2023 Office and Hospital Evaluation and Management Services Review

PRESENTED BY:

TRACY BIRD, FACMPE, CPC, CPMA, CEMC, CPC-I

FOR

BLUE CROSS BLUE SHIELD KANSAS

Goals for the Presentation

- Review 2021 changes using MDM or time
- Review 2023 E&M changes using MDM or time
- Discuss common trouble spots and potential documentation problems with the new guidelines

Hospital and Office Are Now Aligned

Code Selection

Based on:

Medical Decision Making

OR

Total Time

(History and Exam only require what is relevant to the encounter)

Deleted Codes

- 99201 Office
- Hospital Observation codes: 99217-99220
- Consultation codes: 99241 and 99251
- Nursing Facility Evaluation code: 99318
- Domiciliary codes : 99234-99238
- Rest Home codes: 99334-99337
- Custodial Care codes: 99339 and 99340
- Home/Residence Service Code: 99343
- Prolonged Service codes: 99354-99357

CODE	TOTAL TIME	2023 Office, Hospital or Other Outpatient E/M Audit Form -MDM (2 out of 3 required) OR TOTAL TIME. Time listed without a range requires total amount of time be met.		
		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
99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99221
99231
99234
99243
99253
99304
99308
99342
99348
99283
	30-44
	20-29
	40
	25
	45
	30
	45
	25
	15
	30
	30
		Low
		• 2+ self-limited or minor problems; 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 observation level of care
			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
			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

99204
99214
99222
99232
99235
99244
99254
99305
99309
99344
99349
99284
	45-59
	30-39
	55
	35
	70
	40
	60
	35
	30
	60
	40
		Moderate
		• 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR
		• 2+ stable chronic illnesses; OR
		• 1 undiagnosed new problem with uncertain prognosis.
		• 1 acute illness with systemic symptoms; OR
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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

99205
99215
99223
99233
99236
99245
99255
99306
99310
99345
99350
99285
	60-74
	40-54
	75
	50
	85
	55
	80
	45
	45
	75
	60
		High
		• 1+ chronic illnesses with 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
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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 of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

CODE	TOTAL TIME	2023 Office, hospital, or other outpatient E/M audit form- MDM (2 out of 3 required) OR total time. Time listed without a range requires total amount of time to be met 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
99202 **99212** **99242** **99252**	**15-29** **10-19** **20** **35**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99221
99231
99234
99243
99253
	30-44
	20-29
	40
	25
	45
	30
	45
		Low
		• 2+ self-limited or minor problems; OR
		• 1 stable chronic illness; OR
		• 1 acute, uncomplicated illness or injury
		• 1 stable acute illness OR
		• 1 acute uncomplicated illness or injury requiring inpatient or observation level of care
			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
			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

99204
99214
99222
99232
99235
99244
99254
	45-59
	30-39
	55
	35
	70
	40
	60
		Moderate
		• 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR
		• 2+ stable chronic illnesses; OR
		• 1 undiagnosed new problem with uncertain prognosis;
		• 1 acute illness with systemic symptoms; OR
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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

99205
99215
99223
99233
99236
99245
99255
	60-74
	40-54
	75
	50
	85
	55
	80
		High
		• 1+ chronic illnesses with 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
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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 of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

CODE	TOTAL TIME	2023 Office, hospital, or other outpatient E/M audit form- MDM (2 out of 3 required) OR total time. Time listed without a range requires total amount of time to be met 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
99202 **99212** **99242** **99252**	**15-29** **10-19** **20** **35**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213** **99221** **99231** **99234** **99243** **99253**	**30-44** **20-29** **40** **25** **45** **30** **45**	**Low** • 2+ self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury • 1 stable acute illness OR • 1 acute uncomplicated illness or injury requiring inpatient or observation level of care	**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 **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**
99204 **99214** **99222** **99232** **99235** **99244** **99254**	**45-59** **30-39** **55** **35** **70** **40** **60**	**Moderate** • 1+ chroni progressi • 2+ stable • 1 undiagn prognosis • 1 acute ill • 1 acute co		**additional diagnostic** ry with identified rs or surgery without risk factors antly limited by social
99205 **99215** **99223** **99233** **99236** **99245** **99255**	**60-74** **40-54** **75** **50** **85** **55** **80**	**High** • 1+ chroni progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Category 1: Tests, documents, or independent historian(s)** • **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** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**ional diagnostic** *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 of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Only 2 out of 3 categories need to be met

