Crossroads Health Resources

Coding • Credentialing • Compliance

E/M Coding Conundrums 2026 AAPC of KC

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The Basics

Aren’t all audits the same?

Does the specialty really matter?

Is it worse to have services overcoded or undercoded?

Guess Who I am Describing

He has been around for over 50 years.

Universally known by young and old.

Published in hundreds of papers around the world.

Has appeared on television every holiday season.

He dances to music and believes that joy is a right and responsibility.

He is loyal without being clingy, funny without trying too hard.

He's a lifestyle icon, a morale booster, and living proof that if you're going to lie on the roof, you might as well do it like a legend.

What Was the Point of This?

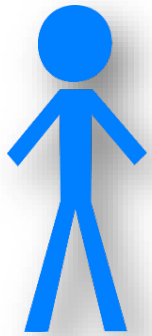
Without specific details, you cannot determine what the item was that I described.

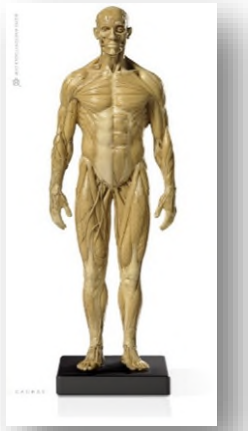
Without specific details, medical record documentation may not contain enough information to clearly identify the service(s) rendered or the condition(s) the patient may have.

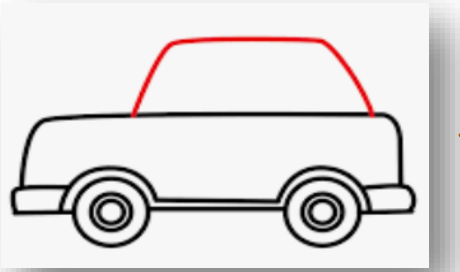
Words, Pictures, and Paint Strokes

	Ok	Better
Paint the picture	The patient presents with a cough.	The patient has a 3-day history of a wet, loose cough.
Be graphic with words	Pain in abdomen.	The patient has rebound pain in the right lower quadrant.
Explain severity	Right ankle is painful and swollen.	Right ankle is painful and swollen. On a scale of 1 to 10, the pain is 9. The patient is unable to ambulate.
Tell the story	Patient has hematuria.	The patient has a permanent urinary catheter that was changed last week. The patient has developed hematuria with clots since the catheter change.

Examples







Complexity Among Specialties

HIGHER COMPLEXITY SPECIALTIES

Neurosurgery

Cardiothoracic surgery

Interventional cardiology

Radiation oncology

LESSER COMPLEXITY SPECIALTIES

Dermatology

Allergy/immunology

Psychiatry

Family medicine

Internal medicine

Does the specialty impact how we interpret the E/M Guidelines?

**This is not a scientific list, just a Google search

E/M Guidelines Do Not Change by Specialty

Cardiology does not have one set of E/M guidelines while orthopedics, pediatrics, and family medicine have another. The medical decision making framework remains the same. We are still evaluating the problems addressed, the data reviewed and analyzed, and the risk of patient management.

Auditors cannot give credit based on what normally happens in that specialty. We cannot fill in the blanks because we understand what the provider probably did. We have to evaluate the story that was actually documented.

Specialty knowledge should help us understand the note. It should not cause us to assume the note says more than it does.

This is why I believe a strong E/M auditor does not need to be a clinical expert in every specialty. The auditor needs to understand the E/M guidelines, know how to research unfamiliar information, and remain objective.

When I audit a note, my questions are the same regardless of specialty.
What problems were addressed?
What data were reviewed or analyzed?
What management decisions were made?
What risk is supported by those decisions?
Does the documentation clearly communicate the work performed?

The specialty may change the language. It may change the medications, diagnoses, and treatment options. It may even change how long it takes the auditor to fully understand the encounter. But it does not change the E/M guidelines.

That consistency is exactly why auditors can review E/M services across specialties, as long as they understand the rules, research what they do not know, and avoid allowing familiarity to replace objectivity.

