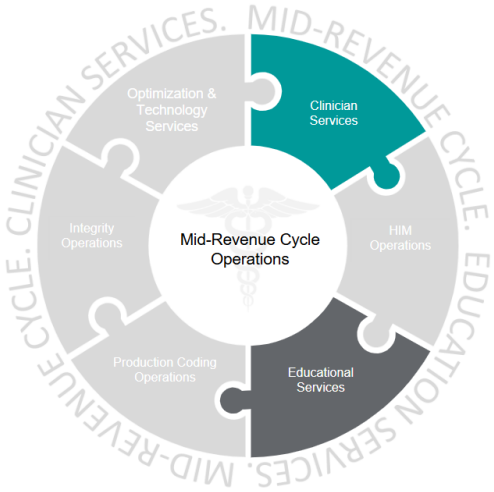
New Clinician Onboarding Coding Foundation

Mid-Revenue Cycle Operations

Presented by Clinician Services



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ENTERPRISE CLINICIAN SERVICES

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Enterprise Clinician Services Overview

Mid-Revenue Cycle Clinician Services acts as essential liaisons between clinicians and the revenue cycle, ensuring precise documentation and coding at the highest level of specificity. Committed to supporting clinicians' exemplary care in documentation, charge capture, and code assignment. Our goal is to optimize financial metrics and operational efficiency.

Clinician Services:

- Clinician Services aims to deliver a **robust coding and documentation** support framework to all employed clinicians across the enterprise and supporting **11+ service line** specialties.
- The Clinician Services team has a mission **to promote a positive** and **engaging experience** for clinicians to ensure their success in coding and documentation to capture their work performed in a **timely, efficient, and a cost-effective manner**.
- **Individual Clinician Services** (ICS) is dedicated to supporting our clinicians throughout the organization. This includes a specialized team dedicated to supporting new clinicians to ensure a smooth and positive coding onboarding experience.
    - **Clinician Onboarding Specialist:** Every newly hired clinician is assigned a **Clinician Onboarding Specialist** who will provide coding support the clinician during the **first six months** of an employment.
    - **Clinician Coding Liaison:** Who is responsible for supporting the clinician for the remainder of their employment.

OVERVIEW OF EVALUATION AND MANAGEMENT

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Overview

- The coding guideline aims **to outline the general principles** of Evaluation and Management coding and documentation

- Documentation requirements were **created collaboratively** by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS)

- Medical record documentation **must include** pertinent facts, findings, and observations regarding an individual's health history, including:
  - Chief complaint
  - Past and present illnesses
  - Examinations
  - Tests
  - Treatments
  - Outcomes

NOTE: If you have any questions about the following services, please reach out to your Onboarding Specialist

Overview

- The **nature and amount** of clinician work and documentation for E/M services depend on the type of service, place of service, and the patient's status

- Medical records serve several purposes, including:
  - Evaluating and planning for a patient's immediate treatment
  - Monitoring a patient's healthcare over time
  - Facilitating communication and continuity of care among clinicians
  - Supporting accurate and timely claims review and payment
  - Assisting with utilization review and quality of care evaluations
  - Enabling the collection of data for research and education

- Current Procedural Terminology (CPT) and ICD-10 codes **reported on the** health insurance claim form should be supported by the documentation in the medical record

DOCUMENTATION GUIDELINES

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Documentation Guidelines

- The medical record **should be complete and legible**
- Your documentation of each patient encounter should include:
  - **Reason** for the encounter (chief complaint) and relevant history, physical exam findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
- If you **don't document** the date, legible name of the observer and your rationale for ordering diagnostic and other services, it should be easily inferred
- **Past and present diagnoses** should be accessible to you or the consulting physician
- Identify appropriate **health risk** factors
- Document **patient's progress**, response to and changes in treatment and revision of diagnosis
- Documentation **should support** diagnosis and treatment codes reported on the claim form or billing statement
- All encounters must contain **a signature**

Documentation Guidelines

- All services should be documented **timely in EPIC**; best practice of same day documentation is preferred
- Clinicians are expected to **regularly review** their electronic health record **In-Basket folders** and complete identified documentation deficiencies, authenticate orders and documents and close encounters

Documentation Requirement

Documentation Components:

Advocate Health electronic health records should include the **complete documentation** of:

- History taking
- Assessments
- Examination, interpretations
- Instructions/education
- Orders/referrals
- Obtaining consent
- Procedures performed
- Diagnoses assigned during an in-person or virtual encounter with a patient
- Authentication; either the **closing** of the encounter OR the **resulting of the order**

NOTE: The author of each medical or clinical record entry must be identified in the medical record.

Signature Requirement:

Medicare requires the services provided or ordered be authenticated by the author. There are two acceptable methods of authentication:

- Handwritten signature
- Electronic signature

When there are multiple authors or contributors to a document, all signatures should be retained so that each individual contribution is identified

Key Documentation Tips

- **Make sure problem lists are kept up to date:**
  - The problem list should reflect the status of each condition (e.g., active, chronic, resolved).
  - Avoid listing every condition the patient has ever experienced.
  - Ensure the highest level of specificity is captured in diagnosis codes.
  - Avoid using default unspecified codes.
  - Default codes may not accurately represent the severity of illness in sicker patients.

- **All problems need to be in the assessment:**
  - Note all problems assessed during the visit in the assessment portion of the record.
  - Code all relevant conditions, not just the reason for the visit.

- **All diagnosis should be documented:**
  - Document all diagnoses involved in the clinician's medical decision-making process.
  - Example: If a medication affects the treatment of the current issue, it should be documented and coded.

- **All chronic conditions documented at least once annually:**
  - Assess all chronic conditions during a face-to-face encounter at least annually.
  - Submit these conditions on the claim, including status codes like amputations, transplant status, ostomies, etc.

Documentation Cautions

Cloning

- **Copying and pasting** previous entries
- Using **templates** or EHR systems
- Acceptable **only in certain cases**, but identical problems or treatments for the same patient are unrealistic
- Authentic authorship and documentation are crucial for proper medical records
- Can lead to denials for lack of medical necessity

Over-documentation

- Adding **irrelevant or false information** to justify higher billing
- Some systems **auto-populate** or generate overly comprehensive documentation that may not match the actual service performed, leading to inaccuracies

Pre-population

- Entering history, exam, or MDM components **before the patient arrives** and discouraged
- When using **pre-populated templates**, only accurate, relevant information should be included
- Review of Systems (ROS), exam findings, or MDM **should not be documented** before the patient visit

Voice-dictated

- Voice-dictated (e.g., Dragon) notes are held to the same standards as other documentation methods
- Clinicians/APPs are responsible **for proofreading** notes for accuracy
- Disclaimers attributing errors to technological issues do not protect against documentation errors.

Documentation Correction in Epic Electronic Health Record

Medical Record Corrections in SmartChart to guide corrections made to patient's medical records:

- Advocate Health has a policy **which outlines** the procedures, responsibilities, and decision-making process for correcting documentation errors or potential errors in the electronic health record (EHR)
- Clinicians will receive additional guidance on this policy during **Epic training**
- Document corrections may be requested **when clarification is needed** to ensure proper code selection with the highest level of specificity
- Corrections can be made through **addendums, amendments, or late entries** (after a note has been signed) or by editing (before a note is signed)
- Only correct documentation that you have authored or that was created by a scribe on your behalf
- Clinicians **are not permitted** to correct the documentation of another clinician
- While an addendum may be requested for clarification or to address any apparent discrepancies in the documentation, **corrections should not be made** solely for the purpose of claim payment

EVALUATION AND MANAGEMENT

Documentation Guidelines

- E/M codes that have levels of services include a medically appropriate history **and/or** physical examination, when performed
- The **nature and extent of** the history and/or physical examination are determined by the treating clinician or Advanced Practice Professionals (APP) reporting the service
- The **care team** may collect information, and the patient or caregiver may supply information directly (e.g., by electronic health record portal or questionnaire) that is reviewed by the reporting clinician or APP
- The **extent of history and physical examination** is not an element in selection of the level of E/M service codes

Chief Complaint (CC)

This is a **concise statement** describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words. The CC is required for all E/M Services.

