Talk Smart, Code Fast, Next Patient:

The MDM &
ED Documentation

Michael A. Sharma, MPAS, PA-C

Emergency Medicine, UT Southwestern Medical Center, Dallas, TX

Adjunct Professor, Franklin Pierce University, Round Rock, TX

@michaelsharmapa | michael.sharma@gmail.com

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P A
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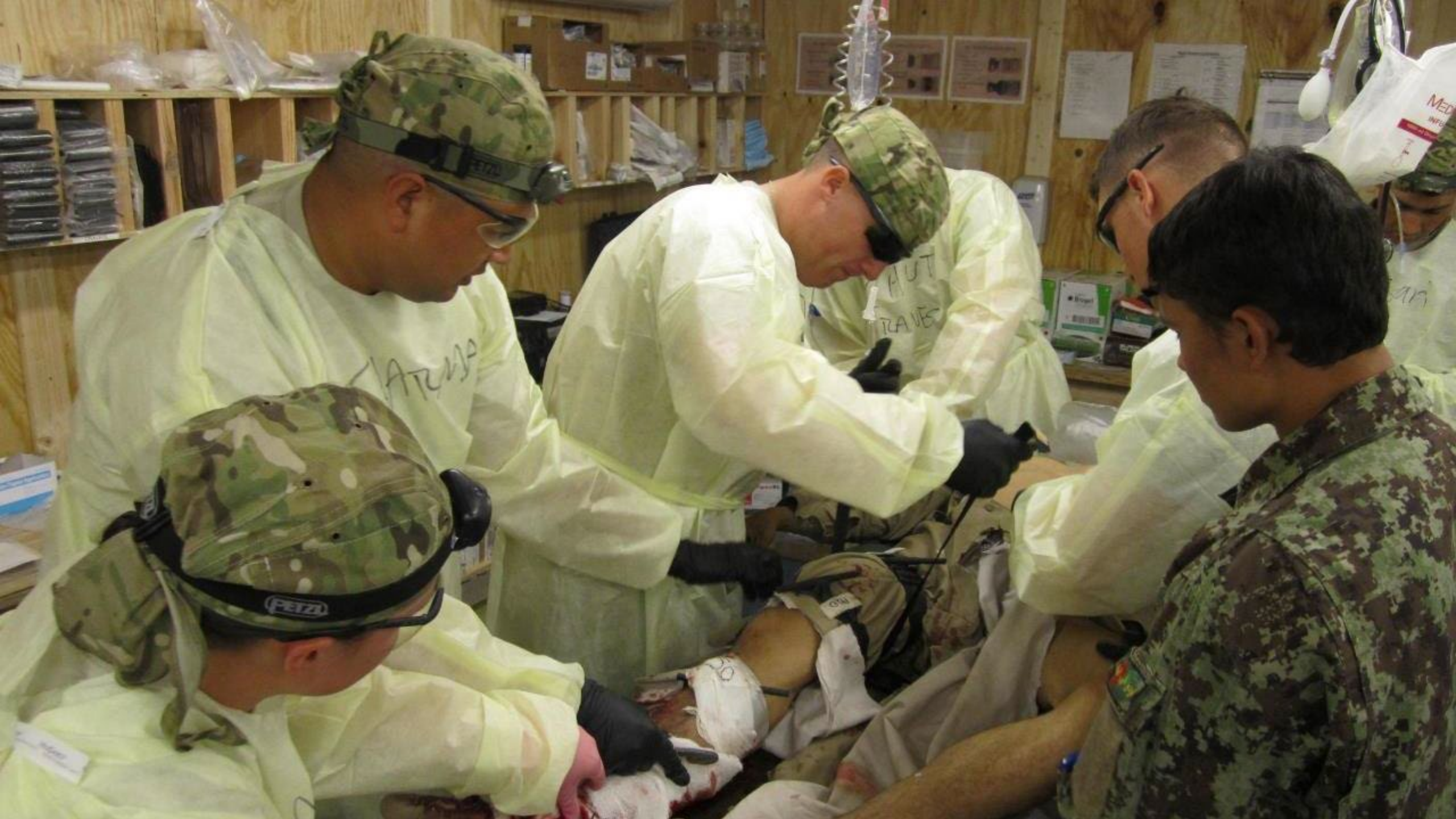
INTEGRITY PERSISTENCE ATTITUDE PROFESSIONALISM
ARMY NAVY AIR FORCE COAST GUARD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I have no conflicts of interest or financial disclosures to disclose in relation to this program or presentation.

Disclosures

Disclaimer

- The views expressed in this talk are mine and mine alone
- These recommendations are for emergency medicine practices
- There may be similarities to coding in other practice settings
- Consider primarily following any practice-specific requirements
- No financial benefit from you using any of the resources mentioned
- Recommend against buffing your workup; keep providing great, appropriate care
- Things can change

Objectives

- Background
- The Why
- Selecting an E/M Code
- Level 5 Encounters
- Level 4 Encounters
- Other Encounters
- There’s An App For That
- Resources
- Summary & Conclusion

Agenda

- Background
- The Why
- Selecting an E/M Code
- Level 5 Encounters
- Level 4 Encounters
- Other Encounters
- There’s An App For That
- Resources
- Summary & Conclusion

Background

- On 1/1/2023, AMA & CMS instituted a major change to the way emergency department visits capture the complexity of their visits
- Summarized in *AMA CPT Evaluation & Management (E/M) Code and Guideline Changes* document; further clarifications published monthly in *CPT Assistant* ($)
- Unofficial guidance also suggested by ACEP Coding and Nomenclature Committee; last update in November 2023
- Goal was to simplify, increase clinical relevance, & “get rid of the junk”

So Why Are People Doing Stuff Like This?

Any old chart reviewed: The patient has been made a 3 times recently in the past month for perinephric abscess, has been noncompliant with his medications, CHF exacerbation although his echocardiogram is normal.
Patient has a past medical history of Asthma, Depressive disorder, not elsewhere classified, Diabetes, Hypertension, and Schizophrenia.

Discussed care ☐ consultant ☐ hospitalist for admission they accepted patient ☐ social worker for resources Reviewed external records ☐ EMS ☐ Nursing home ☑ Admission ☐ Clinic visit Diagnostic test considered using clinical decision rule ☐ PERC ☐ Canadian Head Injury ☐ other	Chronic Illness impacting care ☑ Diabetes ☑ HTN ☐ Substance use disorder ☐ COPD ☐ CAD ☐ Other Care affected by social determinates ☑ homelessness ☑ no insurance Test interpretation discussed with ☐ consultant ☐ radiology Consideration of admission ☐ EDOU ☐ Inpatient

Background

- New vs established patients are not coded differently
- Time is no longer a factor in coding levels except for critical care, obs
- A “medically appropriate” history and/or physical exam should be performed and documented **for coding purposes**
  - The nature and extent are up to you **for coding purposes**
  - No more requirements for data points in history, ROS, or physical exam
  - This is separate from performing and documenting a good history and exam that medicolegally supports decision-making and continuity of care

So What Determines Your E/M Level?

CAUTION

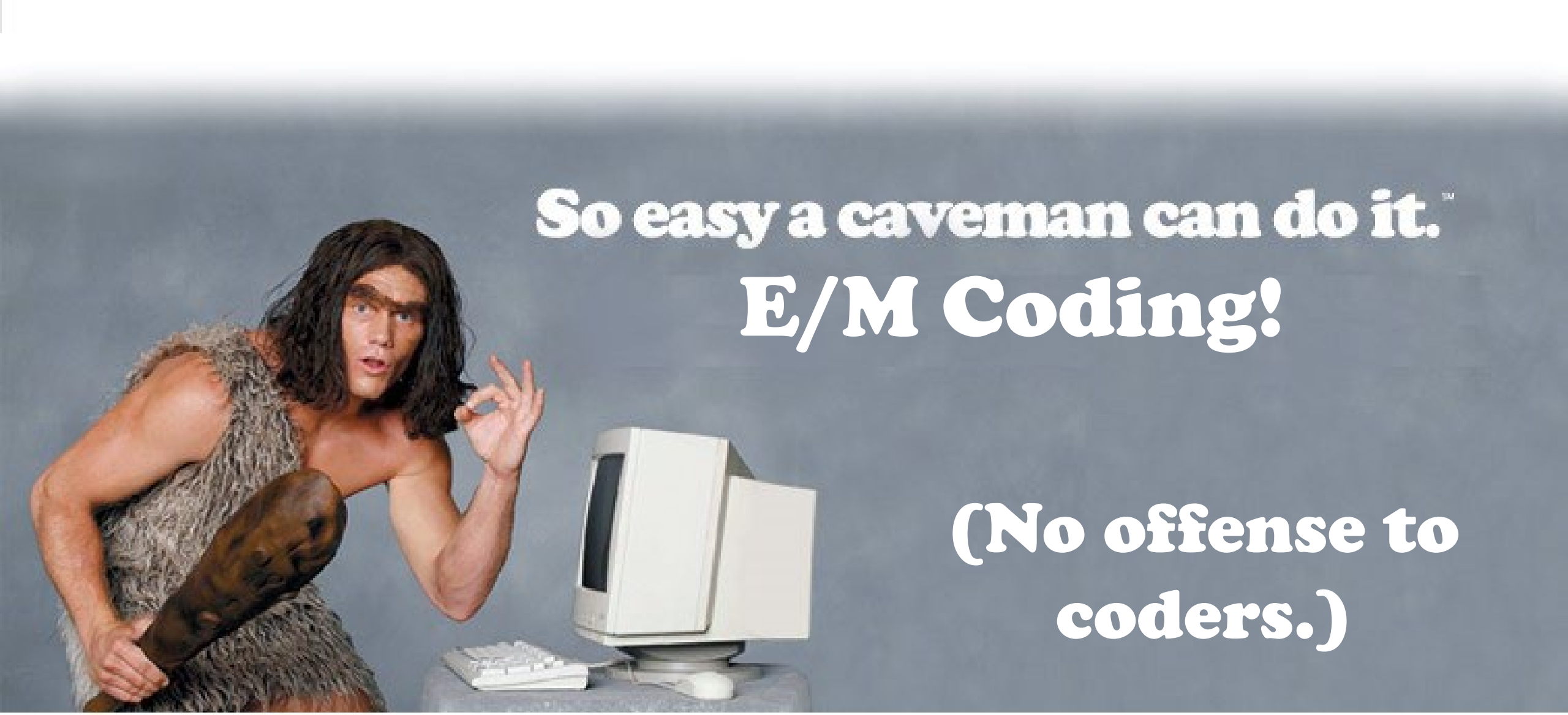
THIS MACHINE
HAS NO BRAIN
USE YOUR OWN

The WHY

- We do really hard work in emergency medicine that is under-recognized
- But the EMR cannot read your mind and capture your thought process
  - You get “credit” for when the **potential** for badness was there and you worked it up, but it ultimately wasn’t there
  - You get “credit” for when disposition (obs, admission) and diagnostics (CT, x-ray, labs) were reasonably **considered** but ultimately not pursued
- Billers and coders have a different education base & skill set than we do

The WHY

- The business of medicine – NPs bring value – or they don't
- Higher E/M coding -> higher RVUs -> more value
- RVUS or pts/hr may factor into your compensation plan
  - You may have RVU targets; you may have pts/hr targets
  - In the end, more RVUs & less charting -> more pts/hr
- This is not hard; it’s just new


So easy a caveman can do it.™
E/M Coding!
(No offense to coders.)

