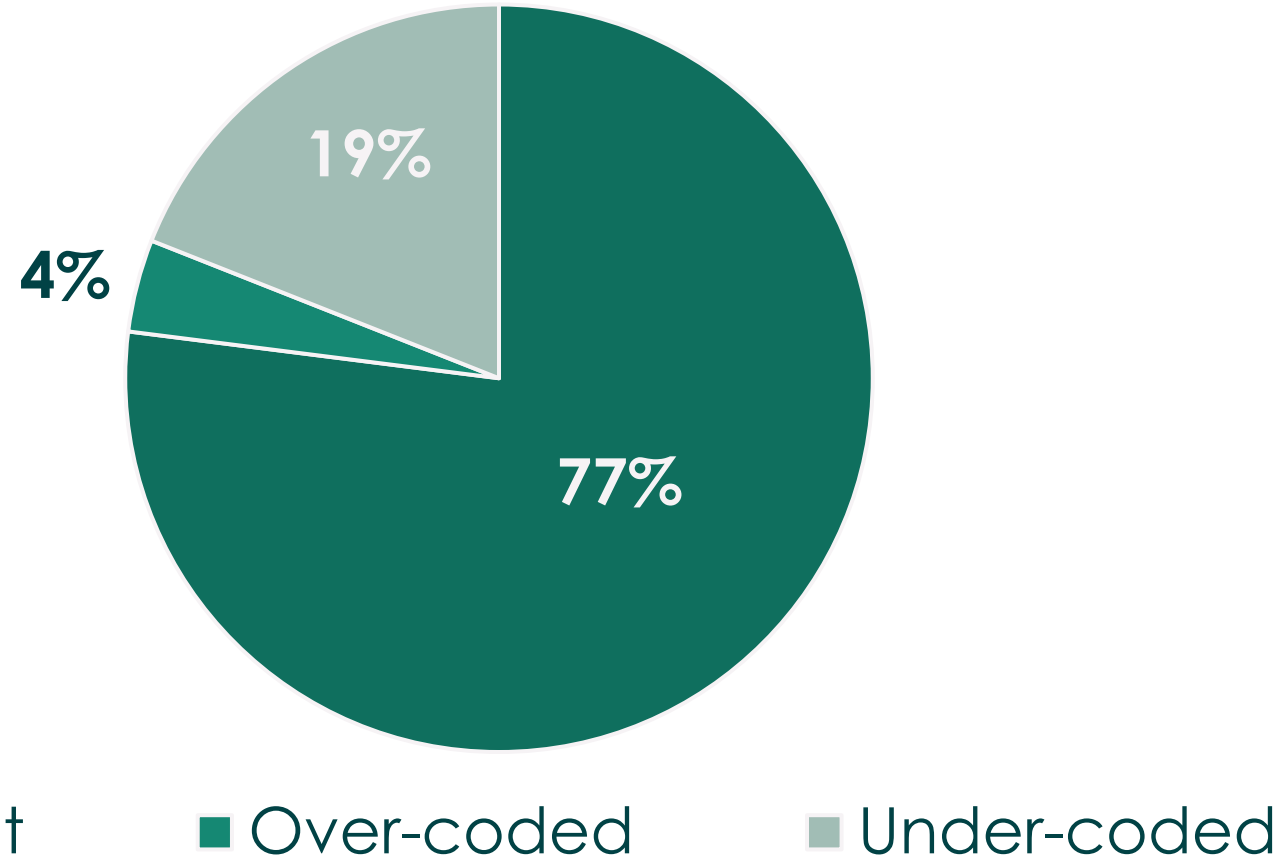
