2025 Practical Application of The 2023 DGs with Clinical Examples

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Disclosures:

- Michael Granovsky, MD, CPC, FACEP
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- National ED Coding and Billing Company

Disclosures:

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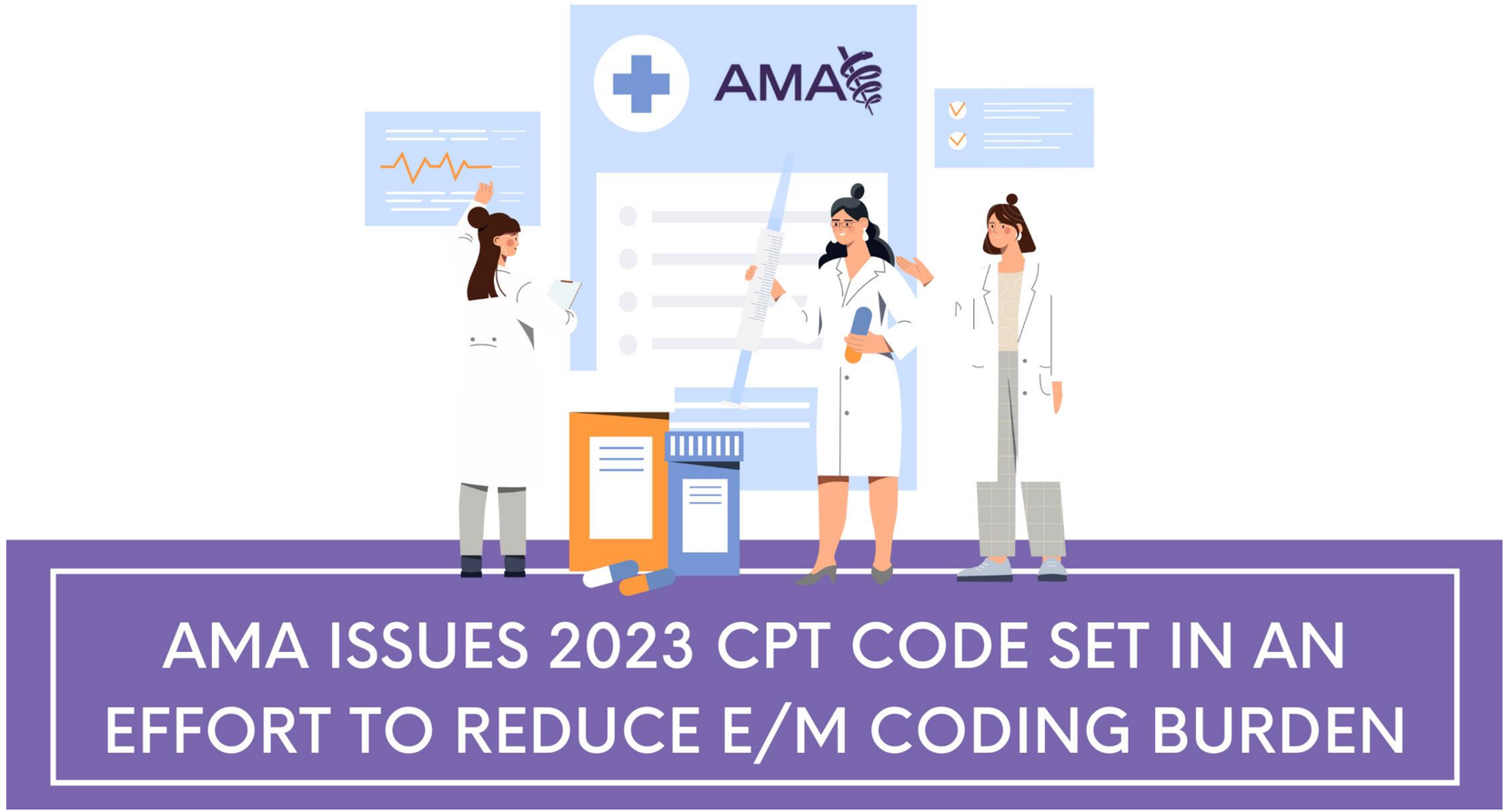
- Chief Coding Officer for Health Care Financial Services of TeamHealth
- President of Team Parker, a coding, compliance and revenue cycle consulting group.
- All content and opinions are my own.