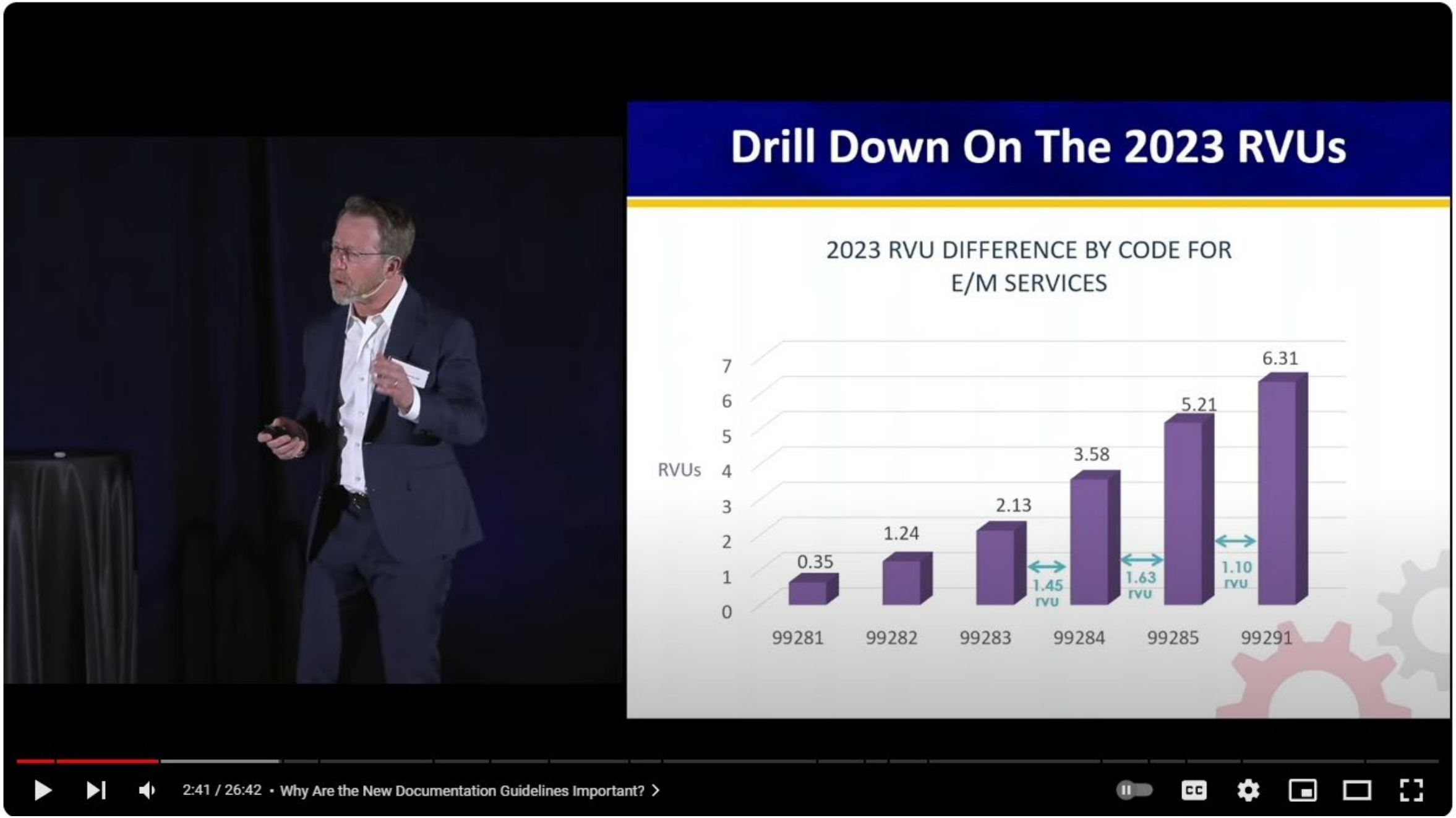
Selecting an Evaluation & Management (E/M) Code

- There are only five E/M codes for ED visits; all depend on your MDM
- 99281 – Emergency department visit for the evaluation and management of a patient that **may not require the presence of** a physician or other qualified **health care professional**
- 99282 – ED visit requiring straightforward medical decision-making
- 99283 – ED visit requiring low medical decision-making
- 99284 – ED visit requiring moderate medical decision-making
- 99285 – ED visit requiring high medical decision-making

Selecting an E/M Code

- Level 1 – 9928**1** – admin / non-medical complaint (rare)
- Level 2 – 9928**2** – straightforward MDM
- Level 3 – 9928**3** – low MDM
- Level 4 – 9928**4** – moderate MDM
- Level 5 – 9928**5** – high MDM
- No matter how much you chart, you will end up with one of these 5 codes. (Not counting critical care patients or observation patients)

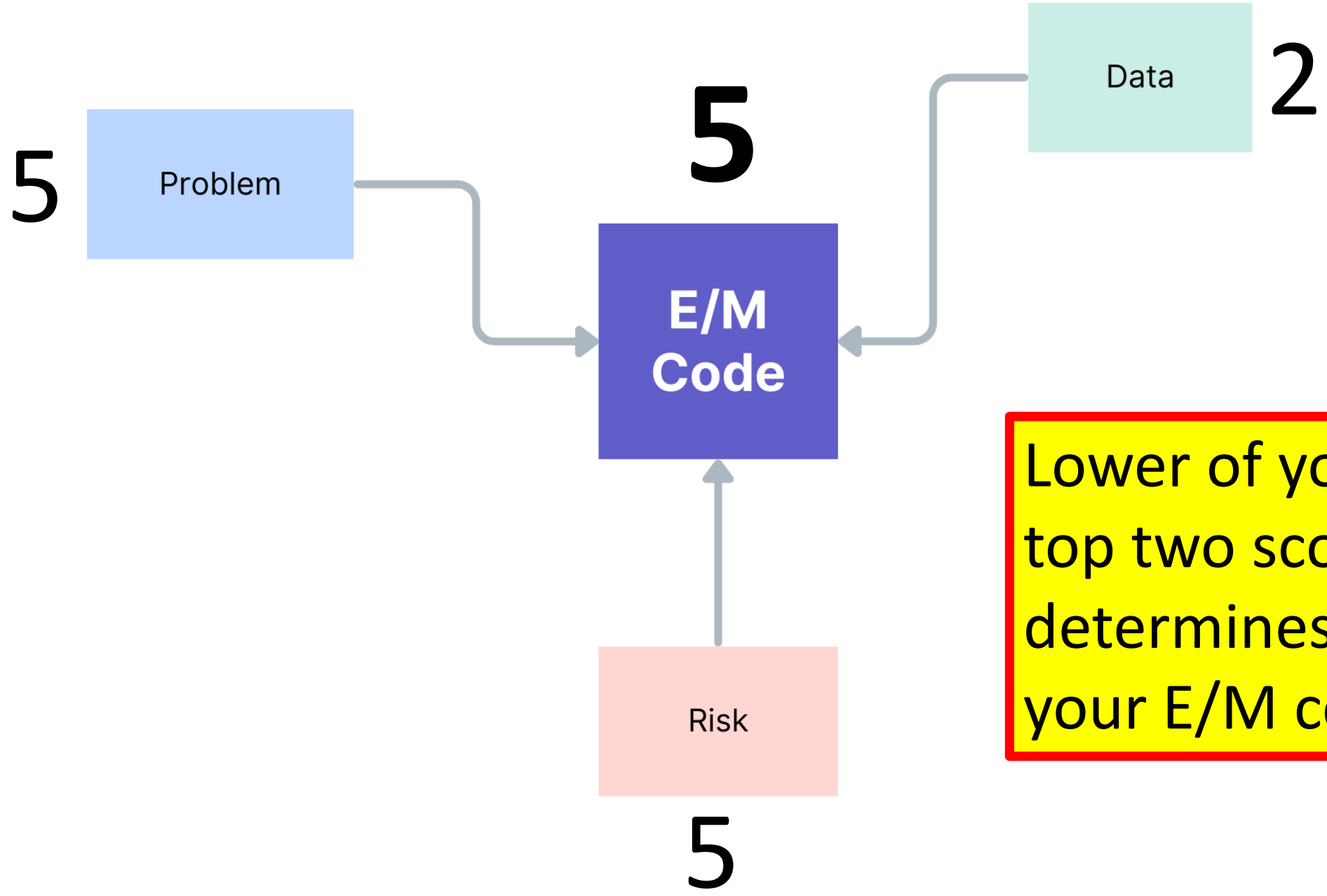
youtube.com/watch?v=F-zGnlUoKzk



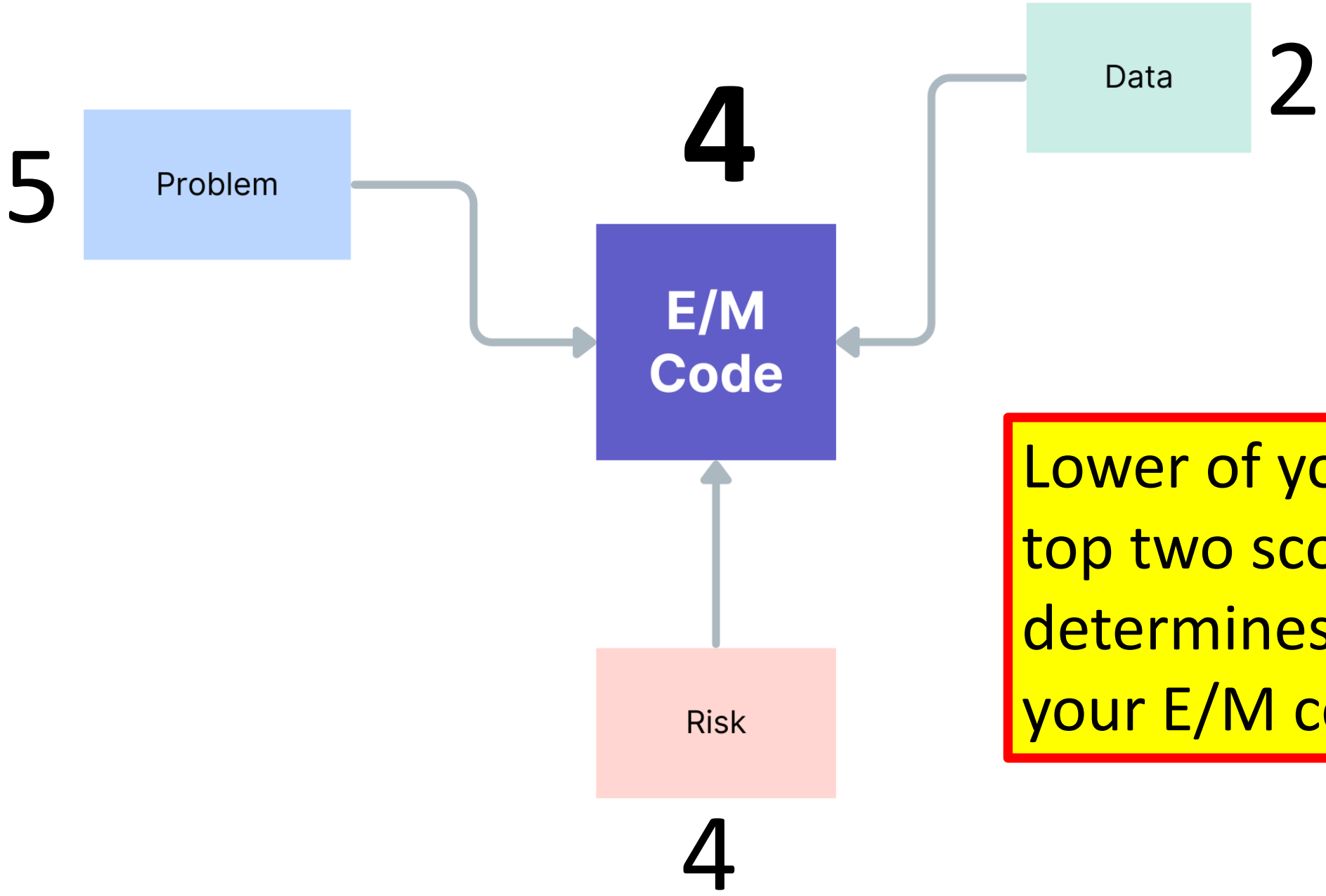
ED Documentation Changes 2023: Keeping Your Shirt | The Emergency Department Leadership Conference

