E/M CODING WORKSHEETS: EASILY TRACK MDM AND TIME

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E/M CODING WORKSHEETS FOR LEVEL-BASED E/M SERVICES

As of Jan. 1, 2023, the coding and documentation guidelines for level-based E/M encounters, including hospital inpatient and observation visits, consults, and services in the emergency department, nursing facility, home and residence, underwent a significant update.

The format now mirrors the guidelines for office and other outpatient visits (99202-99215), which rely on medical decision-making (MDM) or time to determine the level of service.

As a result, history and physical examination will no longer contribute to the level for these visits. Instead, for most visits practices will select codes based on MDM or time. The only exception will be emergency department visits, which will be MDM-only because the codes do not have a time component.

E/M CODING WORKSHEET FOR LEVEL-BASED E/M ENCOUNTERS

DecisionHealth's E/M coding worksheet for level-based E/M encounters is a quick reference guide, and an excellent teaching tool, that provides you with:

- A scoring mechanism to help you quickly and accurately determine the appropriate level of MDM.
- Checklists and examples to keep you visually on track.
- Activity guidelines and references for time-based coding.
- A "review findings" form to document outcomes and add comments and/or suggestions for your team.

Page one of the worksheet is designed for MDM-based coding. In addition to information about the patient, treating provider and encounter, you can score the problem, data and risk — straightforward (SF), low, moderate (mod) or high — to select the level of MDM.

Time-based coding is located on page two of the worksheet. This page also contains basic guidelines for time-based coding and references for reporting prolonged services.

Enter your final calculations for the encounter on page three of the worksheet. This is where you will indicate whether you agree with the original level selected and include suggestions or comments for the coder or treating provider. (Consider some documentation tips on page four of the worksheet.)

As is the case with all chart review tools, the user must be familiar with the relevant guidelines, rules and policies for E/M documentation and coding.

E/M scorecards and other audit tools that are based on the 1995 or 1997 E/M documentation guidelines no longer apply to E/M encounters, but don't throw away the older scoresheets — or delete them from your computer — just yet. You'll need them to review older claims and check the work of outside auditors.

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E/M Coding Worksheet – MDM

Documentation, coding and claims review must follow the relevant 2023 CPT® guidelines and CMS rules or private payer policies for level-based E/M encounters.

Patient name/ID ______________________________ Chief complaint(s) ______________________

Treating clinician/QHP __________________ DOS __________ POS __________ Carrier __________

History documented? ☐ Yes ☐ No Physical Exam documented? ☐ Yes ☐ No

Patient/encounter? New ☐ Established ☐ Initial ☐ Subsequent ☐ N/A ☐ Unknown ☐

Chart signed by treating physician/QHP? Yes ☐ No ☐

Problem	Data	Risk
MINIMAL ☐ Self-limited/minor (≥1)	**MINIMAL/NONE**	**MINIMAL**
LOW ☐ Self-limited/minor (≥ 2) ☐ Stable/chronic (1) ☐ Acute uncomplicated injury/illness (1) ☐ Stable acute illness (1) ☐ Acute, uncomplicated illness/injury requiring hospital (inpatient/observation) level care (1)	**LIMITED (1 category)** Category 1: 2 item types (2 of 1 item or any combination that = 2) ☐ Review prior external note ______ ☐ Review test result ______ ☐ Order test ______ Category 2: ☐ Independent historian	LOW
MODERATE ☐ Stable/chronic (≥ 2) ☐ Chronic w/exacerbation, progression or side effects of treatment (1) ☐ Undiagnosed new w/uncertain prognosis (1) ☐ Acute illness w/systemic symptoms (1) ☐ Acute complicated injury (1)	**MODERATE (1 category)** Category 1: 3 item types (3 of 1 item or any combination that = 3) ☐ Review prior external note ______ ☐ Review test results ______ ☐ Order test ______ ☐ Independent historian ______ Category 2: ☐ Interpret test by another practitioner Category 3: ☐ Discuss management or test interpretation w/external provider/ appropriate source	**MODERATE (examples only)** ☐ Decision regarding elective major surgery without identified patient or procedure risk factors ☐ Diagnosis or treatment significantly limited by social determinants of health ☐ Prescription Rx management
HIGH ☐ Chronic w/severe exacerbation, progression or side effects of treatment (≥ 1) ☐ Acute/chronic illness/injury that poses threat to life or bodily function (1) ☐ *INITIAL NF VISITS ONLY: Multiple morbidities requiring intensive management*	**EXTENSIVE (2 categories)** Category 1: 3 item types (3 of 1 item or any combination that = 3) ☐ Review prior external note ______ ☐ Review test results ______ ☐ Order test ______ ☐ Independent historian ______ Category 2: ☐ Interpret test by another practitioner Category 3: ☐ Discuss management or test interpretation w/external provider/ appropriate source	**HIGH (examples only)** ☐ Decision regarding emergency major surgery ☐ Decision regarding hospitalization/escalation ☐ Rx therapy requiring intensive monitoring for toxicity ☐ Parenteral controlled substances

Problem ________________ Data ________________ Risk ________________ = MDM ________________

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E/M Coding Worksheet – Time

Documentation, coding and claims review must follow the relevant 2023 CPT® guidelines and CMS rules or private payer policies for level-based E/M encounters.

