

## Assigning E/M Levels: MDM Straightforward or Highly Complex?

**Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O**  
*Director of HIM/Coding*  
HCPro  
Brentwood, TN



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### Presented By



- **Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O**, is the director of HIM and coding for HCPro. She manages the Certified Coder Boot Camp® programs. In addition, she specializes in creating custom designed educational programs for PROPEL Coding membership clients. McCall was one of the original ACDIS Advisory Board members and one of the contributors to the development of the CCDS-O certification examination.

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## Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Identify which evaluation and management (E/M) services may be assigned based on complexity of medical decision making (MDM) as one option
  - Apply key American Medical Association (AMA) definitions to elements considered part of medical decision making
  - Assign E/M levels based on sample documentation
  - Describe key issues relating to E/M guidance from the AMA versus CMS
  - Define how to improve documentation efforts to support E/M services provided in hospital settings

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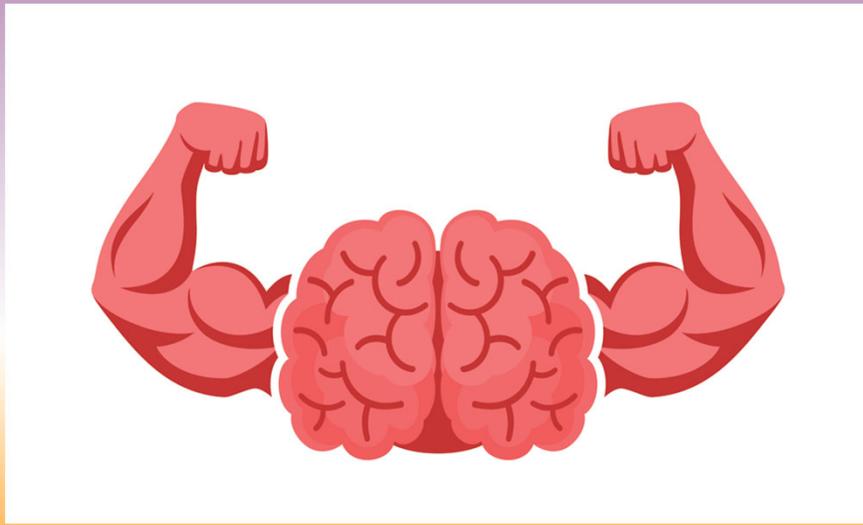
## Types of E/M Services Using **MDM** or Time

- Office/other outpatient services – 99202-99215 (as of CY 2021)
- Inpatient/observation services
  - Initial (admit) – 99221-99223
  - Subsequent – 99231-99233
  - Discharge – 99238-99239
- Consultation services
  - Outpatient – 99242-99245
  - Inpatient/observation – 99252-99255
- Emergency department services (only MDM) – 99281-99285
- Nursing facility services
  - Initial, subsequent – 99304-99310 and discharge – 99315-99316
- Home/residential services – 99341-99350

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# Basing Levels on MDM: “Assessing Brain Power – Tough to Measure”



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## “Grid” – MDM



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Level of MDM (Based on 2 out of 3 Elements of MDM)	N/A	Straightforward	Low	Moderate	High
<b>1</b> Number and Complexity of Problems Addressed at the Encounter	N/A	Minimal • 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 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 complicated injury	High • 1 or more chronic illnesses with severe exacerbation, progression or side effect of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function
<b>2</b> Amount and/or Complexity of Data To Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 out of 3 categories	N/A	Minimal or None	Limited (Must meet the requirements of at least 1 of the 2 categories) <b>Category 1: Tests and documents</b> • Any combination of 2 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test or <b>Category 2: Assessment requiring an independent historian</b> (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Moderate (Must meet the requirements of at least 1 out of 3 categories) <b>Category 1: Tests, documents, or independent historian</b> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of a test performed by another physician/other qualified health (not separately reported) <b>Category 3: Discussion of management or test interpretation</b> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Extensive (Must meet the requirements of at least 2 out of 3 categories) <b>Category 1: Tests, documents or independent historian</b> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source, • Review of the results of each unique test, • Ordering of each unique test, • Assessment requiring an independent historian <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of a test performed by another physician/other QHCP (not separately reported) <b>Category 3: Discussion of management or test interpretation</b> • Discussion of management or test interpretation with external physician/other QHCP/appropriate source (not separately reported)
<b>3</b> Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	Minimal risk of morbidity from additional diagnostic testing or treatment ** Examples: rest, goggles, elastic bandages, superficial dressing	Low risk of morbidity from additional diagnostic testing or treatment • ** Examples: minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives	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	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization, or escalation to hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