Selecting an E/M Code

- Final E/M code depends on your score in three MDM **elements**
- “Problem, “Risk,” and “Data”
- These are also scored at Levels 1-5
- Lower of your top two scores determines your E/M code



Lower of your top two scores determines your E/M code



Lower of your top two scores determines your E/M code

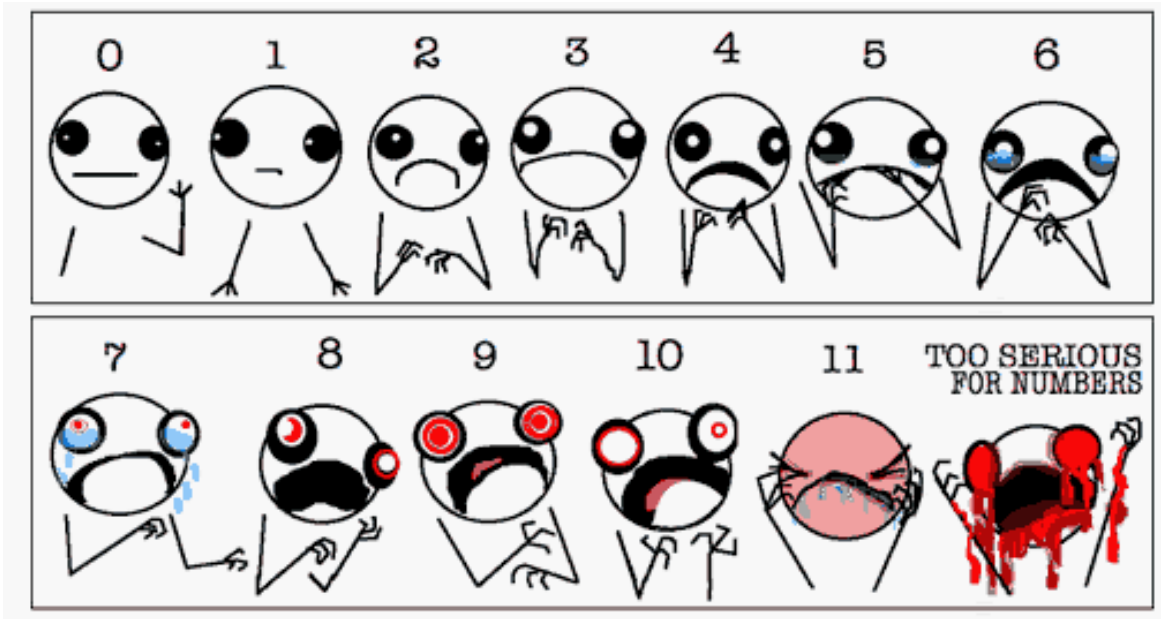
The Elements

- **Problem** – “number and complexity of **problems** addressed (COPA)”
  - Anything they come in concerned about **or** anything you discover
  - We may be missing out on a lot of value here
- **Risk** – “**risk** of complications and/or morbidity/mortality of pt mgmt”
- **Data** – “amount and/or complexity of **data** to be reviewed/analyzed”
  - Where most people probably overchart

Level 5 Problem

- **Chronic illness** (expected duration of 1 year or until death of patient) **with severe exacerbation, progression, or side effects of treatment**

- How “severe” is severe? It’s kind of up to you and the patient.



Level 5 Problem

- **Illness or injury that poses a threat to life or bodily function**
- You get credit even if reasonable **potential** was there.
- Our job in EM is to consider these kinds of illnesses/injuries
- Per ACEP:
  - “Advanced lab” (trop, BNP, d-dimer, lactate) suggests potential high severity
  - “Complex diagnostic study” (CT, US, MRI) suggests potential high severity
  - Consultation to specialist because you were concerned about life/fxn threat
  - You reasonably considered hospitalization

Level 5 Problem

- **Illness or injury that poses a threat to life or bodily function**

- ACEP: Level 5 “should be considered” for **possible**:

Ectopic pregnancy	Ocular emergencies	PE	CHF
Acute intra-abdominal infection/inflammatory process			ICH
BH decompensation	Cardiac arrhythmia	Cardiac ischemia	
Significant blood loss	DKA or other significant diabetic complication		
Significant eye injury	Significant fx/dislocation	Significant infection	
Significant metabolic disturbance	GI obstruction	Torsion	
Kidney stone with potential complications			

Level 5 Risk

- **<u>Parenteral</u> controlled substances**
  - Opioids
  - Benzodiazepenes
  - Ketamine
  - Phenobarbital
- **Decision regarding hospitalization or escalation of hospital-level of care**
  - A pt who you truly considered hospitalizing but otherwise left still meets Level 5 Risk
- **Drug therapy requiring intensive monitoring for toxicity**
- **Decision not to resuscitate or to de-escalate care b/c of poor prognosis**

Level 5 Risk

- **Decision regarding elective major surgery with identified patient or procedure risk factors**
  - Elective – planned in advance for the future

- **Decision regarding emergency major surgery**
  - Emergency – immediately or with minimal delay

Level 5 Risk

- What's the difference between major & minor surgery?
- AMA: "The classification of surgery… is based on the common meaning of such terms when used by trained clinicians. These terms are not defined by a surgical package classification."
- So… it's kind of up to you.

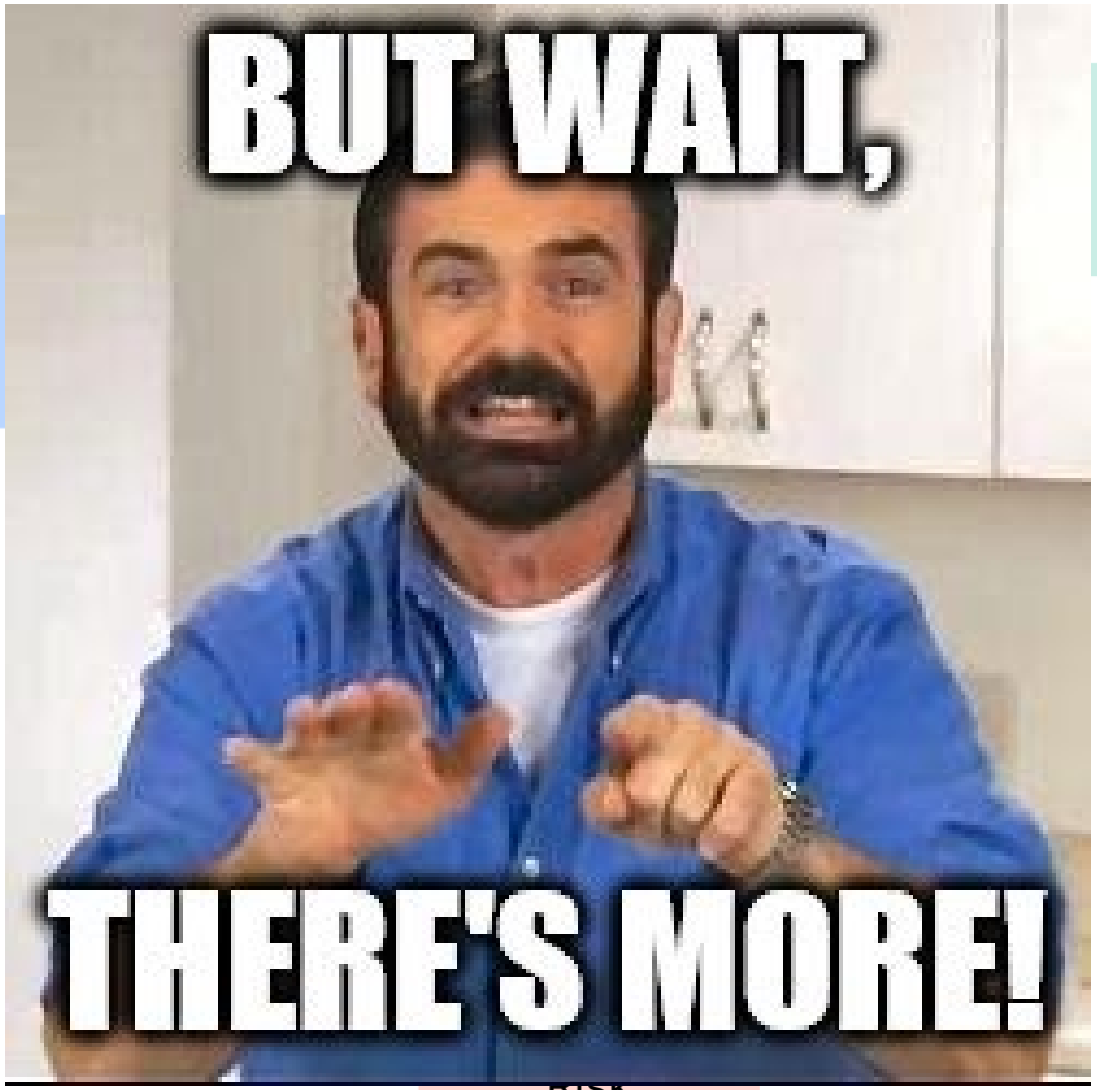
Level 5 Risk

- Anything else help to determine risk?
  - ACEP: “AMA/CPT indicated that it would be impossible to list all the possible patient management decisions in the MDM grid. . .

    The examples listed in the risk column are not exhaustive and may not be the only patient management decisions to be taken into account when establishing the level of risk when calculating the E/M service.”
- In short… it’s kind of up to you.

Categories!

Problem Element



Data Element

Risk Element

Level 5 Data

- For a Level 5 Data element, you must fulfill two out of three categories:
  - **Consult** – aka “discussion of management or test interpretation with external physician / other appropriate source”
  - **Independently interpret** a test where an interpretation/report usually follows
  - **Tests / documents / independent historians** – at least 3 from the following:
    - Order a unique test – each unique test is 1 pt
    - Review the results of a unique test – each unique test is 1 pt
    - Review of prior external notes – each note is 1 pt
    - The pt’s assessment requires independent historian/s – 1 pt only, regardless of # of historians
- If you **do not either consult or independently interpret** a test, it is **impossible to get a Level 5 Data** score

Level 5 Data – “Consult” Tips

- **Interactive** exchange directly with HCW on another service

Counts

- Talking **or messaging** with EM clinician in another department (observation / urgent care)
- Talking **or messaging** with EM clinician at another hospital

Doesn’t Count

- Talking to fellow EM PA/NP or EM physician on your service
- Reading a chart
- Taking message from or talking with “nonclinical intermediary,” family, informal caregiver

Level 5 Data – “Independently Interpret” Tips

- Common things we can independently interpret are EKGs, imaging
- Labs are not counted as things we independently interpret
  - From a billing perspective, it’s assumed that if we ordered a lab, we’re interpreting the result
  - Medically / medicolegally, consider still documenting your medical decision making regarding your interpretation of your labs

Level 5 Data – “Independently Interpret” Tips

- One way of documenting independent interpretation would be:

  “___(Test)___ independently interpreted by me: _____”

- You do not have to interpret @ level of cardiologist or radiologist
  - Write about presence/absence of things pertinent to you
  - Fracture, dislocation, radio-opaque FB, soft tissue swelling
  - Pneumothorax, effusion, infiltrate, consolidation, cardiomegaly
  - Wave morphologies, intervals, ST segment / T-wave abnormalities, “killer” EKG patterns

