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Solid Documentation for Medical Decision Making in E/M: Ensure Your Providers Get a GOLD Medal and Not a "Participation" Trophy

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hcpro

Presented By

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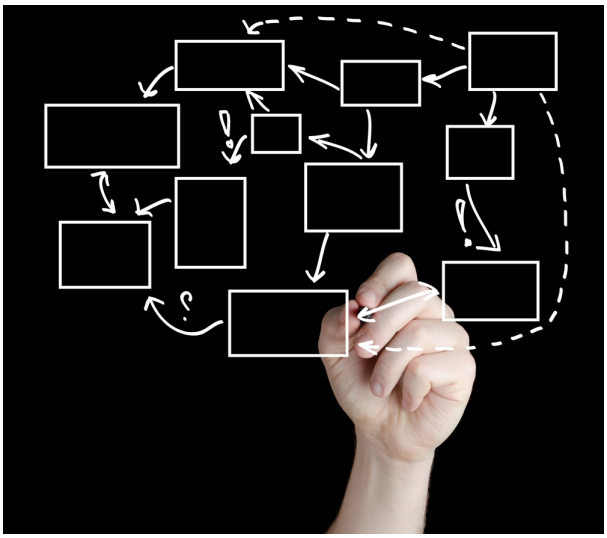
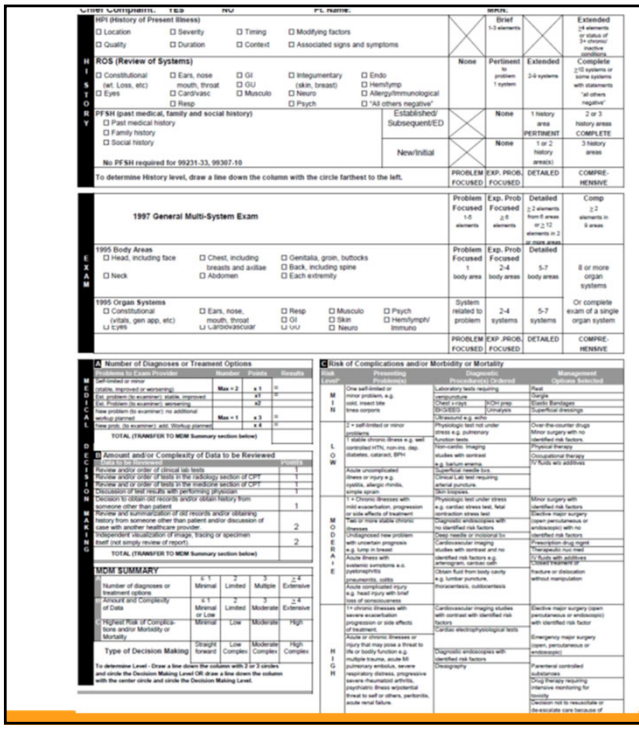
Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Explain how to accurately classify the number of problems and complexity for medical decision making (MDM) needed for evaluation and management (E/M) code assignment
  - Identify how to count data elements accurately towards MDM
  - Define two levels of risk of morbidity/mortality to MDM
  - Identify three common pitfalls in documentation that do not support MDM

E/M Coding – Is It REALLY That Simple?



Does E/M coding sometimes feel like this for your providers?



Are you kidding me??!

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Comparison – OV and Other E/M Services

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use Key Components (History, Examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use Key Component (History, Examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates. *Time is **not** a descriptive component for E/M levels of emergency department services*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

Source: <2022 CPT Manual>

Caution

CMS 1995/1997 guidelines not applicable for this category

THESE ARE **ONLY** FOR OFFICE VISIT/OUTPATIENT VISIT CODES – **FOR NOW**

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Are the History and Exam – Optional or Required?

