Coding and Billing for Long-Term Care

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- Non-Physician Practitioner Change for 2022
- Documentation Reminders
- Coding Guidelines for 2022
- Diagnosis Coding Reminders
- BIG Changes Coming in 2023!

Split/Shared Services

"A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them.*

Payment is made to the practitioner who performs the substantive portion of the visit. Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations."

Medicare Claims Processing Manual, Chapter 12, Section 30.6.18.A

Split/Shared Requirements

- Sites of service:
  - Hospital
    - Inpatient
    - Outpatient
    - Emergency department
  - Nursing Facility - excluding those services which must be performed by an MD
- Both providers must be employed in the same group practice

Split-Shared Services – Changes for 2022

- Now allowed for critical care – can sum the time between physician and NPP
- May be performed in Nursing Facility setting when allowed by state law
- Services must be billed under provider who performed "substantive portion"
  - 2022 – one of 3 key components – history, exam, medical decision making OR more than half of total time
  - 2023 – more than half of total time
- Both providers must be identified and individual who provided substantial portion must sign and date
- Modifier FS must be appended

Medicare Claims Processing Manual Chapter 12, Section 30.6.1A

"…Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported…."

Signature Requirements

- "as soon as is practicable"
- Expectation is that electronic documentation will be completed within 48 hours

Initial Nursing Facility Care

	99304	99305	99306
	3 of 3	3 of 3	3 of 3
History	chief complaint 4 or more HPI 2 - 9 ROS 1 element PFSH	chief complaint 4 or more HPI 10 or more ROS complete PFSH	chief complaint 4 or more HPI 10 or more ROS complete PFSH
Examination	2 - 7 systems/areas (in detail)	8 or more systems	8 or more systems
Medical Decision-Making	(must meet 2 of 3) minimal diagnoses minimal/no data minimal risk	(must meet 2 of 3) multiple diagnoses moderate data moderate risk	(must meet 2 of 3) extensive diagnoses extensive data extensive risk
Time (only relevant if counseling >= 50%)	25 minutes	35 minutes	45 minutes

Initial Visit Issues

- Lack of extended HPI to support level of service
- For chronic illnesses, HPI should include ***status*** of chronic conditions
- Complete Review of Systems not documented appropriately
- No Family History documented

Evaluation and Management

Key Components

- History
- Examination
- Medical Decision-Making

History Elements

- Chief Complaint
- History of Present Illness
- Review of Systems
- Past, Family, Social History

History of Present Illness should reflect the conditions YOU are treating.

Established the medical necessity of the service

HPI Issues
Interpretation of Elements

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs and Symptoms

HPI – 1997 Guidelines

In lieu of elements of HPI, provider may document the status of 3 chronic conditions

- Cannot simply state that the patient has the condition, must also give the status.
  - DM type 2 well controlled with diet
  - HTN controlled with Toprol
  - Hyperlipidemia – pt is attempting to control with dietary changes, however levels still elevated

CMS has clarified that this can also be used with 1995 Guidelines

Review of Systems

the patient's answers to specific questions relating to organ systems

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Nervous
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/Immunologic

Review of Systems

- The history element that is most often lacking
- May indicate "All other systems negative" after documentation of related system
  - But must list at least one system specifically
- "ROS – Negative" is insufficient documentation for complete Review of Systems

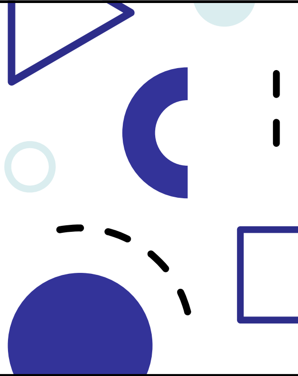
Past, Family, Social History

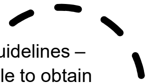
Past – illnesses; surgeries; current medications; allergies

Family – hereditary diseases; health status of parents, siblings, children

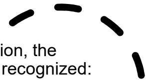
Social – smoking, alcohol, drug use; marital status; living arrangements; employment; education; day care (for children)

For initial visit, need all three areas to support comprehensive history.





