# Refresher: Guidelines for E/M Coding

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Hard to believe that the new evaluation and management (E/M) guidelines have been in place for urgent care for 4 years. These guidelines created by the American Medical Association (AMA) were a complete shift from what was previously published by the Centers for Medicare & Medicaid Services. Instead of bullet points, levels are determined by the work involved in treating a patient.
E/M codes can be leveled by either medical decision making (MDM) or time. Here is a summary of the guidelines to help your providers.

**Medical Decision Making Documentation Requirements**
E/M services still need an appropriate history and/or examination to be codable. The amount of documentation is up to the provider. There is no specified criteria of what each history or examination should include.

There are 3 elements for determining the level of the visit.

1. Number and complexity of problems addressed
2. Amount and/or complexity of data to be reviewed and analyzed
3. Risk of complications and/or morbidity or mortality of patient management

**1. Number and Complexity of Problems Addressed**
This is the element that has the most errors—with providers choosing either too high or too low. It is imperative that all providers understand the definition of each option for proper selection.

The problem addressed level is based on the patient's presenting problem. It drives the testing and treatment options. This is not based on the final diagnosis but rather the symptoms and diagnoses being ruled out. It won't always correlate to the management risk. Follow the AMA guidelines for the definition of problems addressed.

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Below are definitions provided by AMA CPT 2021 for acute, uncomplicated illness or injury and acute illness with systemic symptoms. These are the options most common in the urgent care space.

| Problems Addressed | Condition Evaluated or Treated at the Encounter by the Reporting Provider |
|---|---|
| **Self-limited or minor** | Transient and runs a definite and prescribed course |
| **Acute** | Recent or new short-term problem |
| **Chronic** | Expected duration of at least a year or until death of the patient |
| **Uncomplicated** | Treatment considered but low risk of morbidity |
| **Complicated** | Extensive injury that requires evaluation of body systems that are not part of the injured organ |
| **Stable** | Patient has met treatment goals |
| **Systemic symptoms** | Symptoms cause a high risk of morbidity without treatment |
| **Exacerbation** | Worsening but does not require hospitalization |
| **Severe exacerbation** | Progression with significant risk of morbidity and may require hospitalization |
| **Undiagnosed** | Differential diagnosis that likely results in a high risk of morbidity without treatment |
| **Threat to life or bodily function** | Poses a threat in near term without treatment |

Acute, uncomplicated illness or injury:

- A recent or new short-term problem with low risk of morbidity for which treatment is considered.
- There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
- A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

Acute illness with systemic symptoms:

- An illness that causes systemic symptoms and has a high risk of morbidity without treatment.
- For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications; see the definitions for self-limited or minor or acute, uncomplicated.

**2. Amount and/or Complexity of Data to be Reviewed and Analyzed**

Count all labs (80000 series), whether billed or not, as an order, and give 1 data point for each unique test. Radiology tests (70000 series) and tests from the Medicine section (90000 series) will be counted for data only if they are an outside referral (ie, not billed by the practice).

Unique tests are defined as a CPT code regardless of the number of times they are billed. For example, influenza tests (CPT 87804) are counted as 1 order even though the CPT is billed twice.

**3. Risk of Complications and/or Morbidity or Mortality of Patient Management**

Management risk is based on the final diagnosis and the treatment plan. This includes possible management options selected and those considered, but not selected. Social determinants of health should also be considered.

**Time**

Within an urgent care setting, few visits will be leveled based on time. It is an option that should be considered in cases that take longer than expected based on the MDM. In these rare circumstances, the provider must document total time spent on the day of the encounter both face-to-face and non-face-to-face.

These items do not count toward total time:

- Time spent by clinical staff
- Time spent performing procedures

If 2 providers see the patient, you can count the time for both of them. Both will have to document their portion of the visit, however, and the time spent by each provider should not overlap. Time also includes work performed on the patient's case while they are not in the office.

Training your providers on these E/M coding concepts will have a direct impact on the health of your urgent care business. ■

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