- REQUIRED!!
- Time spent obtaining history and exam are counted as “intra-service” time
- Conditions in the history of present illness (HPI) and relevant chronic conditions can contribute to medical decision making
- Exam findings support diagnosis, ordering of diagnostic tests and other contributory elements to MDM
- Continuity of care
- Contributory conditions for other reimbursement methodologies (e.g., risk adjustment)

E/M – Based on MDM

- Medical Decision Making – 99202-99215

Key component-based services	99202-99215
Number of Diagnoses or Management Options	Number and **Complexity of Problems Addressed**
Amount and/or Complexity of Data to be Reviewed	Amount and/or Complexity of Data to be Reviewed **and Analyzed**
Risk of Complications and/or Morbidity or Mortality	Risk of Complications and/or Morbidity or Mortality **of Patient Management**

AMA Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

1 2 3

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited *(Must meet the requirements of at least 1 of the 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 the result(s) of each unique test*; ◦ ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** *(For the 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

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Table 2 (MDM)

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • 2 or more stable chronic illnesses; **or** • 1 undiagnosed new problem with uncertain prognosis; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; ◦ Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (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
99205 99215	High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; ◦ Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (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 • Decision not to resuscitate or to de-escalate care because of poor prognosis

E/M – Based on MDM

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

<Source: 2022 CPT Manual>

E/M – Based on MDM

- Complexity of problems addressed – MDM Focus
  - Multiple new or established conditions may be addressed at the same time
  - Comorbidities/underlying conditions are ONLY considered in selecting a level if they are ADDRESSED and their presence increases amount of data reviewed/analyzed or increases risk of complications.
  - Do not count individual symptoms that are integral to a condition

Key Word is ADDRESSED!!

E/M – Based on MDM

- Complexity of problems addressed – MDM Focus
  - Document ALL treatment/management options discussed (even if not selected)
  - Document all comorbidities/underlying conditions that increases amount of data reviewed/analyzed or increases risk of complications

*What CANNOT BE Counted as Addressed?

1. Notations that another provider is following a patient for a condition
2. Referrals without evaluation (history, exam, MDM)

MDM – Complexity of Problems Addressed

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter
99211	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem
99203 99213	Low	**Low** • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury

AMA

E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Minimal problem** – a problem that may not require the presence of a physician/other QHCP (99211)
  - **Self-limited or minor problem** – A problem that runs a definite and prescribed course, is transient and is not likely to permanently alter health status
  - **Stable, chronic illness** – A problem with an expected duration of at least a year or until death.
    - Examples – well-controlled HTN, NIDDM, cataracts, BPH
  - **Acute, uncomplicated illness/injury** – A recent or new short-term problem with low risk of morbidity (little to no) with treatment. Full recovery is expected
    - A self-limited or minor problem that is NOT resolving with a definite and prescribed course = Acute uncomplicated, illness/injury
    - Examples – Cystitis, rhinitis, or simple sprain

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MDM – Complexity of Problems Addressed

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function

AMA

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E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Chronic illness with exacerbation, progression or side effects** – A chronic illness that is acutely worsening, poorly controlled or progressing requiring additional care (but not hospitalization)
  - **Chronic illness with severe exacerbation, progression or side effects** – Chronic illness with significant risk of morbidity and may require inpatient hospital level of care.
    - Example – Acute on chronic renal failure due to contrast administration

This includes patients with a chronic condition who are not at "goal"; document steps to achieve goal. *<WPS Medicare>*

E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Undiagnosed new problem with uncertain prognosis** – A problem with a differential diagnosis that COULD result in a high risk of morbidity without treatment.

If the patient knows they have the condition, it is not a "new problem" regardless of provider *<WPS Medicare>*

MEDICAL D	A Number of Diagnoses or Treament Options			
	Problems to Exam Provider	Number	Points	Results
	Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
	Est. problem (to examiner): stable, improved		x1	=
	Est. Problem (to examiner): worsening		x2	
	New problem (to examiner): no additional workup planned	Max = 1	x 3	=
	New prob. (to examiner): add. Workup planned		x 4	=
	TOTAL (TRANSFER TO MDM Summary section below)			

E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Acute, complicated injury** – An injury which requires treatment and evaluation of other body systems that are directly not part of the injured organ. Treatment options are multiple and associated with risk of morbidity.
    - Example – head injury with brief loss of consciousness
  - **Acute illness with systemic symptoms** – An illness that cause systemic symptoms (e.g. fever, body aches and fatigue) with a high risk of morbidity without treatment.
    - Examples – pyelonephritis, pneumonitis or colitis
    - Note: Systemic symptoms in a minor illness will be considered self-limited or acute, uncomplicated illness/injury (e.g., low fever and aches with minor cold, sinus infection)

E/M – Based on MDM

- Definitions of "Problems" and Conditions in MDM
  - **Acute or chronic illness that poses a threat to life or bodily function** –Acute illness with systemic symptoms or chronic with exacerbation and/or progression in the near term without treatment.
    - Example: Acute MI, pulmonary embolus, psychiatric illness posing threat to self or others, acute renal failure

Pop "Doc" Quiz – Raise of Hands

- A provider documents a patient is being seen in the office for an **acute upper respiratory infection.** The patient also has **type 2 DM** which affects the medical decision on which medication to prescribe (and is documented) appropriately
  - Number and complexity of presenting problems would be classified as:
    - Low?
    - Moderate?