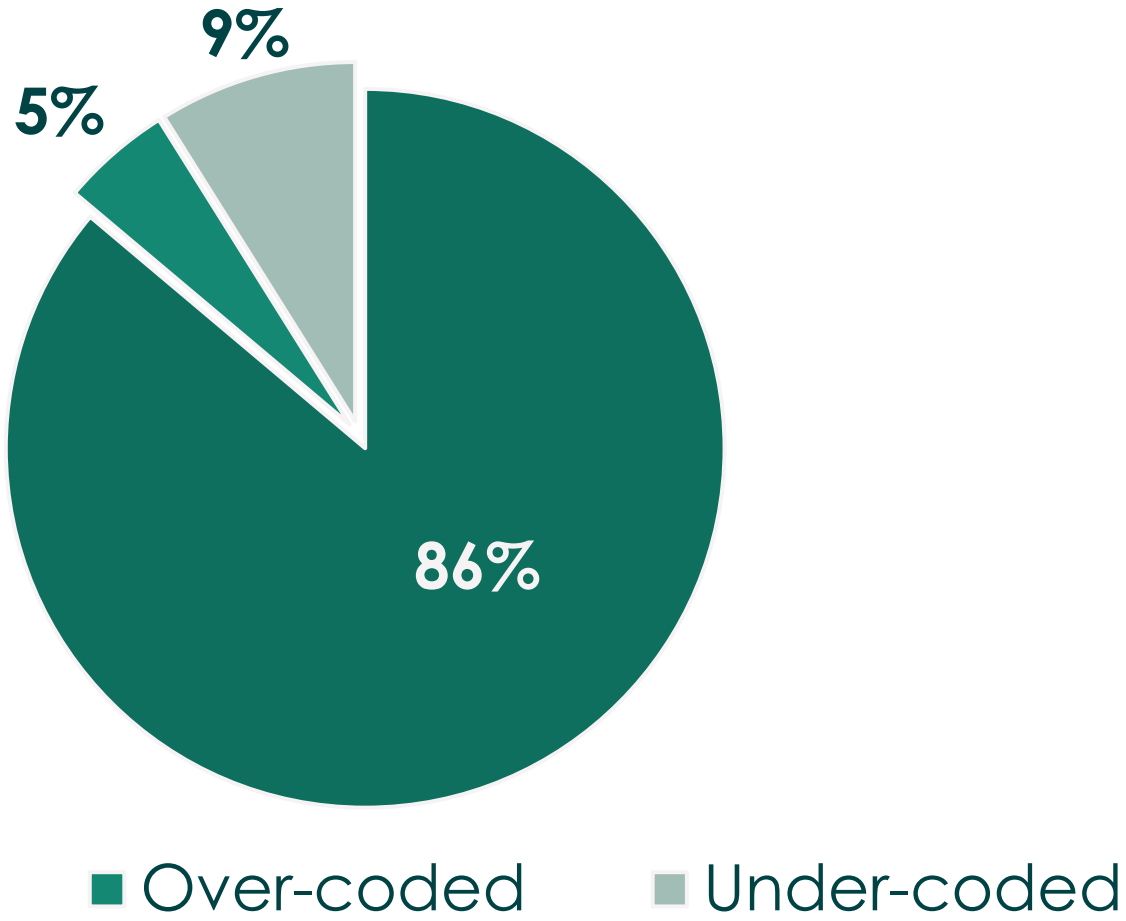


