CODING & COMPLIANCE INITIATIVES, INC.

Documentation and Coding Training

My Background

- My connection to coding and documentation
- My connection to clinical processes
- My connection to ICD-10
- My connection to YOU

About the program

- The following program is founded upon the principles of coding, documentation and regulatory compliance. At times it may represent an interpretation by the presenter. Even though the presenter has made every effort to produce reliable content, attendees are encouraged to verify the information prior to implementing changes within their practice

- Medical necessity
- General principles
- Orders
- Documentation shortcuts
- Evaluation and Management
- Documentation Examples
- Learning Lab
- ICD-10 Updates

Medical Necessity

Medical necessity from payer's perspective

- Services provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except for clinical trials, not for experimental, investigational, or cosmetic purposes.

- The medical record must support all codes submitted to third party payers.

Medical necessity from payer's perspective

- **CCI recommends that Providers develop a habit of beginning each document with a clearly defined reason for the service, whether E/M or a procedure.**

- **Document a reason for each order (meds, diagnostics, and procedures).**

- To avoid denials for medical necessity, or accusations of over coding or false claims, documentation must be an accurate representation of the service and thoroughly define the need for the service.

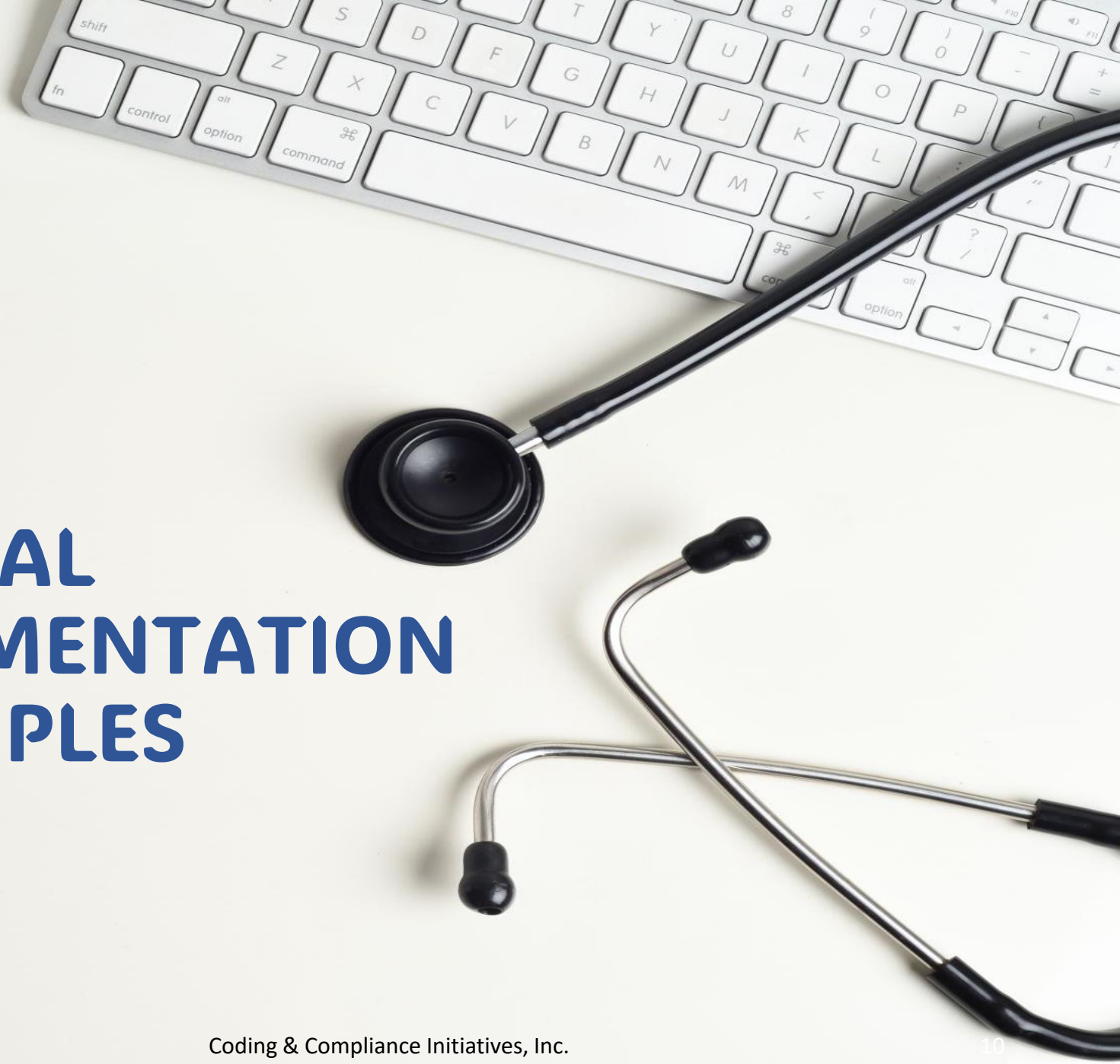
Common obstacles

- Unedited text - templates.
- Inconsistencies in documentation.
- Copy and pasted notes.
- Assessments that do not link a specific reason to each diagnostic service or procedure ordered.
- Services provided (repeated) too frequently according to payer policy.
- Lack of awareness of payer policy (LCD/NCD)

Common obstacles

- Know what information is prepopulated in your EMR
  - Findings need to be consistent throughout the note. *If the HPI says positive for cough and ROS says denies cough – there is a discrepancy.*
- Beware of copying/pulling forward notes. While the ability to copy/pull forward is helpful for documenting visits for patients with chronic care problems – the documentation must be updated to reflect the current visit.

GENERAL DOCUMENTATION PRINCIPLES



Best Practices

- General principles of medical record documentation apply to all medical and surgical services and settings.

- They are instrumental for:
  - Continuum of care
  - Risk mitigation
  - Coding
  - Billing

Stand alone document

- The documentation for each encounter, E/M or procedure, **should "stand alone."** Records need to clearly illustrate:
  - The reason for the encounter (medical necessity)
  - Details of what took place
  - Final assessment/outcome
  - Instructions to the patient

- If missing, challenges under audit will ensue.

- Then we start to back peddle…

Completing the note

- Document as soon as possible:
  - reduces risk of you forgetting any details
  - ensures all team members are updated on any changes to the patient's condition or management of the patient
  - can't bill until the note is complete and authenticated

ORDERS

Orders MLN dated September 2023

CMS offers the following:

- *The majority of improper lab services payments identified by CERT come from **insufficient documentation**. Insufficient documentation means the patient medical records are missing something.*
- *Sufficient documentation supports:*
  - *Intent to order (for example, a signed progress note, signed office visit note, or signed physician order)*
  - *The medical necessity of ordered services*

We don't consider tests not ordered by the physician to be reasonable and necessary.

When completing progress notes, the provider should clearly indicate all tests to be performed - "run labs" or "check blood" alone doesn't support intent to order.

Diagnostic test order requirements are met if there's:

- *A signed order or requisition listing the specific tests.*
- *An unsigned order or requisition listing the specific tests and an authenticated medical record supporting the physician's intent to order the tests (for example, "order labs," "check blood," and "repeat urine" aren't acceptable).*
- *An authenticated medical record supporting the physician's intent to order specific tests.*

DOCUMENTATION EXAMPLES

- *Patient w/ cough. Needs labs and Xray.*

✓*Patient with a history of a persistent cough over the past few weeks. Given her history, will obtain a 2-view chest x-ray and cbc w/ diff.*

✓*Assessment: urinary frequency and urgency. + wbc on UA. Send for C&S.*

Screening vs. diagnostic services

- The diagnosis (reason for the test) should differentiate between screening and diagnostic testing.
- This can impact reimbursement for the lab and out of pocket expense for the patient.

For example:

- Annual (6 mo check) lipid panel for a patient with a known diagnosis of hyperlipidemia and an A1c for a diabetic are not screening labs.
- The intent of the test must be linked to the order.

