Emergency Medicine

Elements of Medical Decision Making				
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 unit 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**
99282	**Straightforward**	• 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99283	**Low**	• 2 or more self-limited or minor problems; • 1 stable chronic illness; • 1 acute uncomplicated illness or injury; • 1 stable acute illness; • 1 acute, uncomplicated illness or injury requiring hospital IP/OBS level of care	**Limited** (Must meet the requirements of at least 1 of 2 categories) **Category 1: Tests and documents** • Any combination of 2 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test **Category 2: Assessment requiring an independent historian(s)**	**Low risk of morbidity from additional diagnostic testing or treatment**
99284	**Moderate**	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; • 2 or more stable, chronic illnesses; • 1 undiagnosed new problem with uncertain prognosis; • 1 acute illness with systemic symptoms; • 1 acute, complicated injury	**Moderate** (Must meet the requirements of at least 1 of 3 categories) **Category 1: Tests and documents** • Any combination of 3 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test o Assessment requiring independent historian **Category 2: Independent interpretation of tests** (performed by another physician/other qualified health care professional (not separately reported). **Category 3: 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:** • Prescription drug management • Decision regarding minor surgery will 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
99285	**High**	• 1 or more chronic illnesses with severe exacerbation, progression, of side effects of treatment • 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 of 3 categories) **Category 1: Tests and documents** • Any combination of 3 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test o Assessment requiring independent historian **Category 2: Independent interpretation of tests** (performed by another physician/other qualified health care professional (not separately reported)). **Category 3: 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:** • 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 to de-escalate care because of poor prognosis • Parenteral controlled substances

Emergency Medicine

- A chief complaint is a required element when documenting an encounter.
- While a medically appropriate history and examination should be performed, the history and examination are not used to select the level of E/M service.
- Time may not be used to select level of E/M services for the Emergency Department because services typically involve encounters with several patients on a variable intensity basis over an extended period. Time is still applicable when performing Critical Care Services.
- The level of service is based on MDM.
- These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented.
- When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.
    - Example: EKG is ordered. The physician interprets the EKG and documentation supports the interpretation charge (93010). The EKG is not counted in the data section when determining the MDM.
- Additional Documentation Tips:
    - If the history is given by someone other than the patient, or in addition to the patient's history, document who gave the additional information.
    - Document any information reviewed from an external source (including an outside emergency room, clinic notes, etc.)
    - The assessment and plan should show what was done for each condition managed/assessed and evaluated or treated. Those conditions not managed evaluated or treated should not be reported.
        - Example: Patient (with diabetes) presents to the emergency department for evaluation of ankle pain. The ankle pain is diagnosed as a sprain. The diabetes is not managed, evaluated, assessed or treated. Only the ankle sprain is reported.
    - Use language such as chronic, acute, acute on chronic as applicable.
    - Identify chronic conditions as stable or not stable.
    - Document the severity of an exacerbation of an acute or chronic condition as mild, moderate, severe.
    -
- CPT® code 99281 has been revised to decrease the level of service to align with the service level of code 99211. In addition, the code descriptor has been revised to specifically say "may not require the presence of a physician or other qualified health care professional."

Note: Coders may use the entire record/encounter note to determine the level of service.

Emergency Medicine - FAQ

Q: When charts are reviewed will anything contained in the HPI be usable toward determining MDM complexity?

- Examples: review of prior records and collateral from family / EMS often ends up as narrative in HPI, PMHx and PSHx as they contribute toward complexity of condition / risk factors may end up in another portion of the chart rather than MDM. Does everything need to be referenced in the MDM*?*

A: *While the history component is no longer considered in determining the overall level of service, information contained in the history component may be used in determining the overall MDM. This information does not need to be documented in the MDM/ED course.*

Q: Data review requirement: Traditionally data (EKG review, independent XR interpretation) is templated in objective data, do these items need to be moved to MDM? If they're in objective data and clearly documented as independently reviewed does this need to be explicitly referenced in MDM?