Goal of The New Guidelines: Make Documentation More Clinically Relevant



Document What We Have Always Been Doing

"The 2023 Documentation Guidelines make documentation easier, freeing physicians from time-wasting administrative tasks that are clinically irrelevant to providing high-quality care to patients."

"These new modifications to the E/M codes extend to inpatient and observation care services, consultations, emergency department services, nursing facility services, home and residence services, and prolonged services."

AMA press release 2023 Documentation Guidelines

2023 DGs: Note Bloat Solution?
Note Length and Documentation Time

THE PRACTICE OF EMERGENCY MEDICINE/BRIEF RESEARCH REPORT

New Coding Guidelines Reduce Emergency Department Note Bloat But More Work Is Needed

Note Length and Documentation Time

- Study design
  - February 2018 through June 2023
  - 1,679,762 notes
- Primary outcome
  - Note length
  - Documentation time

2023 DG: Documentation Burden

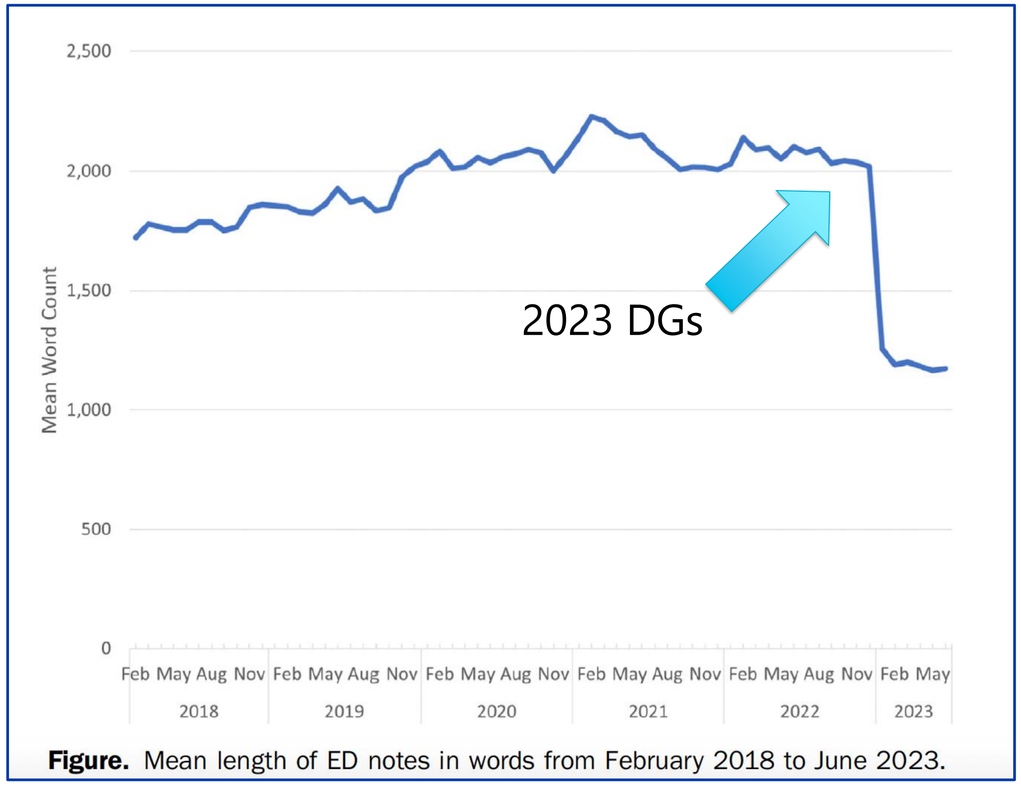


Figure. Mean length of ED notes in words from February 2018 to June 2023.