Tips for Implenting Guidelines

- Have your compliance officer directly involved in developing work-flow and implementing new guidelines.
- Communicate closely with coding and billing (revenue cycle) to ensure they are auditing documentation and providing feedback and coaching.
- IT can help ensure ancillary staff have access to areas in the EMR they can assist with documentation.
- If your EMR has a code calculator and providers have been using, make sure your system recognizes MDM or time.
- Identify a clinical champion to reinforce documentation changes
- Practice managers and nursing managers need to ensure training and education for the team's new responsibilities

Number & Complexity of Problems Addressed

- A problem is considered addressed when:
  - MEAT is documented: Monitored, Evaluated, Assessed or Treated)
  - Consideration of further testing or tx that ***may be elected or not*** based on the patient and the risk/benefit
  - Noting another professional is managing the problem without further assessment or care coordination **does not qualify as "being addressed."**
  - Referral without evaluation does **not quality as "being addressed".**

Number and Complexity of Problems Addressed

- The problem's status at that encounter.
  - Office – status of the patient today and what you address
  - Hospital – problem being managed or co-managed

    **Keep in mind… May not be the reason for hospital admission

Number & Complexity of Problems Addressed

- Symptoms may cluster around a specific diagnosis and each symptom is NOT a unique condition.
- Comorbidities and underlying disease need to be addressed. To list on the claim.
- Final diagnosis may not determine complexity or risk.
  - Extensive evaluation may be required to reach a conclusion that signs and symptoms don’t represent a highly morbid condition.
  - Presenting signs and symptoms may appear as a highly morbid condition and may drive MDM even when the final diagnosis is not highly morbid.

CODE	TOTAL TIME	2023 Office, Hospital or Other Outp Number and Complexity of Problems Addressed	ient E/M Audit Form -MDM (2 out of 3 required) OR TOTAL TIME. Time listed without a range requires total amount of time be met. Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213 99221 99231 99234 99243 99253 99304 99308 99342 99348 99283	30-44 20-29 40 25 45 30 45 25 15 30 30	**Low** • 2+ self-limited or minor problems; 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 observation level of care	**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 **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**
99204 99214 99222 99232 99235 99244 99254 99305 99309 99344 99349 99284	45-59 30-39 55 35 70 40 60 35 30 60 40	**Moderate** • 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR • 2+ stable chronic illnesses; OR • 1 undiagnosed new problem with uncertain prognosis. • 1 acute illness with systemic symptoms; OR • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **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** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**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
99205 99215 99223 99233 99236 99245 99255 99306 99310 99345 99350 99285	60-74 40-54 75 50 85 55 80 45 45 75 60	**High** • 1+ chronic illnesses with 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	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **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** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**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 of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Minimal Problems Addressed

- Minimal problem:
  - Very low complexity presenting problems
  - One that may not require the presence of the physician or other QHP.
    - “You should have called your Mom first”

Low Complexity Problems Addressed

- 2 or more Self-limited or minor problems:
- One that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status.
- 1 acute uncomplicated illness or injury
- Stable Chronic Problem:
  - ***This is a condition at goal***
- 1 Stable acute illness
- Acute uncomplicated illness or injury requiring hospitalization either in patient or observation

Moderate Complexity Problems Addressed

- Chronic condition with exacerbation, progression or side effects of treatment:
  - **A patient who is not clinically at treatment goal.**
  - **Acutely worsening or poorly controlled**
- 2+ Stable chronic illnesses
  - **A patient with 2 stable problems that are clinically at treatment goal.**
- 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
- Acute complicated injury
- Acute illness with systemic symptoms:

  Has a high risk of morbidity without treatment. **Systemic symptoms such as fever, body aches, or fatigue is a minor illness that may be treated to alleviate symptoms but does NOT MEET THIS DEFINITION.**

High Complexity Presenting Problems

- 1 or more chronic conditions with severe exacerbation, progression or side effects of treatment
- 1 acute or chronic illness or injury that poses a threat to life and bodily function