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## Assigning E/M Levels by the “Grid”

- “Three” elements of MDM
  - Number and complexity of problems addressed during the encounter
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications and/or morbidity/mortality of patient management
    - **To determine overall “level” → Must meet (or exceed) for two out of the three elements!**
- Four “levels” of medical decision making
  - Straightforward
  - Low
  - Moderate
  - High

Some categories will include straightforward/low into the same E/M code (e.g., 99221 – initial inpatient/observation care)

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## MDM: Number and Complexity of Problems Addressed

- Multiple new or relevant chronic/established conditions may be addressed during the same encounter.
- Comorbidities/underlying conditions are ONLY considered in MDM if they are “ADDRESSED”, and their presence increases amount of data reviewed/analyzed or increases risk of complications.
  - May not always be the “presenting problem” as being the most complex condition addressed!
- Do not count individual symptoms that are integral to a condition.

Key Word is  
ADDRESSED!!

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## MDM: Number and Complexity of Problems Addressed

Element	Number and Complexity of Problems Addressed at the Encounter	
	Minimal	Low
	<ul style="list-style-type: none"> <li>• 1 self-limited or minor problem</li> </ul>	<ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems</li> <li>or</li> <li>• 1 stable chronic illness</li> <li>or</li> <li>• 1 acute uncomplicated illness or injury</li> <li>or</li> <li>• 1 stable acute illness </li> <li>or</li> <li>• 1 acute uncomplicated illness or injury requiring inpatient or observation level of care </li> </ul>

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## MDM: Number and Complexity of Problems Addressed

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	
	Moderate	High
Element	<ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment</li> <li>or</li> <li>• 2 or more stable chronic illnesses</li> <li>or</li> <li>• 1 Undiagnosed new problem with uncertain prognosis,</li> <li>or</li> <li>• 1 acute illness with systemic symptoms,</li> <li>or</li> <li>• 1 acute complicated injury</li> </ul>	<ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with severe exacerbation, progression or side effect of treatment</li> <li>or</li> <li>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</li> </ul>

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## MDM: Number and Complexity of Problems Addressed

- Definitions of “problems” and conditions in MDM
  - **Chronic illness with exacerbation, progression or side effects:** A chronic illness that is acutely worsening, poorly controlled or progressing requiring additional care (but not hospitalization)
    - Example: Sickle cell anemia
  - **Chronic illness with **severe** exacerbation, progression or side effects:** Chronic illness with significant risk of morbidity and **may require inpatient hospital level of care.**
    - Example: **Severe** chronic obstructive pulmonary disease (COPD) exacerbation

This includes patients with a chronic condition who are not at “goal”; provider should document steps to achieve goal.

\*Provider should classify severity based on their expert clinical judgement\*

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## E/M: Based on MDM

- Definitions of “problems” and conditions in MDM
  - **Undiagnosed new problem with uncertain prognosis:** A problem with a **differential diagnosis** that COULD result in a high risk of morbidity without treatment.

If the patient knows they have the condition, it is not a “new problem” regardless of provider <WPS Medicare>

Nice Try  
But:  
**NOPE**  
!!!



