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A better choice

2023 EM Coding Guidelines

Topics

EM Coding
- Time-Based Billing
- MDM Guidelines
- Clinic Scenarios
- Level Fives
- Medical Optimization
- Clinic Consultations
- New vs Established
- Deleted Codes
- Hospital EM

Other Coding Tips
- Xrays
- Injections
- Office EM Modifiers 24 & 25
- Repeat Injections
- Smoking Cessation
- Incident To
- Shared Visits

Evaluation & Management

EM codes include services such as office visits, hospital visits and consultations.

Federal Documentation Guidelines

- Applies to Medicare & Medicaid encounters
- Most commercial payers also use the federal guidelines

Evaluation & Management

2021 brought the first revision to the Guidelines since 1997; the purpose is to reduce the administrative burden & update the coding rules to reflect current medical practice.

In 2021 and 2022 the changes applied only to Office EM codes 99202 - 99215. Effective January 1, 2023 - ALL EM visits are coded based on Medical Decision Making or Time (Office, Hospital, Consultations).

Time Guidelines

Time will be based on Total Visit Time

- Contributing factors include: preparing for the visit (such as reviewing tests); getting or reviewing the history; performing the exam; counseling and providing education to the patient, family or caregiver; ordering medicines, tests, or other procedures; communicating with other healthcare providers; documenting in the medical record; interpreting results and sharing that information with the patient; and care coordination.

- One item you cannot include: if you are getting reimbursed separately for a test, you cannot count it in time calculation. For example, xray where you bill for the technical component and the interpretation. You may count time for reviewing and interpreting xray, MRI or CT results if the interpretation of the results are billed by another entity.

Clinic Visits Time Chart

EM Code	Minutes
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99212	10-19
99213	20-29
99214	30-39
99215	40-54

Time Statement

If you select your office EM code based on the Time criteria, you must document a Time statement to support, for example:

Total time spent on the day of the encounter was _____, excluding time spent for services reported separately.

2023 Guidelines for MDM

As previously, the Level of MDM will be based on 2 out of 3 categories (or elements) of MDM. They are:

Elements of Medical Decision Making

- 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 (Patient or Procedure Risk)

2 of 3

CPT E/M Office
Level of Medical Decision Making (MDM)

Category 1 Category 2 Category 3

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making 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	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Meeting 2 of 3 categories will determine the MDM.

Cat 1: Problems Addressed

Used to be ‘Presenting Problem’ and a New problem counted more than an established problem

No longer distinguish between New problem and Established problem

Problem(s) must be ‘addressed’ (not just an existing co morbidity that you do not nothing about or does not affect your MDM)

Cat 1: Problems Addressed

Level Three – Low
- 2 or more minor problems
- 1 stable chronic condition
- 1 acute uncomplicated condition

Level Four – Moderate
- 1 chronic condition with exacerbation
- 2 or more stable chronic conditions
- 1 undiagnosed condition with uncertain prognosis
- 1 acute complicated condition

Level Five – High
- 1 or more chronic condition with severe exacerbation
- 1 acute or chronic condition that poses a threat to life or bodily function

Cat 2: Data

It was Data before but it’s gotten much more detailed.

Now the category has been further subdivided into choices within each level of MDM; for example, there are 3 choices or ways to meet Moderate MDM under Data.

Cat 2: Data Definitions

External records – from an external physician/provider, facility or healthcare organization.

An independent historian – family member, witness, or other individual who provides patient history when the patient can't provide a complete history or the provider thinks a confirmatory history is needed.

Independent interpretation (of a test interpreted by another provider) – an interpretation of a test for which there is a CPT and interpretation is customary. For example, our MRIs are interpreted by Triad Radiology.

An external physician or other qualified healthcare professional – someone who is not in the same group practice or is classified as a different specialty or subspecialty.

Appropriate Source – a professional who is not a healthcare professional but may be involved in the management of the patient, ie; case manager, parole officer, lawyer, teacher. It does not include family or informal caregivers.

Cat 3 Risk: Level Three - Low

The previous examples provided have been deleted and the new revised guidelines give no examples for Low Risk

Previous examples were:

Physical and Occupational Therapy

Home Exercises

OTC medications

Braces, splints, orthotics

Minor surgery with no increased risk – procedure with 10 day global

Cat 3 Risk: Level Four – Moderate

Prescription drug management.

Minor Surgery with increased Risk - procedure with 10 day global with increased patient or procedure risk.

Major Surgery - no identified Risk; Major - procedure that has a 90 day global.

Social determinants of health (SDOH) - economic and social conditions that influence health, for example; food or housing insecurity, transportation issues, lack of education, social isolation, and other constraints. Documentation must support how the SDOH limits diagnosis and/or treatment.

Cat 3 Risk: Level Five – High

Major surgery with increased risk - decision regarding elective major surgery (90 day global) with identified patient or procedure risk factors

Emergency major surgery - decision regarding emergency major surgery (90 day global)

Hospitalization - decision to hospitalize immediately

2 of 3

CPT E/M Office
Level of Medical Decision Making (MDM)

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Meeting 2 of 3 categories will determine the MDM.