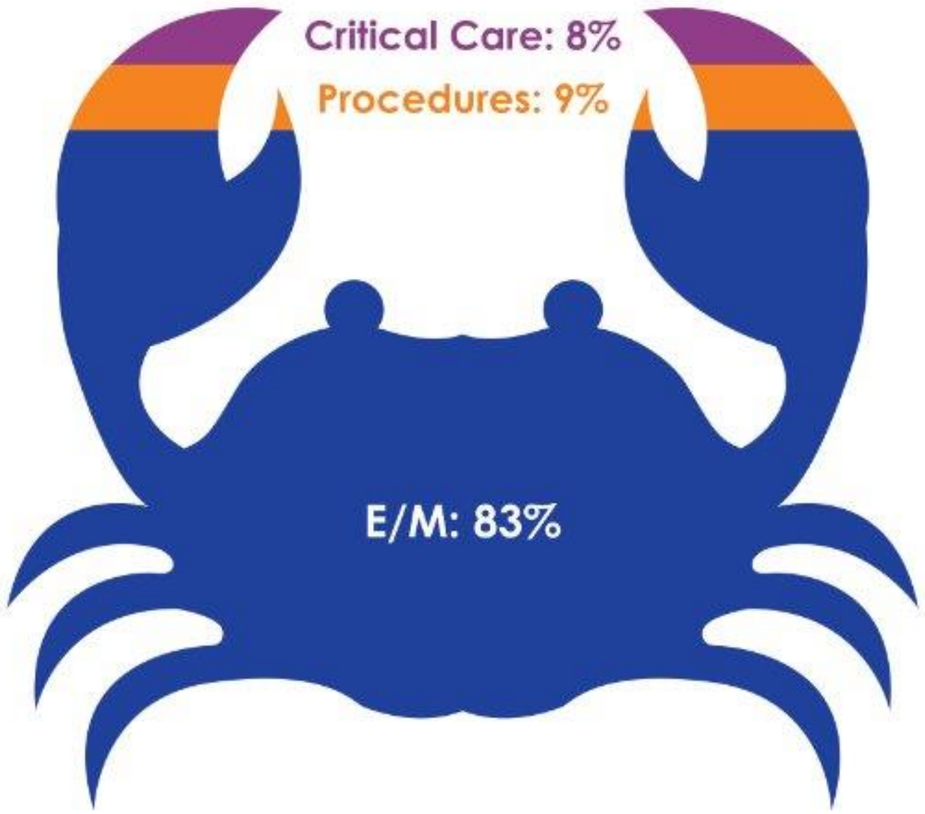
Annals *of* Emergency Medicine
An International Journal

- Word Count Decrease: 40%
- Documentation Time:
  - No meaningful decrease

<u>Conclusions:</u>
Embracing new guidelines and practices, we reduced the length of ED provider notes by 872 words.

Despite this, the time clinicians spent documenting did not change significantly.

Value of the Documentation Guidelines

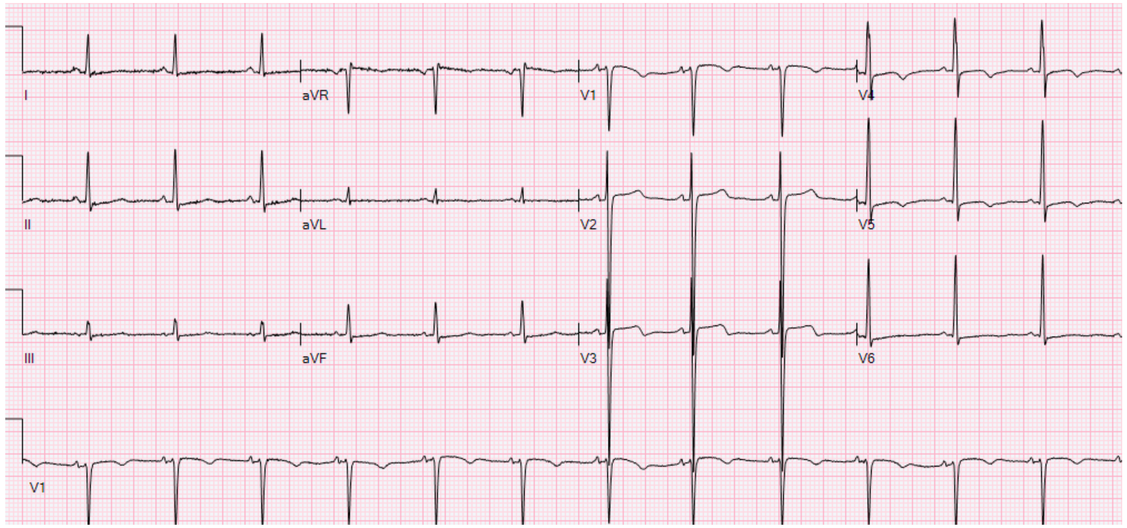


Most RVUs come from 99281-99285

History and Exam - Not Used to Code the Chart

Clinically Relevant History

- CC: chest pain
- 56 yo with a hx of htn, DM, tobacco use presents with SSCP x 1 week. Episodes occur with exertion and are associated with diaphoresis and nausea. Resolve with rest. Pt states his father had bypass surgery in his 40s. Denies SOB, fatigue back pain, or vomiting.