DOCUMENTATION EXAMPLES

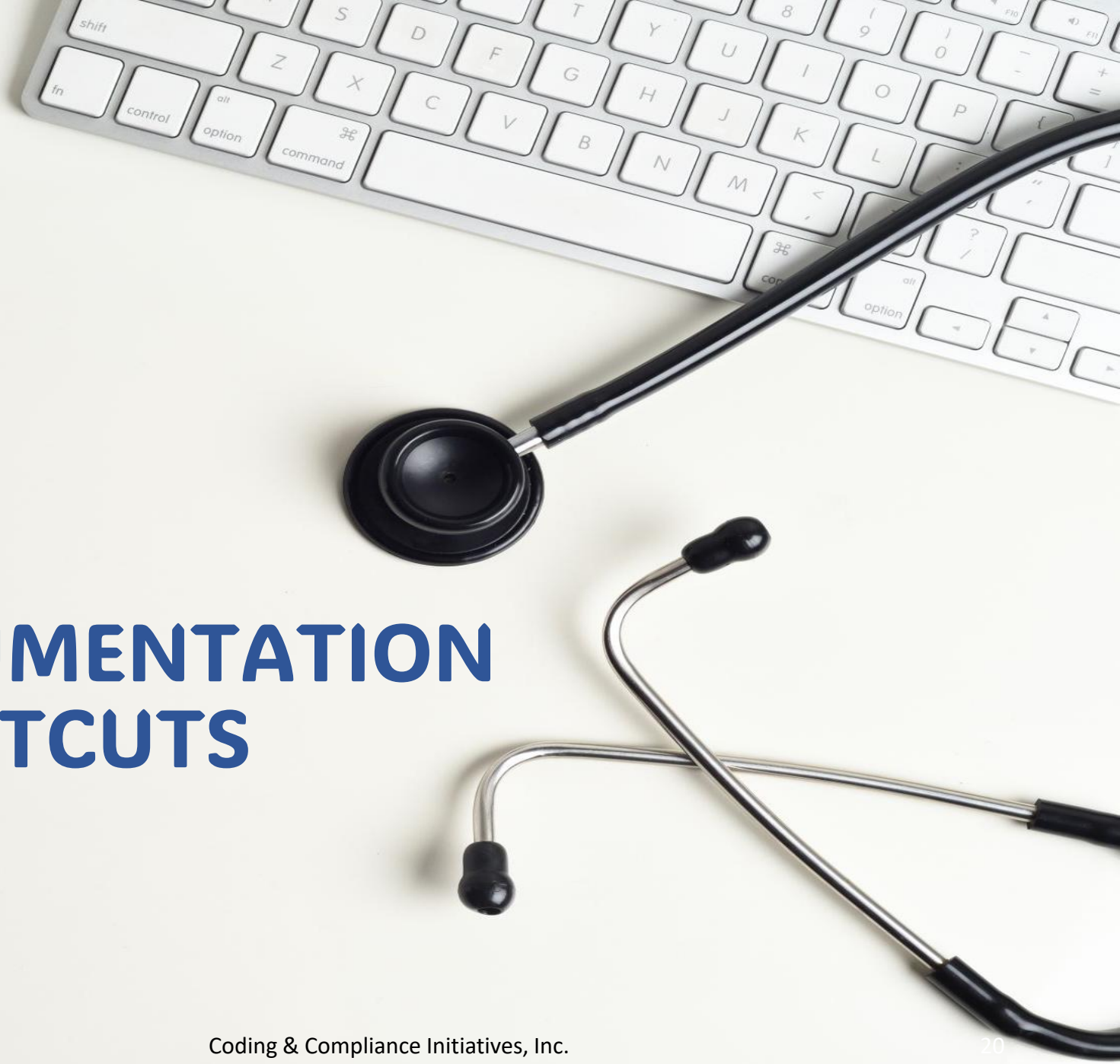
- *Annual wellness labs: CMP, PSA, cbc, lipid panel, A1c*

✓ *Annual wellness labs → CMP, PSA, cbc*

✓ *Hyperlipidemia → Lipid panel*

✓ *DM II → A1c*

DOCUMENTATION SHORTCUTS



Copy and Paste

Taken from CMS publication, **Ensuring Proper Use of Electronic Health Record Features and Capabilities**

Copy and paste or cloning can lead to redundant and inaccurate information in EHRs. Using this feature can cause authorship integrity issues since documentation cannot be tracked to the original source.

Cloned documentation lacks the patient specific information necessary to support services rendered to each patient. This can affect the quality of care and can cause improper payments due to:

- *False impression of services provided to the patient.*
- *Coding from old or outdated information that may lead to "upcoding."*

- *Create a policy on copy and paste and weigh efficiency against the potential for inaccurate, fraudulent, or unmanageable documentation.*
- *Set policy requiring the provider to modify copied information to be patient-specific and related to the current visit.*
- *Set policy controlling and limiting the use of the copy and paste function.*
- *Include proper notation and clear attribution of copied information.*

DOCUMENTATION EXAMPLE

Patient was involved in a motor vehicle crash in September 2023. Since then, she has been experiencing ongoing chronic neck pain. X-rays and MRI show degenerative changes but no acute findings. Records from orthopedic were reviewed, indicating she has failed conservative measures, including, PT, home exercise program, OTC meds. Today she presents with worsening pain.

If this HPI is carried forward from visit to visit unedited, it may lead to over coding. The outdated information would be credited for:

- A chronic problem that is worsening
- Review of 2 radiology reports and reviewing external records

The same could happen with the assessment and plan. Credit for work/risks that were not applicable to that date (meds/tests, etc).

DOCUMENTATION EXAMPLE

10/26/24. *Patient was involved in a motor vehicle crash in September 2023. Since then, she has been experiencing ongoing chronic neck pain. X-rays and MRI show degenerative changes but no acute findings. Records from orthopedic were reviewed, indicating she has failed conservative measures, including, PT, home exercise program, OTC meds. Today she presents with worsening pain.*

01/22/25. *Patient's chronic pain has improved, but still not at goal, interfering with her ability to work at her computer for longer than 30 min at a time.*

✓ ***3/27/25.*** *The patient reports her chronic neck pain has greatly improved since having the injections. Able to work for longer periods of time, reaching her goal.*

3/27 accurately represents:
- ✓ Current status (at goal)
- ✓ Data (none)

Macros or smart phrases

According to CMS, *"This is similar to populating by default. A macro is expanded text triggered by abbreviated words or keystrokes. Macros allow users to generate much documentation with one click. The practice is also referred to as 'charting by exception."*

CCI recommends treating macros as an introduction to the topic and then completing with patient-specific information.

DOCUMENTATION EXAMPLES

- ✓ **Macro1**. *The patient will be set up with physical therapy. The patient was informed that therapy is only effective if the plan is adhered to, as ordered, and that the therapist's at-home program is followed...* ***She will attend PT twice a week for 6 weeks for posture/body mechanics and strengthening with the goal of reducing her pain and increasing her ability to perform ADL's (see above for a description of current challenges she faces).***
- ✓ **Macro 2**. *The patient and/or caregiver was counseled on the risks associated with the medication(s) as prescribed today. The patient and/or caregiver was instructed on when to call the office or go to the emergency room. The patient's and/or caregiver's questions were answered in full...* ***Discussed Tylenol #3's potential impact on pregnancy. Patient was cautioned to use sparingly. Do not take with allergy medications. No refills will be given over the phone. The manufacturer's printout was given to the patient.***

DOCUMENTATION EXAMPLE

- *Repetitive, superfluous, outdated documentation on every visit, with no patient specifics, loses credibility.*

i have personally seen and examined the patient, reviewed the labs and imaging data, reviewed the assessment and plan and agree with above vitals notedGeneral: Alert, well nourished, no acute distressEye: Pupils equal, EOMI, normal conjunctiva, no scleral icterusENMT : Normocephalic, normal hearing, ears/nose inspection non-revealing, moist oral mucosa, no sinus tendernessNeck: Supple, non-tender, trachea midline, no thyroid enlargement or tendernessRespiratory : Normal respiratory effort, clear to auscultationCardiovascular: Regular rate and rhythm, no murmur or pedal edemaGastrointestinal: Soft, non-tender, non-distended, normal bowel sounds, no masses, no hepatomegalyMusculoskeletal: No digital clubbing or cyanosis, Gait NormalSkin: Skin is warm, no rashes or lesionsNeurologic: Cranial Nerves grossly intact, DTR intact, Sensation to touch intactPsychiatric: Good judgment and insight, Oriented X3, appropriate mood and affect I provided a substantive portion of the care of this patient. I personally provided more than half of the total time dedicated to treatment of this patient. I have personally performed the history and physical exam in its entirety, for this encounter