99203 99213	Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury
99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury

Pop "Doc" Quiz

- A provider documents a patient is being seen in the office for an **acute upper respiratory infection.** The patient also has **type 2 DM** which affects the medical decision on which medication to prescribe (and is documented) appropriately
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99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury

E/M – Common "Problems Addressed" Q & As

<WPS Medicare>

- Can you add together two "low" MDM conditions such as a stable chronic illness (diabetes) and an acute uncomplicated illness/injury (e.g., viral infection) to classify as "moderate" MDM?
  - NO! Both descriptions are in the low category of the Number and Complexity of Problems Addressed.

Number and Complexity of Problems Addressed
N/A
Minimal • 1 self-limited or minor problem
Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury

MDM – Amount/Complexity of Data

- Complexity of problems addressed – MDM Focus

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	
99211	N/A		N/A	
99202 99212	Straightforward		Minimal or none	

99203
99213
	Low		**Limited**
			(Must meet the requirements of at least 1 of the 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 the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	

LOW= 2 documents OR an independent historian

MDM – Amount/Complexity of Data

- Key Definitions

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

Do not count tests as MDM if reported separately

  - **Test** – imaging, laboratory, psychometric, or physiologic data.
    - A lab "panel" is ONE test.
    - Tests with overlapping elements are not unique even though different CPT
  - **External** – External records, communications and test results are from an external physician/QHCP or facility.
    - External physician/QHCP = one who is not in the same group practice or is a different specialty or subspecialty.
    - "Unique source" = one provider even if multiple notes reviewed
  - **Independent historian** – Any individual who provides history in addition to the patient who may be unable to provide a complete or reliable history.
    - Due to conditions like dementia, unconsciousness
    - Can include a parent for a minor patient

Documentation should identify WHY

MDM – Common "Test" Q & As *<WPS Medicare>*

- What does it mean by a test "not separately reported"?
  - The provider submitting the E/M does not submit a separate charge (i.e., CPT code) for the service.
  - Examples can include:
    - Global, technical or professional portion of a radiology service
- What documentation should be entered to support review of a test?
  - Documentation should support the provider reviewed the findings and the result of his/her review. This would include a signature and date.

Count the test as MDM **OR** bill the CPT code for the test – Cannot count as BOTH

MDM – Common "Test" Q & As *<WPS Medicare>*

- Can a test be counted as "ordered" even if the patient never goes in for testing?
  - YES! The provider made the decision to order the test so it may be counted.
  - Ordering can also be counted if a test was considered but not selected after discussion
    - E.g., patient requests imaging but provider discusses lack of benefit
  - Ordering can also be counted if a test was not performed but due to the risk of the specific patient it was not
  - DOCUMENTATION IS REQUIRED TO SUPPORT!! *<CPT Errata 3/9/2021>*

MDM – Common "Test" Q & As *<WPS Medicare>*

- Does review of tests include a patient's verbal statement of the results?
  - NO! A patient stating the results is not the same as viewing the actual test result.
- What if there is not a unique CPT code for a "test" that is performed during an encounter? How is this reflected in MDM?
  - If there is no unique CPT code for the test, it is likely considered part of the history/exam and does not impact MDM level selection.
    - Example: Self completed PHQ-9 (Patient Health Questionnaire) for depression screening

MDM – Common "Test" Q & As <WPS Medicare>

- What if a provider reviews a lab test the day prior to an encounter may the review be counted towards the "review of a lab test" element for amount of data reviewed and analyzed? (The provider has not counted the order/review previously).
  - If the practice has not previously counted the order/review of the test, it may be counted for today's MDM.