Examples of **Acceptable** Documentation
• Hypertension • Follow up of diabetes • Recheck of otitis media • Chest pain

Examples of **Unacceptable** Documentation
• The patient presents for a recheck • 3-month follow-up • Medication refill

History Components

- E/M codes for inpatient, outpatient, office and consultative services include a medically appropriate history when performed. The history is made up of three elements:
  - History of Present Illness;
  - Review of Systems;
  - Past, Family, Social History

- The **nature and extent** of the history are determined by the clinician reporting the service
- The **extent of history and physical examination** is not an element in selection of the level of E/M service codes

HISTORY OF PRESENT ILLNESS (HPI)	REVIEW OF SYSTEMS (ROS)	PFSH HISTORY
__Location __Severity __Timing __Quality __Duration __Modifying Factors __Context __ Associated Signs & Symptoms	__ Constitutional __ENMT __ Respiratory __ Genitourinary __ Cardiology __ Gastroenterology __Eyes __Integumentary __ Psychiatric __ Musculoskeletal __ Hematologic/Lymphatic __ Neurologic __ Endocrine __Allergic/Immunologic __ All others reviewed and are negative	___ Past History ___ Family History ___ Social History

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Exam Component

- E/M codes for inpatient, outpatient, office and consultative services include a medically appropriate exam when performed
- The nature and extent of the exam is determined by the clinician submitting the LOS
- The extent of history and physical examination is not an element in selection of the level of E/M service codes

Body Area	Organ Systems
❑ Head, including Face	❑ Constitutional
❑ Neck	❑ Eyes
❑ Chest, including Breast and Axilla	❑ Ears, Nose, Mouth and Throat
❑ Abdomen	❑ Cardiovascular
❑ Genitalia, Groin, Buttocks	❑ Respiratory
❑ Back	❑ Gastrointestinal
❑ Each Extremity	❑ Genitourinary
	❑ Musculoskeletal
	❑ Skin
	❑ Neurologic
	❑ Psychiatric
	❑ Hematologic/Lymphatic/Immunologic

NOTE: The table above contains examples of body areas and organ system that may be included in exam, not necessarily an all-inclusive list

Choose the Code That Characterizes Service

Choose a CPT code that best represents the:

- Patient type
  - New
  - Established
- Service type
  - Initial
  - Subsequent
- Place of service
- Level of E/M service

Patient Type

Solely for the purpose of distinguishing between **new and established patients**, professional services are those **face-to-face services** rendered by clinician or APPs who may report evaluation and management services.

New	Established
A **new** patient is one who has **not** received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belong to the same group practice, within the past **three** years.	An **established** patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belong to the same group practice, within the past **three** years.

NOTE: The CMS definition of a group practice states that physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

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Service Type

Some categories of service **do not differentiate** between new or established patients, such as hospital inpatient and observation care.

For distinguishing between initial and subsequent visits, professional services are those **face-to-face services** rendered by clinician or APPs who may report evaluation and management services.

Initial Service:

Patient has not received any professional service(s) from the physician or qualified health care provider or another physician or other qualified health care provider of the exact same specialty and subspecialty who belongs to the same group practice, during admission and stay.

Subsequent Service:

Patient has received professional service(s) from the physician or qualified health care provider or another physician or other qualified health care provider of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

NOTE: A stay transitioning from observation to inpatient is considered a single stay.

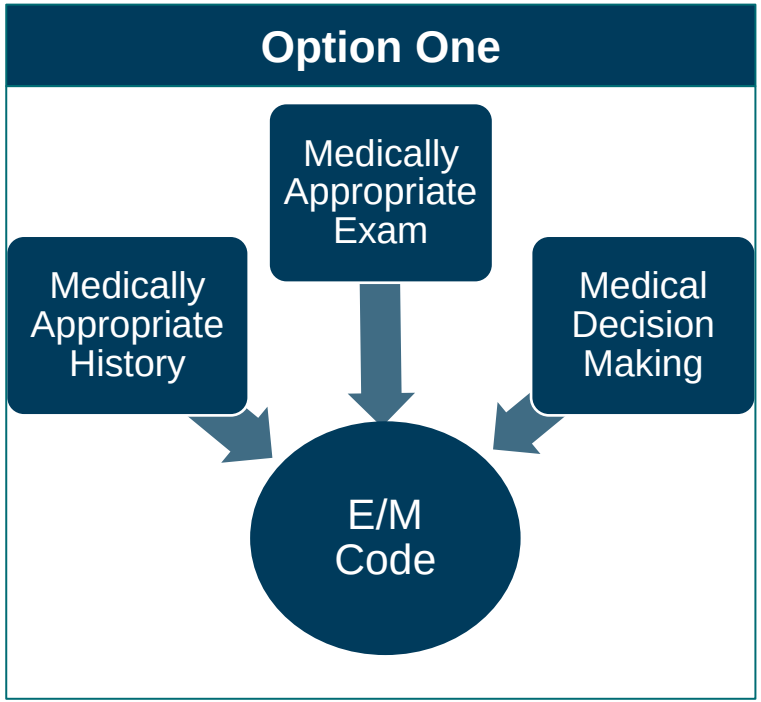
Place of Service

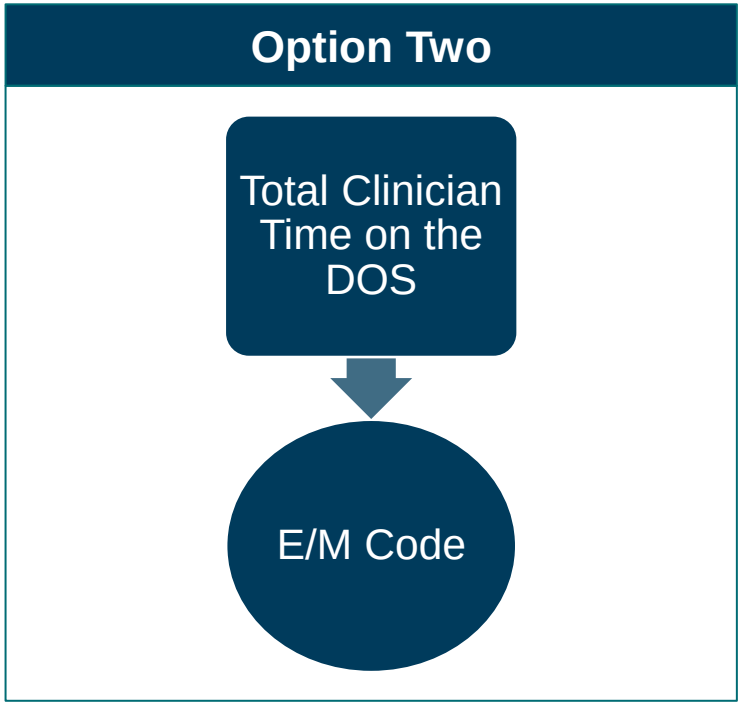
CMS categorized E/M services into different settings depending on where the service is furnished. Examples of settings include:

- Office/Outpatient
- Hospital/Observation (Inpatient or Outpatient)
- Emergency Department (ED)
- Nursing Facility (NF)
- Patient Home/Residence
- Telehealth

Evaluation and Management Code Selection

E/M codes are determined by one of two options





MEDICAL DECISION MAKING (MDM)

What Do You Mean By MDM?