Focused Exam Can Reduce Note Bloat

Physical Exam

Vitals Reviewed.

Constitutional:

General: + diaphoresis.

Appearance: Normal appearance.

HENT:

Head: Normocephalic and atraumatic.

Eyes:

Extraocular Movements: Extraocular movements intact.

Neck:

Vascular: No carotid bruit.

Cardiovascular:

Rate and rhythm: Normal rate and regular rhythm.

Murmur: no murmur present

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Psychiatric:

Mood and Affect: Mood normal.

MDM Drivers COPA, Data, Risk

COPA: The Power of a Differential Diagnosis Presenting Symptoms and Final Diagnosis

*"The **final diagnosis** for a condition **does not**, in and of itself, **determine the complexity or risk**, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."* **2025 CPT Professional Edition page9**

*"Therefore, **presenting symptoms** that are likely to represent a highly morbid condition **may "drive" MDM** even when the ultimate diagnosis is not highly morbid."* **2025 CPT Professional Edition page 9**

While not at all required, a differential diagnosis powerfully links the presenting symptom to the work up and the consideration of a highly morbid condition

Differential Diagnosis Demonstrates Complexity of Care

Differential diagnosis

- Describe the differential diagnosis as it relates to your workup
  - CT ordered to evaluate for intracranial hemorrhage (better)
    - Instead of "CT negative" (acceptable)
  - Troponin ordered to evaluate for ACS (better)
    - Instead of "troponin negative"(acceptable)

COPA: Low vs Moderate- Stable or Not?

Stable Chronic Illness- Low COPA

Chronic Illness with exacerbation- Moderate COPA

"A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity ***without*** *treatment is significant."*

2023 CPT Documentation Guideline Release page 15

Data: Review of External Notes

- **ACEP FAQ:** External notes are any records, communications, test results, etc., from an external physician/QHP, facility, or health care organization.
- Any notes that come from outside their emergency department
  - Inpatient charts, nursing home records, EMS reports, ED charts from another facility or ED group
  - Medical records from prior visits to the same emergency department do not qualify as they are the same physician group/specialty
- A review of a discharge summary from a prior inpatient stay and review of nursing home records would each count as 1, for a total of 2 "points" for Category 1

Data: Discussion of Management

Discussion of management with other clinicians or **appropriate source**

- Hospitalist, consultant, urgent care
- Pharmacy, mental health liaison, case management, social work

> *"**Appropriate source:** For the purpose of the **discussion of management** an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers."*
>
> **CPT 2023 E/M Guideline page 17**

Risk: When Is it Prescription Drug Management?

ACEP FAQ: "What qualifies as prescription drug management in moderate risk?"

- Provider has administered, prescribed, or evaluated current medications during the ED visit.
  - Administration of prescription strength medication in the ED
  - A prescription written to be filled at the pharmacy
  - Discontinuation or modifications to the patient's existing medication dosages
  - After consideration of the current medications, the decision to maintain the current medication regimen
- Per CPT : "Simply reviewing a medication list does not constitute prescription drug management."

COPA Vignettes

COPA Vignette: Differential Diagnosis

Differential Diagnosis Documentation Pearls:

1. List the Differential Diagnosis considered for the patient:
    - Separate designated section or
    - Within an MDM narrative or
    - Both
2. May use rule out, possible or probable if desired (not for Final ICD-10 Diagnosis)
3. Address the problems in the Differential Diagnosis during the encounter:

> *"A problem is addressed or managed when it is evaluated or treated at the encounter…"*

> *"This includes consideration of further testing or treatment that may not be elected…"*

2025 CPT Professional Edition page 10

COPA Vignette: Differential Diagnosis

History of Present Illness:

58 yo male presents with epigastric pain started last night after eating dinner. Pain gradually got worse, now radiating to his back, and started with nausea and vomiting. Thinks he may have had a fever but is unsure. Past history of HTN and DM.