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## MDM: Amount/Complexity of Data

- **“Unique Test”:** Imaging, laboratory, psychometric, or physiologic data
  - A lab “panel” is ONE test (e.g., CMP, BMP, CBC)
    - Different CPT code = different test (generally)
    - Additional tests not in a panel should be counted separately
  - Review of serial lab results from the same test = one unique test (e.g., serial glucose values)



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## MDM: Amount/Complexity of Data

- **Review/order of unique tests:** It is inherently assumed the provider who orders a test will review the results—Cannot count separately as order (1 test) and review (1 test)



- What documentation should be entered to support review of a test?
- Documentation should support the provider reviewed the findings and the result of his or her review in the plan of care.

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## MDM: Amount/Complexity of Data

- Order of test with separately billable interpretation by **another provider** (e.g., radiology services)



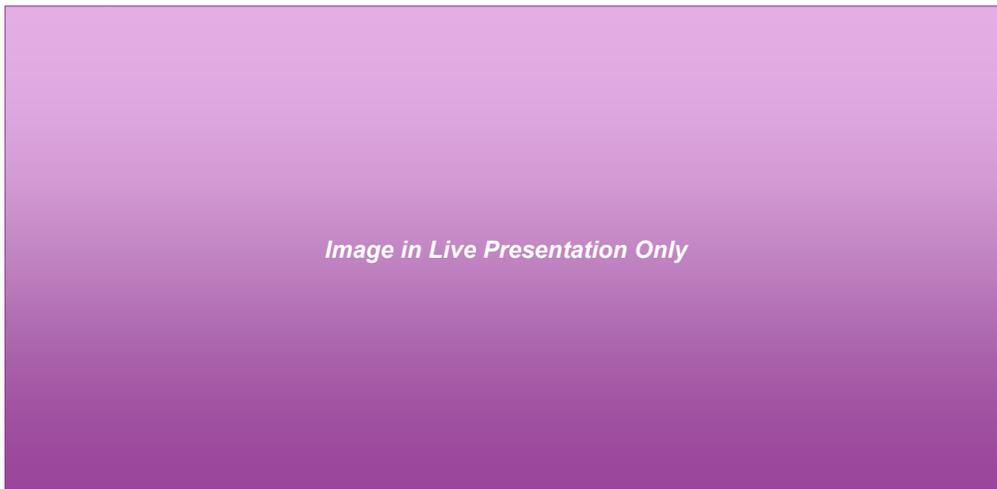
- Order of test with separately billable interpretation by the **same physician** (e.g., EKGs)



Count the test as MDM **OR** bill the CPT code for the test—Cannot count as BOTH

## Separately Reported “Professional Components”

- Separately reportable services



## Separately Reported “Professional Components”

- How can I tell if there is a separate “professional component” for a service?
  - <https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf>
  - <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>
  - “Modifier” and/or “PCTC” Column

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Global	MULT SURG	BLT SURG
76700		Us abd/ aorta screen asa	A	1	XXX	0	0
76700	20	Us abd/ aorta screen asa	A	1	XXX	0	0
76700	TC	Us abd/ aorta screen asa	A	1	XXX	0	0

Figure 8: Payment Policy Indicators Search Results

## MDM – Amount/Complexity of Data

**MODERATE** = Three documents **OR** independent interpretation **OR** Discussion with source  
**ONE CATEGORY**

**EXTENSIVE** = Three documents **OR** independent interpretation **OR** Discussion with source  
**MUST MEET TWO CATEGORIES!**

Amount and/or Complexity of Data To Be Reviewed and Analyzed  
\*Each unique test, order, or document contributes to the combination of 2 out of 3 categories

### Moderate

*(Must meet the requirements of at least 1 out of 3 categories)*

**Category 1: Tests, documents, or independent historian**

• Any combination of 3 from the following:

- Review of prior external note(s) from each unique source,
- Review of the results of each unique test,
- Ordering of each unique test,
- Assessment requiring an independent historian

**Category 2: Independent interpretation of tests**

• Independent interpretation of a test performed by another physician/other qualified health (not separately reported)