March 2021



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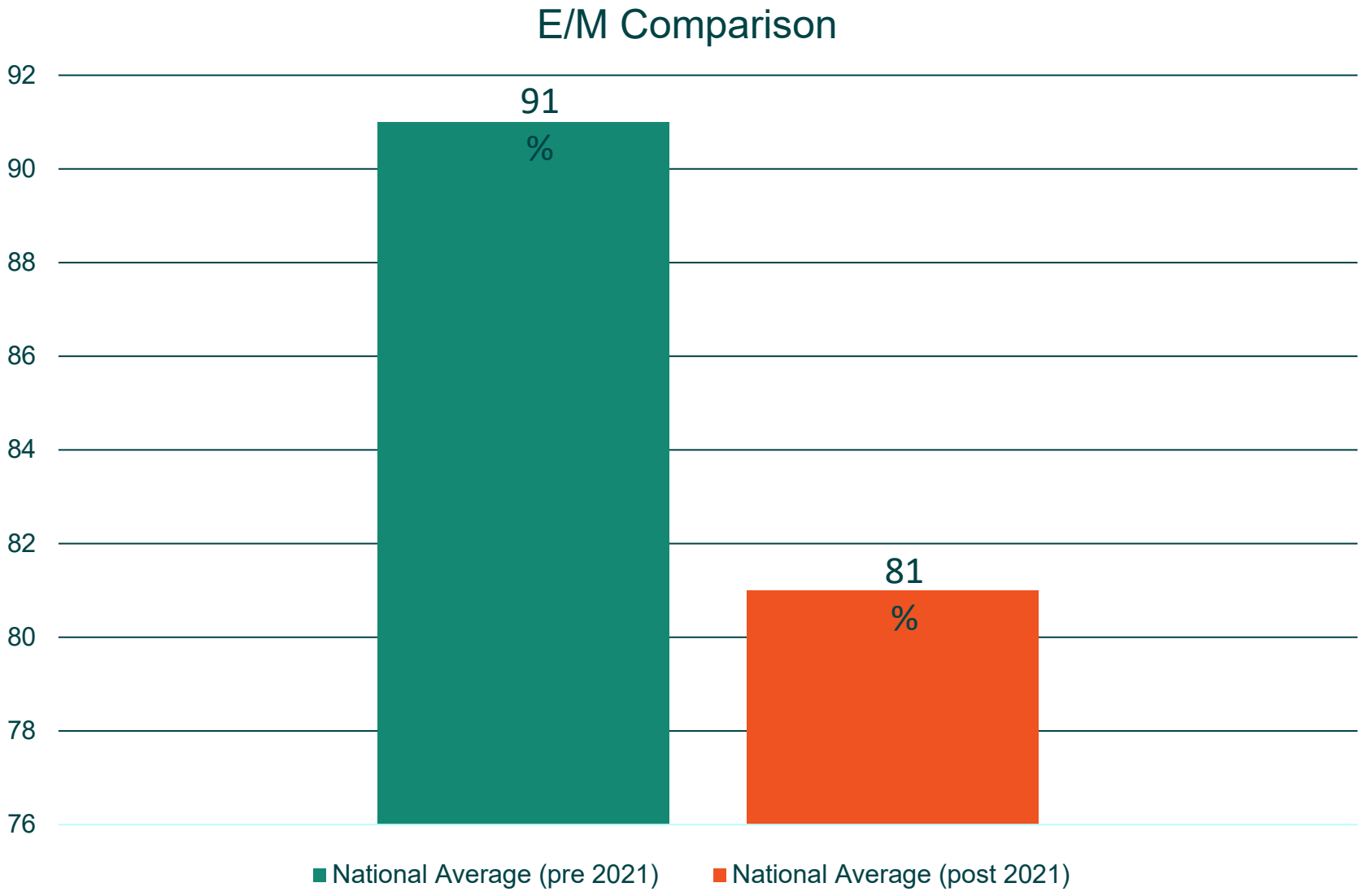
E/M Comparison
92
90
88
86
84
82
80
78
76
91
%
81
%
National Average (pre 2021)
National Average (post 2021)

Documentation Challenges

Reason for Change

- Reduce administrative burden
- Align with how patient care is delivered today
- Reduce the need for audits

Requirements for Documentation

- Reason for the encounter
- Patient history
- Examination
- Review of prior test results
- Assessment
- Plan of care
- Date and identity of the provider performing the service

Requirements for Documentation

- Reason for ordering diagnostic tests and ancillary services
- Appropriate health risk factors
- Patient's response to treatment and any changes in treatment
- Procedure codes and diagnosis codes should be supported by the documentation
- The information must be legible

Common Questions

Providers I work with continuously just want to note issues in the A/P without noting anything in the history or exam.

MDM – Complexity of Problems Addressed

MDM – Complexity of Problems Addressed

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Do multiple acute, uncomplicated illness or injuries make a moderate number and complexity of problems addressed?

Case Example - ENT

Patient is an 89 YO male who presents with nosebleed left side x 2 weeks. Went to ER twice and had packing. He was not told to come off the Warfarin even after second nosebleed.

Appropriate ROS, PFSH and exam.

Assessment

Epistaxis

Anticoagulation Complication

Instructions

Nosebleed instructions provided

If bleeds again and goes to ER, would strongly consider 7-10 days off the warfarin.