Clinician Can Make Documenting MDM Simple With This **Understanding**

Note: Using this structured approach significantly improves documentation quality, compliance, and reimbursement outcomes.

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MDM Level of Service

Medical Decision Making for E/M codes are defined by **three elements**.

MDM
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications and/or Morbidity or Mortality of Patient Management

There are **four types** of MDM as detailed below:

- **Straightforward (SF)** - self-limited or minor problem
- **Low** - stable chronic illness or acute, uncomplicated illness or injury
- **Moderate** - chronic illnesses with exacerbation, progression, or side effects of treatment; or undiagnosed new problem with uncertain prognosis; or acute illness with systemic symptoms; or acute complicated injury
- **High** - chronic illnesses with severe exacerbation, progression, or side effects of treatment; or acute or chronic illness or injury that poses a threat to life or bodily function

Selecting Level of Service Based on Medical Decision-Making (MDM)

The medical record must document the chief complaint along with a **medically appropriate history and/or physical examination**.

To justify a specific code level, at least **2 out of the 3** elements of Medical Decision Making (MDM) for that code level must be met or exceeded.

MDM Table

Level of MDM	Elements of MDM		
	Number and Complexity of Problems Addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
Straightforward	1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment **Examples only**: • Gargles • Elastic bandages • Superficial dressings • Rest • Other minimal risk testing or treatment
Low	2 or more self-limited or minor problems **OR** 1 stable, chronic illness **OR** 1 acute, uncomplicated illness or injury **OR** 1 stable, acute illness **OR** 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	(Must meet the requirements of at least 1 of 2 categories) **Category 1: Tests and Documents** Any combination of 2 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)**	Low risk of morbidity from additional diagnostic testing or treatment **Examples only**: • Minor surgery with no identified risk factors • Physical/Occupational therapy • IV fluids without additives • Over the counter drugs • Other low risk testing or treatment
Moderate	1 or more chronic illness 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, uncomplicated injury	(Must meet the requirements of at least 1 of 3 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian **OR** **Category 2: Independent interpretation of test(s)** **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 pr 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 • Other moderate risk testing or treatment
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	(Must meet the requirements of at least 2 of 3 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian **OR** **Category 2: Independent interpretation of test(s)** **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 risks • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances • Other high-risk testing or treatment

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Selecting Level of Service Based on Medical Decision-Making (MDM)

1	2	3
Number and complexity of problems addressed at the encounter: • A problem is addressed or managed when it is evaluated or treated at the encounter by the clinician or Advanced Practice Professionals (APP) reporting the service. • Referral without evaluation (by history, exam, or diagnostic study) or consideration of treatment does not qualify as being addressed.	**Amount and/or complexity of data to be reviewed and analyzed:** • Tests, documents, orders, or independent historian(s). Each unique test (as identified by a CPT Code), order, or document is counted to meet a threshold number. • Independent interpretation of tests. • Discussion of management or test interpretation with external clinician/APP or appropriate source.	**Risk of complications and/or morbidity of patient management:** • Includes possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

Level of MDM	Number and Complexity of Problems Addressed
Straightforward	1 self-limited or minor problem
Low	2 or more self-limited or minor problems **Or** 1 stable, chronic illness **Or** 1 acute, uncomplicated illness or injury **Or** 1 stable acute illness **Or** 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
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, uncomplicated injury
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

Number and Complexity of Problems Addressed

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Level of MDM	Amount and/or Complexity of Data to be Reviewed and Analyzed
Straightforward	Minimal or None
Low	(Must meet the requirements of at least 1 of 2 categories) **Category 1: Tests and Documents** Any combination of **2** from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)**
Moderate	(Must meet the requirements of at least 1 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 **OR** **Category 2: Independent interpretation of test(s)** • Independent interpretation of a test performed by another clinician/QHP (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)

Amount and/or Complexity of Data to be Reviewed and Analyzed

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Level of MDM	Amount and/or Complexity of Data to be Reviewed and Analyzed
High	(Must meet the requirements of at least 2 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 OR **Category 2: Independent interpretation of test(s)** • Independent interpretation of a test performed by another clinician/QHP (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)

Amount and/or Complexity of Data to be Reviewed and Analyzed

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Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment **Examples only:** Gargles Elastic bandages Superficial dressings Rest Other minimal risk testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment **Examples only:** Minor surgery with no identified risk factors Physical / Occupational therapy IV fluids without additives Over the counter drugs Other low risk testing or treatment
Moderate	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 Other moderate risk testing or treatment
High	High risk of morbidity from additional diagnostic testing or treatment **Examples only:** Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery with identified patient or procedure risk factors Decision regarding emergency major surgery Decision regarding hospitalization or escalation of hospital-level care Decision not to resuscitate or to de-escalate care because of poor prognosis Decision regarding parenteral controlled substances Other high-risk testing or treatment

Risk of Complications and/or Morbidity or Mortality

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Risk of Complications and/or Morbidity or Mortality

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a clinician or other qualified health care professional in the same specialty. **For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated**. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

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

Social determinants of Health
Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. Social determinants of health are the environmental conditions where people are born, live, earn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. There are 5 domains of social determinants of health: ○ Economic stability ○ Access to and quality of education ○ Access and quality to healthcare ○ Neighborhood and built environment ○ Social/community context Documentation should specify the social determinant(s) that is complicating the medical decision making for the patient's plan of care.

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

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. The monitoring is
- performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.
- Examples may include documentation of:
    - Monitoring chemotherapy drugs.
    - Frequent EKGs needing to be done due to medications.
    - Daily INR lab tests to monitor Warfarin levels previously abnormal.
    - Certain cardiac drugs (e.g., Digoxin), specific antibiotics (e.g.,
    - Vancomycin and Gentamycin), anti-seizure agents, bronchodilators, immunosuppressant drugs, chemotherapeutic agents, certain psychiatric drugs and drugs used to treat HIV/AIDS.

Note: This is not an all-inclusive list

Risk Associated with Patient's Condition

- All diagnostic and surgical procedures carry inherent risks.
- When selecting "HIGH" risk on the MDM table, please take the following external risk factors into account:
  - Advanced age or debility
  - Previous surgical complications
  - Existing cardiac conditions
  - Existing lung conditions

Please ensure that your documentation accurately reflects the severity of the condition when selecting high-level services.

TIME

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Evaluation and Management Code Selection Based on Time

- For coding purposes, time for these services is the **total time** on the date of the encounter
- It includes both the face-to-face time with the patient and/or family and non-face-to-face time personally spent by the clinician and/or other qualified health care professional(s) on the day of the encounter
- It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s)
- When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection

Activities Included in Total Time

Activities:
- Preparing to see the patient (e.g., 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, or procedures
- Referring and communicating with other health care professionals (if not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Do not count time spent on the following:
- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

Time Requirements

- Time alone may be used as the determining factor for selecting the E/M code.
- Based on **total time spent** for the E/M service on the date of the encounter
- Does **not** have to be time spent in counseling and/or coordination of care
- Includes **face-to-face and non-face-to-face** time personally spent by the physician and/or qualified health care professional
- **Excludes** time on activities “normally performed by office staff”
- Total time on the date of the encounter must meet or exceed time threshold

CPT Code	Total Time (Minutes)	CPT code	Total Time (Minutes)
New Patient Visit		Established Patient Visit	
NA	NA	99211	NA
99202	15	99212	10
99203	30	99213	20
99204	45	99214	30
99205	60	99215	40

Note: The calendar date of the encounter is defined as running from midnight to midnight.

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Evaluation and Management Code Selection Based on Time

Time spent on services reported separately, for example procedures, is not included in the total time.