Level 5 Data – “Tests/Documents/Historians” Tips

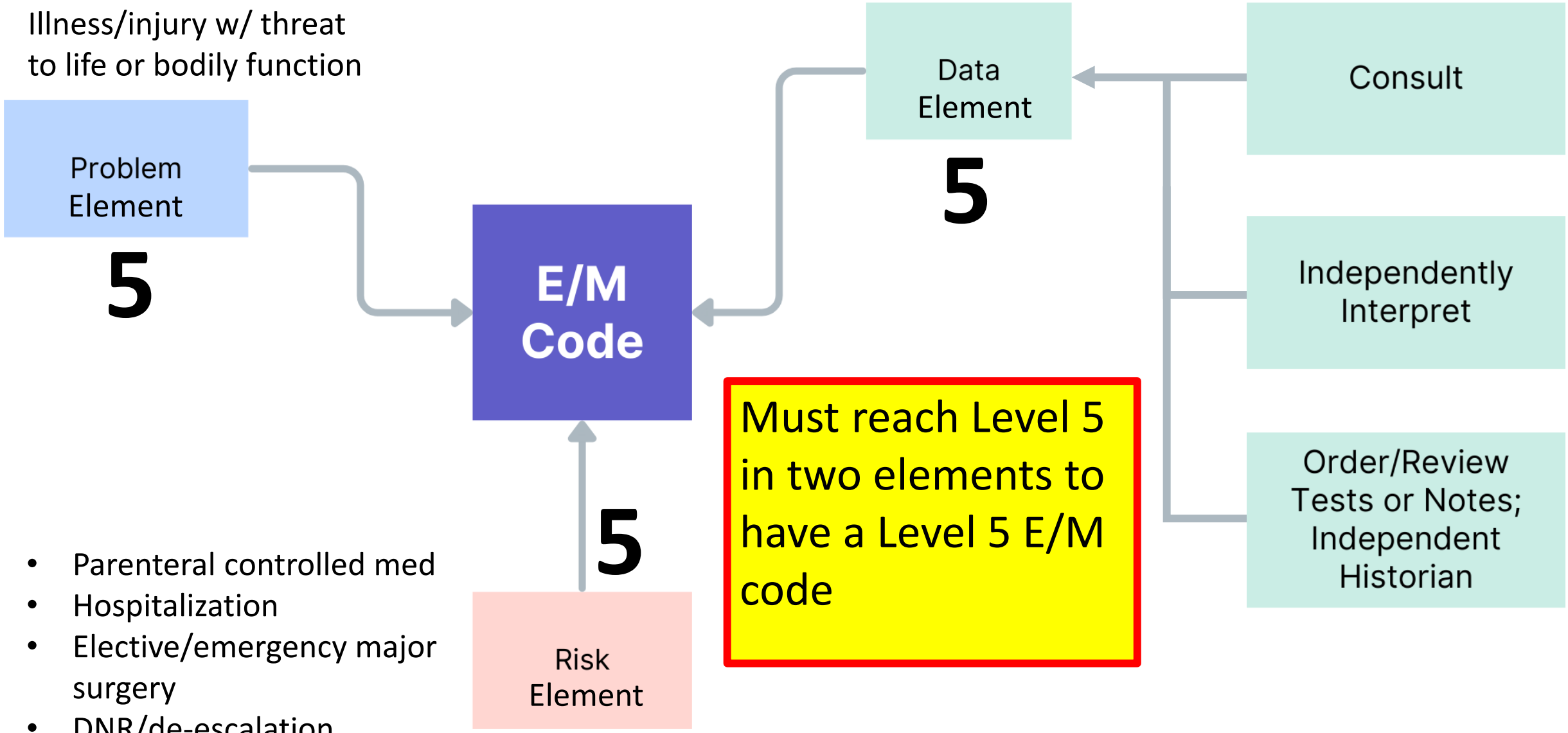
- Once you count to 3 in this category, **you fulfill it for coding**
- If multiple labs/images are under one CPT code, it’s considered one test (ex: CMP, 2/3/4-view imaging of a particular structure, CT w/ & w/o contrast)
- Serial tests of the same kind only count as one test (POC glucose, EKG)
- If **you order** tests it is also assumed you **reviewed** them – no double-counting
- Reviewing results ordered by **other** clinicians on **this/previous** visit counts
- If you considered test but clinically ruled out the need, it still counts
- If you considered test but didn’t after shared decision-making, it still counts

Level 5 Data – “Tests/Documents/Historians” Tips

- Note reviewed must be from **external** service to count towards reviewing prior external notes – UC, observation, psych, hospitalist, clinic, other ED
- Reviewing the PDMP counts as 1 external note
- For **all** the independent **historians** you interview…

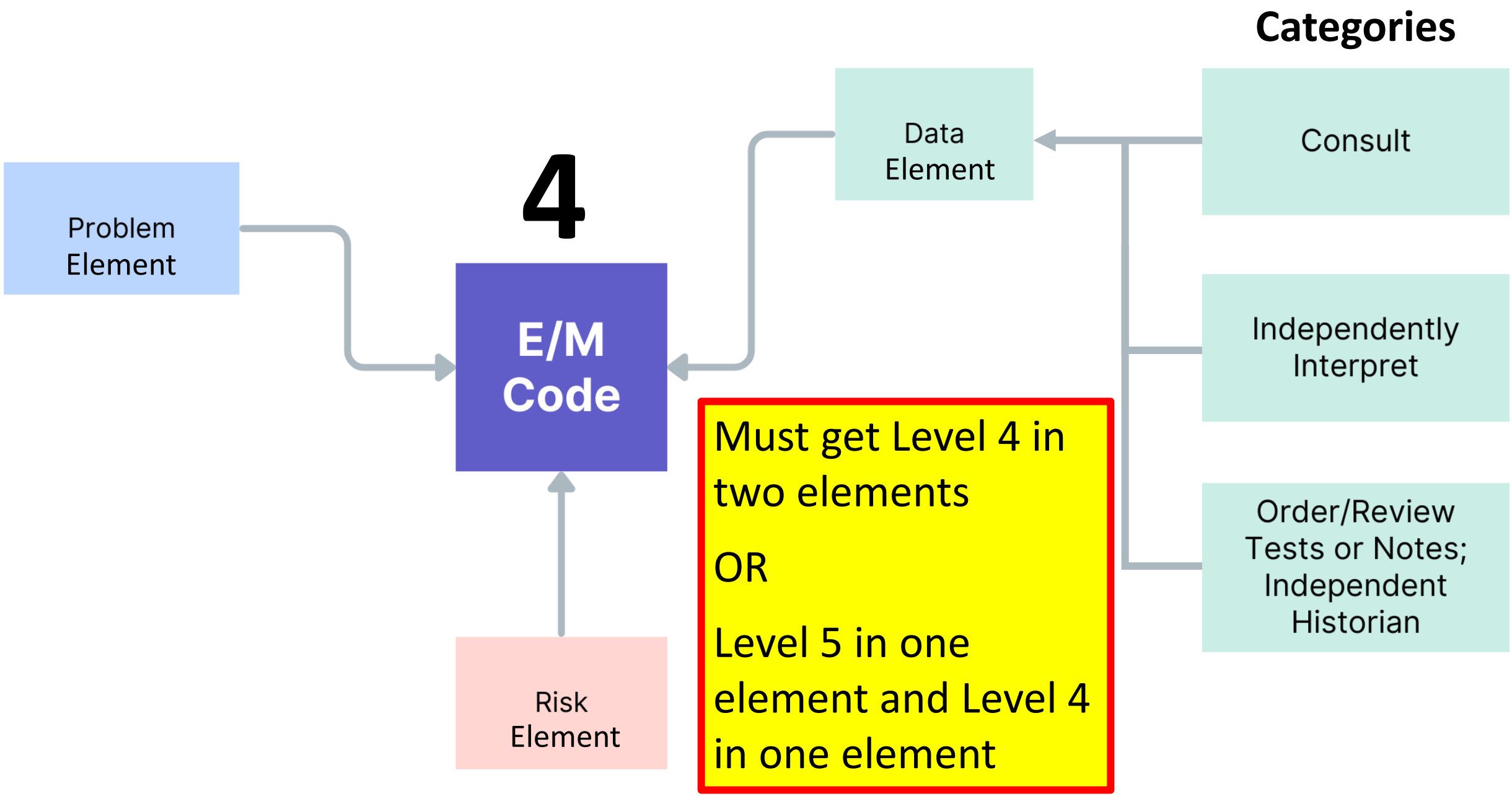
  - Independent historians can be used when the patient can’t provide a complete/reliable history for any reason (development, AMS, urgency)
  - This can be EMS, a parent or other guardian, a spouse, or a witness – must obtain history directly from the historian
  - An interpreter is not considered an independent historian

- Chronic illness w/ severe complication
- Illness/injury w/ threat to life or bodily function



2+ Categories

- Parenteral controlled med
- Hospitalization
- Elective/emergency major surgery
- DNR/de-escalation


Categories
4
Problem Element
E/M Code
Data Element
Consult
Independently Interpret
Order/Review Tests or Notes; Independent Historian
Risk Element
Must get Level 4 in two elements
OR
Level 5 in one element and Level 4 in one element

Level 4 Problem

- **Chronic illness with exacerbation**
  - Ex: HTN above goal, DM with hyperglycemia, chronic pain w/ exacerbation
- **2+ chronic illnesses at baseline,** to include behavioral health d/o
- **Undiagnosed new problem with uncertain outcome**
  - A problem that potentially "represents a condition likely to result in high risk of morbidity without treatment"
  - Ex: undifferentiated chest or abdo pain, or headache (or could it be Level 5?)
- **Acute illness with systemic symptoms**
  - Illness must have high risk of morbidity without treatment
  - Ex: pyelonephritis with fever, chills, fatigue, myalgia, or N/V

Level 4 Problem

- **Acute complicated injury** – an injury:
  - Which requires eval of other body systems not part of the injured organ
  - That is extensive, OR
  - For which tx options are multiple and/or associated with risk of morbidity

  - Ex: head injury requiring evaluation for intracranial emergency
    chest or abdominal injury requiring evaluation for injury to internal organ
    injury to multiple areas of the body

  - ACEP: accidents/injuries that required imaging to rule out significant conditions are considered **complicated**, regardless of final dx

Level 4 Risk

- **Prescription drug management** – includes:
  - Giving rx-level med in the ED (incl lidocaine inj, tetanus booster, rabies vax)
  - Prescribed meds to be filled at pharmacy (ibuprofen 400mg considered OTC)
  - **Continuation** / discontinuation / modification of patient's existing rx meds
- **Decision re: minor surgery with identified pt/procedure risk factors**
- **Decision re: elective major surgery w/o pt/procedure risk factors**
- Again, it's kind of up to you what constitutes major/minor surgery

Level 4 Risk

- **Diagnosis or treatment significantly limited by social determinants of health (SDOH)**
  - SDOH – any social or economic condition that may significantly limit dx/tx
  - Examples: homelessness, unemployment, un/underinsured, substance use d/o, in custody of law enforcement, poor health literacy
  - Just stating the presence of SDOH is not enough; limitations should be discussed
  - Examples of limitations: inability to afford rxed meds, inability to obtain needed surgery or otherwise access health care
  - ICD-10 code for the SDOH is not required to be listed as part of final diagnosis
  - Language barrier / need for interpreter does not count

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Advancing Health in America

Table 1
ICD-10-CM Code Categories

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z58 – Problems related to physical environment	Inadequate drinking-water supply, and lack of safe drinking water.
Z59 – Problems related to housing and economic circumstances	Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.
Z60 – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
Z62 – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, personal history of unspecified abuse in childhood

Google
"AHA SDOH Z codes"

WHOMELESS

Z59.0 Homelessness – increases complexity and risk due to inability to follow up with a practitioner or clinic; likewise, inability to contact the patient with confidence if follow up needs adjustment or medications need a variance; risk is higher that the patient will not fill medications and find a safe place for repeated doses and maintenance of medication hygiene so that it doesn't become ineffective due to moisture/light/heat. Discharge from the ED delayed/complicated by finding a shelter and safe place to stay during recovery.