Number and Complexity of Problems Addressed: Common Documentation Trouble Spots

- Documentation in HPI of co-morbid conditions without status.
- No mention of chronic or co-morbid conditions until A&P
- Determining the right category of presenting problem
- Under documented HPI
- No HPI for hospital subsequent visits. E.g. “Patient better today”
- Threat to life and bodily function – documentation needs to support work up even if end result is not high complexity
- Chronic conditions stable means “Clinically at goal”
- Exacerbated condition is one that is “Clinically not at goal”

Amount and Complexity of Data to be Reviewed and Analyzed

CODE	TOTAL TIME	2023 Office, Hospital or Other Outpatient E/M Audit Form -MDM (2 out of 3 required) OR TOTAL TIME. Time listed without a range requires total amount of time be met.		
		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
99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99221
99231
99234
99243
99253
99304
99308
99342
99348
99283
	30-44
	20-29
	40
	25
	45
	30
	45
	25
	15
	30
	30
		Low
		• 2+ self-limited or minor problems; 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 observation level of care
			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
			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

99204
99214
99222
99232
99235
99244
99254
99305
99309
99344
99349
99284
	45-59
	30-39
	55
	35
	70
	40
	60
	35
	30
	60
	40
		Moderate
		• 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR
		• 2+ stable chronic illnesses; OR
		• 1 undiagnosed new problem with uncertain prognosis.
		• 1 acute illness with systemic symptoms; OR
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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

99205
99215
99223
99233
99236
99245
99255
99306
99310
99345
99350
99285
	60-74
	40-54
	75
	50
	85
	55
	80
	45
	45
	75
	60
		High
		• 1+ chronic illnesses with 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
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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 of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

Guidelines for Data

- The data includes :
  - Medical records, tests, and other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
  - Includes data from multiple sources or interprofessional communication
  - Ordering a test may include those considered but not selected after shared decision making with the patient. Alternatively, a test normally performed may be too risky for the patient and is not ordered but would have been considered in another circumstance.
  - Documentation is required to support a test considered but not done.
  - Tests that have overlapping elements are not unique and only count as 1 test
  - Unique Source- Physician or QPP in a distinct group or different specialty or sub-specialty or a unique entity. The review of ALL materials from one unique source count as one element toward MDM

Definitions in Data Category

- Independent Historian
  - Parent, guardian, surrogate, spouse, witness who provides history in addition to history provided by patient who is unable to provide a complete or reliable history due to developmental stage, dementia, or psychosis
  - ***Does not include translation services***.
- Appropriate Source
  - Professionals who are not health care professionals but may be involved in the management of the patient lawyer, parole officer, case manager, teacher)**Does not include discussions with family or informal caregivers
- Discussion of management or test interpretation
  - Discussion with an external provider or an appropriate source

Limited Data

- Must meet requirements of at least 1 of the 2 categories
- Category 1: requires **any combination** of 2 of the following
  - Review of prior external notes- unique source
  - Review of results of each unique test
  - Ordering of each unique test (defined by separate CPT code) (includes review)
- Category 2: Assessment requiring independent historian

Moderate Data

- Must meet the requirements of at least 1 out of the 3 categories
- Category 1: Any combination of 3 of the following
  - Review of external notes unique source
  - Review results of unique test
  - Ordering (includes review) of unique tests
  - Assessment requiring independent historian
- Category 2: Independent interpretation of a test ordered by another physician or QHP (not reported separately- (meaning billed)
- Category 3: Discussion of management or test interpretation (with external physician or QPP or appropriate source

Extensive data

- Must meet requirements of 2 of the 3 categories
- Category 1: Any combination of the 3
  - Review external notes, external source
  - Review results, external source
  - Ordering unique tests (includes review)
- Category 2: Independent Interpretation of tests
- Category 3: Discussion of management or test interpretation with external physician or QPP/ appropriate source

Amount and Complexity of Data to be Reviewed Common Documentation Trouble Spots

- Double dipping on ordering and reviewing a test
- Unclear who ordered and who is reviewing what tests
- Misinterpretation of what an independent historian is
- Not understanding unique source
- Not understanding unique test
- Counting data elements for items billed separately (EKG's, X-rays, other diagnostic testing)
  - **Exception- point of service waived lab tests may be counted**