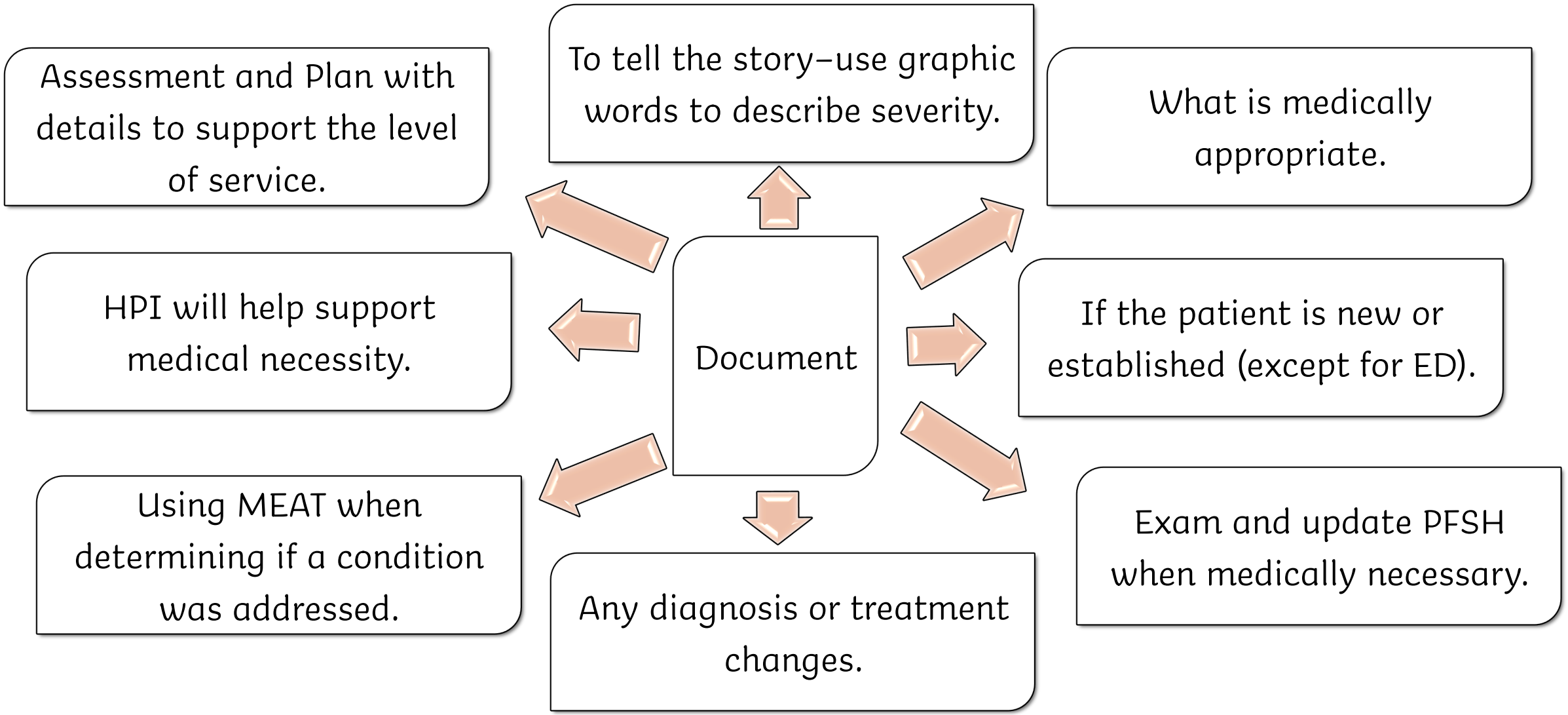
NAMAS Weekly SpotLight 08.11.2026: Does Specialty Matter in E/M Auditing?

	MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity/Mortality of Patient Management
99202, 99212 99242, 99252 99282	Straightforward	Minimal ° 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99221, 99231 99203, 99213 99243, 99253 99283	Low	Low (1 or more bullets below) ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment *Decision regarding minor surgery without identified patient or procedure risk factors*
99222, 99232 99204, 99214 99244, 99254 99284	Moderate	Moderate (1 or more bullets below) ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
99223, 99233 99205, 99215 99245, 99255 99285	High	High (1 or more bullets below) ° 1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment; ° 1 acute or chronic illness or injury that poses a threat to life or bodily function	High (must meet requirements of at least **2 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: ° Drug therapy requiring intensive monitoring for toxicity ° Decision regarding elective major surgery with identified patient or procedure risk factors ° Decision regarding emergency major surgery ° Decision regarding hospitalization or escalation of hospital-level care ° Decision not to resuscitate or to de-escalate care because of poor prognosis ° Parenteral controlled substances

MEAT (meatier) Principle

Documenting "MEAT" for co-existing conditions helps support medical necessity in treating presenting problem.