MDM – Data

If a provider documents multiple lab results or test results, what is the best practice for using those towards MDM when unsure if this same provider/group previously ordered the tests (without going back to review prior notes)?

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

MDM – Risk

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The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

What level of risk would you assign if a provider ordered testing such as Echo, U/S, etc. Would this be straightforward or low risk. Can you follow the old examples under table of risk for 95/97 guidelines as there are not examples under risk for straight forward and low?

Do you have to document total time and MDM?

Yes

No

No, it is not required to document both. The criteria that best describes the work done should be documented.

Time Documentation Recommendations

- Include only the time for the date of service
- Clinical staff time can not be included
- Time spent performing other billable services can not be included
- Total time needs to be documented
  - Not required to associate the time to each activity
- Activities performed need to be documented
- Audit concerns

Can resident’s time be counted toward total time?

Yes

No

CMS Teaching Physician Guidelines for reporting resident services for time-based codes have not changed. In the PFS CY2022 Final Rule, CMS clarifies that resident time can not be counted in total time

Prolonged Services Confusion

- New prolonged services codes used only with level 5 when time is used for determining the level

- Differences between CPT and CMS

Prolonged Services Time – CPT

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1, 99417 x 1
90-104 minutes	99205 x 1, 99417 x 2
105 minutes or more	99205 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Services Time – CPT

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-69 minutes	99215 x 1, 99417 x 1
70-84 minutes	99215 x 1, 99417 x 2
85 minutes or more	99215 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Services Time – 2021 Final Rule

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
60-74 minutes	99205
89-103 minutes	99205 x 1, G2212 x 1
104-118 minutes	99205 x 1, G2212 x 2
119 minutes or more	99205 x 1, G2212 x 3 or more for each additional 15 minutes

Prolonged Services Time – 2021 Final Rule

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
40-54 minutes	99215
69-83 minutes	99215 x 1, G2212 x 1
84-98 minutes	99215 x 1, G2212 x 2
99 minutes or more	99215 x 1, G2212 x 3 or more for each additional 15 minutes

When assessing the level of risk associated with procedures, are global days for surgical procedures used to determine whether a procedure is minor or major?

Yes

No

Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

CPT 2023 E/M Changes

Changes in 2023: Evaluation and Management Guidelines

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.

Changes in 2023: Evaluation and Management Guidelines

The risk of complications and/or morbidity or mortality of patient management. This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family.

Changes in 2023: Evaluation and Management Guidelines

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Changes in 2023: Evaluation and Management Guidelines

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.

Changes in 2023: Evaluation and Management Guidelines

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

Changes in 2023: Evaluation and Management Guidelines

Independent historian(s): An individual (eg, 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 (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Changes in 2023: Evaluation and Management Guidelines

Problem addressed: For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

Changes in 2023: Evaluation and Management Guidelines

- The MDM table has been revised to support the changes in the other categories.

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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
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 (1 out of 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

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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
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 (1 out of 3 categories) Category 1: Tests and documents ■ 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 Category 3: Discussion of management or test interpretation	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

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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
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	High (2 out of 3 categories) Category 1: Tests and documents ■ 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 Category 3: Discussion of management or test interpretation	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 care** ■ Decision not to resuscitate or to deescalate care because of poor prognosis ■ **Parenteral controlled substances**

Changes in 2023: Inpatient and observation services

- Observation discharge (99217), initial observation (99218, 99219, 99220), and subsequent observation (99224, 99225, 99226) were deleted.

- Initial hospital care (99221-99223), subsequent hospital care (99231-99233), admission and discharge on the same date of service (99234-99236), and hospital discharge (99238, 99239) codes and guidelines were revised.

Changes in 2023: Inpatient and observation services

- Initial: “the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.”
- Subsequent: “the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.”

Changes in 2023: Inpatient and observation services

When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date.

