Summary of E/M Documentation and coding for 2023

Reason for care in clinical terms (not recheck, follow up or regular visit) but detail of the reason (diagnoses or symptom for care)

- There are four types of medical decision making:
  1) **STRAIGHTFORWARD**; 2) **LOW;** 3) **MODERATE** AND 4) **HIGH**

- The 99211 and 99281 the level of MDM does not apply as these are services provided by support staff under the direct supervision of a physician or other qualified health care professional

- **Medical Decision Making is defined by 3 elements**:
  - The number and complexity of the problems addressed during the encounter (see below)
  - The amount and/or complexity of data to be reviewed and analyzed for the care of the patient u and documented
  - The risk of complications and/or morbidity or mortality of patient management – this would include identified condition prognosis and risk, identified medication with use, risk and management and long term functional concerns

Pertinent history and/or exam with the identified level of problem identified from **see attached grid)**:

- Minimal problem (nursing level of care) – BP check, weight check, education
- Self limited or minor problem – resolving
- **Stable, chronic illness (something at least 12 months in duration)**
- Acute, uncomplicated illness/injury
- **Acute uncomplicated illness or injury requiring hospital inpatient or observation level of care**
- **Stable, acute illness**
- **Chronic illness w/exacerbation, progression, side effects**
- **Undiagnosed new problem with uncertain diagnoses – that can cause major medical issues**
- **Acute illness with systemic symptoms**
- Acute complicated injury
- **Chronic illness w/severe exacerbation, progression or side effects of treatment**
- **Acute or chronic illness or injury that poses threat to life or body function**

When time is used for the level of care:

- Pre-visit preparing to see and care for the patient – review of records, calls, reports
- Time face-to-face with the patient
- Time throughout the day of the visit involved in direct patient care (orders, discussion, review, etc.)
- Unique documentation (ISP, care plans, goals/objectives, etc.)
- Specific time range for each level of care will be identified in the office or identified set time in a facility setting
- Additional coding will be available for prolonged care that can only be added to the highest level of E/M codes – 99205 for new patients and 99215 for established patients; Hospital 99223, 99233, Nursing home 99306, 99310 and home visits at the highest level 99345, 99350

Documentation should identify:

Reason for care:

Pertinent history – that supports condition status

Pertinent exam – that supports condition status

Data reviewed pertinent to care plan (includes order and reviewed)

- [] Lab
- [] Imaging
- [] Cardio diagnostics
- [] Documentation by others _____

Narrative for the assessment and plan:

Primary diagnosis (es)

1. _____
   Status (drop down menu with identified "chronic, acute, wording from 2023 guidelines)
   Plan for condition – lab, monitoring, referral, education, etc. (may be drop down or narrative)
2. (same for each condition managed as above for all primary conditions)

For medications include for each medication:

Medication for.. to be taken (2 x per day, with meals	Benefits or purpose (lower BP)	Risks (weight gain, headaches, etc.)

Contributing or secondary diagnoses that impact overall care:

1. (example) blindness managed by Ophthalmology
2. (example)Fractured hip coordinated with ortho

Any identified history or psych-social determinates of health that impact care/plan

Return plan and or coordination with others