Monitor	• Signs • Symptoms • Disease progression or regression
Evaluate	• Test results • Medication effectiveness • Response to treatment
Assess	• Ordering tests • Discussion • Review records • Counseling
Treat	• Medications • Therapies • Other modalities
Impactful	• Is the information impactful to the **current** encounter?
Relevant	• Is the information relevant to the **current** encounter?


Assessment and Plan with details to support the level of service.
To tell the story–use graphic words to describe severity.
What is medically appropriate.
HPI will help support medical necessity.
Document
If the patient is new or established (except for ED).
Using MEAT when determining if a condition was addressed.
Any diagnosis or treatment changes.
Exam and update PFSH when medically necessary.

Low vs. Moderate

Chronic
1 stable

2 or more stable
1 or more with exacerbation…

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Moderate	Moderate (1 or more bullets below) ° **1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;** ° **2 or more stable, chronic illnesses** ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° **Prescription drug management** ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
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Number & Complexity of Problems Addressed at Encounter

Level 2

*1 self-limited/minor problem

Level 3

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

Level 4

1 or more chronic illnesses w/exacerbation
*2 or more stable chronic illnesses
1 undiagnosed new problem w/uncertain prognosis
1 acute complicated injury

Level 5

1 or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment
1 acute or chronic illness or injury that poses a threat to life or bodily function

Can you "stack" multiple conditions to reach a higher level?

No *

Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- 99212 vs 99213
- 99213 vs 99214
- Uncomplicated vs complicated illness or injury.
- Acute, complicated injury.

	MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter
Level 2	Straightforward	Minimal ° 1 self-limited or minor problem
Level 3	Low	Low ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Level 4	Moderate	Moderate ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury
Level 5	High	High ° 1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment; ° 1 acute or chronic illness or injury that poses a threat to life or bodily function

Level 2 vs. Level 3

	MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter
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Level 3	Low	Low ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

LEVEL 2 - STRAIGHTFORWARD

- Minor illness:
  - Simple cold
  - Sore throat
  - Minor rash
- Recheck on improving minor issue
- Vaccination review/lab results with minimal decision making
- OTC meds, rest

LEVEL 3 - LOW

- Stable chronic problems
  - Stable hypertension
  - Well controlled diabetes
  - Routine medication refill without complications
- Acute uncomplicated illness
  - UTI
  - Mild sinusitis
  - Mild gastroenteritis
- Multiple minor problems
- Recheck of condition not improving as expected, require change in treatment

99213 vs 99214

Patient with increased nasal congestion for 2 weeks now with cough and chest congestion. Likely viral infection. Follow up with PCP if no improvement. Prescribed steroids, Tussin Pearls and cough syrup.

Patient with increased nasal congestion for 2 weeks now with cough and chest congestion. He has underlying asthma exacerbation and extensive respiratory history with recurrent aspirations. Will start antibiotics, change steroids, and add stronger cough syrup. Likely viral infection. Follow up with PCP if no improvement. Prescribed steroids, Tussin Pearls and cough syrup.

Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity/Mortality of Patient Management
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Uncomplicated vs Complicated Illness or Injury

Acute Uncomplicated

Short-term, new, or recent health issue with low risk of mortality and no long-term functional impairment, requiring little to no active treatment for full recovery.

- These self-limited conditions are generally minor
- Managed with OTC meds, antibiotics

Low **Level 3**	Low ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

Acute Complicated

Sudden, severe medical condition posing a high risk of morbidity or functional impairment without prompt treatment.

- Requires extensive, multi-system evaluation and complex, sometimes surgical, management.
- Management is challenging, requiring extensive, high-risk, or long-term treatment.
- An injury which requires treatment that includes evaluation of body systems not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Examples

Uncomplicated

- **Respiratory:** Acute sinusitis, viral pharyngitis, common cold.
- **Skin/Musculoskeletal:** Minor abrasions, localized infections (cellulitis), simple sprains.
- **General:** Simple cystitis (UTI), allergic rhinitis, conjunctivitis.