1995 Documentation Guidelines –
"If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history."



For purposes of examination, the following ***body areas*** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

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1995 Exam Elements – Organ Systems

For purposes of examination, the following ***organ systems*** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Comprehensive examination is of 8 organ systems

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Medical Decision-Making

- Number of Diagnosis and Management Options
- Amount and Complexity of Data
- Table of Risk

Number of Diagnoses and Management Options

- Self-limited or minor problem
- Established problem – improving
- Established problem – worsening or failing to change as expected
- New problem – no additional workup
- New problem – with additional workup

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Documentation of Time-Based Visits

- When the code is based on time, time must be documented!!
- General statements such as “lengthy discussion” are not sufficient
- Time is not pertinent to coding the visit level unless more than half the time was spent in counseling and coordination of care
- Can you round up?
  - Per AMA, you can round up as times are meant to be average
  - Per CMS, you cannot round up, time must be met or exceeded

Subsequent Care

	99307	99308	99309	99310
	2 of 3	2 of 3	2 of 3	2 of 3
History	interval history chief complaint 1-3 HPI	interval history chief complaint 1-3 HPI 1 ROS	interval history chief complaint 4 or more HPI 2 - 9 ROS pertinent PFSH	interval history chief complaint 4 or more HPI 10 or more ROS complete PFSH
Examination	1 system	2 - 7 systems	2 - 7 systems (in detail)	8 or more systems
Medical Decision-Making	(must meet 2 of 3) minimal diagnoses minimal/no data minimal risk	(must meet 2 of 3) limited diagnoses limited data low risk	(must meet 2 of 3) multiple diagnoses moderate data moderate risk	(must meet 2 of 3) extensive diagnoses extensive data high risk
Time (only relevant if counseling >= 50%)	10 minutes	15 minutes	25 minutes	35 minutes

Detailed Examination

- "extended examination"
- 3-4 comments about the affected organ system
- Not important how the documentation is labeled, but the content of what is documented – e.g., "Neck" and "Extremities" are often concerned with the Vascular system, which is part of the Cardiovascular

Nature of Presenting Problem (from the CMS Table of Risk)

Self-limited or minor problem	99307
Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury	99308/99318
One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic conditions Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	99309/99318
One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illness that poses a threat to life or bodily function Abrupt change in neurologic status	99310

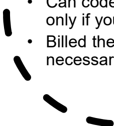
Annual Assessment

99318 – all components required

- Detailed history
  - chief complaint
  - 4 or more HPI or status of 3 chronic conditions
  - 2 - 9 ROS
  - 1 element PFSH
- Comprehensive examination - 8 or more systems examined
- Low to moderate medical decision-making
- 30 minutes

THIS CODE IS TO BE DELETED IN 2023

Discharge Day Management



Coded based on time spent in discharge activities:

- 99315 - 30 minutes or less
- 99316 - More than 30 minutes
  Time must be documented or default to 99315
  Dictation time not included in billable time
- Can code a discharge for deceased patient not seen on the date of death only if you are the one who pronounced.
- Billed the date the face-to-face work of the discharge is done, not necessarily the date the patient leaves

Prolonged Services

- When services exceed the average time for a particular CPT code by more than 30 minutes –

  99356 – first hour (30-74 mins)

  99357 – each additional half hour

Prolonged Services - Inpatient

- May be billed when the time spent exceeds the average time for that code by more than 30 minutes
- The most common use may be when patient needs to be seen more than once per day. Requires documentation of time at every encounter.

  99307 – 10 minutes

  99308 – 15 minutes

  99309 – 25 minutes

  99233 – 35 minutes

Prolonged Services Billed to Medicare –

- requires face-to-face time even in an inpatient setting even though CPT says floor/unit time

"In the case of prolonged inpatient services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services."