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

CODE	TOTAL TIME	2023 Office, Hospital or Other Outpatient E/M Audit Form -MDM (2 out of 3 required) OR TOTAL TIME. Time listed without a ra…		
		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
99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99221
99231
99234
99243
99253
99304
99308
99342
99348
99283
	30-44
	20-29
	40
	25
	45
	30
	45
	25
	15
	30
	30
		Low
		• 2+ self-limited or minor problems; 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 observation level of care
			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
			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

99204
99214
99222
99232
99235
99244
99254
99305
99309
99344
99349
99284
	45-59
	30-39
	55
	35
	70
	40
	60
	35
	30
	60
	40
		Moderate
		• 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR
		• 2+ stable chronic illnesses; OR
		• 1 undiagnosed new problem with uncertain prognosis.
		• 1 acute illness with systemic symptoms; OR
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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

99205
99215
99223
99233
99236
99245
99255
99306
99310
99345
99350
99285
	60-74
	40-54
	75
	50
	85
	55
	80
	45
	45
	75
	60
		High
		• 1+ chronic illnesses with 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
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **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
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			Category 3: Discussion of management or test interpretation
			Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				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 of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

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

- Prescription Drug Management
  - Relates to any drugs or medications requiring prescription by a physician or QPP
  - Does **not** include over the counter medication even if a prescription is written
- Surgery
  - Minor or major based on common meanings of the terms used by clinicians not by the global surgical package.
  - Elective or emergency surgery determined by timing of the procedure related to patient' condition
  - Risk factors for surgery are those relevant to the patient and the procedure
- Social Determinants of Health
  - Economic and social conditions influencing the health of people and communities. Diagnosis codes Z55-Z65.

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

- Drug therapy requiring intensive monitoring for toxicity
  - A therapeutic agent that has the potential to cause serious morbidity or death
  - Not primarily used for the assessment of therapeutic efficacy.
  - Not performed less than quarterly.
  - Monitoring by history or examination does not qualify- must be laboratory test, physiologic test or imaging
- Parenteral controlled substances
  - Qualifying drugs can be found at: https://www.ecfr.gov/current/title-21/chapter-II/part-1300/section-1300.01

Moderate Risk of Morbidity from Additional Diagnostic

- 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

Example of Social Determinants of Health ICD-10 Codes Z55-Z65

Social Determinents of Health ICD-10 codes		
Z55	Problems related to Education and Literacy	
Z55.0	Illiteracy and low-level literacy	
Z55.1	Schooling unavailable or unattainable	
Z55.2	Failed school examinations	
Z55.3	Underachievement in school	
Z55.4	Educational maladjustment and discord with teachers and classmates	
Z55.5	Less than a high school diploma	
Z55.8	Other problems related to education and literacy	
Z55.9	Problems related to education and literacy, unspecified	
Z56	Problems related to employment and unemployment	
Z56.0	Unemployment, unspecified	
Z56.1	Change of job	
Z56.2	Threat of job loss	
Z56.3	Stressful work schedule	
Z56.4	Discord with boss and workmates	
Z56.5	Uncongenial work environment	
Z56.6	Other physical and mental strain related to work	
Z56.8	Other problems related to employment	
	Z56.81	Sexual harrassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment	

Z57	Occupational exposure ot risk factors	
Z57.0	Occumpational exposure to noise	
Z57.1	Occumpational exposure to radiation	
Z57.2	Occupational exposure to dust	
Z57.3	Occupational exposure to other air contaminants	
	Z57.31	Occumpational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture	
Z57.5	Occupational exposure to toxic agents in other industries	
Z57.6	Occupational exposure to extreme temperature	
Z57.7	Occupational exposure to vibration	
Z57.8	Occupational exposure to other risk factors	
Z57.9	Occupational exposure to unspecified risk factor	
Z58	Problems related to physical environment	
Z58.6	Inadequate drinking-water supply	
Z59	Problems related to housing and economic circumstances	
Z59.0	Homelessness	
	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
Z59.1	Inadequa housing	
Z59.2	Discord with neighbors, lodgers and landlord	
Z59.3	Problems related to living in residential institution	
Z59.4	Lack of adequate food	
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food

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 of care
  - Decision not to resuscitate or to de-escalate care because of poor prognosis
  - Parenteral controlled substances