Complicated

- First visit is uncomplicated, but it isn't healing so they are coming back for treatment.
- **Respiratory:** Pneumonia or acute asthma exacerbation.
- **Infections:** Complex cellulitis, severe infection, or sepsis.
- **Cardiac/Neuro:** Acute myocardial infarction or stroke.
- **Injuries:** Head injury with brief loss of consciousness, compound fractures, or injuries with neurovascular damage.

Acute or Chronic Illness/Injury That Poses Threat to Life or Bodily Function

- An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

Level 5	High	High ° 1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment; ° 1 acute or chronic illness or injury that poses a threat to life or bodily function

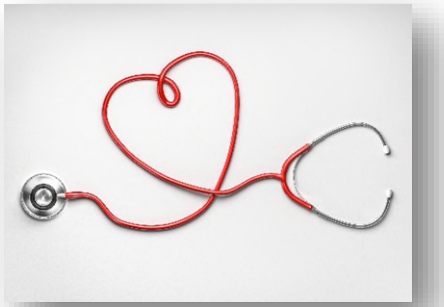
Providers need to THINK IN INK

Statement documented

Patient is stable

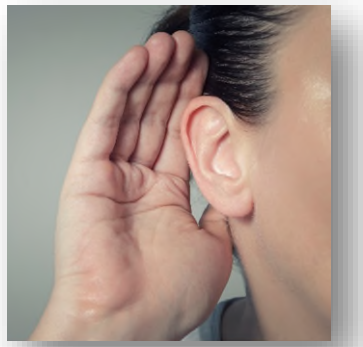
Physician

Patient is no longer in a life-threatening critical state but not out of the woods!



Coder

Patient has improved and is no longer critical.



Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- Independent interpretation of tests
- Review and/or order of each unique test

	MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
Level 2	Straightforward	Minimal or none
Level 3	Low	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
Level 4	Moderate	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)
Level 5	High	High (must meet requirements of at least **2 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)

Independent Interpretation of Tests

AMA definition: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This **does not** apply when the physician or other qualified healthcare professional is **reporting the service or has previously reported the service for the patient**. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Independent Interpretation of Tests

- The provider gives their own independent interpretation.
- Documentation should include why their interpretation was needed.
  - Have your provider add the why the independent interpretation was necessary.
- They are not receiving reimbursement for the interpretation.
- They must have a report, but that report does not need to be a typical complete report.
  - Narrative within the office visit would suffice.

Extensive (must meet 2 of these 3 categories) – Level 5 Visits

Category 1 Tests and Documents (any count of 3)

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

Category 2

- Independent interpretation of tests performed by another provider (not separately billable)

Category 3

- Discussion of management/test interpretation with external provider (not separately billable)

High	High (must meet requirements of at least **2 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)

Moderate (must meet 1 of these categories) - Level 4 Visits

Category 1 Tests and Documents (any count of 3)

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

OR

Category 2

- Independent interpretation of tests performed by another provider (not separately billable)

OR

Category 3

- Discussion of management/test interpretation with external provider (not separately billable)

MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
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Limited must meet Category 1 or 2 – Level 3 Visits

Category 1 Tests and Documents (any combo of 2)

- Review prior external note(s) each unique source
- Review results of each unique test
- Ordering each unique test