Advance Care Planning

- 99497 – Advance care planning; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- +99498 – each additional 30 minutes

Advance Care Planning

Payment for CPT codes 99497-99498

- With or without completing forms
- Must be performed by physician or NPP
- Deductible or cost-share applicable if performed by itself or same day as E&M
- No limitation as to specialty or frequency
- “other qualified health care professional”
- Incident-to guidelines apply
- CPT time rules apply
- May not be billed with critical care codes 99291-99292

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CPT Time Rule

CPT 2021 Professional

“A unit of time is attained when the midpoint is passed.”

Regarding Advance Care Planning codes

99497 – requires documentation of at least 16 minutes face-to-face with patient.

+99498 – as an add-on to 99497, requires documentation of at least 46 minutes face-to-face with the patient.

ACP – same day as E&M

- “reasonable and necessary for the diagnosis and treatment of illness or injury”
- Same diagnosis as visit

Example –

72yo female with end-stage Parkinson’s with dementia is seen for visit at which she also wishes to discuss her wishes for future care. An advance directive is completed and executed according to applicable state law.

ACP – same day as E&M

Documentation: "In addition to the time spent in evaluation and management of Mrs. ----'s Parkinson's disease, we spent 45 minutes discussing her wishes regarding nursing home care as her condition progresses as expected."

- Billed with same diagnosis as E&M
- Patient cost-share and deductible apply

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Diagnosis Coding

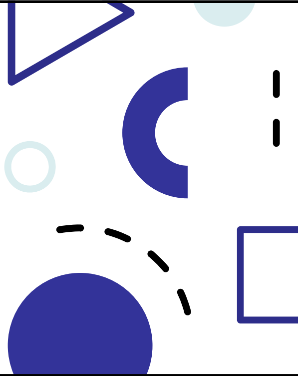
"Every patient deserves a complete and accurate story."

Steps to Correct Diagnosis Coding

- The appropriate code or codes from A00.0 through U07.1, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.
- For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems or reasons for the encounter.

Steps to Correct Diagnosis Coding

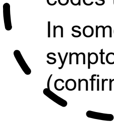
- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.



Steps to Correct Diagnosis Coding

- List first the ICD-9-CM/ICD-10-CM code for the diagnosis, condition, problem or other reason for the encounter shown in the medical 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 physician.



Steps to Correct Diagnosis Coding

- Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, or working diagnosis. Rather, code the condition(s) to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit.
- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Steps to Correct Diagnosis Coding

- Code all documented conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Unspecified

- Sometimes there is not enough known about the patient's condition to be more specific – NOS – Not Otherwise Specified or unspecified
- Sometimes you know more, but there is not a code that specific – NEC – Not Elsewhere Classified

Focus on specificity where it affects treatment or further defines severity.

Diagnosis Coding Example - Diabetes

- Patient has uncontrolled diabetes with several complications, including retinopathy, neuropathy, and vascular insufficiency with foot ulcers
- Physician codes unspecified diabetes E11.9
- Cost of care for patient far exceeds that expected for the uncomplicated, in-control condition that has been coded.

Example of Expected Costs for Diabetes Care

Dx Code	Dx Description	Expected Annual Cost of Care
E11.9	Diabetes with no complications	$1,400
E11.319	Diabetic retinopathy	$2,200
E11.40	Diabetic neuropathy	$3,500
E11.22	Diabetic chronic kidney disease	$4,300

Diabetes

Five Categories
- E08 – DM due to underlying condition
- E09 – Drug or chemical-induced DM
- E10 – Type 1 DM
- E11 – Type 2 DM
- E13 – Other specified DM

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Combination Codes

Code as many complications as are documented
- Type
- Body system affected
- Complications affecting that system
- Additional code may still be needed if further specificity documented

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Diabetes – "with"

Certain conditions are assumed to be complications of diabetes – unless the provider states that they are not

(List is not exhaustive)