Templates

Taken from CMS publication, **Ensuring Proper Use of Electronic Health Record Features and Capabilities**

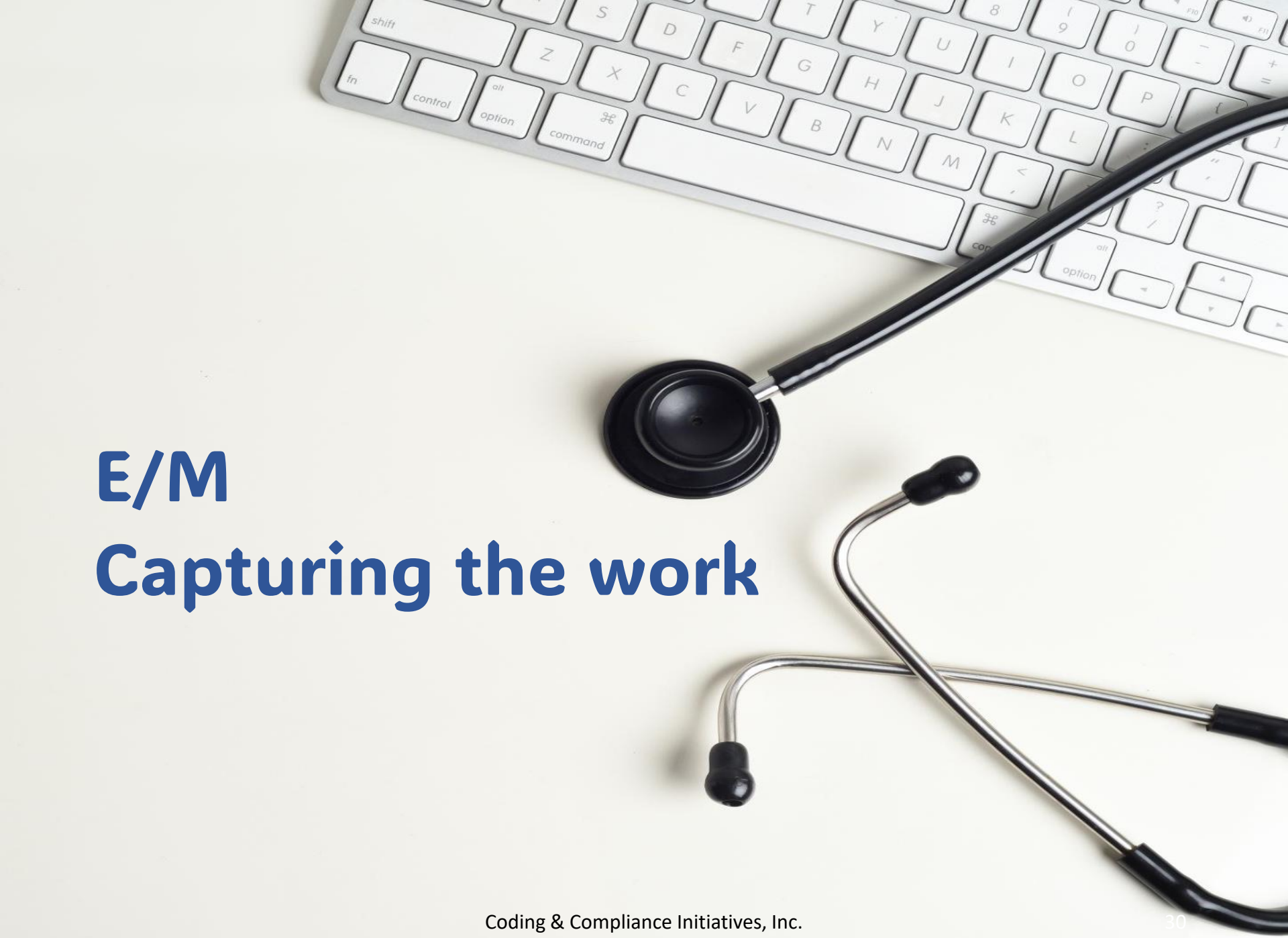
- *Use of templates may expose a physician to liability for false claims as the additional documentation may lead to upcoding.*
- *Documenting accurately can be problematic if the structure of the note is not a good clinical fit and does not reflect the patient's condition and services. Over documenting may be encouraged by using templates to meet reimbursement requirements even when services are not medically necessary or are never delivered.*
- *Set policy requiring providers to modify templates so that documentation clearly reflects specific conditions and observations unique to the service and clearly identify the services.*

DOCUMENTATION EXAMPLE

✓Reason for I&D **Abscess right forearm in addition to oral antibiotics**

PROCEDURE: The **right forearm** was prepared and draped in the usual, sterile manner. The site was anesthetized with **1%** lidocaine with epinephrine. A **linear** incision along the local skin lines was made and **purulent material was** expressed. Bleeding was **minimal**. Packing: **plain gauze was used.**

The patient tolerated the procedure well without complications. Standard post-procedure care was explained and return precautions are given.



E/M
Capturing the work

History and Exam

- Per CPT, the history and exam documentation requirements are now minimal, looking for, "**medically appropriate**."
  - *Nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.*

Get rid of the fluff: Excessive ROS/PFSH and exams. Concentrate on patient's progress instead

- The history still has a considerable amount of influence on the visit. It's part of the diagnostic process.
  - **Sets the tone for the visit by providing vital information such as-**
    - ✓ Severity – sense of urgency
    - ✓ Chronicity – chronic vs. acute
    - ✓ Associated sx/sx's that may lead to differential
    - ✓ Status – if chronic, "stable" vs. "unstable"
    - ✓ Acute – improving or worsening

History

- Subjective – describe the patient's condition (i.e., their story)
  - complaint
  - onset
  - quality
  - severity
  - status of chronic conditions

Exam

- Document your observations
- Document finding from your exam

- DO NOT just click and template without updating what you performed and remove what you did not perform

Assessment

- Diagnosis or signs/symptoms
- If the diagnosis has already been made – comment on whether it is improving, stable, not at goal, etc.
- Only include diagnoses that were evaluated and managed during this visit OR diagnoses that impacted the management and this should be clearly documented (i.e., unable to start patient on xxx due to CKD)

Plan

- What is the plan (i.e., ancillary or diagnostic services ordered, referral made, new medication, change in medication, etc.)

- When will they return to be seen and why (i.e., return in 3 weeks to evaluate h/a; f/u in 6 months for DM and HTN).

Medical Decision-Making Components

Problems Addressed	Data Analyzed	Risk of Management Options
❑Acute or Chronic condition?	❑Lab/x-ray	❑Therapies / procedures
❑Chronic - Stable or worsening?	❑Records reviewed	❑Med management
❑Acute- uncomplicated or complicated condition?	❑Discussions w/ other provider	❑Social determinants
❑Moderate or severe exacerbation?	❑Independent historian	❑Hospitalization

Complexity of Problems addressed at the encounter (COPA)

- ***Problem addressed:*** A problem is addressed or managed when it is **evaluated or treated**. This would be supported by:
  - ✓Updates within the history
  - ✓The examination
  - ✓Referencing ancillary/diagnostic results
  - ✓When it's included in the assessment and plan

- Includes those conditions where further testing or treatment will not take place due to risk/benefit analysis or patient's (surrogate's) choice. Document this.