Payers expect providers to develop processes to not count 2X (order and review)

MDM – Common "Test" Q & As <WPS Medicare>

- If a provider orders a CBC, lipid panel and a CMP how are these tests counted?
  - Each test has its own unique CPT code, therefore counts as 3 separate tests → Moderate data reviewed.
  - The differentiation between single or multiple unique tests is defined in accordance with the CPT code set. Diagnoses do not have to be different for each test.
    - EXCEPTION! Bilateral x-rays are counted as two "tests" even though is reflected in one CPT code (with modifier-50 or –RT/-LT)

MDM- CPT Errata – "Analyzed"

- What does "analyzed" mean?
  - Process of using the data as part of MDM for diagnosis, evaluation or treatment.
  - Assumptions are tests that are ordered are analyzed
    - Count at time of order
  - Tests ordered outside the encounter may be counted in the encounter in which they are analyzed/reviewed.
  - Recurring orders may be counted for each new result in the encounter it was analyzed/reviewed.
    - Example - Monthly PTTs → 1 test each time ordered/reviewed

Separately Reported "Professional Components"

- Separately reportable services

▶Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed

<Source: 2022 CPT Manual>

MDM – Amount/Complexity of Data

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed (*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.)

99204
99214
	Moderate	Moderate
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

99205
99215
	High	High
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

MODERATE = 3 documents OR independent interpretation OR Discussion with source ONE CATEGORY

HIGH = 3 documents OR independent interpretation OR Discussion with source MUST MEET TWO CATEGORIES!

MDM – Amount/Complexity of Data

- Key Definitions
  - **Independent interpretation** – The interpretation of a test for which there is a unique CPT code, and an interpretation or report is customary.
    - This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient.
  - **Appropriate source** – For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher).
    - Does not include discussion with family or informal caregivers.

E/M – Common "Independent Interpretation" Q & As *<WPS Medicare>*

- Can a clinical lab test be counted as "independent interpretation"?
  - NO! This element is for those services having a separate professional component. This could include radiology, some cardiology services (e.g., EKGs), anatomical pathology.
  - Clinical lab tests are mostly 100% technical services.

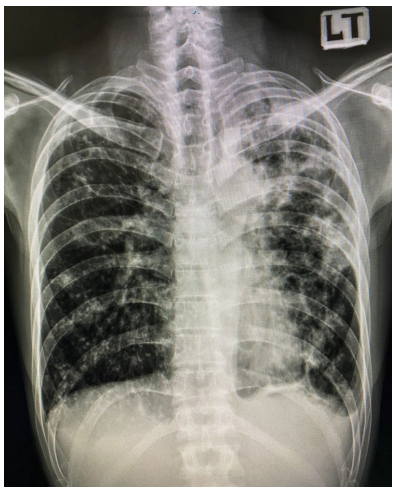
MDM – CPT Guidelines for "Test Interpretation"

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM.◀

<Source: 2022 CPT Manual>

E/M – Common "Independent Interpretation" Q&As

- What is the difference between "review of results" of a radiology test and "independent interpretation"?
  - Cutting and pasting the radiology report into the note is not independent interpretation
  - Documentation should support that a review of the actual images was performed and supplemental documentation from the provider with their interpretation.
    - However, does not have to conform to usual standards of report.



MDM – CPT Errata "Combination of Data Elements"

- Data elements may be **summed**. *<CPT 2022>*
- Example: Test ordered (1) + external note reviewed (1) + independent historian (1) = 3 – Moderate

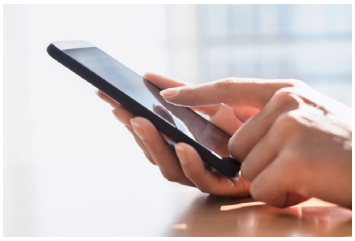
Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*

Moderate
(Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
• **Any combination of 3 from the following:**
  • Review of prior external note(s) from each unique source*;
  • Review of the result(s) of each unique test*;
  • Ordering of each unique test*;
  • Assessment requiring an independent historian(s)
or
Category 2: Independent interpretation of tests
• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
or
Category 3: Discussion of management or test interpretation
• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

E/M – Common "Discussion of Management or Test Interpretation" *<WPS Medicare>*

- What if a provider sends a summary of their visit with the patient to the patient's primary care provider is this considered "discussion" of patient management?
  - NO! Discussion means "the action or process of talking about something in order to reach a decision or to exchange ideas."
- What if two providers are texting or messaging each other about a patient's care? Is this considered "discussion?"
  - Yes, using technology is a valid source, however, must be initiated and completed within a day or two.