North Carolina and Georgia Division Clinicians:

Charlotte/Navicent/Floyd (Encompass) Autotext: **.timeattestation**

> "On the day of the visit I spent *** minutes (SmartList inserted here).This time does not include any time spent performing procedures or assessments that are separately billable."

WI Division and IL Division Clinicians:

EPIC Smartphrase: **.TIMELOS** = Total time I spent today on this appointment is*** minutes

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OFFICE VISITS AND OTHER OUTPATIENT SERVICES

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Universal Concepts for Office or Other Outpatient Services

Where the Service Took Place	• Office or Other Outpatient Setting
Type of Service	• New or Established • Problem Visit
Documentation Requirements Needed	• Reason for the encounter, relevant history and physical exam, health risk factors, updated problem list, patient's response to and/or changes in treatment, diagnoses that were part of medical decision making, assessment and plan
Code Requirements Needed	• Medically appropriate history and exam • Level of MDM OR total time
Which Part Did the Clinician Personally Perform	• Split/Shared not allowed • Incident to rule applies (est. patient, est. problem, direct supervision-on site)

Office and Other Outpatient Locations

Office

- Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Off Campus Outpatient Hospital

- A portion of an off-campus hospital professional-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Urgent Care Facility

- Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

On Campus Outpatient Hospital

- A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

New and Established Services

(99202-99205) New Patient

- A **new patient** is one who has **not received** any professional services from the physician/ qualified health care professional or another physician/ qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, **within the past three years.**

(99211-99215) Established Patient

- An **established patient** is one who **has received** professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, **within the past three years.**

CODE SELECTION BASED ON MDM OR TOTAL TIME			
PATIENT TYPE	**CPT**	**MDM**	**TIME**
New Patient (Office or Outpatient)	99202	Straightforward	15 Minutes
	99203	Low	30 Minutes
	99204	Moderate	45 Minutes
	99205	High	60 Minutes
Established Patient (Office or Outpatient)	99212	Straightforward	10 Minutes
	99213	Low	20 Minutes
	99214	Moderate	30 Minutes
	99215	High	40 Minutes

ADVOCATE HEALTH

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
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; **or** • **1** stable acute illness; **or** • **1** acute, uncomplicated Illness or injury requiring hospital inpatient or observation level of care	**Limited** **(Must meet the requirements of at least 1 of the 2** categories) Category 1: Tests and documents • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* 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**

ADVOCATE HEALTH

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
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

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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

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 or escalation of hospital level of care
				•Decision not to resuscitate or to de-escalate care because of poor prognosis
				•Decision regarding parenteral controlled substances

ADVOCATE HEALTH

Prolonged Care Codes with Office and Other Outpatient

AMA	
New Patient	**CPT Code 99417**
60 minutes	99205
75 minutes	99205 x1 and 99417 x1
90 minutes	99205 x1 and 99417 x2
105 minutes or more	99205 x1 and 99417 x3 or more for each additional 15 minutes
Established	**CPT Code 99417**
40 minutes	99215
55 minutes	99215 x1 and 99417 x1
70 minutes	99215 x1 and 99417 x2
85 minutes or more	99215 x1 and 99417 x3 or more for each additional 15 minutes

Medicare / CMS	
New Patient	**HCPCS Code G2212**
60 minutes	99205
89 minutes	99205 x1 and G2212 x1
104 minutes	99205 x1 and G2212 x2
119 minutes or more	99205 x1 and G2212 x3 or more for each additional 15 minutes
Established	**HCPCS Code G2212**
40 minutes	99215
69 minutes	99215 x1 and G2212 x1
84 minutes	99215 x1 and G2212 x2
99 minutes or more	99215 x1 and G2212 x3 or more for each additional 15 minutes

Note: CPT code 99417 is applied to non-Medicare patients and Code G2212 is applied to Medicare patients.

Example : Office Visit – New Patient

Patient:
43-year-old female; chaperone present

Chief Complaint:
Heavy menstrual bleeding

HPI: She is here because of significant and chronic menstrual bleeding for years. Ultrasound reveals relatively normal size uterus. Periods are now coming every 20 days for the last 3 months and are heavy. She has a lot of cramping associated with it as well.

OB history significant for 2 previous C-sections with cervical cerclage this. She has had several miscarriages as well. She is bleeding fairly heavy.

Patient's medications, allergies, past medical surgical, social and family histories were reviewed and updated as appropriate.

Ultrasound shows heterogenous tissue. I reviewed the ultrasound as well. There is a 3 small approximately 1 cm fibroid with a submucosal component appreciated that is not identified by radiology

Problem List Items Addressed This Visit

Genitourinary and Reproductive
Menorrhagia with regular cycle - Primary

Plan:
1. I reviewed adenomyosis with the patient which I think is what she has at this point. I do want to try medication first. She has tried birth control pills t
well with her. I placed her on Slynd which is a progesterone only birth control pill that may help with her bleeding as well. If this helps we may go ahea
consider placing her on an IUD as well. If she truly has adenomyosis then she may need hysterectomy. I recommended that we could also try an endc
ablation but in people with adenomyosis it has been my experience that it does not really help with pain although the bleeding may stop.

ADVOCATE HEALTH

Example : Office Visit – New Patient

Here we have a **new** patient office visit.

Final E/M Code Selection

Number and Complexity of Problems Addressed:

- 1 chronic illness with exacerbation, progression or side effects of treatment.

Amount and/or Complexity of Data to be Reviewed and Analyzed:

- Independent interpretation of an ultrasound previously performed.

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

- Prescription drug management for the new prescription

MDM: Moderate

New Patient Office E/M Code: 99204

ADVOCATE HEALTH

CONSULTATIONS

ADVOCATEHEALTH

Consultation

(99242-99245) Office or other outpatient, new or established patients

- Evaluation and management of a patient, provided at the request of another physician, other qualified health care professional or appropriate source to recommend care for a specific condition or problem. This requires a medically appropriate history and/or examination with medical decision making or time.

(99252-99255) Inpatient or observation, new or established patient

- Evaluation and management of a patient, provided at the request of another physician, other qualified health care professional or appropriate source to recommend care for a specific condition or problem. This requires a medically appropriate history and/or examination with medical decision making or time.

CODE SELECTION BASED ON MDM OR TOTAL TIME			
PATIENT TYPE	**CPT**	**MDM**	**TIME**
Office or Other Outpatient, New or Established	99242	Straightforward	20 Minutes
	99243	Low	30 Minutes
	99244	Moderate	40 Minutes
	99245	High	55 Minutes
Inpatient or Observation, New or Established	99252	Straightforward	35 Minutes
	99253	Low	45 Minutes
	99254	Moderate	60 Minutes
	99255	High	80 Minutes

NOTE

Organizational "Modifier TIME" will be used by clinicians to indicate that **Consultation Evaluation and Management (E/M)** codes are selected **based on time**.
Go to Modifier Time – Updates for Consultation Codes – News Flash for more information.

ADVOCATE HEALTH

Consultation Crosswalk on NC/GA Division

SERVICE SETTING	CPT	NC/GA INTERNAL CODES	MDM	TIME
		NEW / EST		
Office/Outpatient	99242	I1702 / I1712	Straightforward	20 Minutes
	99243	I1703 / I1713	Low	30 Minutes
	99244	I1704 / I1714	Moderate	40 Minutes
	99245	I1705 / I1715	High	55 Minutes
Inpatient/Observation	99252	I1722	Straightforward	35 Minutes
	99253	I1723	Low	45 Minutes
	99254	I1724	Moderate	60 Minutes
	99255	I1725	High	80 Minutes
Emergency Dept	99242	I1742	Straightforward	20 Minutes
	99243	I1743	Low	30 Minutes
	99244	I1744	Moderate	40 Minutes
	99245	I1745	High	55 Minutes

Consultation Vs Referral

- A **consultation** is a type of evaluation and management service provided at the **request** of another physician or appropriate source to either **recommend care** for a specific condition or problem or to determine **whether to accept responsibility** for ongoing management of the patient's entire care or for the care of a specific condition or problem.