DOCUMENTATION EXAMPLE

✓ *42-year male, with a complicated medical history, recently diagnosed with diabetes. Extensive discussion was had with the patient about the risks of uncontrolled diabetes. This included risks vision problems, nerve damage, increased risk of stroke, heart attack, other circulation problems, kidney damage, etc. Patient was provided detailed information on diabetes. Patient agrees to begin treatment and meet with a dietitian.*

In the assessment we would except to see the diabetes – we may see other diagnoses (i.e., complicated medical history), however, the provider would need to connect the dots unless the complicated history is documented as being evaluated

Complexity of Problems addressed at the encounter (COPA)

- When comorbidities and underlying diseases are identified, document their **direct impact** on the visit and how they effect the amount of data or **(documented) patient-specific risks** for management (e.g. immunocompromised patient, ESRD, etc.)

DOCUMENTATION EXAMPLE

Patient with DM II, with chronic hyperglycemia due to noncompliance, presents with a puncture wound to his foot from a nail he stepped on in his yard. He continues to smoke cigarettes daily. Patient is at greater risk for infection and delayed healing due to poor circulation from his diabetes and smoking.

Assessment:

- *Puncture wound left foot*
- *DM II with hyperglycemia*
- *Nicotine dependence*
- *Noncompliance with medical treatment*

Healthy Patient: COPA for an uncomplicated wound = low

Patient w/ DM + smoking: COPA for an uncomplicated wound in a noncompliant hyperglycemic diabetic who smokes = moderate

Complexity of Problems addressed at the encounter (COPA) - Differentials

- Include differential diagnoses when they apply since COPA is based on the presenting problem (and distinct possibilities) and not necessarily the final diagnosis. Record them in the history or in the assessment.

- Diagnostic work up or the provider's actions should be consistent with ruling out the differential(s). (Proof of thought)

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.
  - Breast lump
  - GI bleed

- *This means your provider is working the patient up because they don't have a diagnosis yet*

DOCUMENTATION EXAMPLES

Patient 1. *HPI: Patient states she felt a "lump" in her right breast last week, approximately the 2 o'clock position. Now she "cannot find it" but she kept the appointment anyway. She described it as firm. Exam was negative.* ***Given family history and personal risk factors, a mass is certainly a possibility.*** *Patient says she been meaning to enroll in the high-risk breast clinic but just hasn't done it yet. Diagnostic mammogram ordered.*

Patient 2. *Assessment/Plan:*
Abdominal pain, dyspepsia, and weight loss of undetermined origin. Pain worsening over the past few weeks. Takes ASA daily. Frequent alcohol use. ***Concern for peptic ulcer*** *vs. GERD. Needs EGD and referral.*

Problems addressed at the encounter

- Document chronic vs. acute if not evident. (e.g., back pain)
- For chronic conditions, the **status must** be documented. Those that are **not stable (not at PATIENT'S goal) are weighted more** than those that are.

According to the AMA, *"A coder should not determine whether a patient's medical problem or illness is stable or worsening. The patient's physician or other QHP is expected to determine whether the medical problem or illness is stable or worsening."*

Chronic Illness with Exacerbation

- A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

- **Documentation is important**

DOCUMENTATION EXAMPLES

Patient 1. *Diabetes with Hyperglycemia, HgbA1c 9.2%. Increase basal insulin (e.g., glargine) from 20 units to 25 units nightly. Reinforce proper timing and titration based on fasting glucose. Continue metformin 1000 mg BID if renal function remains appropriate. Reassess need for prandial insulin or consider adding a GLP-1 receptor agonist if A1c remains elevated at follow-up.*

Instruct patient to check blood glucose 3–4x/day (before meals and at bedtime).Patient to maintain glucose log and bring to next visit.

DOCUMENTATION EXAMPLES

Patient 1. *HTN: Blood pressures continue to trend upwards the past two weeks despite increasing Lisinopril from 10mg to 20mg. Include the goal – Goal <130/80* (MODERATE)

Patient 2. *HTN: Blood pressures well controlled with Lisinopril.* (LOW)

Patient 3. *HTN: add HCTZ as directed. Continue Lisinopril* (???)

Acute, Uncomplicated Illness/Injury

- A recent or new short-term problem with low risk of morbidity for which treatment is considered.
    - Little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
    - A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

DOCUMENTATION EXAMPLES

Patient 1. *Sinus infection, no significant underlying conditions* (Low)

Patient 2. *Low back pain, started on NSAID and order for PT.* (LOW)

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’ or ‘acute, uncomplicated.’
  - Systemic symptoms may not be general but may be single system.
- Examples may include pyelonephritis, pneumonitis, or colitis.

DOCUMENTATION EXAMPLES

Patient 1. Patient presents with acute onset of abdominal pain, diarrhea, and systemic symptoms including fever and fatigue. Symptoms are consistent with possible infectious or inflammatory colitis. No signs of chronicity or complications (e.g., GI bleeding, hypotension, dehydration) at this time.

Stool studies: culture, C. difficile toxin/PCR, ova & parasites, fecal leukocytes/lactoferrin; CBC, CMP, CRP.

Consider abdominal imaging (CT abdomen/pelvis with contrast) if concern for severe colitis or alternative diagnoses (e.g., appendicitis, diverticulitis, IBD).

Antidiarrheals withheld until infection ruled out

Empiric antibiotics (e.g., ciprofloxacin + metronidazole) if moderate-severe symptoms, systemic toxicity, or high-risk patient

Acute, Complicated Injury

- An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

- Example: head injury with brief loss of consciousness.

DOCUMENTATION EXAMPLES

Patient 1. *Concussion / Minor Traumatic Brain Injury (TBI) – With brief LOC; GCS 15 on presentation; no focal neurological deficits. Scalp contusion – Mild swelling over right temporal region, no laceration. Neck strain – Reports posterior neck pain and stiffness; no step-offs or midline tenderness. Fall risk – Contributing factors include recent medication change and dehydration.*

Full neurologic exam completed – no focal deficits, cranial nerves intact. Monitored in office for 30 minutes — no worsening of symptoms.

Ordered non-contrast head CT to rule out intracranial hemorrhage due to LOC. Consider c-spine imaging if neck pain persists >48 hrs or worsens.

Discussed red flags (e.g., worsening headache, confusion, vomiting, visual changes, seizure).24-hour supervision recommended; no driving or high-risk activity for 48–72 hours.

Advised acetaminophen for headache (avoid NSAIDs for 24 hours).Encourage fluids and rest; no screen time for 24 hours.

Chronic Illness with Severe Exacerbation

- The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

DOCUMENTATION EXAMPLES (Assessment)

Patient 1. *Chronic Obstructive Pulmonary Disease (COPD) – Severe Acute Exacerbation, requiring hospital admission Patient presents with significant worsening of respiratory symptoms over the past 5 days, including marked dyspnea at rest, increased work of breathing, use of accessory muscles, and audible wheezing. Oxygen saturation in clinic is 85% on room air and 89% on 2L nasal cannula. The patient is unable to speak in full sentences and has been minimally responsive to home inhalers. Productive cough with thick yellow sputum noted. Mild confusion and somnolence are concerning for hypercapnia.*

Chest exam reveals diffuse wheezing with diminished breath sounds at the bases. No signs of heart failure or pneumonia on bedside assessment, but due to the rapid progression and lack of outpatient response, this presentation meets criteria for inpatient admission for management of respiratory failure risk.

DOCUMENTATION EXAMPLES (Plan)

- *Immediate transfer to ED for hospital admission.*
- *Spoke directly with ED attending to coordinate transfer and give report.*
- *Anticipated treatment will include IV corticosteroids, nebulized bronchodilators, supplemental oxygen, and possible non-invasive ventilation (BiPAP) if respiratory status worsens.*
- *Request inpatient pulmonary consult. Reviewed advance directives and patient's preference for full code at this time.*
- *Family notified and will meet patient at the hospital.*

Acute or Chronic Illness or Injury that poses a threat to life or bodily function

- An acute illness with systemic symptoms, or 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.
  - Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

DOCUMENTATION EXAMPLES (Assessment)

Patient 1. *Major Depressive Disorder, recurrent, severe, with psychotic features (F33.3)The patient reports a two-week history of worsening mood, insomnia, poor appetite, and social withdrawal.*

Endorses suicidal ideation with a specific plan (overdose on prescription medication) and intent, but no prior attempts.