Initial Hospital Inpatient or Observation Care

Code	MDM	Time
99221	Straightforward or Low	40 minutes met or exceeded
99222	Moderate	55 minutes met or exceeded
99223	High	75 minutes met or exceeded

If a service is 90 minutes or longer, use prolonged service code 993X0

Subsequent Hospital Inpatient or Observation Care

Code	MDM	Time
99231	Straightforward or Low	25 minutes met or exceeded
99232	Moderate	35 minutes met or exceeded
99233	High	50 minutes met or exceeded

If a service is 65 minutes or longer, use prolonged service code 993X0

Hospital Inpatient or Observation Care Including Admission and Discharge Services

Code	MDM	Time
99234	Straightforward or Low	45 minutes met or exceeded
99235	Moderate	70 minutes met or exceeded
99236	High	85 minutes met or exceeded

If a service is 100 minutes or longer, use prolonged service code 993X0

Changes in 2023: Consultations

- Codes 99241 and 99251 were deleted.

- The other codes and guidelines in this category were revised.

Changes in 2023: Consultations

- A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.
- The consultant's opinion and any services that were ordered or performed must also be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

Office or Other Outpatient Consultations

Code	MDM	Time
99242	Straightforward	20 minutes met or exceeded
99243	Low	30 minutes met or exceeded
99244	Moderate	40 minutes met or exceeded
99245	High	55 minutes met or exceeded

If a service is 70 minutes or longer, use prolonged service code 99417

Inpatient or Observation Consultations

Code	MDM	Time
99252	Straightforward	35 minutes met or exceeded
99253	Low	45 minutes met or exceeded
99254	Moderate	60 minutes met or exceeded
99255	High	80 minutes met or exceeded

If a service is 95 minutes or longer, use prolonged service code 993X0

Changes in 2023: Emergency Department

- The codes and guidelines in this category were revised.

Changes in 2023: Emergency Department

For critical care services provided in the emergency department, see Critical Care guidelines and 99291, 99292. Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes and critical care services are provided.

Emergency Department

Code	MDM
99281	May not require the presence of a physician or other qualified health care professional
99282	Straightforward
99283	Low
99284	Moderate
99285	High

Changes in 2023: Nursing facility services

- Annual nursing facility assessment (99318) was deleted.
- All other codes in this category were revised as well as the guidelines.

Changes in 2023: Nursing facility services

When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a high-level MDM-type specific to initial nursing facility care by the principal physician or other qualified health care professional is recognized. This type is:

Multiple morbidities requiring intensive management: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

Initial Nursing Facility Care

Code	MDM	Time
99304	Straightforward or Low	25 minutes met or exceeded
99305	Moderate	35 minutes met or exceeded
99306	High	45 minutes met or exceeded

If a service is 60 minutes or longer, use prolonged service code 993X0

Subsequent Nursing Facility Care

Code	MDM	Time
99307	Straightforward	10 minutes met or exceeded
99308	Low	15 minutes met or exceeded
99309	Moderate	30 minutes met or exceeded
99310	High	60 minutes met or exceeded

If a service is 95 minutes or longer, use prolonged service code 993X0

Nursing Facility Discharge Services

- These services require a face-to-face encounter with the patient and/or family/caregiver that may be performed on a date prior to the date the patient leaves the facility. Code selection is based on the total time on the date of the discharge management face-to-face encounter.

Changes in 2023: Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

- The codes and guidelines for this category were deleted.

Changes in 2023: Home Services

- All codes were revised as well as the guidelines.

Home or Residence Services – New Patient

Code	MDM	Time
99341	Straightforward	15 minutes met or exceeded
99342	Low	30 minutes met or exceeded
99344	Moderate	60 minutes met or exceeded
99345	High	75 minutes met or exceeded

If a service is 90 minutes or longer, use prolonged service code 99417

Home or Residence Services – Established Patient

Code	MDM	Time
99347	Straightforward	20 minutes met or exceeded
99348	Low	30 minutes met or exceeded
99349	Moderate	40 minutes met or exceeded
99350	High	60 minutes met or exceeded

If a service is 75 minutes or longer, use prolonged service code 99417

Changes in 2023: Prolonged Services

- Deletion of codes 99354-99357
- Revisions to 99358, 99359, 99415, 99416
- Revision to 99417
- New prolonged service 993X0

Prolonged Services – 2023 CPT

Total Duration of Office or Other Outpatient Consultation Services (use with 99245)	Code(s)
Less than 70 minutes	Not reported separately
70-84 minutes	99245 x 1, 99417 x 1
80-99 minutes	99245 x 1, 99417 x 2
100 minutes or more	99245 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Services – 2023 CPT

#★✚●993X0 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)

(Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)

Prolonged Services – 2023 Proposed Rule

GXXX1 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report GXXX1 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0,

99415, 99416).