Risk of Complications and/or Morbidity or Mortality of Patient Management
Common Documentation Trouble Spots

- Misunderstanding of what drugs are included in “intensive monitoring” Need to be checking toxicity not efficacy
- Understand risk factors to a patient that makes the overall risk either moderate or high. E.g. patient scheduled for colonoscopy but has a bleeding problem and stage 4 cancer.
- Using the minor and major surgery 10 days or 90 days to determine surgical status.
- Risk is based on patient management not as much the treatment. This takes into consideration each patients needs

Billing By Time

Time Requirements

- Time can be used **in place of** MDM.
- Time is **NOT USED IN ER**.
- Total time on date of encounter includes face to face and non face to face time.
- Only count time related to the current patient.
- Does not include time spent performing separately reported services.
- When billing by time you must meet the entire time defined by the code to bill that level of service
  - E.g. 99222 (Moderate level hospital Admission) requires a total of 55 minutes dedicated to activities for that patient in the 24 hour period of the face to face visit.

Activities Included in Time

- Preparing to see the patient (review records, tests)
- Obtaining or reviewing separately obtained history
- Performing medically appropriate exam and or evaluation
- Counseling and educating patient and family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health professionals
- Documenting in the medical record
- Independently interpreting results
- Care coordination
- Documentation of activities and total time spent.

Common Trouble Spots Using Time

- No activity statement
- All notes document exact same amount of time on every patient
- Statements like: “ I spent about …”

Hospital Changes 2023

Split/Shared 2023

- Split/shared visits between physicians and NPPs are ***only allowed in hospital setting.***
  - FS modifier required for billing
- Split/shared requires the billing provider does the “substantive portion” of the visit **Must be documented to support billing** (Proposed to continue in 2024)
- Substantive defined as one of the 3 key components of
  - History
  - Exam
  - MDM
  - More than half total time spent. Time in this case is used to select the billable provider NOT the level of E&M.

Split/Shared Using Time

- When using time, both physician and NPP must document their time. Any time spent together, only count one provider's time. Time can be added together for billing.
- One provider must have a face to face with the patient
- Carve out time spent performing billable services from E&M time.

In-patient and Observation Care Services

- A medically appropriate history and exam are still required but don't count toward final code selection.
- Observation may ONLY be billed by the provider admitting the patient to observation.(AI Modifier) All other providers involved in the patient's care will bill office /outpatient visit codes. ** Providers will need to know the status of the patient's they are seeing**.
- Admitting provider bills initial hospital or Observation with AI modifier.
- All other physicians treating the patient for the first time may also bill initial codes.

In patient and Observation Care Services

- Patient seen in the office and admitted to the hospital:
  - Medicare only bill one E&M.
  - CPT says each service can be billed (Payer rules may vary).
  - Separate documentation showing the work in both locations must be present.
- Remember 2 levels of hospital discharge: 99238 and 99239. If billing the higher must document time over 30 minutes.
- When billing by time, total time and activity statements required.

Inpatient and Observation, Admission and Discharge Same Day

- Requires two or more encounters on the same date. One is initial admit, the second is discharge.

Inpatient/Observation Service codes	Time Based		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
			MDM level is based on 2 out of 3 elements below:		
99234 – Admit & Discharge	45 mins	OR	Straightforward or Low	Limited	Low
99235 – Admit & Discharge	70 mins		Moderate	Moderate	Moderate
99236 – Admit & Discharge	85 mins		High	Extensive	High
99238 – Discharge only	30 mins or less		Medicare requires a face-to-face interaction.		
99239 – Discharge only	31 mins or more		Medicare requires a face-to-face interaction.		

Inpatient and Observation, Admission and Discharge Same Date Discharge Day Management

- CMS final rule for “8 to 24 hour” rule
- Less than 8 hours bill 99221-99223 not the admit discharge same day
- If 8 hours or more spans 2 dates use 99221-99223 and discharge

Hospital Length of Stay	Discharge On	Codes to Bill
< 8 hours	Same calendar date as admission or start of observation	99221-99223
8 hours or more	Same calendar date as admission or start of observation	99234-99236
< 8 hours	Different calendar date as admission or start of observation	99221-99223
8 hours or more	Different calendar date as admission or start of observation	99221-99223 and 99238,99239

Critical Care Reminders

- 2023 is now allowing split/shared visits for critical care.
- Can be billed on the same date of service as an E&M IF the E&M happened BEFORE the patient's condition worsened warranting critical care AFTER that visit.
- Critical care is NOT A PLACE but a life threatening/ organ failure status.
- Critical Care (99291 & 99292) are timed codes only. Time must be documented to support billing critical care services.