WILLITERATE

Z55.0 Illiteracy & Low-Level Literacy – increased risk and complexity due to higher risk of noncompliance with general instructions; delays due to longer explanation at discharge of disease and treatment plan; higher risk of noncompliance with medications and risk higher of adverse effects and medication complications from misunderstandings of prescription instructions and warnings.

WLIVESALONE

Z60.2 Problems living alone – increased risk and complexity due to living alone and lack of any healthcare advocate at home to check on compliance with the treatment plan and give independent advice for any further intervention, follow up, help with transportation, and any alteration in care.

WLOWINCOME

Z59.6 Low Income – increased complexity and risk because of difficulty obtaining proper medications, treatment supplies, and transport to see providers for care.

WPOVERTY

Z59.5 Extreme Poverty – increased risk and complexity due to difficulty obtaining supplies for treatment and medications; also more difficulty finding transportation to health care facilities and providers.

WPRISON

Z65.1 Imprisonment & Other Incarceration – increased complexity and risk due to unreliable history related to the incarceration environment and possible repercussions related to other inmates; limited ability to follow up with specialists related to incarceration and increased risk of noncompliance with a treatment regimen while incarcerated.

WRELEASEPRISON

Z65.2 Problems Related to Release From Prison – increased risk and complexity due to lack of any medical record from prison; *delays in discharge due to medication needs and medication reconciliation;* increased risk of noncompliance with a treatment regimen and access to providers and medications after release.

WSUBSTANCEABUSE

(ICD-10 code [F code] will vary depending on Drug of abuse, specified ***) – increased risk and complexity due to hesitancy to give an accurate history in regards to substances of abuse and quantity/frequency of use; higher risk of noncompliance with general instructions; higher risk of noncompliance with prescribed medications and risk is higher of adverse effects and medication complications from drug interactions with substances of abuse.

Level 4 Data

- For a Level 4 Data element, you must fulfill **one** out of three categories you've already seen:
  - **Consult** – aka "discussion of management or test interpretation with external physician / other appropriate source"
  - **Independently interpret** a test where an interpretation/report usually follows
  - **Tests / documents / independent historians** – at least 3 from the following:
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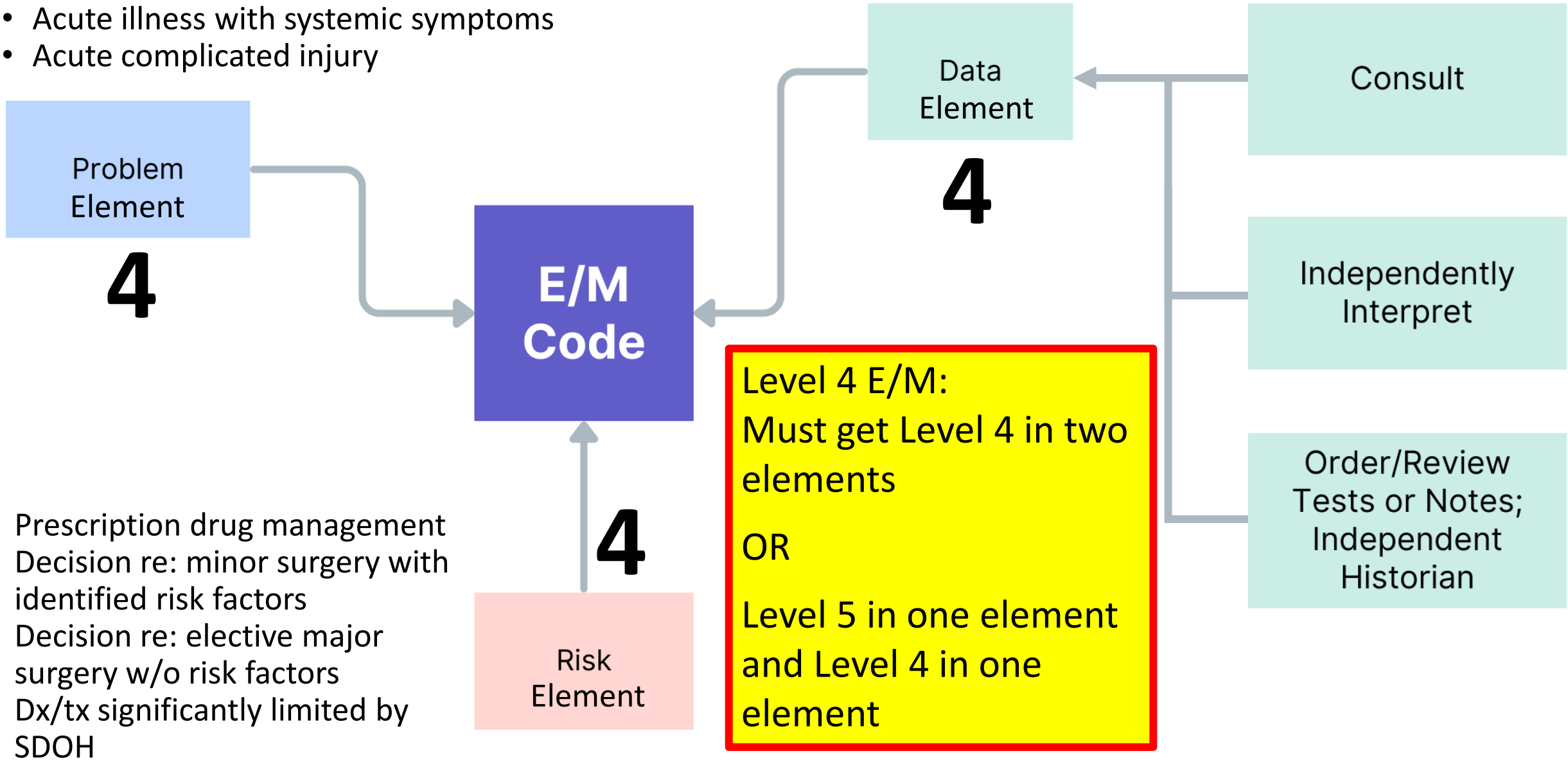
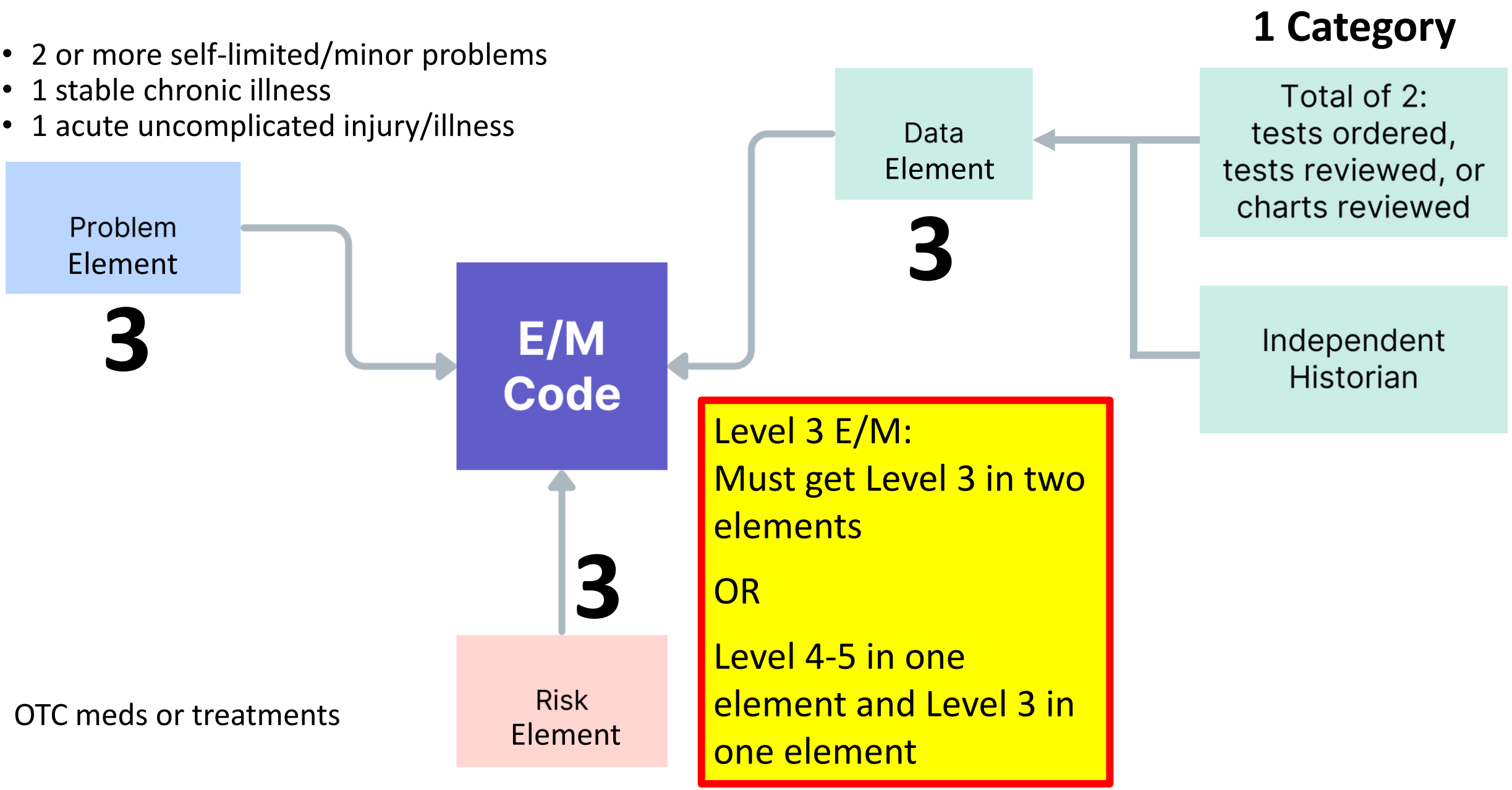
    - Review the results of a unique test – each unique test is 1 pt
    - Review of prior external notes – each note is 1 pt
    - The pt's assessment requires independent historian/s – 1 pt only, regardless of # of historians

- Chronic illness with exacerbation
- 2+ chronic illnesses at baseline
- Undiagnosed new problem with uncertain outcome
- Acute illness with systemic symptoms
- Acute complicated injury