(Do not report GXXX1 for any time unit less than 15 minutes).

Prolonged Services Time – GXXX1

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99223	105 minutes	Date of visit
99233	80 minutes	Date of visit
99236	125 minutes	Date of visit to three days after

Prolonged Services – 2023 Proposed Rule

GXXX2 (Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report GXXX2 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0).

(Do not report GXXX2 for any time unit less than 15 minutes)).

Prolonged Services Time – GXXX2

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99306	95 minutes	1 day before visit + date of visit +3 days after
99310	85 minutes	1 day before visit + date of visit +3 days after

Prolonged Services – 2023 Proposed Rule

GXXX3 (Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report GXXX3 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417).

(Do not report GXXX3 for any time unit less than 15 minutes)).

Prolonged Services Time – GXXX3

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99345	141 minutes	3 days before visit + date of visit + 7 days after
99350	112 minutes	3 days before visit + date of visit + 7 days after

What to Expect

- Continued refinement of the guidelines
- Collaboration is required for success
- Ongoing education will be necessary

Case Example

Time seen by clinician. 1835

Chief Complaint: Ankle and leg injury

History present illness

15-year-old male patient complains of an injury to the leg and foot. The injury occurred shortly prior to arrival. The injury allegedly occurred while playing football at local high school field, another player fell on his leg and foot. Mother states she saw the child when he fell, his leg twisting when the other players fell on him. Patient did not continue playing any more football, mother states he's not walking on his leg at all secondary to pain. No other complaints of pain, injury or illness.

Case Example

Patient's allergies: NKDA
Patient's current medications: no routine prescription medications

Review of systems: All other systems negative.
Social History. Public school, lives with family
Family History: Noncontributory visit today

Case Example

Physical Exam, Vital Signs: Afebrile, VSS

General, well appearing, well nourished

Patient Status. Alert and cooperative

Heart: RRR, no MRG

Lungs: CTAB

Case Example

Ankle: Right ankle, diffuse tenderness medial and lateral malleolus, minimal swelling laterally, ROM normal flexion, normal plantarflexion , no obvious deformity, skin is intact. Neurovascular status: 2+ pedal pulses, capillary refill less than 2 seconds Achilles tendon non tender, no step off. The foot, knee and hip are without pain or tenderness and with full range of motion

Leg: Right, diffuse pain tibia-fibula, no obvious swelling. Patient has poison ivy bilateral lower legs, no infection. Mother states he has medication for his poison ivy.

Intervention Xray: Right tibia fibula and foot negative for acute bony injury

Case Example

Immobilization was achieved by the application of OCL stirrup short leg splint applied by ortho tech

Immobilization device was then check to assure good neurovascular flow and effectiveness of positioning before the patient was discharged

Crutches dispensed. Crutch walking safely with good use of crutches

Case Example

Diagnosis:
Ankle injury from trauma
Acute sprain right ankle
Contusion right leg

Disposition: The patient was discharged 1855. Discussion regarding radiology to review x-rays and in the event of a discrepancy we will notify patient/family.

Prescriptions: Prescription for Vicodin

Discussion regarding ice, elevation, rest leg and ankle, nonweightbearing until follow up

Follow up: Instructions given to follow up with MD or orthopedics in 4-5days. May return to ER or orthopedics sooner for worsening symptoms

Treatment plan discussed with patient/family who are in agreement.

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	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	None to Minimal	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

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	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	None to Minimal	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Sources

AMA E/M Resources: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

AMA 2021 Technical Corrections https://www.ama-assn.org/practice-management/cpt/errata-technical-corrections

AMA 2023 E/M Guidelines https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

CMS 2023 Proposed Rule https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule

AAPC Website https://www.aapc.com/evaluation-management/em-coding.aspx

Questions?