OR

Category 2

- Assessment requiring an independent historian

MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
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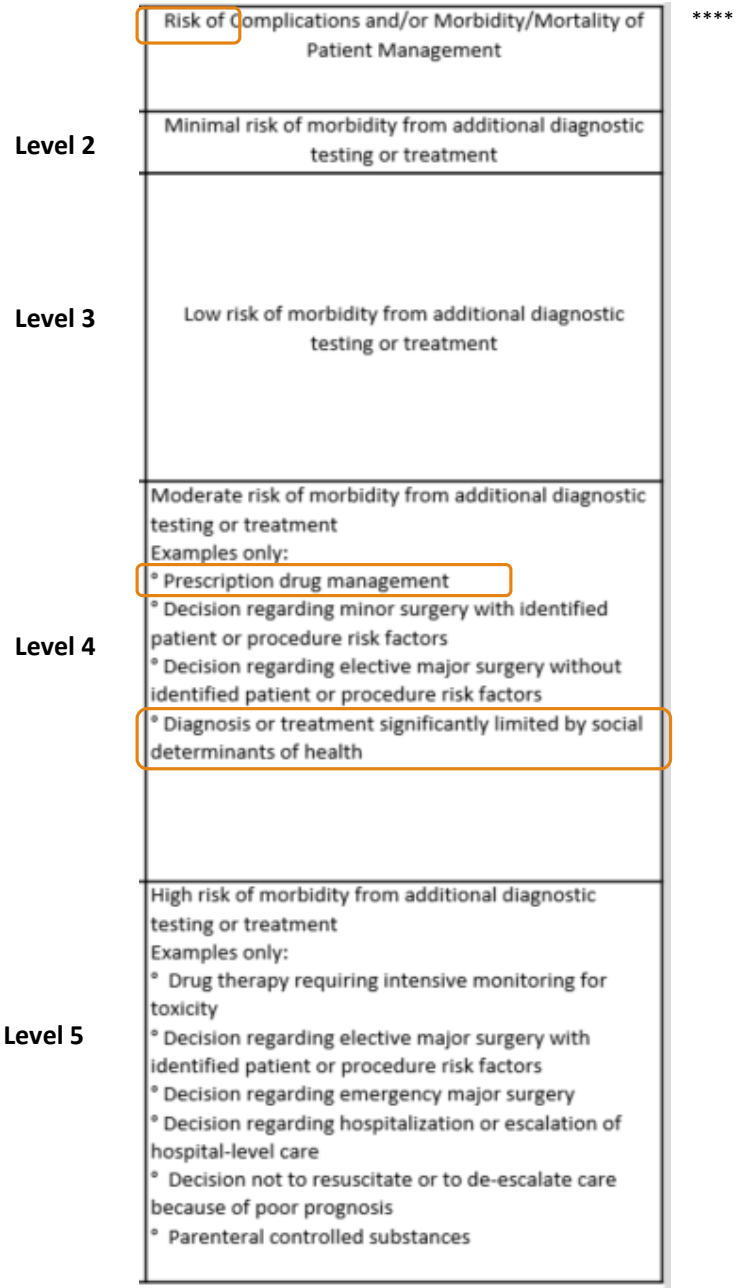
Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- What is risk?
- Prescription drug management
- SDOH



	Risk of Complications and/or Morbidity/Mortality of Patient Management ****
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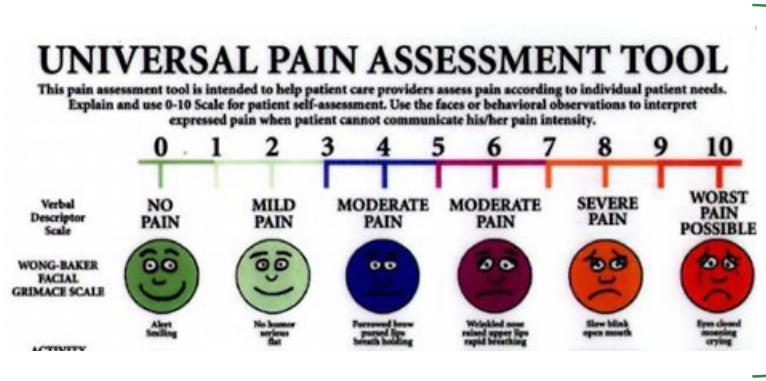
What is Risk?

- Risk - The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.
  - For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
  - Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.
- Risk as it relates to Column 3 – the risk associated with the outcomes of what is or isn't being done for the patient at this encounter.

Risk

Consider if the patient were to leave today without any treatment – what is the risk to their well being?

The higher the risk to the patient, the higher the risk on the grid.



	Risk of Complications and/or Morbidity/Mortality of Patient Management
Level 2	Minimal risk of morbidity from additional diagnostic testing or treatment
Level 3	Low risk of morbidity from additional diagnostic testing or treatment
Level 4	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
Level 5	High risk of morbidity from additional diagnostic testing or treatment Examples only: ° Drug therapy requiring intensive monitoring for toxicity ° Decision regarding elective major surgery with identified patient or procedure risk factors ° Decision regarding emergency major surgery ° Decision regarding hospitalization or escalation of hospital-level care ° Decision not to resuscitate or to de-escalate care because of poor prognosis ° Parenteral controlled substances

Noridian PDM

Evaluation and Management: Prescription Drug Management

The American Medical Association (AMA) owns the CPT codes and CMS has an agreement with the AMA to use these codes. When CMS does not develop separate policy, Noridian will follow the AMA Evaluation and Management (E/M) guidelines.