Reports auditory hallucinations commanding self-harm.

Patient's affect is flat, with psychomotor retardation. Insight and judgment are impaired.

This presentation represents a psychiatric emergency due to imminent risk of self-harm and impaired reality testing.

DOCUMENTATION EXAMPLES (Plan)

- *Immediate psychiatric hospitalization for safety, stabilization, and intensive treatment.*
  - *Involuntary commitment initiated under state mental health code for suicidal ideation with plan and psychosis.*
  - *Psychiatry consult completed; patient accepted for direct admission to inpatient psychiatric unit.*
- *Safety measures implemented in office:*
  - *Patient placed under constant observation.*
  - *No access to sharps, medications, or personal belongings.*
- *Medical clearance initiated:*
  - *Vitals stable; EKG and basic labs (CBC, CMP, urine tox) ordered to ensure safe transfer.*
- *Family notified with patient consent; crisis plan discussed.*
- *Psychiatric medications: Restart fluoxetine and olanzapine upon admission pending inpatient evaluation.*
- *Documentation of patient's suicidal intent and hallucinations added to EHR and communicated with inpatient team.*
- *Return precautions and 1:1 monitoring reinforced until transfer.*
- *Full collateral history and psychosocial background to be reviewed by inpatient team.*

Amount and/or complexity of data to be reviewed and analyzed (Data)

Analyzed:

- Tests are imaging, laboratory, psychometric, or physiologic data. Count the order or the review, but not both.
- Tests ordered outside the encounter (such as phone call from nursing staff), are counted at the subsequent encounter when reviewed and analyzed.

Thoroughly document all phone calls with patients. If orders are generated (diagnostics or meds), ensure medical necessity is captured.

Data

Unique:

- A unique test is defined by CPT coding.
- A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity.

Data – Proof of thought Diagnostics

Diagnostic results copied into a progress note may not be given data credit as reviewed/analyzed without a comment about them, even if brief.

For the most thorough record, and to achieve credit for the work and thought processes of the provider, CCI recommends that the provider comment individually on the result of each test that contributed to the encounter.

DOCUMENTATION EXAMPLES

The AMA uses as an example:

"A notation such as 'WBC elevated' or 'chest x-ray unremarkable' is acceptable documentation of the review of lab, radiology, or other diagnostic tests."

Other examples, *"UDS consistent with meds, US no signs of thrombosis"*

Data

- ***External:*** Records, communications and/or test results from an external source, such as a physician, other qualified health care professional (QHCP), facility, or health care organization.
- ***External physician, QHCP, or Facility:*** Someone not in the same group or in a different specialty or subspecialty. Includes licensed professionals practicing independently, or a facility or organizational provider such as hospital, nursing facility, or home health agency.
- ***Discussion:*** Requires an interactive exchange. Must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges within progress notes does not qualify. The discussion does not need to be on the date of the encounter but counted only once and only when used in the decision making of the encounter. Can be asynchronous (no need to be in person) but must be initiated and completed within a short time period (eg, within a day or two). An example is using a HIPAA secure messaging app, etc.

DOCUMENTATION EXAMPLES

External notes:

✓ *"**A review of the records** from last week's inpatient stay reveals the patient was initially admitted for hypotension, dizziness, and syncope. Has ESRD. Was on peritoneal dialysis, but while hospitalized, was changed over to hemodialysis."*

DOCUMENTATION EXAMPLES

Interactive Discussion:

"Spoke with Dr. __, infectious disease, and he agrees patient needs anaerobic coverage since she has not improved after 9 days of antibiotics. Will hospitalize."

This brief note checks the boxes:

- ✓ We know who the provider spoke with.
- ✓ The note conveys the discussion and outcome.

Data

Independent historian(s):

- An individual (eg, guardian, surrogate, spouse, witness) who provides or supplements the patient's history. (Patient unable or unreliable [dementia, psychosis etc] or confirmation is needed.)

- Does not include translation services.

- Information does not have to obtained in person but must be garnered directly from the historian.

DOCUMENTATION EXAMPLES

Independent historian:

- ✓ *"Due to cognitive deficits, **the patient is unable to reliably provide a history**. I spoke with his wife who contributed the following: According to her, he has been much more agitated over the past week and has had several crying spells…"*
- ✓ *"The **infant's** history of present illness was taken from the mother. According to the mom, the fever started yesterday…"*

Data

Independent interpretation:

- Personally interpreting a test, ***when not billing for the interpretation***, is a category 2 data point. For example, personally viewing a chest x-ray image. Make it evident that it was YOUR interpretation.
- Test must be associated with a CPT code.
- Provider must document his/her interpretation but doesn't have to be at the level of detail needed for billing the interpretation. (a brief summary suffices).

DOCUMENTATION EXAMPLES

- ✓ *"Chest x-ray, images viewed by me, shows lungs are clear. Normal cardiac silhouette"*

- ✓ *"My interpretation of the ECG indicates normal sinus rhythm."*

Risk of complications and/or morbidity or mortality of patient management (RISK)

- Risk criteria applies to management decisions made during the day of the encounter. Per the guidelines, "the risk from the condition is distinct from the risk of the management."
- Risk is based upon the usual behavior and thought processes of a physician or QHCP in the same specialty.
- Trained clinicians may have their own definition of *high, medium, low*, or *minimal* risk. They do not require quantification (unless possibly under audit?) – Use evidenced based medicine if/when applicable.
- Risk is based upon consequences of the problem(s) addressed when appropriately treated.
- **Risk also includes diagnostics or management options (hospitalization) when not carried out** (due to contraindications, or patient choice, etc.).

RISK

- ***Social determinants of health:*** Economic and social conditions that impact health or ability to obtain care (homeless, unable to affords meds/food, etc.)
  - Document what they are and how they impact the decision-making process/plan.
- ***Drug therapy requiring intensive monitoring for toxicity:*** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
- ***Surgery (minor or major, elective, emergency, procedure or patient risk):***
  - ***Risk Factors, Patient or Procedure:*** those relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Risk – Proof of thought
Prescription drug management

- For each drug listed in the plan, there should be either an action (start/stop/change/continue) or a comment regarding efficacy. Otherwise, it's more of a problem list and medication list.

- Always include meds prescribed, dispensed, or administered and their quantity and strength.

DOCUMENTATION EXAMPLES

- *Diabetes II – takes Metformin*
- *Seizure disorder – on Keppra*

This is more of a problem list & med list

✓ *Diabetes II – Metformin 2000mg daily. Recent A1c was acceptable at 6.5.* ***Continue*** *with current dosing.*

✓ *Seizure disorder – on Keppra, 500mg BID.* ***No seizure activity for more than 6 mo's, doing well****. Continue Keppra as directed*

Prescription Drug Management

Risk – Proof of thought

- Comorbidities and underlying diseases should be documented when they increase the complexity and/or risks. Make the connection for the reader

- Document those that directly impact the visit.

DOCUMENTATION EXAMPLE

✓ *"After speaking with oncology, I explained to the patient that due to multiple comorbidities including end stage renal disease, multiple myeloma, being on chemotherapy with immunosuppression, as well as his ongoing diarrhea due to Astrovirus, he will need to be admitted vs. being treated as an outpatient. Patient is in agreement with the plan of care."*

In summary: Assessment & Plan

- Create a clearly defined assessment and plan for each condition that was monitored, evaluated, assessed or treated.
  - List the condition
  - Include the status
  - Create a plan, even if follow-up PRN

- What is the future plan – while you may know what the plan is for that specific patient, disease process, etc., if another provider has to pick up where you left off it is extremely helpful to have the information documented.

DOCUMENTATION EXAMPLES

Portions of this plan are not clear

- *Frequent falls - felt to be more related to poor cognition - PT/OT/ST - meds reviewed; would benefit from med reduction*
- *Low back pain – on gabapentin - ensure good control pain*
- *Seizure disorder – seizure precautions*
- *Insomnia tylenol prn - add melatonin 10 with goal/hope of tapering off temazepam*
- *Afib -on amidodarone and BB - on reduced dose eliquis (age, weight)*
- *Diastolic CHF - ensure good control blood pressures*

- ❑ Were the conditions addressed?
  - Updates in the history?
  - Is there a plan?
- ❑ Can we determine if chronic or Acute?
- ❑ If chronic, do we know status (stable vs. worsening?)
- ❑ Can the risks associated with management (the plan) be abstracted?