**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)

### Extensive

*(Must meet the requirements of at least 2 out of 3 categories)*

**Category 1: Tests, documents or independent historian**

• Any combination of 3 from the following:

- Review of prior external note(s) from each unique source,
- Review of the results of each unique test,
- Ordering of each unique test,
- Assessment requiring an independent historian

**Category 2: Independent interpretation of tests**

• Independent interpretation of a test performed by another physician/other QHCP (not separately reported)

**Category 3: Discussion of management or test interpretation**

• Discussion of management or test interpretation with external physician/other QHCP/appropriate source (not separately reported)

Data elements may be summed for Category 1

### Example:

Test ordered (1) + external note reviewed (1) + independent historian (1) = 3 – Moderate data reviewed/analyzed

## MDM: Amount/Complexity of Data

- Key definitions
  - **Independent interpretation:** The interpretation of a test for which there is a unique CPT code, and an interpretation or report is customary.

### CAUTION!

Do not count review of lab tests as “independent interpretation”  
 \*\*Clinical labs are considered “results only” tests which are 100% technical services



## E/M – Common “Independent Interpretation” Q & As

- What is the difference between “review of results” of a radiology test and an “independent interpretation”?
  - Cutting and pasting the radiology report into the ED note is not independent interpretation
  - Documentation should support that a review of the actual images was performed and supplemental documentation from the provider with their interpretation.
    - However, does not have to conform to usual standards of report.
    - Example: “I personally reviewed the MRI of the knee and recommend proceeding with a TKR due to extent of DJD”.



*Image in Live Presentation Only*

## MDM: Risk of Morbidity/Mortality

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



**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

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## E/M: AMA Guidance on Prescription Drug Management

- Simply adding the current medication list to the provider's note and documenting "reviewed" does **not** meet the definition of prescription management.
- Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided.
- Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit.
  - "Stable hypertension; continue valsartan 10 milligrams, will refill for 4 months until next follow-up visit."
- <https://www.ama-assn.org/system/files/2021-06/ama-em-updates-organizations-moving-forward-paper.pdf>

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## MDM: Risk of Morbidity/Mortality

- What is considered “**surgery with risk factors**”? Is it the surgery or the patient’s coexisting conditions that increase overall risk?
  - BOTH! The individual patient may present special risks due to an underlying disease or the surgical procedure could be inherently risky in all patients with a known increased operative risk.

Be sure documentation identifies underlying conditions or reasons

Is this surgery risky for THIS specific patient based off coexisting conditions?

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## MDM – Minor/Major Surgery – Moderate/High Risk

*Image in Live Presentation Only*

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## E/M: Common “Minor/Major Surgery” Q&As

- How is it determined if a surgery is “minor” or “major”?
  - As a starting point, the global days (0 and 10) generally refer to a minor procedure and (90 days) refer to a major procedure.
  - However, other considerations may factor in that are patient-specific.
    - **DOCUMENTATION is key!**



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## MDM: Risk of Morbidity/Mortality

- Key definitions
  - **Social determinants of health (SDOH)**: Economic and social conditions that influence the health of people and communities
    - Examples: Food insecurity or homelessness

Documentation should clearly identify how the SDOH limited treatment/management options and how this affected MDM!

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## MDM: Risk of Morbidity/Mortality

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



High risk of morbidity from additional diagnostic testing or treatment Examples only:

- Drug therapy requiring intensive for toxicity,
- Decision regarding elective major surgery with identified patient or procedure risk factors,
- Decision regarding emergency major surgery,
- Decision regarding hospitalization, or escalation to hospital level of care
- Decision not to resuscitate or to de-escalate care because of poor prognosis
- Parenteral controlled substances

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## MDM: Risk of Morbidity/Mortality

- Decision regarding hospitalization or escalation of hospital-level care
  - Discussion of possible hospitalization is also included, even if the decision ends up being no.