Prescription drug management may be part of the Medical Decision Making (MDM) element when choosing the level of E/M code supported by documentation. The variables involved when determining the risk will depend on the patient's condition(s), age, co-morbidities, lifestyle, and other medications. One patient with Coronary Obstructive Pulmonary Disease (COPD) will have different risks when compared to other patients with COPD. One may be older, one may have diminished health, or one may have cancer with COPD.

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of an E/M visit. There is a mindset that because it says prescription (RX) management, if a provider prescribes, the risk level qualifies as moderate. A prescription being written or discontinued, or a decision to maintain a current medication or dosage would need to be supported in documentation that the provider evaluated the medications.

Note: Simply listing current medications is not considered "prescription drug management."

Documentation for prescription drug management would need to show the work and/or risk involved by the billing provider when managing a prescription.

- Is the prescription something that could be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?
- Is the prescription a non-complex drug for a patient with no allergies or complications? Example – a patient taking anticoagulants.
- Did the patient have a stroke and is there a risk they may sustain a subsequent hemorrhage?

Additional considerations for prescription drugs that may support risk management when included in the documentation:

- Ability of a patient to self-administer the medication. Education to the patient on performing injectables or ability to open a pill bottle and take a pill out.
- Caregiver or family member at home to monitor the effects of the drug.
- Any concern about the patient's understanding with taking their medication.

Adding new or deleting drug(s) should include narrative in the medical note to explain why the change was made.

If determining the level of E/M code based on total time, the MDM elements would not apply.

***WPS does not appear to have a document like this on their webpage.*

Noridian PDM

AMA Publication

Appropriate documentation of prescription drug management continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate. Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided. Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: "Stable hypertension; continue valsartan 10 milligrams, will refill for 4 months until next follow-up visit." Simply stating that the medication list was reviewed will not meet the definition of prescription management.

AMA 2023 Webinar Questions and Answers

There is no "blanket" guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management.

Additional Resource

- AMA Evaluation and Management (E/M) Guidelines 2023

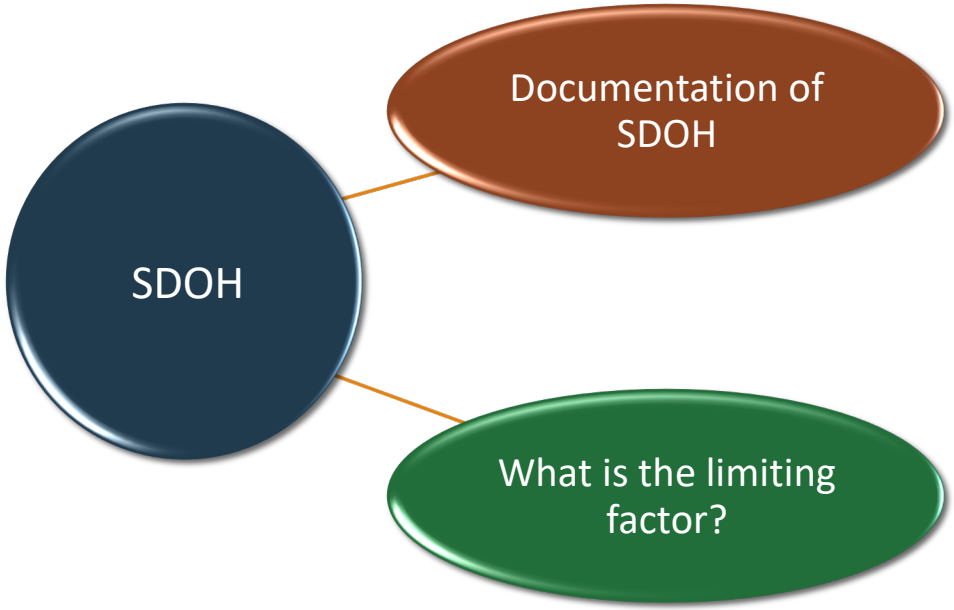
This article is written at the suggestion of the Provider Outreach and Education Advisory Group.