- A **referral** is the process whereby a physician or other qualified healthcare professional who is providing management for **some or all** a patient's problems relinquishes this responsibility to another physician or other qualified healthcare professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.

3 R’s Of Consult Documentation

REQUEST

A written or verbal request (service to order) to see the patient and consult in care. – Must be found in the chart.

REASON

The reason for consultation must be documented by the consulting clinician in the medical record.

RESPONSE

Respond back to the requesting clinician in a written report. Can be sent in the EHR.

ADVOCATE HEALTH

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
99242 **99252**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99243 **99253**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury; **or** • **1** stable acute illness; **or** • **1** acute, uncomplicated Illness or injury requiring hospital inpatient or observation level of care	**Limited** **(Must meet the requirements of at least 1 of the 2** categories) Category 1: Tests and documents • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* 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**

ADVOCATE HEALTH

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
99244 **99254**	**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

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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

99245
99255
	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 or escalation of hospital level of care
				•Decision not to resuscitate or to de-escalate care because of poor prognosis
				•Decision regarding parenteral controlled substances

ADVOCATE HEALTH

Prolonged Care Codes with Consultations

Outpatient	
Office Outpatient	**CPT Code 99417**
55 minutes	99245
70 minutes	99245 x1 and 99417 x1
85 minutes	99245 x1 and 99417 x2
100 minutes or more	99245 x1 and 99417 x3 or more for each additional 15 minutes

Inpatient or Observation	
Inpatient or Observation	**CPT Code 99418**
80 minutes	99255
95 minutes	99255 x1 and 99418 x1
110 minutes	99255 x1 and 99418 x2
125 minutes or more	99255 x1 and 99418 x3 or more for each additional 15 minutes

Example – Consultation Services

Initial Orthopaedic office consultation for a 40-year-old female **requested by her PCP** for left arm pain. She was playing tennis yesterday when she accidentally hit her left forearm with her own racquet. Her arm was examined and diagnosed as a **simple are contusion** for which no further treatment is needed.

Final E/M Code Selection

- **Number and Complexity of Problems Addressed:** Self-limited or minor problem
- **Amount and/or Complexity of Data to be Reviewed and Analyzed:** Minimal
- **Risk of Complications and/or Morbidity or Mortality of Patient Management:** Minimal risk
- **MDM:** Straightforward

- **Consultation E/M Code:** 99242

HOSPITAL INPATIENTS AND OBSERVATION CARE SERVICES VISITS

ADVOCATEHEALTH

Hospital Billing

The below categories include initial, subsequent and discharge hospital codes provided to patients designated as inpatient or observation status.

Hospital Visit CPT Codes

- Initial Hospital Inpatient or Observation Care 99221-99223
- Subsequent Hospital Inpatient or Observation Care 99231-99233
- Discharge Hospital Inpatient or Observation Care 99238-99239
- Admit/Discharge Hospital Inpatient or Observation Care same date 99234-99236

Initial and Subsequent Hospital Service : Inpatient/Observation

(99221-99223) Initial hospital inpatient or observation care

- An **initial** service may be reported when the patient **has not received** any professional services from the physician or other qualified healthcare professional of the **exact same specialty and subspecialty** who belongs to the same group practice during the **admission and stay**.

(99231-99233) Subsequent hospital inpatient or observation care

- A **subsequent** service is when the patient **has received** professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, during the **admission and stay**.

CODE SELECTION BASED ON MDM OR TOTAL TIME			
PATIENT TYPE	CPT	MDM	TIME
Initial Inpatient or Observation Care	99221	Low	40 Minutes
	99222	Moderate	55 Minutes
	99223	High	75 Minutes
Subsequent Inpatient or Observation Care	99231	Low	25 Minutes
	99232	Moderate	35 Minutes
	99233	High	50 Minutes

ADVOCATE HEALTH

Hospital Inpatient or Observation Care: Same Day Admission and Discharge

(99234-99236) Hospital inpatient or observation care, for the evaluation and management of a patient **including admission and discharge on the same date**, which requires a medically appropriate history and/or examination with medical decision making or time.

Same Day Admit/Discharge				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99234	Medically appropriate history and/or examination		Straightforward /Low	45
99235			Mod	70
99236			High	85

ADVOCATE HEALTH

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
99221 **99231** **99234**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99221 **99231** **99234**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury; **or** • **1** stable acute illness; **or** • **1** acute, uncomplicated Illness or injury requiring hospital inpatient or observation level of care	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **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**

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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
99222 **99232** **99235**	**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

CPT Code	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *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

99223
99233
99236
	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 or escalation of hospital level of care
				•Decision not to resuscitate or to de-escalate care because of poor prognosis
				•Decision regarding parenteral controlled substances

ADVOCATE HEALTH

Inpatient and Observation Discharge

Inpatient and Observation Discharge Services

The hospital discharge day management codes are to be used to report the total duration of time spent by the Admitting/Supervising Physician or Other Qualified Health Care Professional for final hospital discharge of a patient.

CPT Code 99238 - has no minimum time requirement, therefore documentation of time is not required.

CPT Code 99239 - **requires** documentation of time.

- When 99239 is billed and documentation of time is not identified in the medical record, the service will be submitted for payment based on what the documentation supports
- Only the clinician managing the patient's discharge should utilize the 99238 or 99239. Other clinicians performing concurrent care services should report subsequent hospital care codes (99231-99233)

Hospital Discharge	
99238	Hospital inpatient or observation discharge day management; 30 minutes or less
99239	Hospital inpatient or observation discharge day management; more than 30 minutes

Prolonged Care Codes with Hospital Inpatient

AMA	
Initial	**CPT Code 99418**
75 minutes	99223
90 minutes	99223 x1 and 99418 x1
105 minutes or more	99223 x1 and 99418 x2 or more for each additional 15 minutes
Subsequent	**CPT Code 99418**
50 minutes	99233
65 minutes	99233 x1 and 99418 x1
80 minutes or more	99233 x1 and 99418 x2 or more for each additional 15 minutes

CMS	
Initial	**HCPCS Code G0316**
75 minutes	99223
90 minutes	99223 x1 and G0316 x1
105 minutes or more	99223 x1 and G0316 x2 or more for each additional 15 minutes
Subsequent	**HCPCS Code G0316**
50 minutes	99233
65 minutes	99233 x1 and G0316 x1
80 minutes or more	99233 x2 and G0316 x3 or more for each additional 15 minutes

Note: CPT code 99418 is applied to non-Medicare patients and Code G0316 is applied to Medicare patients.

ADVOCATE HEALTH

Prolonged Care Codes with Same Day Admission and Discharge

AMA	
Hospital admission and discharge on same date	**CPT Code 99418**
85 minutes	99236
100 minutes	99236 x1 and 99418 x1
115 minutes	99236 x1 and 99418 x2
130 minutes or more	99236 x1 and 99418 x3 or more for each additional 15 minutes

CMS	
Hospital admission and discharge on same date	**HCPCS Code G0316**
85 minutes	99236
110 minutes	99236 x1 and G0316 x1
125 minutes	99236 x1 and G0136 x2
140 minutes or more	99236 x1 and G0136 x3 or more for each additional 15 minutes

Note: Prolonged Care code G0316 includes date of visit plus 3 days after for services provided after a Hospital Admit/Discharge on the same day.
Note: CPT code 99418 is applied to non-Medicare patients and Code G0316 is applied to Medicare patients.