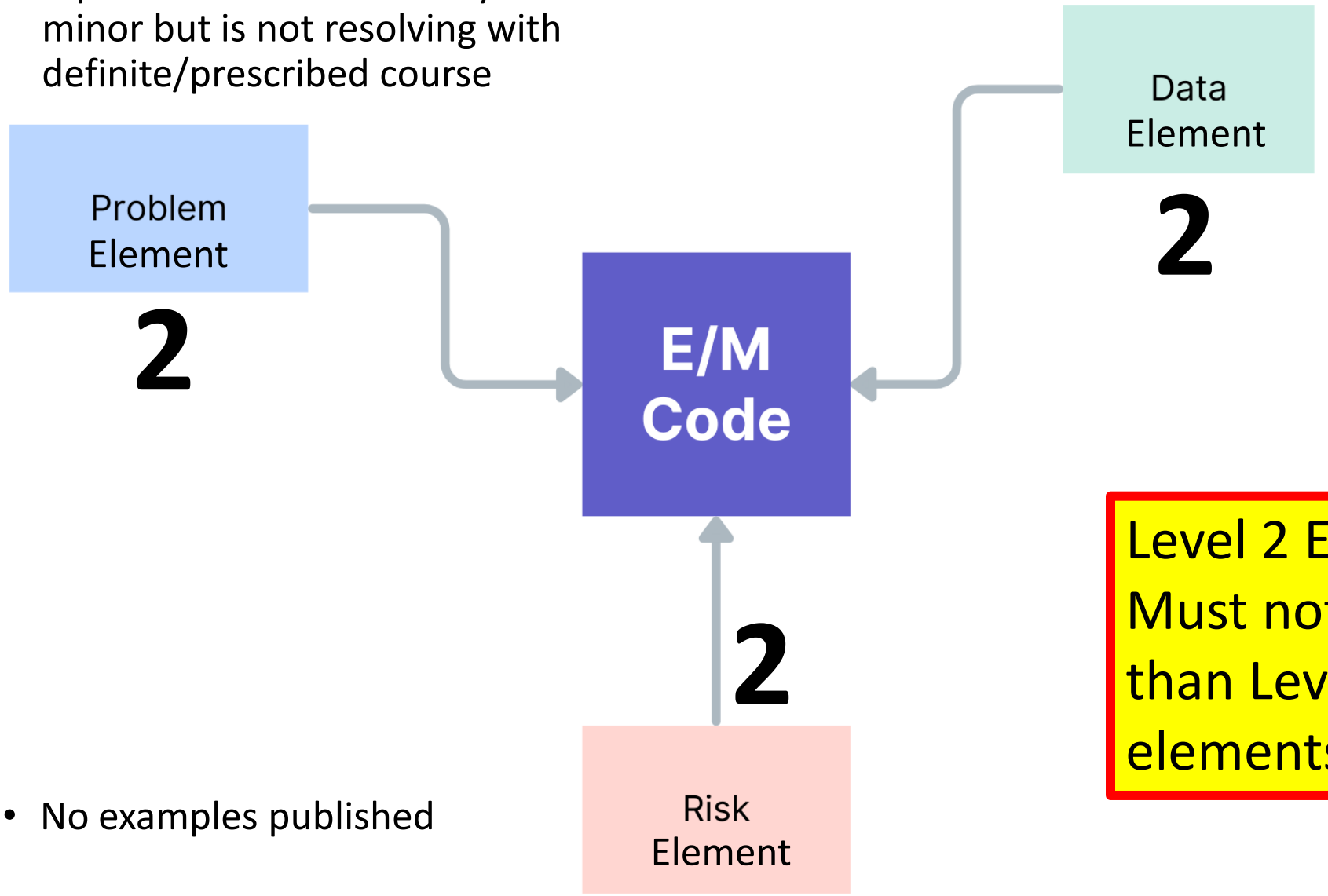
- Prescription drug management
- Decision re: minor surgery with identified risk factors
- Decision re: elective major surgery w/o risk factors
- Dx/tx significantly limited by SDOH

- 2 or more self-limited/minor problems
- 1 stable chronic illness
- 1 acute uncomplicated injury/illness



- OTC meds or treatments

- **1 self-limited/minor problem:**
  A problem that is normally self-limited or minor but is not resolving with definite/prescribed course