Patient presents with 18 hours of worsening epigastric pain and tenderness, with low grade fever, nausea and vomiting. Initial vital signs: 99.0, HR 100, BP 120/70, RR 14. Patient has tenderness to RUQ and epigastric area, possible Murphy's sign, appears uncomfortable. Labs include CBC, CMP, lipase, and lactic acid. Additionally, an ECG and troponin. IV fluids for sepsis, early antibiotics and pain medication ordered.

DDx: cholecystitis, gallstone pancreatitis, sepsis, ACS, ascending cholangitis

Reassessment: patient HR now in the 70s, feels improved. WBC is 22, LFTs and lipase elevated, ECG and troponin negative. MRCP ordered.

Reassessment: MRCP shows stone in the CBD with pancreatitis and ascending cholangitis; hospitalist, GI and surgery on page.

Reassessment: GI to take for ERCP tonight, and hospitalist admitted. Surgery on board. Discussed diagnosis and plan with patient and family; answered all questions.

Clinical Impression:
Ascending cholangitis, Pancreatitis, Gallstones
DM, HTN

COPA Vignette: Differential Diagnosis

- 58 yo male with HTN, DM presents with epigastric abdominal pain radiating to the back with nausea, vomiting, low grade fever over the last 18 hours. Physical exam RUQ/epigastric tenderness, Murphy's sign, low grade temp.
- **DDx: cholecystitis, gallstone pancreatitis, ascending cholangitis, sepsis, ACS**

- Labs: WBC 22, LFTs and lipase elevated. ECG and troponin negative. Lactic acid negative. MRCP shows ascending cholangitis, pancreatitis.
- **MDM: Patient presents with RUQ/epigastric pain. Work up is to r/o cholecystitis, gallstone pancreatitis, ascending cholangitis, sepsis, ACS. On review of the labs, ECG, and MRCP final diagnosis is ascending cholangitis and pancreatitis.**

COPA Vignette: "Stable"

"Stable for purposes of categorizing MDM is defined by specific treatments goals for an individual patient. ***A patient who is not at his or her treatment goal is not stable****."*

2025 CPT Professional Edition page 11

Low COPA:

- 1 stable, chronic illness

Moderate COPA:

- 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
- 2 or more stable, chronic illnesses

Low vs Moderate COPA

COPA Vignette: “Stable”

72 yo female presents with a history of HTN. Took her blood pressure at home and had one elevation last week. Patient currently has no symptoms. Currently her blood pressure in the ED is 124/76.

Treatment goals are met for HTN.

Reassured patient and advised her to continue her HTN medications as prescribed.

Low COPA:
1 stable chronic illness

72 yo female presents with a history of HTN. Took her blood pressure at home and was persistently elevated so came to the ED. Patient currently has no symptoms. Currently her blood pressure in the ED, after repeat measurement, is 168/110. Lab and ECG work up is negative.

Treatment goals are not met for HTN.

An additional HTN medication is prescribed and patient is advised to follow up in 2-3 days for repeat blood pressure check.

Moderate COPA:
1 chronic illness with exacerbation

DATA Vignettes

DATA Vignette: External Note Review

External records, communications and/or test results examples to consider:

- EMS run sheet
- Health Information Exchanges:
  - EPIC Care Everywhere review
  - PDMP review (Prescription Drug Monitoring Programs)
- Previous admissions
- Nursing facility reports
- Appropriate source documents (e.g., case manager note, parole officer report, etc.)
- Consultant written communication (consult note)

Independent Historian and External Record Review

History of Present Illness

56 y.o. M sent here by SNF for evaluation after aspiration today. History is limited due to pts acuity.

Independent Historian

According to EMS, pt had a witnessed choking event during lunch and subsequently became hypoxic to 86% on RA and hypotensive in 90s/50s. He was placed on 2L NC enroute.

ED Course

External Record Review: pt was recently discharged from this facility – pedestrian struck vs scooter with multiple facial/rib fractures.
Most recent Echo [date] showed an EF of 55%, with concern for sepsis will order 30 cc/kg bolus

External record review

DATA Vignette: Discussions

Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source

> *"Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange."*
>
> **2025 CPT Professional Edition page 12**

DATA Vignette: Discussions

Meets Interactive Discussion Criteria

- Discussed with radiologist…
- I talked to Dr. Slash who recommended…
- Via EPIC chat Dr. Bone states…
- Spoke with case management…
- HIPAA secured communication platforms
  - EPIC messaging