Example – Hospital Inpatient

ILLNESS EVALUATION:

History obtained from: Mother

- The patient is a 15-month-old female born full term previously healthy presenting with cough, congestion, fever, and increased work of breathing.
- A few days prior to arrival, patient developed cough and nasal congestion. On the day of arrival, patient developed fever 103F and increased work of breathing. Mother gave Motrin which did not help. Mother also reports that the patient had some eye redness several days ago. Due to difficulty breathing, mother brought patient to the ED. Tolerating normal PO intake. Normal wet diapers. No diarrhea or emesis. No rash. No cyanosis or apnea. No noisy breathing. Normal activity level. No sick contacts, but patient does attend daycare Immunizations up to date. No history of wheezing. No asthma or allergies. Mom has history of asthma and allergies.

ROS:

Constitutional: Positive for appetite change and fever. Negative for activity change.
HENT: Positive for congestion and rhinorrhea. Negative for ear pain and trouble swallowing.
Eyes: Positive for redness.
Respiratory: Positive for cough. Negative for wheezing.
Increased work of breathing
Cardiovascular: Negative for cyanosis.
Gastrointestinal: Negative for abdominal distention, abdominal pain, constipation, diarrhea, nausea and vomiting.
Endocrine: Negative for polyuria.
Genitourinary: Negative for difficulty urinating.
Musculoskeletal: Negative for gait problem and myalgias.
Skin: Negative for color change and rash.
Allergic/Immunologic: Negative for immunocompromised state.
Neurological: Negative for seizures and syncope.
Psychiatric/Behavioral: Negative for confusion.

PHYSICAL EXAM:

BP(I) 112/65 (BP Location: LLE - Left lower extremity, Patient Position: Supine)
Comment: pt. crying/kicking leg
Pulse 125/Temp100.4 °F (38 °C) (Rectal)
Resp (I) 44 Ht 30.32" (77 cm) Wt 11.2 kg (24 lb 9.7 oz) SpO2 100% BMI 18.82 kg/m²
No intake or output data in the 24 hours ending 07/03/23 0416
Constitutional: She is not toxic-appearing
HENT: Head: Normocephalic and atraumatic
Right Ear: Tympanic membrane and external ear normal.
Left Ear: Tympanic membrane and external ear normal.
Nose: Rhinorrhea present.
Mouth/Throat: Mouth: Mucous membranes are moist. Pharynx: Oropharynx is clear. Neck: Normal range of motion.
Eyes: Conjunctivae normal. Pupils: Pupils are equal, round, and reactive to light.
Cardiovascular: Normal rate and regular rhythm.
Normal pulses. Normal heart sounds.
Pulmonary: Effort is normal. No respiratory distress or retractions. No wheezing. **Coarse breath sounds**
Abdominal: Abdomen is flat. No distension. Soft with no tenderness.
Musculoskeletal: No deformity or signs of injury. Normal ROM
Skin: Warm and dry. Capillary refill takes less than 2 seconds.
Neurological: No focal deficit present.
Mental Status: She is alert.

LABORATORY DATA:

Component	Date	Value
Rapid SARS-COV-2 by PCR	07/03/2023	Not Detected
Influenza A by PCR	07/03/2023	Not Detected
Influenza B by PCR	07/03/2023	Not Detected
RSV BY PCR	07/03/2023	Not Detected

IMAGING STUDIES: **No orders to display**

ASSESSMENT/PLAN: Patient 15-month-old female, full term previously healthy presents with acute onset cough, congestion, fever, and increased work of breathing. History/Exam is most consistent with viral bronchiolitis. Low suspicion for pneumonia given non focal lung exam. **Stable on room air, improved work of breathing**.
Principal Problem: **Bronchiolitis**
Plan:- **Tylenol 15mg/kg Q6H PRN - Ibuprofen 10mg/kg Q6H PRN**
Patient and plan discussed with family, nursing staff, and the attending and senior resident.

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Example – Hospital Inpatient

Final E/M Code Selection

Number and Complexity of Problems Addressed:

- 1 stable acute illness

Amount and/or Complexity of Data to be Reviewed and Analyzed:

- Ordering of each unique test
- Assessment requiring an independent historian(s)

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

- Low risk of morbidity from additional diagnostic testing or treatment

MDM: Low

Hospital Inpatient E/M Code: 99221

ICD-10-CM

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What is ICD-10-CM?

ICD-10-CM stands for International Classification of Diseases, 10th Revision, Clinical Modification. It is a diagnosis coding system used in the United States for classifying and coding diseases, conditions, and other health-related issues.

Purpose of ICD-10-CM:

- Standardizes medical diagnoses for billing, reporting, and research
- Helps track disease trends and public health statistics
- Supports reimbursement and claims processing

Structure of ICD-10-CM Codes:

- **Alphanumeric Format:** Codes range from 3 to 7 characters (e.g., E11.9 for Type 2 Diabetes Mellitus without complications)
- **First Character:** Always a letter (A-Z)
- **Second & Third Characters:** Numbers that define the condition further
- **Fourth to Seventh Characters:** Used for additional details like severity, location or episode of care

Examples:

- **K40.90** - Unilateral inguinal hernia, without obstruction or gangrene
- **C18.1** - Malignant neoplasm of appendix

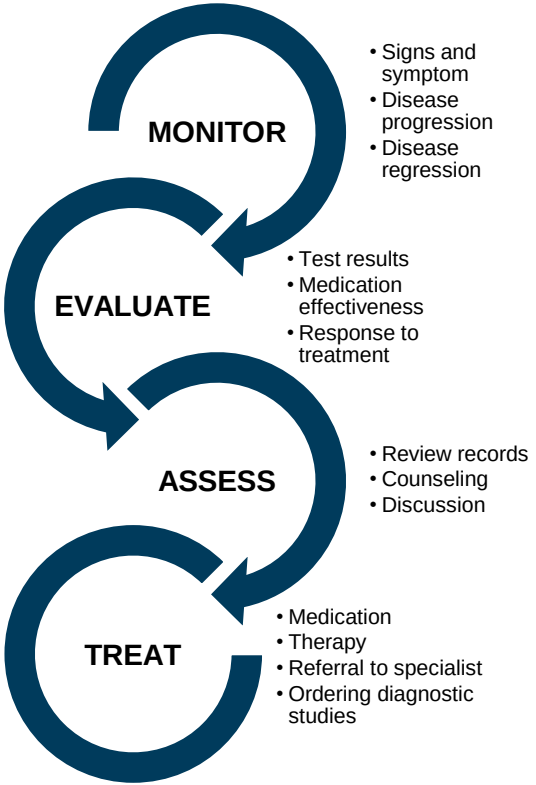
Chronic Conditions Reminder

- **Specificity**
  - Document each diagnosis to the highest degree of specificity
  - Document all complications and comorbidities
- **All Known Conditions**
  - Document confirmed conditions using MEAT criteria
- **All Chronic Conditions**
  - Yearly basis
- **All Problem Pertinent Conditions**
  - Document ANY chronic conditions that affect the care and treatment of the patient on that date of service
- **A combination code is a single code used to classify:**
  - Two diagnoses, or
  - A diagnosis with an associated secondary process (manifestation)
  - A diagnosis with an associated complication
  - Assign only the combination code when that code fully identifies the diagnostic conditions involved

Note: When documentation of combination code lacks necessary specificity in describing the manifestation or complication, a clinician query may be necessary to include an additional code on the claim as a secondary code.

What is Accurate and Complete Documentation?

