Crossroads Health Resources
Coding • Credentialing • Compliance

Directions from the Crossroads – Changes Coming for 2023

Are you ready for more CPT® coding changes? The **time is now** to begin to learn what will affect your coding next year. Did you know that effective 1/1/2023, Evaluation and Management (E/M) codes will no longer require the history *(history of present illness [HPI], review of systems [ROS], and past, family/social history [PFSH])* and examination to *determine* the level of service? This change occurred in 2021 to the Office/Other Outpatient codes (99202 – 99215). The services began to be determined by only Medical Decision Making (MDM) or time. The remainder of codes make the transition at the beginning of next year, including Office Consultations, Emergency Department, Hospital Inpatient Services, Observation, Nursing Facility, and Home/Residence services.

This change will affect all providers who perform E/M services. It will also impact electronic health records (EHR) in how documentation is (or isn't) captured. Providers are accustomed to clicking boxes of information in templates, which has been acceptable documentation format for many years. Will these templates of information include enough documentation to support the services going forward? For example, an initial hospital service (admit) requires a comprehensive history and examination and high medical decision making to support a 99223. Going forward, only the medical decision making or time will be counted towards the level of service. Is the narrative in the Assessment and Plan (A/P) robust enough to support a high level of MDM? This translates into the necessity for the provider to continue to document the medically appropriate history and/or examination, even though that information is not used in determining the overall level of service. What it **does not** mean is that the provider is no longer required to document any history or examination.

How will this impact you or your providers? Keep in mind that documentation for each date of service must stand on its own. Documentation such as "continue meds", will not be sufficient to support medical necessity. Begin getting into the habit of documenting a thorough A/P that includes medication names, doses, changes, and linking the medication to a specific condition.

The new E/M changes remind me of the way providers documented before moving to EHRs; the documentation told a story. The traditional subjective, objective, assessment and plan (SOAP) note would include the history of the patient's condition, an appropriate exam, and the assessment and plan. Providers may need to think back along these lines for our upcoming changes.

One of the goals of changing the documentation requirements is to ease some of the burden that is on the provider for completing medical records. Instead of worrying about how many elements of ROS are documented or if there is a complete PFSH, the provider will focus on the narrative to describe the nature of the presenting problem and medical necessity for the given encounter.

Crossroads Health Resources (CHR) can assist your organization to prepare for this historical change. We can perform a provider documentation audit to evaluate your readiness for this significant change. We can also schedule in-person or virtual training with your organization. CHR will be there to prepare your organization during the remainder of this year as well as after implementation.

Don't wait until December, contact us immediately to schedule your educational audit and training so your providers will be ready to hit the ground running 1/1/2023.