Does Not Meet Interactive Discussion Criteria

- Neurology resident told me…
- Appreciate recs…
- Unit clerk states Cardiology called back and accepts patient
- The ED nurse states Dr. Salt called back and ordered…

DATA Vignette: Discussions

Discussion of management or test interpretation with **external physician/other qualified health care professional**/appropriate source

> *"An external physician or other qualified health care professional who is **not in the same group practice or is of a different specialty or subspecialty**. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency."*
>
> **2025 CPT Professional Edition page 12**

DATA Vignette: Discussions

Discussion of management or test interpretation with **external physician/other qualified health care professional**/appropriate source

- Physicians and APPs
  - Not in same group
  - Not in same specialty
- Dieticians
- Pharmacists
- Physical therapists
- Occupational therapists
- Speech therapists
- Psychologists
- Nursing home staff
- Home health staff

DATA Vignette: Discussions

Discussion of management or test interpretation with **external physician/other qualified health care professional**/appropriate source

Examples to consider:

- *"I spoke to the **dietician** who recommends when the patient returns to rehab they add a protein supplement for his nutritional state."*
- *"The **pharmacist** called and we discussed the best antidote for the prolonged INR."*
- *"The **physical therapist/occupational therapist** assessed the patient and told me they qualify for home health."*
- *"I spoke with the **Speech therapist** and the patient did not pass the swallow study and should remain npo."*

DATA Vignette: Discussions

Discussion of management or test interpretation with external physician/other qualified health care professional/**appropriate source** (professionals who are not health care professionals but may be involved in the management of the patient)

Examples to consider:

- *"I spoke with the **case manager** and she will work on arranging SNF placement."*
- *"The patient's **parole officer** called back and we discussed his assistance with coordinating patient's outpatient dialysis."*
- *"Talked to the patient's **lawyer**, who is their court-appointed POA, and confirmed patient's wishes to allow natural death."*
- *"Discussed with the **social worker** and their assessment of the patient. The patient does not qualify for inpatient psychiatric care."*

RISK Vignettes

RISK Vignette: Prescription Drug Management

ACEP FAQ 43 (in part): **Prescription drug management** is based on documentation that the provider has **administered, prescribed, or evaluated current medications during the ED visit**."

- Common ED examples:
- Ancef and vancomycin IV for diabetic cellulitis.
- Prescription for albuterol and prednisone for asthma exacerbation.
- Tetanus vaccination update for laceration.
- Amoxicillin prescription for otitis media.
- Lidocaine injection for abscess I&D.

RISK Vignette: Prescription Drug Management

Additionally, per CPT:

> *"This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family."*
>
> **2025 CPT Professional Edition page 8**

> *"Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization."*
>
> **2025 CPT Professional Edition page 13**

RISK Vignette: Prescription Drug Management

Other ED examples to consider:

- *"Discussed with parents whether amoxicillin for possible ear infection is indicated. After shared decision making, they opted to not get the prescription and will observe at home."*

- *"Prescription pain medication is not indicated at this time."*

- *"Patient's rash is not an allergic reaction to metformin. Glucose is normal. Continue metformin as prescribed."*

Risk: Care Significantly Impacted by Social Determinants of Health

Social Determinants of Health: ICD-10

Problems related to:

- Homelessness
- Insufficient social insurance
- Housing instability and economic circumstance
- Low income or unemployment
- Insufficient social insurance
- Lack of primary support group
- Living in a residential institution
- Lack of transportation

Care Significantly Impacted by Social Determinants of Health

28-year-old with a history of DM presents with 3-4 days of worsening “rash” on RLE. No fevers, chills, vomiting, or change in PO intake.

Pt notes recent job loss and lack of insurance – safe for discharge – coordinated with pharmacy for medication to go pack.

Patient’s treatment was significantly impacted by a social determinant of health.

ICD-10 Vignettes

ICD-10 Payer Behavior

Reimbursement Policy

Effective Date.....11/14/2021
Reimbursement Policy Number R36

Reimbursement Policy

Cigna allows reimbursement for an E/M service the following criteria are met:

- **E/M services provided must meet the criteria as defined in the CPT® E/M coding guidelines for codes 99281 – 99285 and the 1997 CMS documentation coding guidelines.**
- **Documentation within the medical record must be specific to the patient and the encounter at the time of service. Cloned or "copy and paste" must not be used within the patient documentation. Cigna considers cloned or "copy and paste" identified when the entries in the medical record is worded exactly alike or similar to the previous entries or the medical documentation is exactly the same within different patient records.**

Cigna will adjust Emergency room E/M CPT® codes 99284 and 99285 to reimburse consistent with the appropriate CPT® code 99283 when a single non-complex diagnosis code is submitted on a CMS 1500 claim form. A modifier will not override after the adjustment.