Does NOT include merely sending a patient to the emergency department



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## MDM: Risk of Morbidity/Mortality

- Parenteral **controlled substances**
  - Parenteral = **Substance administered/given by a route other than the alimentary canal (mouth to anus)**
  - Controlled Substance – a schedule I, II, III, IV, or V drug or other substance.
- Electronic Code of Federal Regulations
  - <https://www.ecfr.gov/current/title-21/chapter-II/part-1308>

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## MDM: Summary

- To qualify for a given type of MDM **TWO OF THE THREE** elements (number of diagnoses, amount of data reviewed, and risk of mortality) must be met or exceeded.
  - For example:
    - Patient is admitted for end stage severe COPD exacerbation (one chronic illness with severe exacerbation/threatens life or bodily function) → Number of problems addressed = **High**
    - Provider obtains medically necessary history and exam from the patient and orders 3+ unique lab tests, respiratory support → Amount of data to review = **Moderate**
    - Provider determines patient has poor prognosis and care will be de-escalated → Risk of mortality = **High**

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## MDM: Abbreviated Table

Must meet (or exceed) for two out of three elements for overall MDM

# and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality	Overall Complexity of MDM
Minimal	Minimal or none	Minimal	Straightforward
Low	Limited	Low	Low complexity
Moderate	Moderate ✓	Moderate	Moderate complexity
High ✓	Extensive	High	High complexity

99223

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## Using MDM: The Advantage

- Established definitions
- Complex patients with short visit times
  - Patients with separately reportable procedures during same session
- Patient encounters with multiple tests ordered especially ones including radiology, pathology – Independent interpretation
- Patient encounters resulting in minor/major surgical procedures
- Patients requiring medication-related visits (Rx management, monitoring)



BEST PRACTICE: Document BOTH

A visit can be assigned based on time OR MDM - Choose most advantageous

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Let's Practice!!



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## Case Study: ED

- 19-year-old male with history of asthma with increased “breathing problems”

2 weeks ago the patient's asthma worsened to the point he was using his inhaler 10-14 times a day with temporary relief. He was being woken up due to his shortness of breath. He also reports slight wheezing.

Today, he ran out of his inhaler prompting him to come to the ED.

Denies any fevers or rhinorrhea.

### REVIEW OF SYSTEMS

#### Review of Systems

Constitutional: Negative for chills and fever.

HENT: Negative for congestion, ear pain, rhinorrhea and sore throat.

Respiratory: Positive for **shortness of breath** and **wheezing**. Negative for cough.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.

Genitourinary: Negative for dysuria.

Musculoskeletal: Negative for arthralgias and back pain.

Skin: Negative for rash.

Neurological: Negative for weakness and numbness.

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## Case Study: Observation (OBS)

**Chief Complaint:** Dizziness, presyncope

**History of present illness:** Pt seen and examined at the bedside is an 84 y.o. male with known history of diabetes mellitus, aortic stenosis who is being admitted for further evaluation of dizziness, presyncopal episode. Today he was in the hot tub and when he stood up he felt dizzy, felt like he would pass out. A friend helped him sit down a chair. He was then brought to the ED. Patient denies any chest pains. He says he has been having episode of lightheadedness and his primary care doctor has discontinued his antihypertensives and decreased his Flomax. He denies any shortness of breath with exertion. He claims to be active and exercises regularly.

In the ED his blood pressure was 100/67, heart rate 102. He was noted to have a blood sugar of over 400. Head CT showed no acute abnormality. He was started on IV fluids. He was likewise given aspirin. EKG showed no acute ST-T wave changes. Repeat blood sugar was 347. Patient claims to be compliant with his medications. He is on insulin at night. He denies any new medication.