Scenario #1

Follow up of one chronic problem with an exacerbation AND Rx is now 99214 instead of 99213. (Chronic = condition has lasted or will last a year or more.)

HPI: 46 yo male who presents for follow up of bilateral elbow pain. He had an injection a year ago which helped for a few weeks. The pain is made worse by lifting and lying down. The pain radiates down to the wrist and up to the shoulders at times. There is numbness, tingling in the hands.

PLAN: I recommend that we start him on a scheduled anti-inflammatory medication. We will start meloxicam. He will continue to wear the tennis elbow strap with activity. We will start occupational therapy also to help with pain. I will see him back in 6-8 weeks.

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Scenario #2

Follow up visit with interpretation of MRI or CT is now 99214 instead of 99213. Independent interpretation (by itself) is now Moderate Data - used to be Low.

HPI: Patient is here today for follow-up of his knee. He still has pain with activity. He has some pain at nighttime depending on how much activity he has done.

PLAN: MRI results demonstrate a new tear of the lateral meniscus. There is also some significant degenerative signal in the medial meniscus which may represent sequela from previous injury and surgery verses new horizontal tearing.

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Scenario #3

Acute uncomplicated problem (simple sprains, strains, contusions, etc) AND Rx is now 99203/99213 instead of 99204/99214. Result of eliminating New problem getting more credit.

HPI: 36-year-old gentleman presents with chief complaint of left lower lumbar and side pain. Recently on a golfing trip where he took an aggressive swing and felt like he tore something in his lower lumbar region/side of his abdomen. He noted subsequent pain with any bending or flexion immediately after. No history of herniated disc or lumbar spine issues.

PLAN: His presentation is most classic for an oblique abdominal strain/lower lumbar muscle strain. He is having no radicular symptoms. I recommend rest, anti-inflammatories and conservative treatment to include heat and activity modification. I prescribed him anti-inflammatories and a muscle relaxer for symptomatic relief.

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Level Five in Clinic – How to get there?

Time spent

99215	40 minutes
99205	60 minutes
99245	80 minutes

Add 99417 for each additional 15 minutes (G2212 for Medicare)

MDM: Most common = decision for major surgery with increased risk factors (diabetes, smoking, COPD, blood thinners, morbid obesity, sleep apnea, heart conditions, chronic narcotic use, etc)

MDM: Less common = Data (reviewing outside notes/test results, ordering tests, independent historian AND independent interpretation of test performed by another provider)

Level Five Risk Example

Patient would like to proceed with reverse total shoulder arthroplasty. She has a history of diabetes. We review the risks of high blood glucose with increased risk of infection and decreased healing. Also would issues. Patient acknowledges risks and wants to proceed with surgery. Follow-up for preoperative appointment.

Level Five Risk Example

Patient understands her past medical history of coronary artery disease and recent stent placement does pose an increased risk for potential postoperative complication. She will discontinue Plavix 10 days prior to the procedure until approximately 2 weeks postoperatively which does increase her risk for potential DVT, PE, and MI. We will obtain records from her cardiologist to determine if she is optimized to undergo surgical intervention.

Medical Optimization Efforts

Decisions for major surgery with increased risk factors that require medical optimization efforts

- When recommending a patient for surgery pending medical optimization (increased risk, not regular risk), the tentative decision for surgery visit is Level Four if you plan to evaluate them again to make the final decision about surgery.
- The visit to determine if the patient is optimized and cleared for surgery is the Decision for Surgery visit – Level Five.
- If the Decision for Surgery with increased risk is made and the patient needs minimal testing or clearance (A1C, nicotine, etc), you can bill Level Five and review test results at the pre-operative visit (non-billable).

Clinic Consultations (99242-99245)

The “3 Rs” of a consultation:

- Request - a written or verbal request and the reason for consultation must be documented in the patient’s record by the consultant.
- Render - the consultant renders an EM service to the patient related to the specified problem, and
- Respond - findings and recommendations are communicated back to the requesting physician via written report.

ER, Urgent Care, Self, neighbors & friends are not valid requesters for consultations

Consultation Criteria

The HPI must be clear that it is a CONSULT and not a REFERRAL

- Payers look for the specific word – ‘consultation’
- “Seeing Suzy in consultation for evaluation of left arm pain at the request of Dr Sam Adams”

It can be a Consult even if you decide to treat the patient

Consult means – you are under the impression there is a Provider who is expecting to receive results of your evaluation

- Payers looks for the communication back to specific requester
- Most large payors do NOT pay for Consults (BCBSNC eff 11-1-2022)

New vs Established

A patient is considered NEW when he/she has not had professional face-to-face services from the physician or from a physician of the same specialty in the group within 3 previous years

If you have seen the patient in the past 3 years – even while billing under a different tax ID #, the patient is ESTABLISHED to you

Deleted EM Codes

99201 - Level 1 New Patient Office Visit 1-1-2021

99241 - Level 1 Office Consultation 1-1-2023

99251 - Level 1 Hospital Consultation 1-1-2023

99218, 99219, 99220 - Observation 2 Dates (use initial inpatient 99221, 99222, 99223)

Hospital & Consultation EM Codes

Effective January 1, 2023, these visits are coded just like Office Visits using MDM only or Time.