ICD-10 Guidelines

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

ICD-10-CM 2025 Coding Guidelines, Section 4(A), p27

Signs and symptoms: Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

ICD-10-CM 2025 Coding Guidelines, Section 1(B)(4), p4

ICD-10: Signs and Symptoms

- 85 yo female with HTN presents with left sided chest pain, lasts < 5 min, with SOB, and nausea. Physical exam unremarkable. Serial ECG and troponins negative, HEART score is 3. CXR neg. Discharge home.
- **Diagnosis:**
  - **Atypical chest pain (chest pain, unspecified, R07.9)**

- 47 yo female with HTN presents with left sided chest pain, lasts < 5 min, with SOB, and nausea. Physical exam unremarkable. Serial ECG and troponins negative, HEART score is 3. CXR neg. Discharge home.
- **Diagnosis (more descriptive):**
  - **Precordial chest pain (R07.2)**
  - **Shortness of breath (R06.02)**
  - **Nausea (R11.0)**

ICD-10 Guidelines

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medial record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the provider.

ICD-10-CM 2025 Coding Guidelines, Section 4(G), p27

ICD-10: Coexisting Conditions

- 35 yo male with sudden onset of dyspnea and right sided chest pain. PE unremarkable. Hx/o antiphospholipid syndrome. Extensive work up including labs, ECG, CTA chest neg. DC home.
- **Diagnosis:**
  - **Atypical chest pain (chest pain, unspecified, R07.9)**

- 35 yo male with sudden onset of dyspnea and right sided chest pain. PE unremarkable. Hx/o antiphospholipid syndrome. Extensive work up including labs, ECG, CTA chest neg. DC home.
- **Diagnosis (more descriptive):**
  - **Shortness of breath (R06.02)**
  - **Antiphospholipid syndrome (D68.61)**
  - **Chest pain, unspecified (R07.9)**

Conclusions

Parting Thoughts: Strategies for Success!

- Designate a group champion and support with education and resources
- Group education is paramount
  - Orientation
  - Ongoing chart feedback and tips
- Maximize available resources:
  - EHR templates
  - Revenue Cycle Company
  - ACEP (www.acep.org/reimbursement)

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Educational Appendix: Shared Decision Making

Shared Decision Making: CPT Definition

Shared decision making involves:

- Eliciting patient and/or family preferences,
- Patient and/or family education, and
- Explaining risks and benefits of management options.
- 2024 CPT Professional Edition page 7

Shared Decision Making: CPT Definition

"A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. ***This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.***"

2023 CPT Professional Edition page 7

Shared Decision Making: Risk Hospitalization

Pre-2023 DG

76 yo female with history of multiple abdominal surgeries, SBO, DM, HTN, presents with severe, diffuse abdominal pain for the last 4 days with nausea, and concern for recurrent SBO. Patient work up shows no SBO on CT but has a colitis. Patient pain is minimal now, tolerating po and feels comfortable going home with antibiotics. Will see her PCP in the AM.

Current DG

76 yo female with history of multiple abdominal surgeries, SBO, DM, HTN, presents with severe, diffuse abdominal pain for the last 4 days with nausea, and concern for recurrent SBO. Patient work up shows no SBO on CT but has a colitis; **however, patient was in severe pain initially, is a diabetic, and concern with mildly elevated WBC. Discussed with patient regarding admission versus discharge, and through shared decision-making patient decided to go home.** Patient pain is minimal now, tolerating po and feels comfortable going home with antibiotics. Will see her PCP in the AM.

Current DG ex. Supports High Risk, Decision Regarding Hospitalization

Decision Making: Tests and Treatment

8 yo presents after a fall and closed head injury. Parents request CTH. Based on PECARN rule and with shared decision making with parents CTH not ordered.

Supports Data, ordering of 1 unique test

Offered patient a volar splint for her carpal tunnel exacerbation. After discussion regarding risks and benefits of the splint, patient declines a splint at this time.

Supports Moderate Risk, Rigid Musculoskeletal Immobilization.

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