Last Updated Nov 08 , 2024

https://med.noridianmedicare.com/web/jfb/article-detail/-/view/10534/evaluation-and-management-prescription-drug-management

Social Determinants of Health (SDOH)

- Economic and social conditions that influence the health of people and communities.
- Examples may include food or housing insecurity.
- Not simply including the patient has a SDOH but identifying how does it impact the problem.



Parenteral Controlled Substances

Which medications qualify as parenteral controlled substances in the high section of the risk column?

Controlled Substance – a schedule I, II, III, IV, or V drug or other substance.
Parenteral – substance administered/given by a route other than the alimentary canal.

It is not just the medication; it is the route of administration plus the medication.

Buprenorphine (Suboxone)	Morphine
Diazepam (Valium)	Nubain (nalbuphine)
Fentanyl (Sublimaze, Duragesic)	Pentobarbital
Hydromorphone (Dilaudid)	Phenobarbital
Ketamine	Stadol (butorphanol)
Lorazepam (Ativan)	Sufentanil
Meperidine (Demerol)	Talwin (pentazocine)
Methadone (Dolophine)	Thiopental
Methohexital	Versed (midazolam)
Midazolam (Versed)	

https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs

Templates and Macros

It is a starting point.

Each must be patient specific.

Avoid cloned documentation (same information across different patients or multiple visits on same patient).

Must support medical necessity.

Providers must review and edit before finalizing the note.

Templates and Macros

What templates are allowed?

CMS says a template is a "tool/instrument/interface that assists in documenting a progress note."

Physicians and other medical professionals are allowed to use any format of template that they would like. Physicians can create their own template or collaborate with colleagues and care team members to develop templates that work for their practice needs.

Templates should support collecting and recording all the information needed to ensure optimal patient care, including room to properly document that medical necessity criteria were met. A template can, for example, be a document that includes outlines that allow a physician to add the gathered information or it can involve "templated text" that is precomposed text that can be imported into the note. Experts note, however, that when physicians import templated text, they should review it and revise it as needed for each individual patient.

Some other examples of templates that physician practices use include:

- A complete visit note.
- A visit note that covers just a portion of the encounter, such as a history-only or exam-only template.
- A note tailored for any patient visit.
- A note tailored to a specific type of patient encounter. For example, one note may be used for an annual wellness visit, while another note is used for a visit involving diabetes management.

The AMA recommends that practices review and regularly maintain templates so that they reduce note bloat and the time that physicians spend on unnecessary documentation.

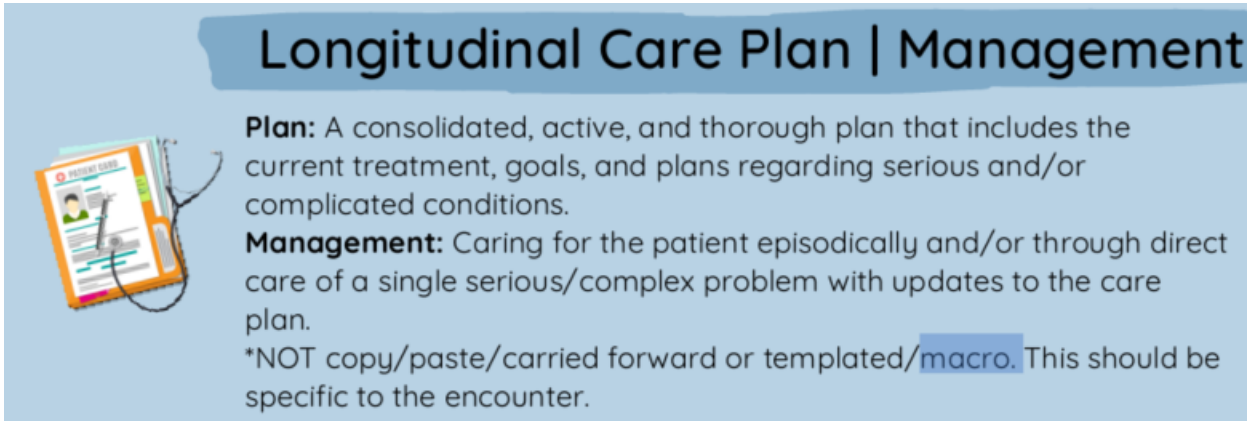
Weighing all the possible risks and treatment options at this time, difficult though it may be knowing the risks and complications, the patient and family have opted to proceed with the noted treatment plan. Should these risks occur, alternative treatment plans have been discussed in detail with the patient and family.