A: *Information contained in the Examination or Objective portion of the note may be used in determining the overall MDM. This information does not need to be documented in the MDM/ED course.*

Q: The "risk" component seems unclear and hardest to quantify and document. Can you comment on requirements in this category for higher level risk (reference AMA chart)?

A: *Per the AMA – Risk is defined as 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. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). 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.*

Q: What are other systems not reliant on Cerner or Epic doing? Can McManus provide us examples of notes from other institutions?

A: *Not at this time*

Q: How granular does the number and complexity of problems need to be? Does this need to be provider driven or can coders pull this information from context in the narrative section? Do we need to separate out diagnoses (acute, life-threatening section, chronic conditions et c?)

A: *The assessment and plan should document all conditions managed/assessed and evaluated/treated. Use descriptors such as acute, chronic, acute on chronic. For chronic conditions, add an additional descriptor to show the condition is stable or not stable. If there is an exacerbation of the chronic condition, use descriptors to show the severity of the condition – mild, moderate, severe.*

Q: External records reviewed – can you clarify whether review of prior ED visits and hospitalizations at our facility count? What about other IHS facilities?

A: *External records include records from outside the emergency department such as clinic notes, notes from outside facilities – including other IHS facilities. Notes from previous ED encounters is not included in the definition of external records.*

Q: For social det of health and medical problems impacting care / risk is it enough to list individual items as problems or does there need to be a discussion about how this impacts care explicitly? Can we put these as diagnoses, like in a list? (Ex: chronic housing instability, diabetes mellitus poorly controlled)

A: *Social Determinants of Health is defined as the environmental conditions where people are born, live, learn, work, play, worship that affect a wide range of health, functioning, and quality-of-life risks and outcomes. The documentation of the assessment and plan should contain the diagnosis related to any/all SDOH.*

Q: Tests considered but not ultimately done – do you need to document your reasoning? (Ex PECARN criteria reviewed, ultimately decided against CT head upon discussion with parents etc).

A: *Yes*

Q: Ddx – is there a minimum number of diagnoses for a higher-level chart? (Chest pain with EKG changes and no VS abnormalities or known risks is one example that comes to mind)
A: *No. Determining the level of overall MDM is strictly based on the severity of the condition, data, and risk of complication of patient management. Chest pain with EKG changes may be considered an undiagnosed new problem with uncertain prognosis (moderate), whereas a definitive diagnosis of MI would be considered 1 acute problem that poses a threat to life or bodily function.*

Q: Prescription management – if you opt out of giving a medication what needs to be documented (Ex discussion re antiviral therapy, is it enough to say you considered it or do you need narrative about risk/benefit, shared decision making etc)?
A: *Document the reasoning behind not giving the prescription, including patient refusal.*

Q: Are there requirements we should be aware of for provider chart review for documentation nationwide, recommendations for how to start to implement a review program (what needs to be included, what has proved helpful)?
A: *The new documentation guidelines do not change the need for quality of care/Peer review programs.*

Q: What is the recommended follow-up for reviewing efficacy of changes made above? Can we schedule follow-up now?
A: *The FY2Q2023 reviews conducted by McManis will focus on the ED and Hospital encounters.*

Q: E/M level determination: How strongly would you recommend that this to be a provider driven vs. coder driven identification for our high-level charts? Do we need any kind of signal to our coding colleagues when we think this should be an E/M level 5 chart?
A: *This should be determined at the facility level. If coding is done by the ED clinician, the coder should review the document to ensure that the level of service is supported as well as verifying that the diagnosis codes are correct and coded to the highest level of specificity.*

Q: Templates:
Suggestions for finding alignment with our coding colleagues so there is a similar approach on how to review the template / extract relevant information?
A: *I would recommend meeting with the coder(s) and periodically performing chart reviews together. For example – Take 5 charts, and using the MDM tool, code the encounter together. If the physician disagrees with the coder, the physician should provide the coder with an explanation regarding the complexity of the patient.*