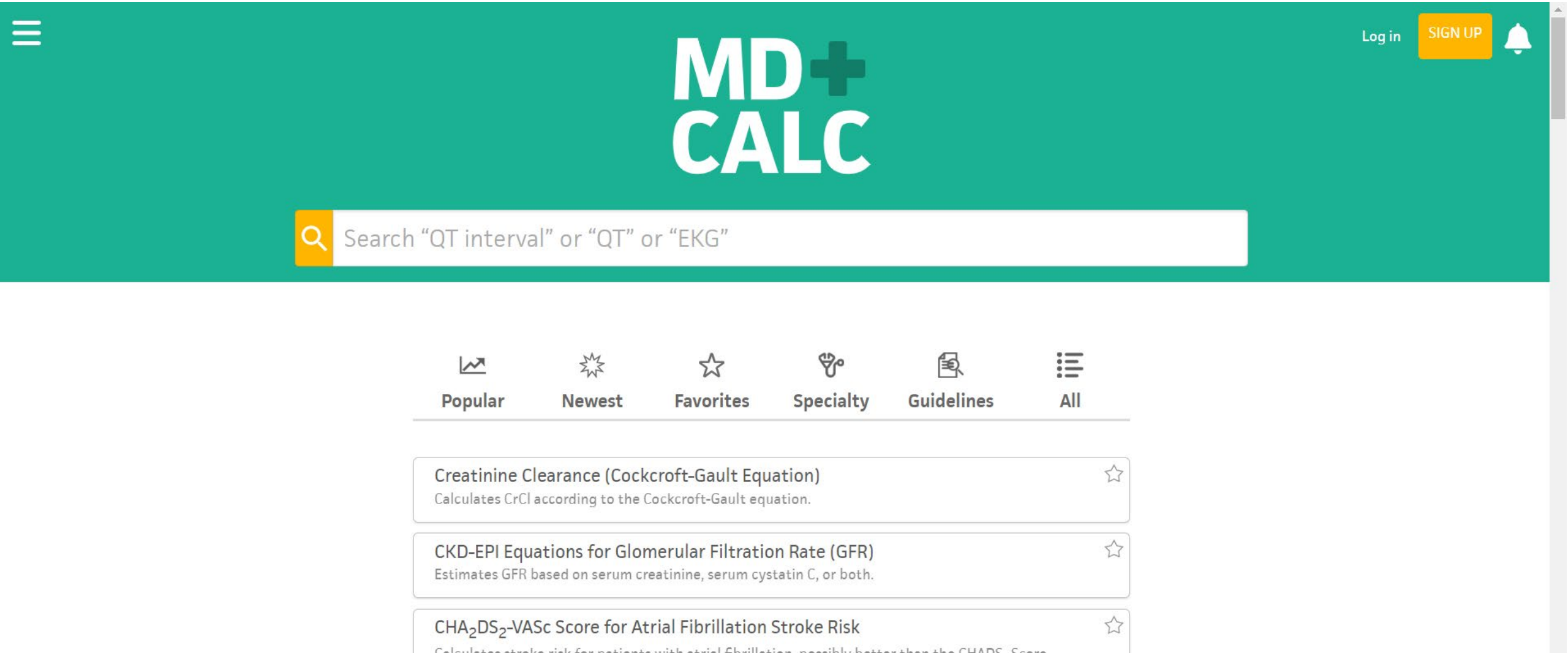


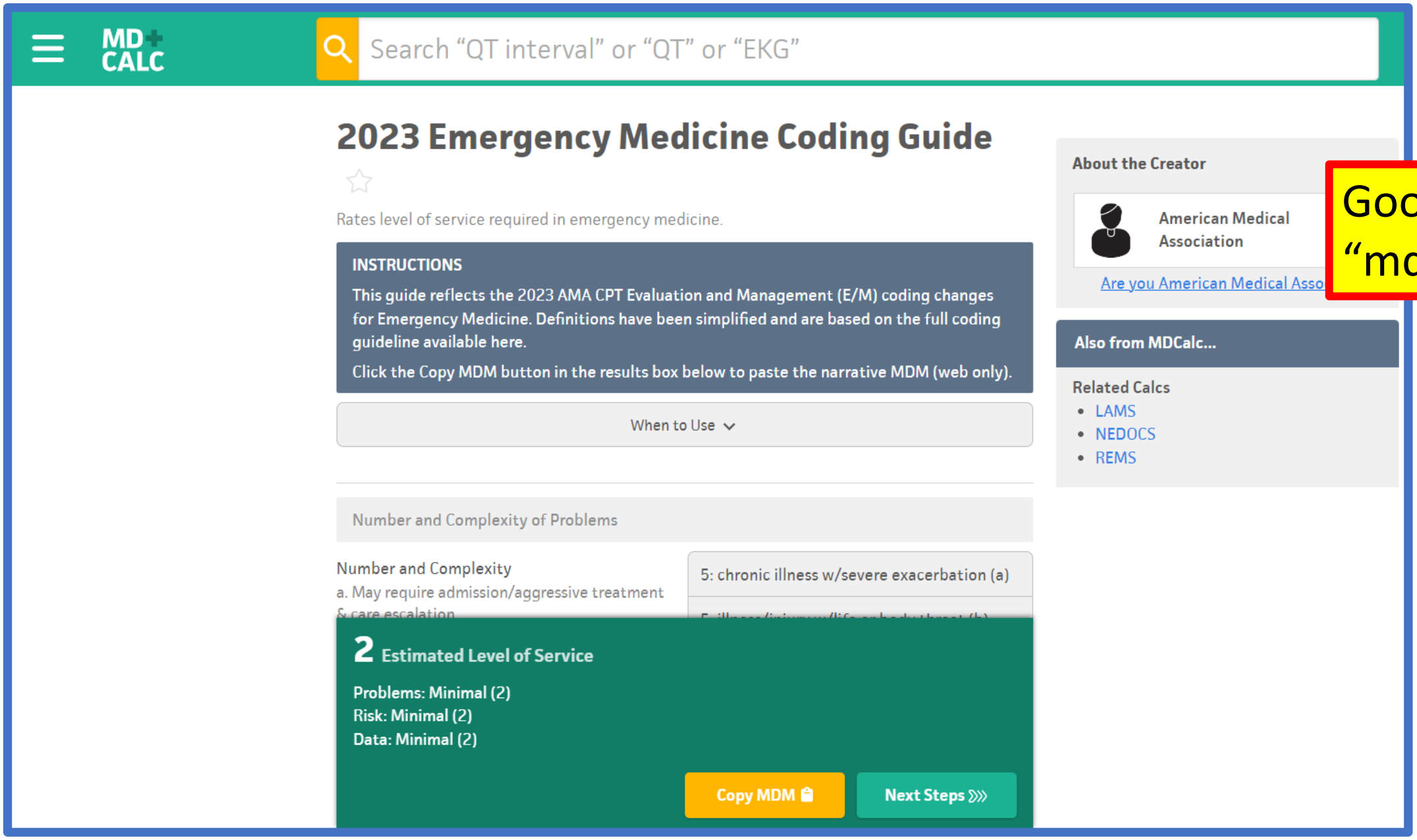
- Minimal or none

- No examples published

Level 2 E/M:
Must not get higher than Level 2 in two elements

There's An App For That





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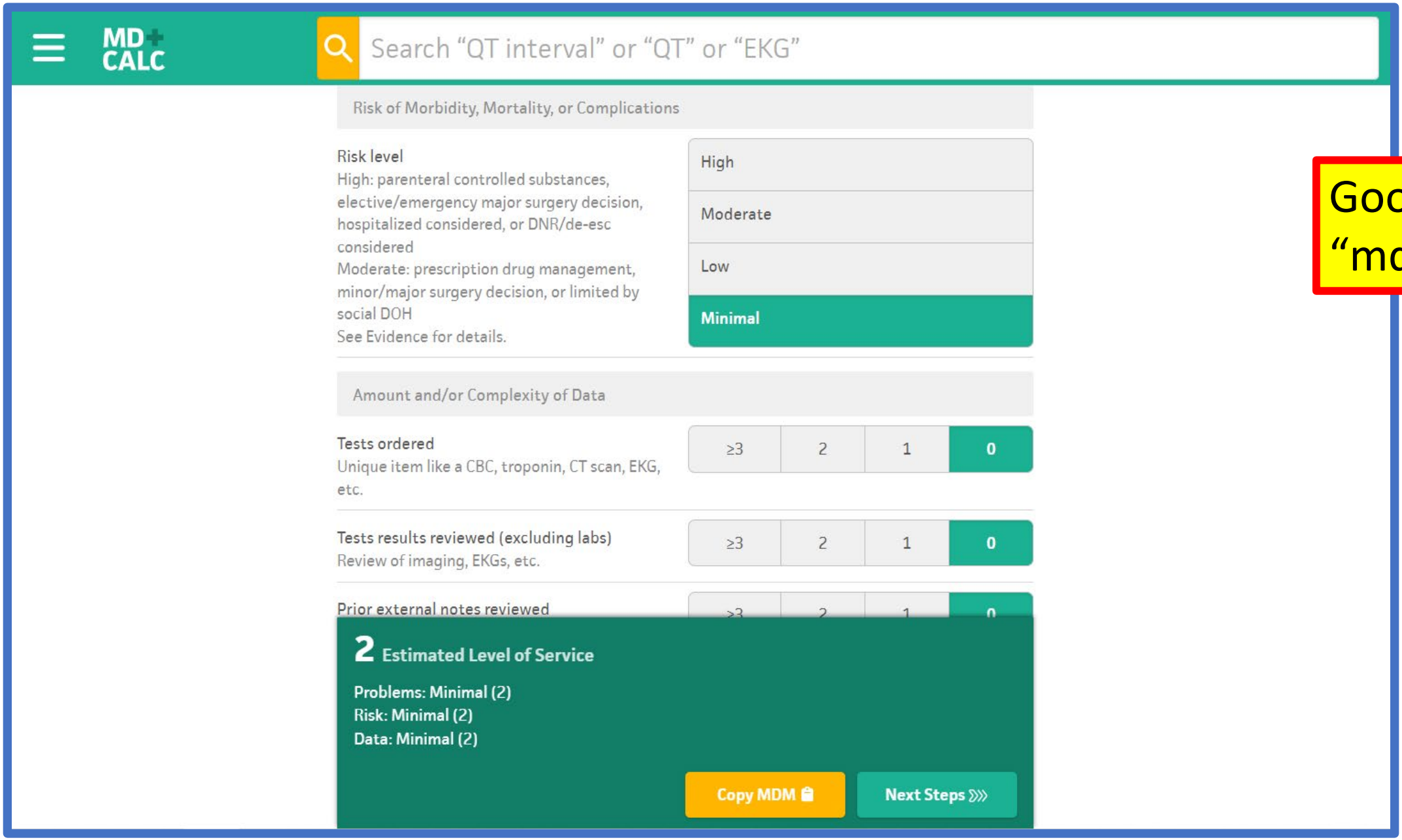

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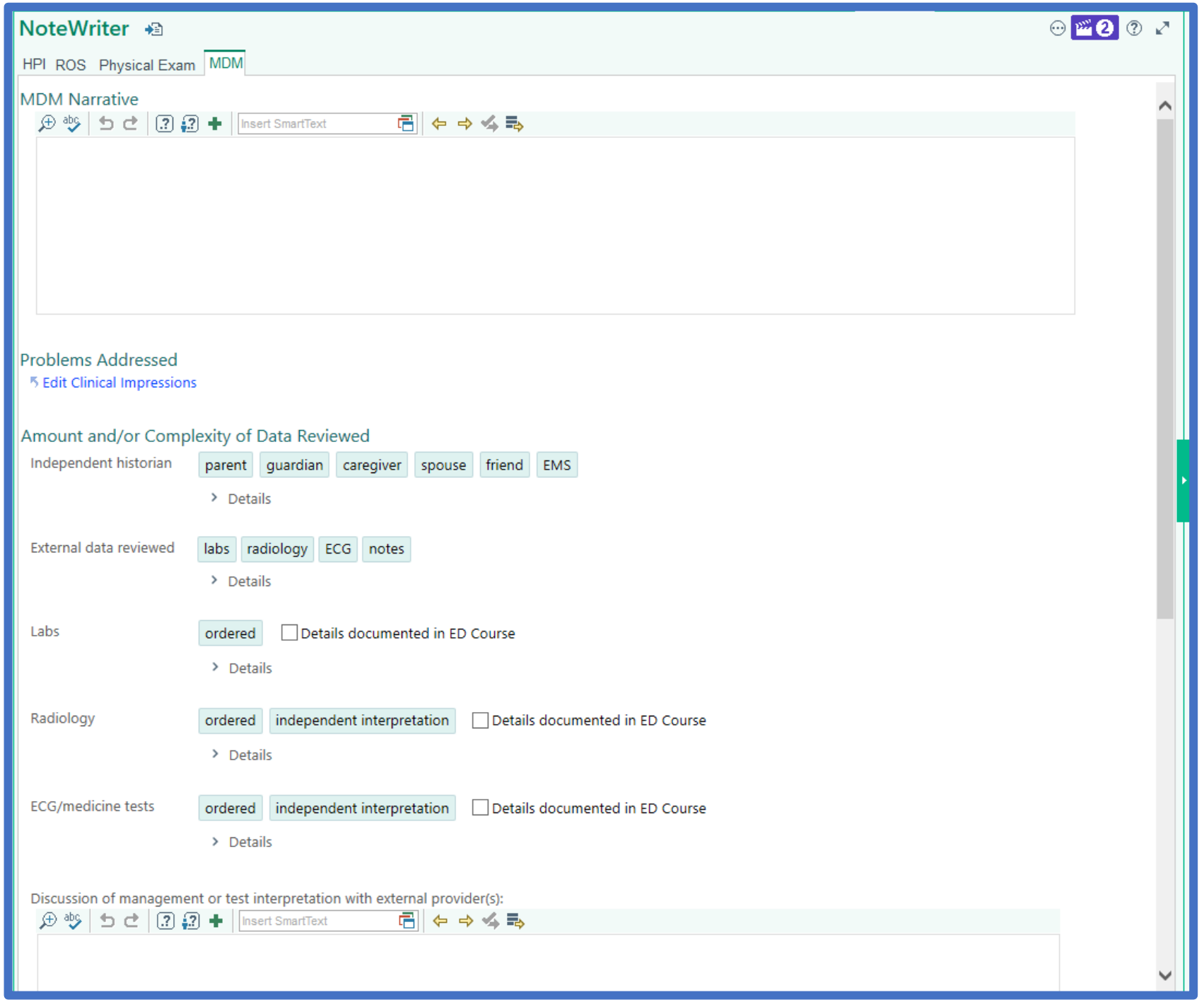

NoteWriter
HPI ROS Physical Exam MDM
MDM Narrative
Insert SmartText
Problems Addressed
Edit Clinical Impressions
Amount and/or Complexity of Data Reviewed
Independent historian
parent
guardian
caregiver
spouse
friend
EMS
Details
External data reviewed
labs
radiology
ECG
notes
Details
Labs
ordered
Details documented in ED Course
Details
Radiology
ordered
independent interpretation
Details documented in ED Course
Details
ECG/medicine tests
ordered
independent interpretation
Details documented in ED Course
Details
Discussion of management or test interpretation with external provider(s):
Insert SmartText

Assessment requiring and independent historian
Independent historian: anyone who provides additional information patient can't provide, does not include interpreters

No | Yes

Independent interpretation of tests
Test interpreted by ER doctor but formal read will be done (and billed for) by another HCP

No | Yes

Discussed management/test interpretation w/external professional
With external physician/other qualified health care professional/appropriate source, not separately reported

No | Yes

5 Estimated Level of Service

Problems: High (5)
Risk: Moderate (4)
Data: Extensive (5)

Copy MDM | Next Steps

» Next Steps | Evidence | Creator Insights

American Medical Association

Are you American Medical Association? Send us a message to review your photo and bio, and find out how to submit Creator Insights!

NoteWriter

HPI ROS Physical Exam MDM

MDM Narrative

Insert SmartText

5 Estimated Level of Service
Problems: High (5)
Risk: Moderate (4)
Data: Extensive (5)

Problems Addressed

Edit Clinical Impressions

Amount and/or Complexity of Data Reviewed

Independent historian: parent | guardian | caregiver | spouse | friend | EMS

Details

External data reviewed: labs | radiology | ECG | notes

Details

Labs: ordered | Details documented in ED Course

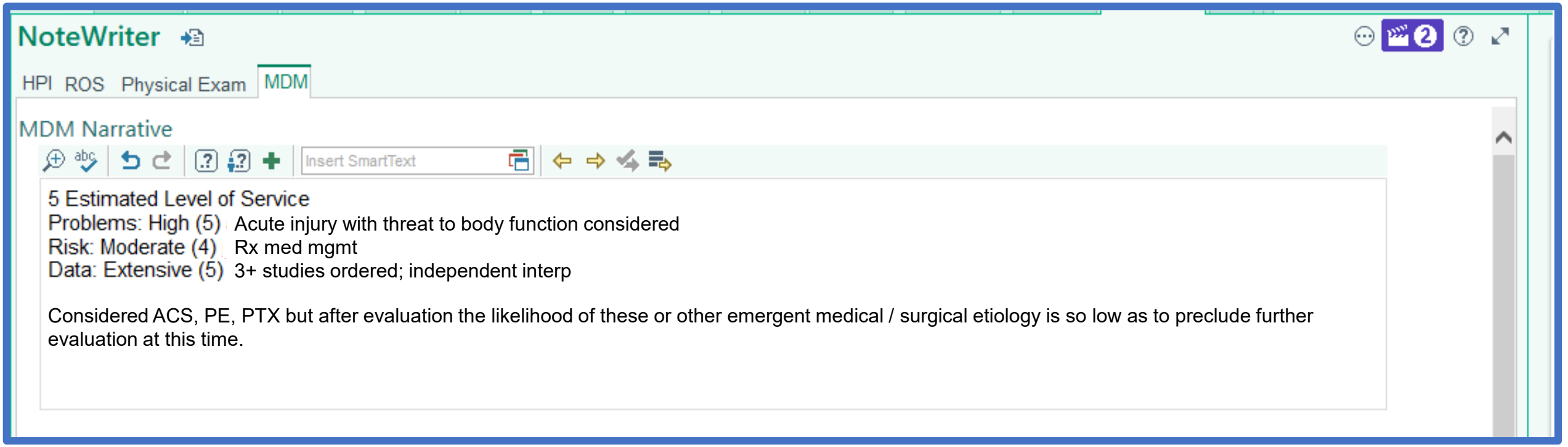
Details

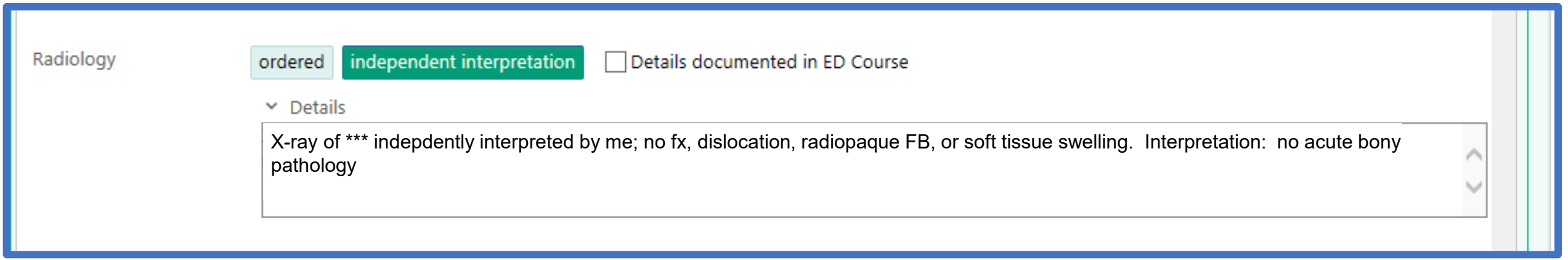
Radiology: ordered | independent interpretation | Details documented in ED Course