Lab Data:

General health panel	
	10/26/22
	1203
WBC	13.3*
HGB	14.4
HCT	43.5
PLT	245
	10/26/22
	1203
NA	136
K	4.9
CL	98
CO2	24
CA	9.7
BUN	21
CREAT	1.36*
GLUCOSE	418*
TOTALPROTEIN	6.8
ALBUMIN	4.0
BILTOTAL	0.4
ALKPHOS	75
AST	11
ALT	10

EKG: first one done in ER on 10/26/2022, normal sinus rhythm, right bundle branch block, first-degree AV block

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## Case Study: OBS

CXR: No acute pathology  
Head CT no acute pathology

**Assessment/Plan:**

1. Presyncopal episode  
Episode of dizziness and lightheadedness  
Aortic stenosis? Cardiac event?  
-Patient will be monitored in telemetry  
-Obtain orthostatic blood pressure  
His primary care doctor has recently discontinued his lisinopril and decreased his tamsulosin dose about a week ago because of his lightheadedness and soft blood pressure.

**Echocardiogram ordered** to assess aortic stenosis. Last echocardiogram by Cardiology was in 2020 where he was noted to have moderate AS with AVA of 1.3 cm. He saw cardiology once in 2020 and has had no follow-up.

**Consider Holter monitoring** in the outpatient if work-up is negative

2. DM type II with neuropathy  
Hyperglycemia  
Blood sugar was over 400 on admission. Patient claims to be compliant with his medications. Will give him glargine tonight with monitoring of blood sugars will adjust his blood sugars accordingly
3. History of BPH  
Continue Flomax at bedtime  
Dose recently decreased by PCP

4. Mild AKI  
Gentle hydration

Admission status; observation

Time: 45 minutes spent on the date of the encounter.

Initial
Minutes / Code
40 / 99221 ←
55 / 99222
75 / 99223

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## Case Study: OBS

# 99222



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Code	99221 (Initial) 99231 (Subsequent)	99222 (Initial) 99232 (Subsequent)	99223 (Initial) 99233 (Subsequent)
Level of MDM (Based on 2 out of 3 Elements of MDM)	N/A	Straightforward/Low	Moderate
Number and Complexity of Problems Addressed at the Encounter	N/A Minimal • 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 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 complicated injury
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## Other E/M Considerations



- AMA guidelines versus CMS guidelines
  - When the patient is admitted to the hospital as an inpatient/OBS in another site of service (ED, office, nursing facility), the services in the initial site **may be separately reported**.
    - Append modifier-25 (**CAUTION!**)
    - “When a patient is admitted to outpatient observation or as a hospital inpatient via another site of service (such as, hospital ED, office, nursing facility), all services provided by the practitioner in conjunction with that admission are considered part of the initial hospital inpatient or observation care when performed on the same date as the admission.” (MPFS Final Rule)
    - However, if different DOS may be separately reported even if less than 24 hours (MPFS Final Rule)
      - Example: Patient seen in office on Monday 4p (99214 billed), then decision to admit on Tuesday at 2p (99223) may be billed

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## E/M: Inpatient/OBS “8–24-Hour Rule” Summary

**TABLE 22: Summary of Final Policy for the “8 to 24-Hour” Rule**

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only*
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge*
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only*
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services* + discharge day management

\*Plus prolonged inpatient/observation services, if applicable.

<MPFS Final Rule>

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## E/M Levels Assigned on MDM: Summary

- Providers may be responsible for assigning their own E/M levels
  - Give specific feedback (e.g., severity of chronic conditions with exacerbation)
  - Counting unique tests and separately reportable CPT codes
  - Independent interpretation of tests – avoid just “cutting/pasting” into note
  - Prescription drug management – document specific decisions!
- Be aware there is a lack of consistency in E/M guidance (AMA versus CMS) and it may be contradictory!
  - “8-to-24-hour rule” for reporting separate E/M visits
  - Counting time and codes used for “prolonged services” (i.e., CPT vs HCPCS II “G codes”)
    - (\* Time must be used as controlling factor)



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## Thank you. Questions?

[smccall@hcpro.com](mailto:smccall@hcpro.com)

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