- CMS requires that an acceptable problem list includes "**evaluation and treatment**" for each condition linked to an ICD-10-CM code.
- According to ICD-10-CM Coding Guidelines, all conditions present during an encounter that impact patient care must be documented and assigned a diagnosis code.
- Accurate documentation by the clinician, based on the patient encounter, is essential.
- Proper documentation and coding are crucial for appropriate reimbursement, as incomplete or inaccurate coding can result in incorrect payments that do not reflect the complexity of care.
- **The M.E.A.T. acronym** (Monitor, Evaluate, Assess, and Treat) supports accurate documentation for risk-adjusted payment, ensuring complete and precise information for coding.



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Specificity In Documentation

Specificity in Documentation

- Document each diagnosis with the **highest degree of specificity**.
- **Include all** complications and comorbidities.
- Document confirmed conditions using the **MEAT criteria**.
- Document all chronic conditions on a **yearly basis**.
- Document any chronic conditions **affecting care** on the date of service.

Combination Codes:

- Used for **two diagnoses**, a diagnosis with an associated secondary process, or a diagnosis with an associated complication.
- Assign only when **the combination code fully captures** the involved diagnostic conditions.

Risk Adjustment Coding

Risk adjustment coding is a healthcare process that assigns diagnosis codes to patients based on their medical conditions, helping insurers and government programs predict healthcare costs more accurately. How It Works:

- **Diagnosis Coding:**
  - Healthcare providers document patients' diagnoses using standardized coding systems like ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification).
- **Hierarchical Condition Categories (HCCs):**
  - Many risk adjustment models, such as those used by Medicare Advantage and the Affordable Care Act (ACA), use HCC coding to group conditions based on their severity and cost impact.
- **Risk Scores:**
  - Each patient's diagnoses are translated into a risk score, which reflects their predicted healthcare costs. Sicker patients receive higher scores, leading to higher reimbursements for their care.
- **Financial Impact:**
  - Insurers and healthcare plans use these risk scores to determine reimbursement rates, ensuring they receive adequate funds to care for high-risk patients.

OTHER SERVICES

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Split/Shared Services

- A split/shared visit is an E/M visit that both a clinician or nonphysician professional (NPP) in the same group perform only in a **facility setting**, and in accordance with applicable law and regulations, either the clinician or NPP can bill the service if they provide it independently.
- Medicare pays the practitioner who performs the **substantive portion** of the visit.
- **Definition of Substantive Portion:**
  - More than half of the total time, or a substantive part of the Medical Decision Making (MDM)
  - At least one provider must have face-to-face contact with the patient, but it doesn't have to be the same provider who performs the main part of the visit or bills for it
  - The substantive portion of the service can include time with or without direct patient contact, and is based on the total time spent, rather than just the time involving patient interaction
- Services must be common in facility settings such as hospital inpatient or outpatient, emergency department, nursing home.
- **Modifier FS** should be appended to E/M codes to report **Split/Shared services**, indicating that **two practitioners participated** in the visit, even if billed under one NPI.
- **North Carolina and Georgia Division clinicians** should use **Modifier FS when the APP** performed the substantive portion of the service, and **Modifier F2F when the clinician** performed the substantive portion.
- The medical record should include:
  - The identity of both practitioners who perform the visit
  - The practitioner that performed the substantive portion of the visit

Teaching Physicians, Residents and Students

- The Teaching Physician must be **personally present** during critical or key portions of the service and patient management when performed by the resident.
- Documentation from both the Teaching Physician and resident **should be combined** for E/M billing, covering medical necessity.
- If the teaching physician chooses **to rely on the medical student's documentation** and not re-document the E/M service, the **requirement is considered met if the physician signs and dates** the medical student's entry in the medical record.
- Claims for services provided by the **resident in the absence of the Teaching Physician** can be submitted **under the Primary Care Exception**.
- The Teaching Physician must verify all resident documentation, including history, physical exam, and medical decision-making, in the medical record.

MODIFIER	DESCRIPTION
GC	This service has been performed in part by a resident under the direction of a teaching physician.
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception.

Meet and Greet Visits

- “Meet and Greet” visits are when the patient just wants to get to know the clinicians so that they can determine if the clinicians is a right fit for them. In this case, the clinicians should enter "no level of service(LOS)" in the LOS field.
- However, if the patient starts to ask questions about their health or wants the clinicians to address any medical concerns that they have, the provider should then inform the patient that this would then become a billable service.

Worker’s Compensation Services

- Patient being seen for a worker's comp injury and a non-work-related medical problem need to have two appointments made on same day and two separate notes (two charges).

- Worker’s Comp insurances will many times request medical recorded to be reviewed, therefore it is very important that only information pertinent to the injury is documented, is patient mentions other concerns, this would be documented in a separate visit.

- Documentation Requirements needed in the in the Worker’s Comp note should include:
    - Date of injury
    - Type of injury
    - The employer

MODIFIERS

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Definition

- **Modifiers** are two-digit numbers, or two-characters, or alpha-numeric codes added to procedure or service codes **to provide additional information or clarification**.
- They are used to indicate that a service or procedure **has been altered** in some way, without changing the basic definition of the procedure.
- Some modifiers cause **automated pricing changes**, while others are used for information only.
- A modifier also may provide details not included in the code descriptor, such as **the anatomic location** of the procedure.
- If more than one modifier is needed, list the payment modifiers those that affect **reimbursement** directly—first.
- Modifiers can convey details such as:
  - The service was performed in a **different** location or under special circumstances.
  - The procedure was partially **reduced or discontinued**.
  - The service was provided by a **specific provider** (e.g., physician assistant, nurse practitioner).
  - The service was a **bilateral procedure** or performed on a specific site (e.g., left or right side).
  - The service or procedure has both **professional** and **technical** components.
- Modifiers **help ensure** accurate billing, coding, and reimbursement by providing context for the services rendered.

E/M Modifiers

E/M modifiers should be applied only to E/M codes.

E/M services during global period might be unbundled with modifiers	
Modifiers	**Description**
24	Unrelated Evaluation and Management Service by the Same clinician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
57	Decision for Surgery

Other E/M modifiers provide additional information	
Modifiers	**Description**
AI	Principal physician of record. Append this modifier to the initial hospital and nursing home visit codes to show that the provider is responsible for the overall care of the patient.
FS	Split (or shared) evaluation and management visit
FT	Unrelated evaluation and management (E/M) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated)

Modifier 25

- Modifier 25 is used to indicate that a patient **received both a significant, separately identifiable evaluation and management (E/M)** service and a procedure **on the same day**, or two E/M services on the same day, provided by the same clinician/APP.
- Modifier 25 allows for proper reimbursement for these scenarios when they are distinct and separately identifiable and supported in the patient record.

- **Example#1**

  A patient presents with a new complaint of shoulder pain and the clinician performs a medically appropriate history and exam. The clinician orders an x-ray and discusses treatment options, and a decision is made to perform a cortisone injection.

  Application: The appropriate E/M code with the modifier 25 should be billed in addition to the appropriate procedure code.

- **Example#2**

  A patient presents for a Medicare Wellness Visit and an office visit is performed on the same date of service.

  Application: The appropriate E/M code with the modifier 25 should be billed in addition to the Medicare Wellness Visit.

  Note: Do not append modifier 25 to Medicare Wellness Visit (MWV) (G0438 or G0439).

THANK YOU FOR YOUR TIME!

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Questions

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APPENDIX

Additional definitions and resources referenced in this presentation.