Patient name/ID ____

Chief complaint(s) ____

Treating physician/QHP ____

DOS ______________________ POS ______________________ Carrier ______________________

Patient/encounter? New ☐ Established ☐ Initial ☐ Subsequent ☐ N/A ☐ Unknown ☐

Chart signed by treating physician/QHP? Yes ☐ No ☐

Activities that count toward total time on the day of the encounter include:

1. Prepare to see the patient (for example, review of test results)
2. Obtain/review separately obtained history
3. Perform a medically appropriate examination and/or evaluation
4. Counsel/educate the patient/family/caregiver
5. Order medications, tests, or procedures
6. Document clinical information in the electronic or other health record
7. Refer and communicate with other health care professionals
8. Independent interpretation of results and communicating results to the patient/family/caregiver
9. Coordination of care

Do not count time for the following activities:

1. Services that are separately reported, including referrals and communication with other providers, independent interpretation of results and coordination of care
2. Travel
3. General education that is not related to the specific patient's care

Prolonged services – add-on codes, 15 minutes/UOS

2023 CPT manual

Same-day prolonged services by the treating physician/QHP

- +99417: Office/other outpatient visit, office/other outpatient consult and home/residence visit
- +99418: Inpatient/observation visit, inpatient/observation consult and nursing facility visit

CMS 100-04, Chapter 12, §30.6.15.1

Prolonged services associated with a face-to-face encounter by the treating physician/QHP

- +G2212: Office/other outpatient visits
- +G0316: Inpatient/observation visits
- +G0317: Nursing facility visits
- +G0318: Home/residence visits

Total time documented by treating physician/QHP ______________________

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MDM	Time	Code
Office/other outpatient – new/established		
N/A	N/A	99211
SF	15	99202
	10	99212
Low	30	99203
	20	99213
Mod	45	99204
	30	99214
High	60	99205
	40	99215
Office/other outpatient consult		
SF	20	99242
Low	30	99243
Mod	40	99244
High	55	99245
Home/residence – new/established		
SF	15	99341
	20	99347
Low	30	99342
	30	99348
Mod	60	99344
	40	99349
High	75	99345
	60	99350
Inpatient/observation – initial/subsequent		
SF or Low	40	99221
	25	99231
Mod	55	99222
	35	99232
High	75	99223
	50	99233

MDM	Time	Code
Inpatient/observation – admit & discharge		
SF or Low	45	99234
Mod	70	99235
High	85	99236
Inpatient/observation consult		
SF	35	99252
Low	45	99253
Mod	60	99254
High	80	99255
Emergency department		
N/A	—	99281
SF	—	99282
Low	—	99283
Mod	—	99284
High	—	99285
Nursing facility – initial/subsequent		
SF	25	99304
	10	99307
Low	25	99304
	15	99308
Mod	35	99305
	30	99309
High	45	99306
	45	99310

Prolonged service and
UOS if reported

____

Review findings

Original code(s) ______________________________ Reviewer agrees? Yes ☐ No ☐

If No, correct code(s). Include UOS for prolonged service if appropriate ______________________________

Additional comments or suggestions ______________________________

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Reviewer name (print & sign) ______________________________ Date __________

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MINOR DOCUMENTATION CHANGES CAN PROVIDE MAJOR BOOST

While it is often difficult to affect provider documentation and template changes, once the changes are explained, providers often become more amenable to making them.

A few simple documentation changes may be beneficial to consider:

- **Document a medically appropriate history and exam for each patient.** Documenting the patient's history can provide clarity on the status of the patient's problems being addressed and support medical necessity for ordered or planned treatments.
- **Document the status of each problem addressed during the encounter.** When providers document the status of a patient problem that is being assessed during the encounter, it provides clarity for scoring the first element of the MDM, which is the number and complexity of problems addressed during the encounter. These details will prevent coders from assigning a lower level of severity for lack of clarity.

A simple statement such as, "insulin-dependent diabetes type 2, not currently at goal" or "severe, persistent asthma with acute exacerbation indicated by" will allow proper scoring of the first column in the MDM table for problems addressed during the encounter.

- **Identify and document the source of any data ordered or analyzed.** Scoring the second element of MDM, the amount and/or complexity of data analyzed, can be a complicated process. If providers do not clearly document where tests were performed, who provided additional patient history, the providers they spoke with, or other required details, scoring could easily be incorrect.

To prevent an issue with this, consider scoring the MDM level on the first and third elements of MDM and only rely on the second element (data analyzed) when one of the others are severely lacking or nonexistent.

- **Document the risks of the recommended treatment specific to the patient.** According to the CPT definition of risk, the third element of MDM, it is assessed based on the "consequences of the problem(s) addressed at the encounter when appropriately treated."

Many treatment options have an element of risk associated with them, such as side effects of prescription drugs or risk of injury due to surgery. Assessing patient risk from the planned treatment (or failure to treat) is a provider responsibility that ensures accurate E/M level scoring.

- **Clarify the total provider time spent on the date of the encounter.** Time spent performing services by clinical/nursing staff should not be combined with provider time. Consider a section header just for this statement and remember that scoring a service based on time no longer requires a statement that 50% or more of the time spent was on counseling or coordinating patient care. Consider instead, a statement such as, "Total provider time: I spent a total of 78 minutes providing patient care today."

RESOURCES

- 2023 CPT Manual
- CMS 100-04, Chapter 12, §30.6.15.1: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf ■

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