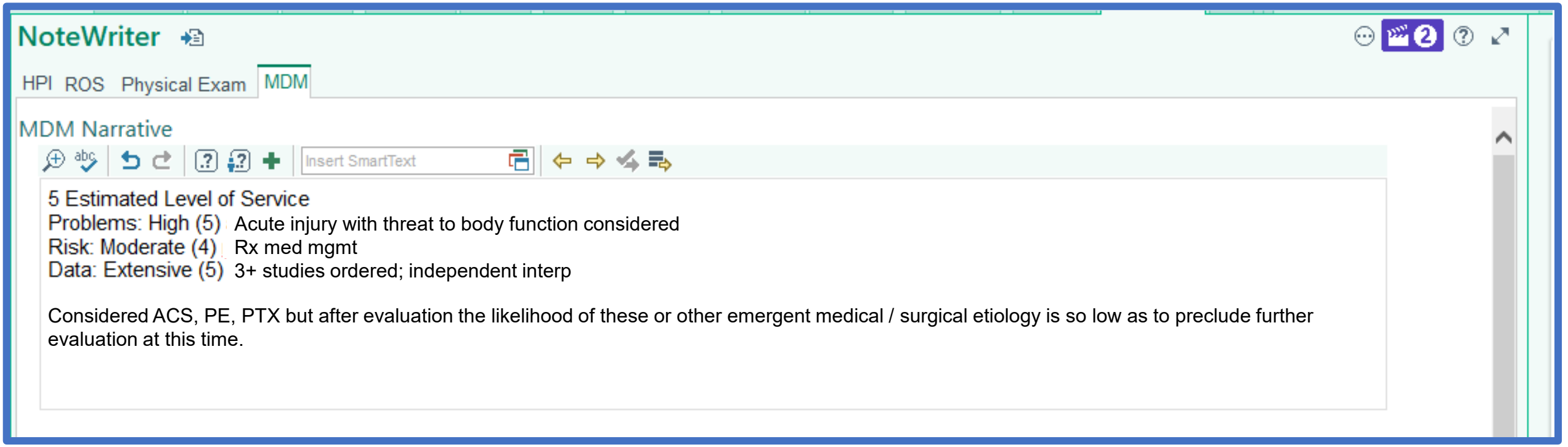
Details

ECG/medicine tests: ordered | independent interpretation | Details documented in ED Course

Details


NoteWriter
HPI ROS Physical Exam MDM
MDM Narrative
Insert SmartText
5 Estimated Level of Service
Problems: High (5) Acute injury with threat to body function considered
Risk: Moderate (4) Rx med mgmt
Data: Extensive (5) 3+ studies ordered; independent interp
Considered ACS, PE, PTX but after evaluation the likelihood of these or other emergent medical / surgical etiology is so low as to preclude further evaluation at this time.


Radiology
ordered
independent interpretation
Details documented in ED Course
Details
X-ray of *** indepdently interpreted by me; no fx, dislocation, radiopaque FB, or soft tissue swelling. Interpretation: no acute bony pathology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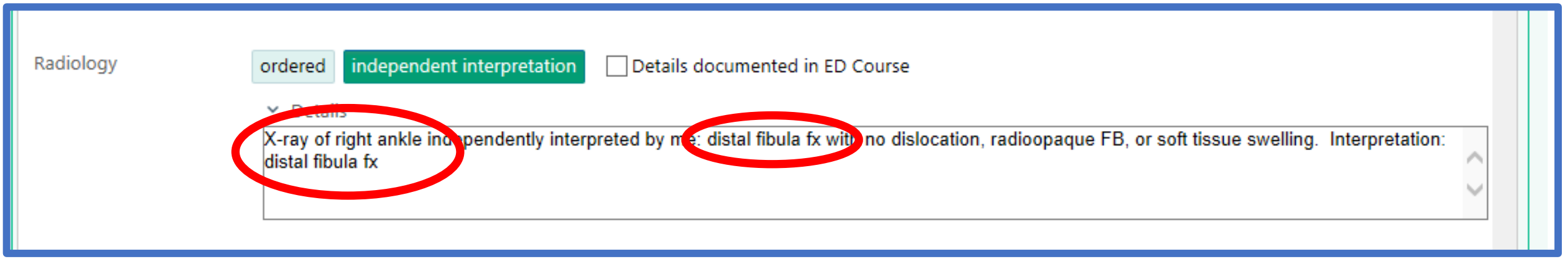
Radiology
ordered
independent interpretation
Details documented in ED Course
X-ray of right ankle independently interpreted by me: distal fibula fx with no dislocation, radioopaque FB, or soft tissue swelling. Interpretation: distal fibula fx

Level 5 Summary

- **Considering** badness gets you a Level 5 Problem score, even if ruled out after workup
  - Significant fx
  - Acute intraabdominal infection/inflammation
  - Kidney stone with complication
  - Cardiac ischemia & arrhythmia
  - Emergent electrolyte abnormality or significant blood loss
  - Ocular emergency

- Parenteral controlleds or even **considering** elective major surgery w/ risk factors, emergency major surgery, or hospitalization gets you a Level 5 Risk score

- You must consult or independently interpret to get a Level 5 Data score
  - Don’t overdocument the “kitchen sink” category – 3 items or 30 items still gets you a Level 4

Level 4 Summary

- Chronic condition (HTN, DM, pain) above = **with exacerbation** (Level 4 Problem)
  - Even if you don't do anything more than **continue** rx med mgmt (which is Level 4 Risk)

- Injuries requiring imaging to rule out significant conditions are <u>at least</u> considered **acute complicated injuries** (Level 4 Problem)

- Giving an rx med in the ED (including injections), even if you don't give rx at discharge, is a Level 4 Risk

- Consulting or independently interpreting **one** test gets you a Level 4 Data
  - So does 3+ items in the "kitchen sink" category

Example 1 – The Broken Ankle

- Usual workflow in some emergency departments:
  - Patient gets medical screening exam
  - Three x-rays are ordered for an ankle injury (foot, ankle, tib/fib)
  - Is roomed in the ED and is found to have a lateral malleolus fracture
  - You look at the x-ray and interpret the fracture
  - A nurse or tech splints the ankle – or maybe orthopedics does this
  - Patient is discharged, with instructions to take acetaminophen and ibuprofen as needed and to follow up with ortho as an outpatient

Example 1 – The Broken Ankle

- Without additional E/M supporting documentation:
- **Problem Element:** coder discretion.
- **Risk Element:** coder discretion. Ibuprofen 600mg, if given in the ED, may be auto-captured for Level 4 by your EMR… or maybe not.
- **Data Element:** coder discretion. The fact that imaging was done is auto-captured, but it may not be clear that 3 tests were done. Perhaps the consultation will be manually captured. Could be anywhere from Level 2-5.

- **Final E/M Code:** ? / ? / ?... could be anywhere from 2-4.
- 1.24-3.58 RVUs, depending on coder discretion

Example 1 – The Broken Ankle

- **With** additional E/M supporting documentation (note: bold is exactly what I would copy from the app; italics are the flavor text that I would add):

5 Estimated Level of Service

Problems: High (5) – *injury with threat to body function*

Risk: Moderate (4) – *rx med mgmt*

Data: Extensive (5) – *3+ studies ordered, independent interp*

(ankle will not function, pt can't walk right if not treated)

may not even need to type anything because you have two Level 5 elements elsewhere… once you justify the two levels that contribute to your E/M, you don't have to further document things for coding purposes

If it's a terrible ankle fx and you consult ortho, you'll probably mention that in your medical decision making section, but there's no need to further document it here… if you interpret the x-ray, you've already made your Level 5 for Data.

- You further note your independent interpretation below
  - "R ankle x-ray independently interpreted by me: lateral malleolus fx w/o dislocation"

- This work gets you **5.21 RVUs** for your E/M code
  - potentially **>4x** the amount of value captured if your coder just gives you a Level 2 E/M
  - **>2x** the amount of value captured if you get a Level 3 E/M

Example 2 – The Med Refill

- Usual workflow:
  - Asymptomatic patient needs a med refill for metformin for their Type 2 diabetes
  - Triage checks a POC glucose – 204 mg/dL
  - You clinically rule out emergent DM complications & the need for further testing
  - Patient is discharged, with a prescription for metformin and whatever outpatient follow-up plan you want to give them

Example 2 – The Med Refill

- Without additional E/M supporting documentation:
- **Problem Element:** coder discretion. 1 chronic illness… maybe Level 3.
- **Risk Element:** Metformin rx may be auto-captured for Level 4.
- **Data Element:** 1 test done. Level 2.

- **<u>Final E/M Code:</u>** 3? / 4 / 2... Level 3, 2.13 RVUs.

Example 2 – The Med Refill

- **With** additional E/M supporting documentation (note: bold is exactly what I would copy from the app; italics are the flavor text that I would add):

4 Estimated Level of Service

Problems: Moderate (4) – *chronic illness w/ exacerbation*

Risk: Moderate (4) – *rx med mgmt*

Data: Minimal (2)

Even if there's no diabetic emergency, the fact that they're above goal makes this a Level 4

- This work gets you 3.58 RVUs
  - **>1.5x** the amount of value captured if your coder just gives you a Level 3 E/M.

- If pt potentially has sx of DKA, you could upgrade your Problem & Data to Level 5s
  - Problem: considered diabetic ketoacidosis
  - Data: order CBC, CMP, and beta hydroxybutyrate
  - This means Level 5 E/M

Other Examples

- The patient with palpitations can be a Level 5 E/M
  - you're considering a cardiac arrhythmia – Level 5 Problem
  - you're ordering at least a CBC, metabolic panel, and an EKG, and then dropping a basic interpretation of that EKG ("EKG independently interpreted by me: no STEMI or equivalents, no lethal arrhythmia; NSR)… Level 5 Data

Other Examples

- The patient suffering from schizophrenia and homelessness can be a Level 4 E/M
  - chronic illness w/ exacerbation, Level 4 Problem (it can be argued that if they were at their baseline, they wouldn't have come in)
  - Social determinant of health – extreme poverty, Level 4 Risk ("increased risk and complexity due to difficulty obtaining supplies for treatment and medications; also more difficulty finding transportation to health care facilities and providers")
  - Or even a Level 5
    - Level 5 Problem: considered a behavioral health emergency
    - Level 5 Risk: continue/consider chronic rx med mgmt plus increased risks with their SDOH

Resources

- ***AMA CPT Evaluation & Management (E/M) Code and Guideline Changes*** – https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

- **ACEP FAQs** – https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs

- **AHA list of SDOH Z-Codes** – https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

- **MDCalc Coding App** – https://www.mdcalc.com/calc/10454/2023-emergency-medicine-coding-guide

Objectives

- Background
- The Why
- Selecting an E/M Code
- Level 5 Encounters
- Level 4 Encounters
- Other Encounters
- There’s An App For That
- Resources
- Summary & Conclusion

What Are Your Questions?

(Before some final slides…)

Michael A. Sharma, MPAS, PA-C

Emergency Medicine, UT Southwestern Medical Center, Dallas, TX

Adjunct Professor, Franklin Pierce University, Round Rock, TX

@michaelsharmapa | michael.sharma@gmail.com

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www.totalem.org

Podcast #206 - ATLS Episode 0: The Beginning of an Adventure

6/30/2020

1 COMMENT

PA Chip Lange (rural EM & POCUS guru) and PA Mike Sharma (urban/ suburban EM & Army veteran) go chapter-by-chapter on ATLS standards, tell tales, and look ahead to emerging trends in trauma care.

(It's a work in progress.)

2view.fireside.fm

Parting Thoughts

- No one likes having their work undervalued; no one likes wasting time charting
- Minor changes to workflow solve both of these problems
- The practice of medicine is harder than learning basic coding info
- Now you'll get credit for the things you do & save time while doing them
- No one will value or understand your hard work more than you

Michael A. Sharma, MPAS, PA-C

Emergency Medicine, UT Southwestern Medical Center, Dallas, TX

Adjunct Professor, Franklin Pierce University, Round Rock, TX

@michaelsharmapa | michael.sharma@gmail.com

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