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IMPORTANT DEFINITIONS

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Key Definitions – Documentation Coding

International Classification of Diseases, 10th edition, Clinical Modifications (ICD-10-CM)	ICD-I0-CM the diagnosis codes maintained by the World Health Organization (WHO). These codes are numeric or alphanumeric, with a three-character category that describes the condition, followed by a decimal and additional characters to specify details like the manifestation or location of the disease.
Current Procedure Terminology (CPT)	CPT published, copyrighted, and maintained by the American Medical Association, CPT is a large set of codes that describe what procedure or service was performed on a patient. CPT codes are an integral part of the reimbursement process. These codes are five characters long and may be numeric or alphanumeric.
Healthcare Common Procedure Coding System (HCPCS)	HCPCS is a main procedural code set for reporting procedures to Medicare, Medicaid, and many other third-party payers. Maintained by CMS, HCPCS is divided into two levels. Level I is identical to CPT and is used in the same way. Level II describes the equipment, medication, and out-patient services not included in CPT.
Modifier	A modifier is a two-character code added to a procedure code to indicate a significant variation that doesn't alter the procedure's definition. Modifiers come in two types: numeric CPT codes and alphanumeric HCPCS codes.
Hierarchical Condition Category (HCC)	HCC is a term that describes the grouping of similar diagnoses into one related category to be used in a risk adjustment payment model.
Risk Adjustment Payment	Risk adjustment payment models are regulated by the federal government to reimburse participating health insurance plans for the medical care of enrollees.
Medical Necessity	Medical necessity, as defined by Medicare, means that payments for services under Part A or Part B will only be made for items or services that are **reasonable and necessary** for diagnosing or treating illness or injury, or for improving the function of a malformed body part.
Unlisted Procedures	Unlisted codes serve an important purpose, these codes are used when no code exists to accurately describe a procedure or service.

Key Definitions – Teaching Physician Services

Teaching Physician	A physician (other than another resident) who involves residents in the care of his or her patients.
Resident	An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting.
Student	An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program
Direct Medical and Surgical Services	Services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital
Teaching Hospital	A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.
Critical/ Key Portion	That part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
Documentation	Notes recorded in the patient's medical records by a resident, and/or teaching physician or others involved in the patient's care.
Physically Present	The teaching physician is in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

Key Definitions – Evaluation and Management

Telemedicine	Synchronous, real-time, interactive encounters between a physician or other qualified health care professional and a patient utilizing either combined audio-video or audio-only telecommunication.
Split/Shared	A split/shared visit is an E/M visit that both a physician or nonphysician professional (NPP) in the same group perform in a **facility setting**, and in accordance with applicable law and regulations, either the physician or NPP can bill the service if they provide it independently.
Incident-to	"Incident To" services are provided under the **supervision of a physician**, typically by nonphysician professional (NPPs), in a physician's office suite or within an institution or a patient's home.
Critical Care	The direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition."

Evaluation and Management

Evaluation and Management (E/M)	E/M Services are at the core of most family medicine practices and represent a category of CPT codes used for billing purposes. There are different levels of E/M codes, which are determined by the physician's or qualified health professional (QHP)'s medical decision-making (MDM) or time involved.
New Patient	A new patient is one who has not received any professional (face-to-face) services (E/M, surgical procedures) from the physician/qualified health care professional or another physician/ qualified health care professional of the same specialty and belonging to the same group practice, within the past three years.
Established Patient	Individual who has received any professional services, E/M service or other face-to-face service (e.g., surgical procedure) from this provider or another provider (same specialty) in the same group practice within the previous three years.
Medical Decision Making (MDM)	MDM is how the clinician assess the degree of difficulty in establishing a patient's diagnosis and treatment plan. E/M codes include four types of MDM: straightforward, low complexity, moderate complexity, and high complexity.
Prolonged Service Codes	Prolonged Service codes are reported with E/M service codes when total visit time spent with patient exceeds a certain time threshold.

What is a "Problem" and When is it "Addressed?"

Problem	A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
Problem Addressed	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. **This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service**. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
Minimal Problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision. **[Straightforward].**

Number & Complexity of Problems Addressed During the Encounter Definitions

Self-limited or minor problem	A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status. **[Straightforward/Low].**
Acute, uncomplicated illness or injury	**A recent or new short-term problem with low risk of morbidity for which treatment is considered.** There is 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. **[Low].**
Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care	A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. **The treatment required is delivered in a hospital inpatient or observation level setting. [Low].**
Stable, acute illness	A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition. **[Low].**
Stable, chronic illness	A problem with **an expected duration of at least a year or until the death of the patient**. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). **'Stable'** for the purposes of categorizing medical decision-making is defined by the specific treatment goals for an individual patient. A patient that is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function (e.g., a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic). The risk of morbidity **without** treatment is significant. **[Low/Moderate].**
Chronic illness with exacerbation, progression, or side effects of treatment	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. **[Moderate].**

Number & Complexity of Problems Addressed During the Encounter Definitions Continued

Undiagnosed new problem with uncertain prognosis	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may include a lump in the breast or abdominal pain **[Moderate].**
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, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. **An example may include pyelonephritis, pneumonitis, or colitis [Moderate].**
Chronic illness with severe exacerbation, progression, or side effects of treatment	The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and **may require escalation in level of care**. **[High].**
Acute or chronic illness or injury that poses a threat to life of bodily function	An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, **that poses a threat to life or bodily function in the near term without treatment.** Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity. Examples may include acute myocardial infarction, pulmonary embolus, sever 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 **[High].**

Amount and Complexity of Data to be Reviewed and Analyzed Definitions

Analyzed	Refers to data used in MDM to aid diagnosis, evaluation, or treatment, even if the data itself (e.g., glucose levels) isn't directly analyzed. When tests are ordered and their results reported, they are presumed to be analyzed during the encounter. If tests are ordered outside an encounter, they are counted in the encounter when analyzed.
Recurring Tests	For tests ordered regularly (e.g., monthly prothrombin time), each result is counted in the encounter when analyzed. New results may be counted as separate data when analyzed in subsequent encounters.
Professional Component	Any service that is reported separately by a physician or qualified healthcare professional is not considered a data element for MDM determination if it is independently reported as a professional service.
Test	Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test. • Tests that do not require a separate interpretation (e.g., test that are results only) and are analyzed as part of the MDM may be counted as ordered or reviewed for selecting an MDM level. • The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the MDM level when the service is reported separately by the physician/APP (e.g., EKG, x-ray).
External	External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
Unique	**A unique test is defined by the CPT code set.** When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. **A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity.** Review of all materials from any unique source counts as one element toward MDM.
Combination of Data Elements	A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

Amount and Complexity of Data to be Reviewed and Analyzed

External physician or other qualified health care professional	**An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.**
Discussion	Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). **Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange**. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it **must be initiated and completed within a short time period (e.g., within a day or two)**.
Independent historian(s)	An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient **who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis**) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.
Independent interpretation	The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. **This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test.** A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.
Appropriate source	For the purpose of the **Discussion of Management** data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient **(e.g., lawyer, parole officer, case manager, teacher)**. It does not include discussion with family or informal caregivers.

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

Surgery – minor or major	The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
Surgery – elective or emergency	Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
Surgery – risk factors, patient or procedure	Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Coding Resources

RESOURCES	DESCRIPTION
CPT Professional	CPT® 2025 Professional Edition is the definitive AMA-authored resource to help healthcare professionals correctly report and bill medical procedures and services. Healthcare professionals want accurate reimbursement. Payers want efficient claims processing. Only the AMA, with the help of physicians and other experts in the healthcare community, creates and maintains the CPT code set.
ICD-10-CM Diagnosis Coding	ICD-10-CM 2025: The Complete Official Codebook provides the entire updated code set for diagnostic coding, organized to make the challenge of accurate coding easier. This codebook is the cornerstone for establishing medical necessity, correct documentation, determining coverage and ensuring appropriate reimbursement.

Resources

- CPT 2025 Professional Edition
- MLN006764_Evaluation_and_Management_Services_Guide_2024-09
- Medicare Claims Processing Manual, Chapter 12
- Medicare Program Integrity Manual, Chapter 6

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