DOCUMENTATION EXAMPLES

- ✓ *ADHD **stable** on Vyvanse. With effectiveness, **will continue** present management*
- ? *Depression **at goal**, continue meeting with therapist*

Acute or Chronic?

- ✓ *Type 1 diabetes mellitus with hyperglycemia. **We will increase Insulin to xxx**. Will refer to dietician.*

Medical-Decision-Making

- Remember the level of service should make sense in the context of the patient's condition.
- For example, when a patient comes in with a sore throat and a strep, COVID and flu are done (3 tests) and a prescription is given – may not always support 99214
  - Just because the data and risk support moderate, if the presenting problem is low – a higher code may not be defensible

Time Based Services

Time-based E/M

- Requires a **face-to-face** encounter between the provider and the patient at some point during the date of service.
- Count the **total time** on the date of the encounter. Does not have to be continuous.
- Include **both the face-to-face time** with the patient and/or family/caregiver **and non-face-to-face time** personally spent by the provider on the day of the encounter
- Encompasses all time **regardless of the location of the provider** (eg, whether on or off the unit or in/outside the office).
- **Exclude time spent on separately billable services**, such as Advance Care Planning, joint injection, etc. **DOCUMENT THIS**

Time-based E/M

Provider's time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, therapies or procedures
- referring to or communicating w/ other health care professionals
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately billed)
- explaining results to the patient/family/caregiver
- care coordination

Ensure the activities (as above) are documented so that the amount of time spent seems appropriate.

DOCUMENTATION EXAMPLE

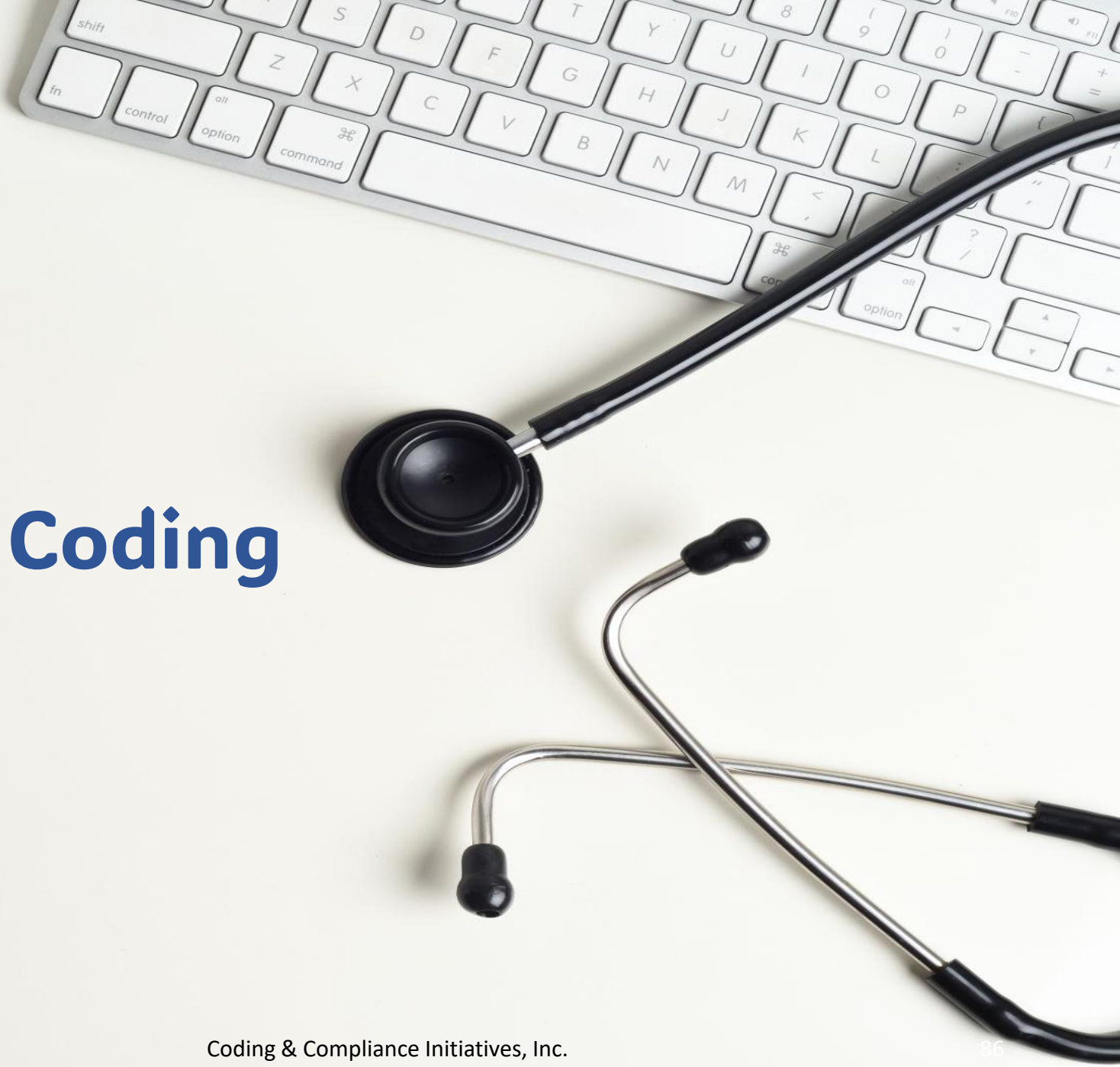
✓ *"50 minutes were spent with on the case today. This excludes time dedicated to the wart removal. Extended time spent documenting the note for this complicated patient.* ***Summary of time****: Patient is noncompliant with her narcotic agreement, receiving pain meds from ER over the weekend. Reviewed outside records (ER visit) which outlined her request for pain medications with complaints of severe pain and state drug database. Reviewed narcotic agreement w/ patient, warned her that future occurrence will result in dismissal from the practice. Ordered additional imaging due to increase in pain. Spoke w/ husband later in the day, he has concerns about her depression. For encounter details, refer to the progress note above."*

When documenting time, be precise. Do not use a CPT code's billing threshold as a default, nor a CPT code's range of time.

DOCUMENTATION EXAMPLE

- ✓ *"35 minutes total time spent on this encounter. **Summary of time**: I spent a significant amount of time with the parents discussing the new diagnosis of Autism. I provided them with support groups in the area and some educational tools. We discussed the importance of therapies and interventions such as speech and occupational therapy…..*