Final Rule Technical Correction – Critical Care For Medicare

- Differences between Medicare time and CPT time for Critical Care
- Medicare instructs to adhere to the time differences
- Medicare requires minimum 104 minutes to add 99292
- Must exclude time spent performing billable services
- Count any time spent performing bundled services including:

Bundled Services	Vascular access
Interpretation cardiac output measures	Collection & Interp physiologic data
Chest x-rays	Computer data such as ECG's
Pulse oximetry	Gastric intubation
Blood gasses	Ventilation management, includes CPAP & CNP

Final Rule Technical Correction- Critical Care

CPT		Medicare & Medicare Advantage	
30-74 min	99291	30-103 min	99291
75-104 min	99291, 99292x1	104-133 min	99291, 99292x1
105-134 min	99291, 99292x2	134-163 min	99291, 99292x2
135-164 min	99291, 99292x3	164-193 min	99291, 99292x3

E&M with Prolonged Care Time (CPT Instructions)

- Not to be used with psychotherapy
- Used for office, office consults, home or residence services and cognitive assessment and care plan
- Can report 99417 once the time of the E&M has been surpassed by 15 full minutes with 99245, 99350, 99483
- Report 99417 with 99205 and 99215 once *minimum required time* of the E&M has been surpassed by 15 minutes.
- Report 99418 with 99223,99233,99236,99255,99306,99310 once time for E&M has surpassed 15 minutes

E/M with Designated Prolonged Care Code	1 unit Prolonged	2 units Prolonged
99205 + 99417	75 mins	90 mins
99215 + 99417	55 mins	70 mins
99223 + 99418	90 mins	105 mins
99233 + 99418	65 mins	80 mins
99236 + 99418	100 mins	115 mins
99245 + 99417	70 mins	85 mins
99255 + 99418	95 mins	110 mins
99306 + 99418	60 mins	75 mins
99310 + 99418	60 mins	75 mins
99345 + 99417	90 mins	105 mins
99350 + 99417	75 mins	90 mins

Prolonged Services Medicare

- No prolonged care with discharge or ER codes
- G0316- for Inpatient or observation prolonged care each additional 15 minutes
- G0317 – Used in nursing facility for prolonged care each additional 15 minutes
- G0318- Used in home or residence for prolonged care each additional 15 minutes
- Initial care must be based on time and must be the highest level of service
- Prolonged time can be with or without direct patient contact

Medicare Prolonged Care: Inpatient, Observation, Admit/Discharge, NF, Home, Residence, Cognitive Assessment & Care Plan

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 Care Clinical Staff Services (Ancillary Staff)

- 2 new codes 99415 and 99416
- Cannot begin using until 30 minutes beyond typical clinical staff time for ongoing assessment of patient during a visit.
- To be used when staff are spending time with patient and/or family/caregiver. Time does not need to be continuous.

E/M Code	Typical Clinical Staff Time	99415 Time Range Minutes	99416 Time Range Minutes
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

Common Documentation Trouble Spots Hospital

- HPI does not support medical necessity for a billable service
- Unclear who is managing what, documentation unclear
- Tests reviewed or ordered, unclear documentation as to who should receive credit
- Statements that are unclear e.g. “Consult Ortho”

Other Common Documentation Issues

- Many practices have not changed their documentation templates to reflect more succinct documentation.
  - HPI * - Good place to set up a medically necessary visit
  - ROS
  - PFSH
- Still using click box documentation creating lengthy notes that have not relevance to presenting problem
- Continue to have “note bloat” for items not relevant to presenting problem
- Medication lists for all meds, but unclear who is managing when statement says “Continue meds”

Importance of ICD-10-CM Codes

- Establish medical necessity when coupled with correct level of CPT
- Sequencing is important
- Clustered diagnoses
- Definitive diagnosis with signs and symptoms
- Tying diagnosis codes to correct CPT codes
- Watch for “Code Also” “Code first”


Questions and Answers