TOP 11 List of Changes in 2023:

1. Billing is based on the number and complexity of problems, the amount or complexity of data, and risk of complications or morbidity and mortality of patient management.

2. The History and Physical are NOT considered elements of the E/M codes. Past Medical History, Review of Systems, and Social History are NOT taken into account for elements of the level of service.

3. Document when obtaining history from an independent historian (e.g., parent, guardian, spouse).

4. Document your review of external notes (e.g., EMS, DC Summary, Clinic).

5. Document tests or treatment considered but not performed.

6. Document your independent interpretation of studies (e.g., XR, CT Scan), review of tests you ordered and/or interpreted (e.g. labs) and cardiac monitor interpretation.

7. Document discussion of management with external provider (e.g., hospitalist, consultant, case manager, social worker, primary care physician).

8. Document if social determinants of health (SDOH) affected choice of management (e.g. homelessness, food insecurity, unemployment, addiction).

9. Document the decision regarding hospitalization (when applicable).

10. Document that you addressed or managed patients’ existing chronic illnesses or conditions when appropriate (e.g. poor control of hypertension or diabetes).

**1. In 2023, billing is based on:**
   a. The number and complexity of **problems**
   b. The amount or complexity of **data**
   c. The **risk** of complications or morbidity and mortality of patient management

**2. In 2023, billing is NOT based on components of the **history and physical exam** though the HPI will help to establish problem complexity.** Past Medical History, Review of Systems, Family History, and Social History are NOT taken into account for elements of the level of service.
   a. This is perhaps the biggest change in 2023 from previous requirements for a certain number of elements in the history and physical exam.
   b. The only requirement in the new release is “a medically appropriate history and/or exam.”
   c. There is no requirement for documentation of these as separate parts of the history. They may be omitted entirely or included in context of the HPI only.
   d. Family History will no longer be required for OBS care.

**3. Document when obtaining history from an **independent historian**.**
   a. If obtaining history from an independent historian such as spouse, guardian, or parent, this should be documented.

**4. Document your **review of external notes**. (e.g., EMS, DC Summary, Clinic Notes)
   a. Any notes authored from a provider outside your group apply.

**5. Document **tests or treatment considered but not performed**.
   a. The ordering and review of the results of tests counts toward **complexity** of data.
   b. A test considered but not ordered will count as credit for **complexity** of data interpreted (e.g., d-dimer for PERC rule, head CT for PECARN, etc.)

**6. Document your **independent interpretation of studies** (e.g., XR, CT Scan, cardiac monitor) and **review of tests** you ordered and/or interpreted (e.g., labs).
   a. Note: If separately reporting or billing for a service (e.g., cardiac monitor), then its interpretation is not included as a data element ordered or interpreted.
   b. An interpretation of a complex study such as a CT scan need not conform to usual standards for interpretation (i.e., that which would be done by a radiologist). However, your interpretation counts as an element of data reviewed.
   c. You need not have ordered the test to interpret it and get credit; if a patient presents with lab work from an outside source, you can document your review and get credit.
   d. Documentation of order and review of 3 unique labs counts as 3 elements (as long as the labs are not grouped; e.g., review of WBC, HGB, PLT is one element of a CBC).

**7. Document discussion of **management with external provider**. (e.g., hospitalist, consultant, case manager, social worker, primary care physician, pharmacist)
   a. This includes conversations which occurred in an asynchronous medium, or those which did not occur in person.
b. Conversations through an intermediary are not included.

8. Document if social determinants of health affected choice of management. (e.g., homelessness, food insecurity, unemployment, addiction)
   a. SDOH are a big change in 2023; when properly documented as they pertain to management of the disease process, they add an element of risk of complications.

9. Document the decision regarding hospitalization (when applicable).
   a. A documented discussion about why a patient was discharged as opposed to being admitted speaks to the risk of complications and morbidity/mortality of a case.

10. Document that you addressed or managed patients’ existing chronic illnesses or conditions when appropriate (e.g., poor control of hypertension or diabetes).

11. Document a focused patient-specific differential diagnosis
    a. A non-templated differential with discussion will help to establish the patient risk complexity.

Additional points worth noting:
- Pulse oximetry is not considered a test. (Don’t waste your time formally “interpreting” it).
- A comprehensive history and comprehensive examination are nice and may be adequate; it will not be considered however in your level of service or billing.
- Translator services are not considered independent historians
- Time is no longer a component of consideration of level of service (for standard codes). (Critical Care is still a time-based service and the time requirements for the various levels will change in 2023).
- The “Level 1” LOS/Chart (99281) is expected to be so simple that it may not even require a physician or AHP to be involved. MDM does not apply at all to this LOS.

Example documentation:
- “Additional history was obtained through the patient’s daughter as an independent historian who reviewed the patient’s chronic medical issues and symptoms which prompted today’s visit.”
- “I reviewed prior external notes available to me in the EMR from when the patient was discharged from the hospital last month.”
- “The patient required continuous monitoring while receiving repeat doses of opiate medications to control his pain.”
- “In my independent interpretation of the CT scan of the head, I did not see evidence of a large intracranial bleed. I await the final interpretation from the radiologist.”
- “I considered the need for admission in this patient with chest pain, but feel that due to normal test results and given his ability to follow-up, he is stable to be discharged and evaluated as an outpatient this week by his PMD.”
- “I discussed with the patient the need for emergency surgery to remove her gallbladder due to active infection.”
- “I discussed the case with the social worker due to the history of domestic violence and my concern for the patient’s safe discharge.”
- “I discussed the case with case manager to ensure that her continuing medical needs could be met at her current residence.”

- “I am prescribing controlled substance pain medications to the patient to help with adequate analgesia while at home over the next few days.”

- “The patient was continuously monitored during fosphenytoin infusion to make sure there his blood pressure remained stable and there were no adverse effects.”

- “The patient also has chronic hypertension and her blood pressure was elevated today, likely due to pain. Her blood pressure improved after administration of pain meds and I counseled her to discuss her HTN management at her next doctor’s appointment.”

- “The patient has chronic diabetes and his blood sugar was high today. I administered IV fluids to help lower the glucose and counseled the patient to discuss his diabetes management with his PMD.”