Other Coding



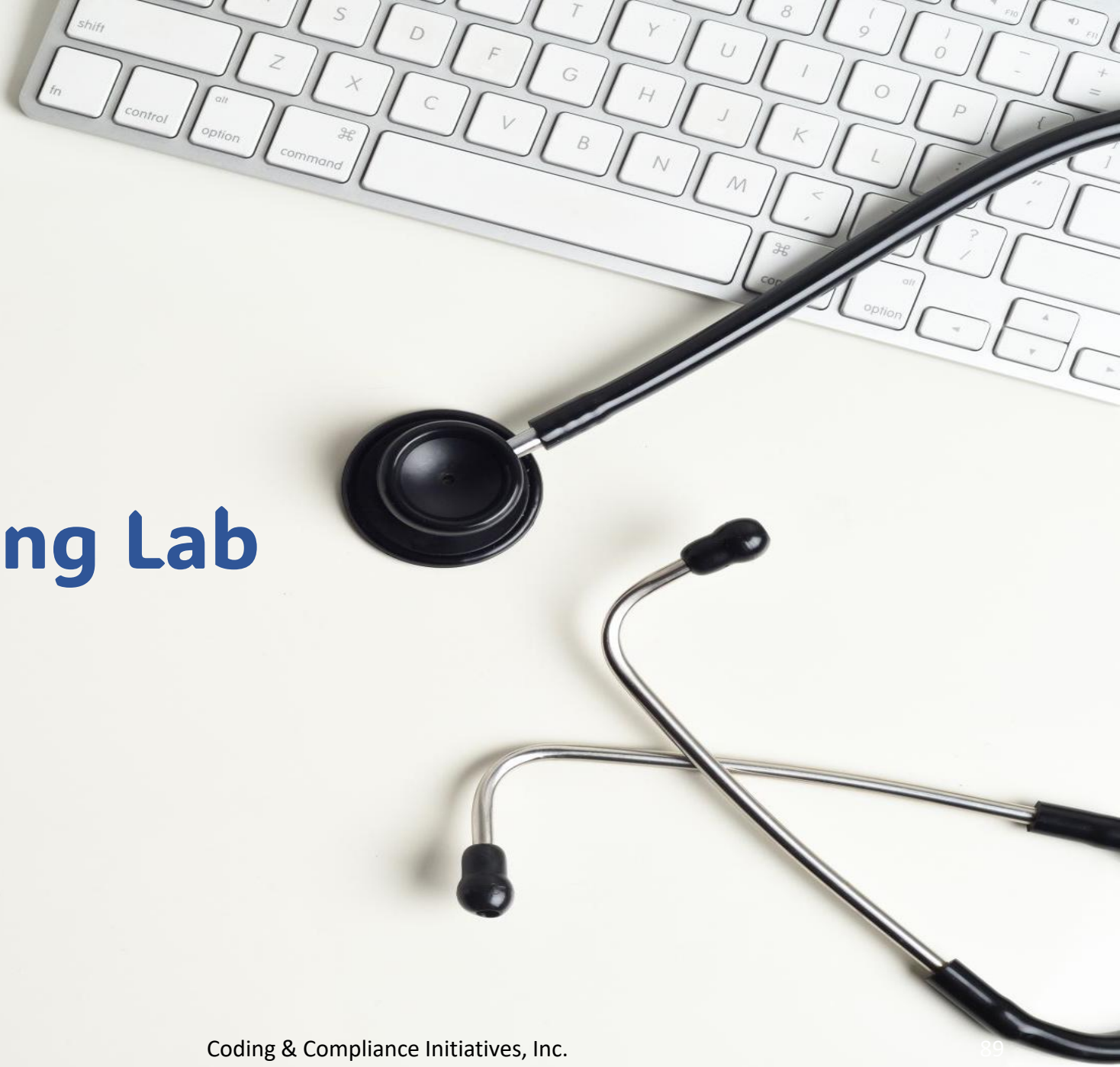
Immunizations

- When reporting CPT codes 90460/90461 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) the documentation must clearly support the provider counseled the patient or parent/guardian.

Pelvic Examination

- A pelvic exam is performed in addition to an evaluation and management service in a non-facility setting. The physician places two lubricated and gloved fingers inside the vagina to palpate the cervix, uterus, and ovaries while using the other hand to gently palpate the top of the uterus with pressure on the abdomen, noting the organs' size, shape, and/or any abnormality.
  - This code is reported in addition to another E/M service provided on the same date of service. Only report 99459 in addition to one of the following E/M services; 99202-99205, 99212-99215, 99242-99245, 99383-99387, or 99393-99397.

Learning Lab



Example #1

- Seizures
- How would you code this?
- Any other comments about the note?

Example #1

- It is difficult to determine if the provider pulled forward the history of breast cancer, brain lesion, etc. or if these documents were from another provider and this provider reviewed them.
- What differentials? Does the patient medical history and treatment make this management more complexity?
- The note says EMS was called at 10:14 – did the provider call and talk to EMS about the patient or staff called?
- It says under Focal Seizure – pt seen in collaboration with Dr. X at bedside … recommendations given – what recommendations?
- What about time?

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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:**
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			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test int
			• Discussion of management or test interpretatic
			professional\appropriate source (not separatel
				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
	High	**High**
		• 1 or more 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
			Category 1: Tests, documents, or independent hi
			• **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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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)
				or treatment
				ty
				ied patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

The overall risk is moderate to high, however, there is not an example listed on the table

Example #2

- Asthma
- How would you code this?
- Any other comments about the note?

Example #2

- The HPI indicates the patient developed an exacerbation and was seen in urgent care, however, it is not clear if this was recently or a while ago

- Was the HTN documented as being evaluated? Document the status in HPI or comment on the blood pressure at this visit.

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99203
99213
	Low	**Low**
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		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
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			(Must meet the requirements of at least 1 of the 2 categories)
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			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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:**
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			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			
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			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #3

- Memory
- How would you code this?
- Any other comments about the note?

Example #3

- The provider did a great job documenting the time spent.

- What about the diagnosis of HTN?
- We should report I11.0 for hypertensive heart disease

Example #4

- Thumb
- How would you code this?
- Any other comments about the note?

Example #4

- What about coding an E/M in addition to the procedure?
- 99213 is supported – the provider evaluated the problem through history and exam, reviewed imaging and then made the decision.
- Modifier RT on the procedure
- Don’t forget the J code for the injectable medication

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99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
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			or
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			(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
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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:**
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			• 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
	High	**High**
		• 1 or more 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:**
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			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #5

- Knee
- How would you code this?
- Any other comments about the note?

Example #5

- What about some HPI on the knee pain (i.e., severity, modifying factors, quality, etc.)?
- Chronic or acute or can you tell?
- Chronic – it says she has had for many years
- We need provider to specify if it is as goal or not

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99203
99213
	Low	**Low**
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		or
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		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
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				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
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				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
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99205
99215
	High	**High**
		• 1 or more 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)
			
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			• **Any combination of 3 from the following:**
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			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
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			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
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Example #6

- Cyst on Cheek
- How would you code this?
- Any other comments about the note?

Example #6

- What about the blood pressure? Does that justify an E/M code?
- There really is not a plan other than keep his appt – would you consider that significant, separately identifiable?
- What if the provider asked patient to log blood pressure, go to ER with xx symptoms, etc.
- As documented – procedure only

Example #7

- Pap and Pelvic
- How would you code this?
- Any other comments about the note?

Example #7

- Does Genitourinary: Negative give you any idea of what questions were asked (i.e., vaginal discharge, pelvic pain, urinary issues, etc.)
- Exam: Genitourinary: thin prep obtained for pap smear and high-risk HPV - ???
- What about documenting the details for example: External genitalia is normal in appearance without lesions, swelling, masses or tenderness. Vagina is pink and moist without lesions or discharge. Cervix is non-tender without lesions or erosions. Uterus is anteflexed, non-tender and normal in size. Ovaries are non-tender without palpable masses or enlargement.
- With the current documentation – Q0091 for the collection of pap

Example #8

- Switching over from another provider
- How would you code this?
- Any other comments about the note?

Example #8

- The documentation does not clearly outline the chief complaint/reason for visit.
- We recommend the provider document in the HPI the status of the chronic conditions (i.e., HTN - takes medications as prescribed, no CP, h/a, etc.) in lieu of "Blood pressure is well-controlled." The HPI should describe what the patient tells you about the condition.
- The HPI and assessment/plan address asthma, however, the documentation does not include a respiratory exam.
- The documentation indicates "continue current regimen," however, it is not clear what the current regimen is.

Example #8

- The HPI says, “needs referral to dermatology,” without any additional details. The exam does not show any skin issues. The treatment plan supports a referral to derm for a “skin check.” The documentation does not indicate any details of what the skin check is for (i.e., lesion, rash, preventive, etc.).

- There are several labs ordered but most are for screening.

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		• 1 acute, uncomplicated illness or injury
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			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
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			moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #9

- Back pain
- How would you code this?
- Any other comments about the note?

Example #9

- GREAT NOTE
- There is an evaluation and plan for every diagnosis
- We can’t determine if the imaging that was reviewed (i.e., pulmonary, lumbar) were ordered by the provider at a previous visit or ordered by another provider. Documentation should specify.

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #10

- Chronic Care follow-up appt
- How would you code this?
- Any other comments about the note?