- autonomic (poly)neuropathy E11.43
- cataract E11.36
- Charcot's joints E11.610
- chronic kidney disease E11.22
- circulatory complication NEC E11.59
- complication E11.8
- dermatitis E11.620
- foot ulcer E11.621
- gangrene E11.52
- gastroparalysis E11.43
- gastroparesis E11.43
- neuropathy E11.40
- ophthalmic complication NEC E11.39
- oral complication NEC E11.638
- osteomyelitis E11.69
- periodontal disease E11.630
- peripheral angiopathy E11.51
- with gangrene E11.52
- polyneuropathy E11.42
- renal complication NEC E11.29
- retinopathy E11.319
- skin complication NEC E11.628
- skin ulcer NEC E11.622

Uncontrolled?

There is no default code for "uncontrolled" – must specify hypo- or hyperglycemia -

E08-E13.641 – with hypoglycemia with coma

E08-E13.649 – with hypoglycemia without coma

E08-E13.65 – with hyperglycemia

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Long-term (Current) Use of Insulin

Z79.4 – Long-term use of insulin

- "long-term" not to be used when insulin is given temporarily to reduce the patient's blood sugar during the particular encounter

Z79.84 – Long-term use of oral antidiabetic meds

And new for 2023 (effective 10/1/2022)

Z79.85 – Long-term use of injectable non-insulin antidiabetic drugs

- Code for insulin pump, Z96.41, is also appropriate – in both Type 1 and Type 2 patients

Hypertension

I10 – hypertension now includes high blood pressure

New category I16 – to be coded in addition to I10-I15 –

- I16.0 Hypertensive urgency
- I16.1 Hypertensive emergency
- I16.9 Hypertensive crisis, unspecified

Assumed linkage between hypertension and kidney failure or hypertension and heart failure

Hypertensive Heart Disease

- I11.0 - Hypertensive heart disease with heart failure
  Use additional code to identify type of heart failure (I50.-)
- I11.9 - Hypertensive heart disease without heart failure

Hypertensive Chronic Kidney Disease

- I12.0 - Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
  Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)
- I12.9 - Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Example

Patient's diagnoses are listed as hypertension, diabetes, chronic kidney disease, and end stage congestive heart failure. Her medications include Metformin and insulin.

- I13.0 - Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
- E11.22 - Type 2 diabetes mellitus with diabetic chronic kidney disease
- I50.84 – End stage heart failure
- Z79.4 – Long-term use of insulin
- Z79.84 – Long-term use of oral antidiabeticdrugs

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COPD

- J44.0 - Chronic obstructive pulmonary disease with acute lower respiratory infection
  Use additional code to identify the infection
- J44.1 - Chronic obstructive pulmonary disease with (acute) exacerbation
- J44.9 - Chronic obstructive pulmonary disease, unspecified

Code both J44.0 and J44.1 in a patient with acute bronchitis and COPD exacerbation

Code J45.- to indicate the status of patient's asthma – mild/moderate/severe and persistent/intermittent.

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When to code history of malignancy?

The condition is coded as "history of" when the malignancy has been eradicated and the patient is no longer receiving treatment and care for that condition.

May differ from clinical guidelines.

Patient was diagnosed with right breast cancer 2 years ago. She underwent mastectomy and completed chemotherapy and is seen for followup.

Z85.3 - Personal history of malignant neoplasm of breast
Z90.11 - Acquired absence of right breast and nipple
Z92.21 - Personal history of antineoplastic chemotherapy

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Alzheimer’s Disease and Other Dementias

- G30.0 Alzheimer's disease with early onset Alzheimer's dementia senile and presenile forms
- G30.1 Alzheimer's disease with late onset Alzheimer's dementia senile and presenile forms
- G30.8 Other Alzheimer's disease Alzheimer's dementia senile and presenile forms
- G30.9 Alzheimer's disease, unspecified