History and Examination elements are still required to support Medical Necessity but no longer impact the EM level.

Hospital EM Coding

Inpatient Consultations 99252 - 99255

- No Medicare
- Most private payors do not pay (just Medicaid and WC)

99252 – Minimal MDM

99253 – Low MDM

99254 – Moderate MDM

99255 – High MDM

Hospital EM Coding

Initial Inpatient EM Visits 99221 – 99223

- H&Ps and Medicare IP consults

99221 – Low MDM

99222 – Moderate MDM

99223 – High MDM

Hospital EM Coding

Subsequent Inpatient EM Visits 99231 – 99233

- Follow up inpatient visits for patients not in global period

99231 – Low MDM

99232 – Moderate MDM

99233 – High MDM

Hospital EM Coding

Emergency Department Evaluations 99282 – 99285

99282 – Minimal MDM

99283 – Low MDM

99284 – Moderate MDM

99285 – High MDM

Other Coding Tips

Xray Documentation

- Documentation must clearly state the # and/or type of views
- ordered by you at the encounter
- AND
- Official interpretation of the X-Ray findings

Failing to document an order for the X-Rays and an official interpretation can result in down coding to bill for Technical Component only

If Rad Techs are involved in billing, make sure you are on the same page about what is billed vs what is documented in the Provider note

Xray Documentation

Non-Compliant Documentation Examples:

- “X-Rays show no changes since last visit”
- “X-Rays of the ankle today show degenerative joint disease”.

Compliant Documentation Examples:

- AP and Lateral lumbar spine X-Rays ordered, taken and reviewed in the office today show lumbar spondylosis with disk space narrowing at L4-5 and L5-S1 and a slight anterolisthesis at L5 and S1.
- Three view X-Ray of the knee ordered, taken and reviewed in the office today reveal severe bone on bone arthritis.

Injections & Drug Billing

Key to document:

- Consent
- Anatomic location of injection
- Medication injected
- Dosage of medication injected
- Results/patient reaction

Drug Billing

- Billed in mg
- Providers like to document in cc
- mg and cc are not always equal

Example:

- Celestone J0702 is billed “per 3mg”
- If you inject 1 cc of 6 mg strength, you bill 2 units

Office Modifiers 24 & 25

24 Unrelated EM During the Post-operative (Global) Period

- Complications are not 'Unrelated'
- Medicare defines Global = all medical services related to surgery including care of complications (only procedures performed in the OR are billable in the Global)

25 Significant, Separately Identifiable EM on the Same Day of Procedure

- Initial injections
- Frequent flyers
- Synvisc/Euflexxa
- There is some EM inherent to all procedures (RVU/reimbursement reflects this: Work RVU has pre, intra and post components)
- Do NOT bill EM code for repeat injection with no new work up

Billing EM Visits with Injections

Do NOT bill EM code for repeat injection with no new work up

- No time limit
- New work up only if something has changed

Do NOT bill EM code if another provider ordered injection

- EM RVU built into injection CPT code includes time evaluating/counseling patient
- Synvisc/Euflexxa that required insurance approval

Time spent on issues NOT related to the injection can be billed (exercises, eventual surgery, etc)

- Bill based on time (do NOT include time spent providing, counseling, or monitoring related to injection)
- Special time statement:
  - ____ *minutes were spent discussing issues unrelated to the procedure performed.*
- 99212 = 10 mins, 99213 = 20 mins, 99214 = 30 mins

Tobacco Cessation Counseling

CPT 99406: Smoking and tobacco use cessation counseling, 3+ minutes

All patients who use any form of tobacco - 99406

Medicare and all commercial payers cover it - including Work Comp and Medicaid ($13-$19 each time depending on payer)

Medical record documentation must state that >3 minutes of cessation counseling was provided

- Not just simply telling the patient he/she needs to quit which is considered minimal counseling and is included in the EM code
- Create a template to include in your A&P for easy & accurate documenting

Cessation counseling must be provided/billed by Physicians and PAs (not clinical staff)

Assess/Assign correct billing Diagnosis code for billing:

- Tobacco Use/dependence (F17.2 codes, NOT Z codes)

Adjunct code to EM code; Mod 25 to EM code when billing 99406

Incident To Billing

Definition: services provided by a PA are billed to Medicare in the supervising Physician's name

Medicare reimbursement 100% vs 85% of the physician fee schedule

Criteria:

- Must be an Established patient
- Must be an established problem initially evaluated by the Physician with care plan by the Physician
- Supervising doctor must be on site and immediately available

Medicare Shared Visits

Hospital EM service that is ‘shared’ between the MD and the PA

MD and PA services may take place at different times on *the billing date of service*

May be billed under the Physician if one of these are met:

- Billing based on TIME and the Physician provided >50% of the TIME
- The Physician personally provided either Exam OR the MDM

If the PA sees the patient for initial consult and MD does not see the patient until the following day for surgery, the consult must be billed in the PA’s own name

OC Resources

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