Example #10

- The documentation indicates here for chronic care follow-up but there are not any chronic conditions documented as being addresses
- Does this support an E/M with a procedure? If yes, why? If no, why?
- How much time was spent on smoking cessation counseling?
- What about coding the ICD-10 code for the lack of health insurance?

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Level of Medical Decision Making (MDM)

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #11

- New patient with back pain and chest pain
- How would you code this?
- Any other comments about the note?

Example #11

- Is the back pain acute or chronic or we can't determine based upon the documentation?
- What about coding the ICD-10 code for homelessness living in shelter?
- Is the Naproxen 500 mg – OTC or prescription only

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #12

- F/U high CBS
- How would you code this?
- Any other comments about the note?

Example #12

- What about the diagnosis codes?
- The HgbA1c is 9.8
- Is the HTN at goal or unclear?

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
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			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:
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				• 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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #13

- Est pt, med change, mood
- How would you code this?
- Any other comments about the note?

Example #13

- What about a psych exam?
- Is the depression at goal or not or unclear?
- How long have they been using methamphetamines?

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
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			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #14

- Sciatic nerve
- How would you code this?
- Any other comments about the note?

Example #14

- Acute or chronic or unclear?
- At goal or not at goal or unclear?

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99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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:
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				• 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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #15

- Leg pain
- How would you code this?
- Any other comments about the note?

Example #15

- Any overall thoughts on the documentation?

- Could the provider have done a better job describing the risks of this patient and complexity of the management options?

- What about ICD-10 code for housed, but risk of losing housing?

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			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
	High	**High**
		• 1 or more 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)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Example #16

- F/U labs
- How would you code this?
- Any other comments about the note?

Example #16

- What about current symptoms on UTI?
- Did the provider do a good job documenting his/her thought process?

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion … moderate or high)
				…ditional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 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)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			…**ssion of management or test interpretation**
			…**ement or test interpretation with external physician/other qualified health care** …**source (not separately reported)**
				…**ed patient or** …**surgery without identified** …**risk factors**
				• Diagnosis or treatment significantly limited by social determinants of health

99205 99215	High	…**least 2 out of 3 categories)** …**ependent historian(s)** …**llowing:** …**(s) from each unique source*;** …**h unique test*;** …**t*;** …**ndependent historian(s)** …**terpretation of tests** …**retation of a test performed by another physician/other qualified health care professional** …**y 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 • Decision not to resuscitate or to de-escalate care because of poor prognosis

The patient does not really fit in a box for risk, however, you can envision the complexity from the differentials - Moderate

The patient does not really fit in a box for problems addressed, however, you can envision the complexity - Moderate

ICD-10 updates 10/01/2024

Presymptomatic Diabetes – Type 1

- These codes are used to identify individual who are at risk of developing Type 1 diabetes but have not yet shown symptoms.
- E10.A- - Type 1 diabetes mellitus, presymptomatic
  - E10.A0 - Type 1 diabetes mellitus, presymptomatic, unspecified
  - E10.A1 - Type 1 diabetes mellitus, presymptomatic, stage 1
  - E10.A1 - Type 1 diabetes mellitus, presymptomatic, stage 2

Hypoglycemia

- E16.A- – Hypoglycemia level
  - E16.A1- Hypoglycemia level 1
  - E16.A2- Hypoglycemia level 2
  - E16.A3- Hypoglycemia level 3

Hypoglycemia

Level 1 hypoglycemia

- Glucose concentration <70 mg/dl
- Should be used as an alert value to help individual avoid more severe hypoglycemia

Level 2 hypoglycemia

- Glucose concentration >54 mg/dl
- This is the threshold at which neuroglycopenic symptoms begin

Level 3 hypoglycemia

- No lab threshold established
- Severe event characterized by altered mental and/or physical functioning independently of the glycemic value which requires third party assistance to treat

Hypoglycemia

Code	Description
E08.64	Diabetes mellitus due to underlying condition with hypoglycemia
E09.64	Drug or chemical induced diabetes mellitus with hypoglycemia
E10.64	Type 1 diabetes mellitus with hypoglycemia
E11.64	Type 2 diabetes mellitus with hypoglycemia
E13.64	Other specified diabetes mellitus with hypglycemia
E16.0	Drug induced hypoglycemia without coma
E16.1	Other hypoglycemia
E16.2	Hypoglycemia, unspecified
	Use additional code for hypoglycemia level, if applicable (E16.A-)

Documentation

- Documentation needs to be clear and detailed to support accurate ICD 10 code selection
- **Specificity:** Type: Type 1, 1.5, Type 2
- **Control:** there is no default code for diabetes documented as uncontrolled. The provider must indicate whether the patient is hypoglycemic or hyperglycemic to determine an appropriate code.
- **Secondary cause**: identify cause (drug or chemical induced) or other underlying condition
- **Complications:** Assign as many codes from categories E08-E13 as needed to identify all of the associated conditions/complications that the patient has related to their diabetes that you are managing during your care or that are affecting the care you are providing. Your documentation needs to connect the dots showing management or co-management.
- **Treatment**: (medication, diet, exercise, insulin pump, or a combination) and current response to treatment

Obesity Classes

Class 1

Adults: BMI of $\geq$ 30-34.9 kg/m^2

Children: BMI $\geq$ 95th percentile to <120% of the 95th percentile

Class 2

Adults: BMI of $\geq$ 35-39.9 kg/m^2

Children: BMI $\geq$ 120% of the 95th percentile to <140% of the 95th percentile or a BMI >35 kg/m^2

Class 3

Adults: BMI of $\geq$ 40 kg/m^2

Children: BMI $\geq$ 140% of the 95th percentile or a BMI >40 kg/m^2

Obesity Classes

Category	Description
E66	Overweight and obesity Use additional code to identify BMI, if known, for adults (Z68.1-Z68.45) or pediatrics Z68.5- Removed Excludes 1 note and moved those to Excludes 2 (Not included here)
Code	**Description**
E66.811	Obesity, class 1
E66.812	Obesity, class 2
E66.813	Obesity, class 3
E66.89	Other obesity, not elsewhere classified

Factors Influencing Health Status

- Z59.71 – Insufficient health insurance coverage
- Z59.72 – Insufficient welfare support


TIME FOR QUESTIONS

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About CCI

- CCI assists our clients improve their documentation quality, coding and billing accuracy, and compliance with health care regulations www.ccipro.net

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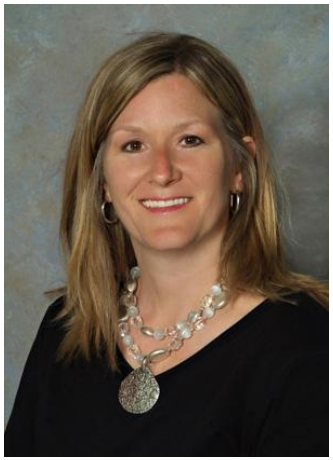

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Ms. Sulzberger is a Licensed Practical Nurse, Certified Professional Coder and ICD-10 Trainer. She received her Bachelors of Science degree in Business Administration from Mid America Nazarene University. Ms. Sulzberger received her nursing license in 1994 and was a practicing clinician at Saint Luke's Health System for several years before transferring to the internal compliance/audit area. She became credentialed as a Certified Professional Coder in 1996 and assisted the Saint Luke's Health System with performing medical record chart audits to verify the accuracy of the internal coding and claims processing.

Ms. Sulzberger spent approximately six years as a coding/billing consultant with National accounting and consulting firms (BKD, Grant Thornton) before becoming the President of Coding & Compliance Initiatives, Inc. (CCI) in April 2003. Ms. Sulzberger assists her clients with improving their operational performance in a variety of critical outcome areas, including coding/billing, corporate compliance, charge capture processes, etc. Ms. Sulzberger works with a variety of health care providers including hospitals, physician practices, and rural health clinics in their daily compliance and operational activities.

Ms. Sulzberger presents locally and nationally on coding topics as well as developing specialized training programs to meet the needs of her clients. Shellie recently was credentialed through American Institute of Healthcare Compliance as a Certified ICD-10 Trainer.