Cut and paste and carry forward elements of this document were validated as accurate, relevant, and up to date for the purpose of today's documentation. This content was reviewed as pertinent to care, and reflect today's medical decision making.

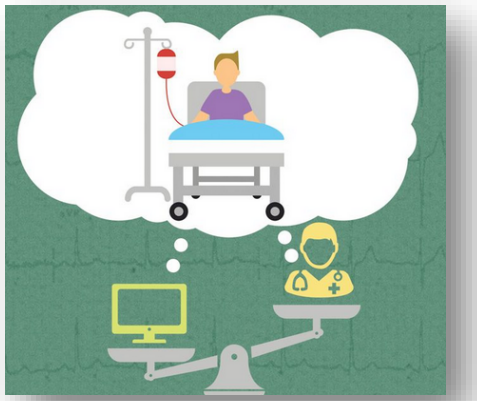
Conflicts in Documentation

New patient to establish care w pcp, no previous pcp
Not currently on any rx meds, takes OTC Vitamin C and Multivitamin
No recent labs, not fasting this afternoon
Denies any problems or concerns today

"I attest that this evaluation and management service is part of an ongoing, longitudinal health care relationship I have with this patient for their single serious, or complex condition."



Parting Words on Medical Decision Making



MDM = more than just the plan.

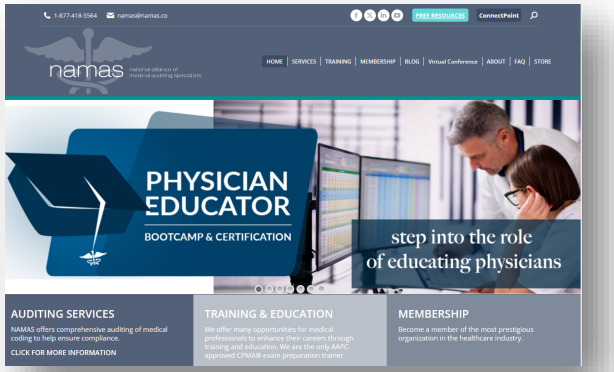
MDM = a composite of problem complexity, data review, and risk analysis.

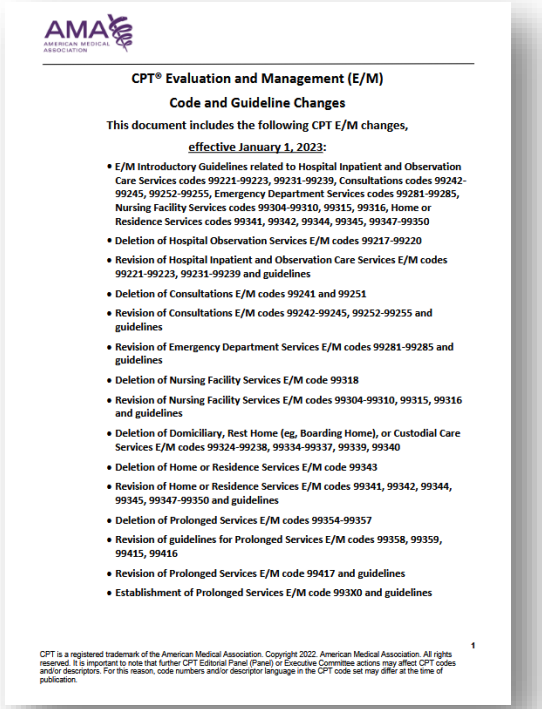
Documentation = individualized proof of that work—not a copy-paste shortcut.

When we apply it this way, the ambiguity fades—and so does much of the frustration around documentation.

Credit Given

NAMAS for many references





AMA

CPT® Evaluation and Management (E/M)

Code and Guideline Changes

This document includes the following CPT E/M changes,

effective January 1, 2023:

- E/M Introductory Guidelines related to Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242-99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350
- Deletion of Hospital Observation Services E/M codes 99217-99220
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines
- Deletion of Consultations E/M codes 99241 and 99251
- Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines
- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines
- Deletion of Nursing Facility Services E/M code 99318
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340
- Deletion of Home or Residence Services E/M code 99343
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines
- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 993X0 and guidelines

AMA 2021 and 2023 Evaluation and Management Guidelines

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Questions?

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