Senility is now coded as symptom code R41.81

Senile dementia coded as nervous and mental code F03

Additional code to specify behavioral disturbance

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CVA or Stroke

- Without any further information, “stroke” is coded as a current condition.
- Late effects of a CVA or stroke are coded from the I69 series – the late effect may be present from the onset or may occur at a later time.
- History of CVA without any residual effects is coded Z86.73 - Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

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Arthritis/Arthropathy

- Differing codes for different types/causes of arthritis
- Site and laterality specific codes
- Arthritis of “multiple site” codes may be applicable
- If category does not contain “multiple site” codes, code each site individually
- If no option for bilateral, code L and R separately
- If OA noted as unilateral involvement of a specific joint, coded as primary localized of that site.
- Arthritis, unspecified type, unspecified site is coded M19.90.

Injury, Poisoning, and other Consequences of External Causes

- Injuries grouped by body part rather than category of injury
- Encompasses 2 alpha characters
  - **S -** Injuries related to body region

    Note: Use secondary code(s) from Chapter 20 to indicate cause of injury
  - **T -** Injuries to unspecified region - Poisonings, external causes – codes that include the external cause do not require an additional external cause code
- Seventh character to indicate episode of care

7th Characters – Episode of Care

- Initial encounter

  The patient is receiving active treatment for the condition – such as surgical treatment, emergency department encounter
- Subsequent encounter

  After patient received active treatment for the condition and receiving routine care during healing or recovery phase: cast change or removal, medication adjustment, other aftercare and follow-up visits following injury treatment
- Sequela

  Complications or conditions that arise as a direct result of a condition ("late effects")
  - Use both the injury code that precipitated sequela and code for sequela – code for sequela first
  - S added only to injury code, not sequela code

Drug Therapy

- Z79.1 – Long-term (current) use of non-steroidal anti-inflammatories (NSAID)
- Z79.2 – Long-term (current) use of antibiotics
- Z79.3 – Long-term (current) use of hormonal contraceptives
- Z79.52 – Long-term (current) use of systemic steroids
- Z79.82 – Long-term (current) use of aspirin
- Z79.83 – Long-term (current) use of bisphosphonates
- Z79.84 – Long-term (current) use of oral antidiabetic drugs
- Z79.890 – Long-term (current) use of hormone replacement
- Z79.891 – Long-term (current) use of opiate analgesic
- Z79.899 – Other long-term (current) drug therapy

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Big Change Coming!

Effective with dates of service 1/1/2023

- Split/shared services with NPP will be billed under provider who documents the most time on the date of service.
- Annual Nursing Facility Visit deleted.
- Domiciliary Codes deleted – use Home codes for Assisted Living Facility visits.
- Services will be coded based on Time or Medical Decision-Making.
- Ability to report visit made in separate site on same day as admission.

Time – Previously and in 2023

2022 and earlier –

- Evaluation and Management services could be coded based on time only if visit was dominated by counseling and coordination of care – and only face-to-face time counted

Beginning in 2023 –

- Visit level will be determined either by Time or by revised Medical Decision Making criteria
- Time is not just face-to-face time

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Time - What Counts?

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Regardless of location of provider

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2023 AMA Times for Nursing Facility Codes

	Time		Time
99304	25	99307	10
99305	35	99308	15
99306	45-59	99309	30
		99310	45

- Time must be met or exceeded – no rounding up!
- Clinical staff time DOES NOT count!
- Only one person per minute – if two providers see patient at same time, only one would be counted for each minute.

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Medical Decision Making

- History and examination are still performed and documented, but whatever is “medically appropriate” – no effect on coding of service.
- Service is coded based on MDM or Time, whichever yields the higher level of service.

Elements of Medical Decision Making

Level of service will be determined by two out of three elements, whether for admission or visit –

- Nature and Complexity of Problems Addressed
  - Complexity of problems and risk from the condition(s)
- Data to be Reviewed and Analyzed
- Risk
  - Risk of treatment

More Info!

- Details from the AMA on the coding changes available now at: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- Look for webinars and other educational opportunities later in 2022.

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