<CPT 2022>



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Pop "Doc" Quiz – *Raise Your Hand*

- A provider orders and reviews the results of a CBC without differential (85027), a CBC with differential (85025), and a urinalysis (81001).
  - How many tests would be counted towards MDM?
    - 2 tests
    - 3 tests

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Pop "Doc" Quiz

- A provider orders/ reviews the results of a CBC without differential (85027), a CBC with differential (85025) and a urinalysis (81001).
  - How many tests would be counted towards MDM?
    - 2 tests
    - 3 tests
  - Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes.
  - For example, a CBC with differential and a CBC without differential both would include white blood cell analysis. *<CPT E/M guidelines>*

Limited
(Must meet the requirements of at least 1 of the 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 the result(s) of each unique test*;
  - ordering of each unique test*

or
Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, se moderate or high)

Moderate
(Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
- **Any combination of 3 from the following:**
  - Review of prior external note(s) from each unique source*;
  - Review of the result(s) of each unique test*;
  - Ordering of each unique test*;
  - Assessment requiring an independent historian(s)

MDM – Risk of Morbidity/Mortality

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A			N/A
99202 99212	Straightforward			Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low			Low risk of morbidity from additional diagnostic testing or treatment

No examples included in the AMA "grid"

MDM – Risk of Morbidity/Mortality

99204 99214	Moderate			**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

AMA

MDM – Risk of Morbidity/Mortality

- **Prescription drug management**
  - The definition has not changed for "Prescription Drug Management" and is based on documented evidence that the provider has evaluated medications as part of a service, in relation to the patient. This may be a prescription that is currently written, discontinued, or a decision to maintain a current medication or dosage. Simply listing current medications is not adequate. *<Noridian Medicare, Nov 2020>*

DOES NOT INCLUDE VACCINATIONS OR USE OF CONTRAST ADMIN FOR IMAGING

"Good control on all current medications, continue as noted"

**Over the counter drugs are not automatically considered "low" therefore were omitted

E/M – Common "Prescription Drug Mgmt" Q & As *<WPS Medicare>*

- If the provider instructs a patient to take a higher dosage of an over the counter (OTC) drug does this count?
  - NO! These are still considered OTC drugs that do not require a prescription.
- Can a prescription refill be counted as "management"?
  - NO! If there is no documentation to report an E/M service.
- Can drug management be counted if the provider reviews pros/cons even if the medications were only considered?
  - YES! You can also count prescription medications considered but not given based on patient interaction, possible other drug interactions, etc.
- Does this include if a provider gives a sample of a prescription drug?
  - YES! This is still considered prescription drug management.

Pop "Doc" Quiz

- Would this suffice for "prescription drug management" for MDM?

Circulatory

Coronary artery disease involving native coronary artery of native heart without angina pectoris - Primary
No significant symptoms of chest pain consistent with coronary artery disease. She does have mild impaired LV systolic function with small regional wall motion abnormality due to a myocardial infarction and stent placed in 2014.

Relevant Medications
losartan (COZAAR) 50 mg tablet

Nonrheumatic aortic valve stenosis
The patient appears to have moderate aortic valve stenosis. Her echocardiogram in July showed a peak velocity of 3.4 m/s but her valve area appears to be at least moderate but likely not severe.. She does have a fairly normal closing S2 sound so I suspect it is not as severe as what it looks like on echo. I recommend that her primary care orders a follow-up echocardiogram again in July of this year we will reevaluate the patient in 1 year

Relevant Medications
losartan (COZAAR) 50 mg tablet

MDM – Risk of Morbidity/Mortality

- What is considered "**surgery with risk factors**"? Is it the surgery or the patient's co-existing conditions that increase overall risk?
  - BOTH! The individual patient may present special risks due to an underlying disease such as diabetes, coronary artery disease, liver disease or pulmonary disease. The surgical procedure could be inherently risky in all patients with a known increased operative risk, such as repair of an abdominal aortic aneurysm when leaking or ruptured. *<Palmetto; palmettogba.com>*

Be sure to document co-existing conditions

"Is this surgery risky for this specific patient based off co-existing conditions?"

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MDM – CPT Errata – Minor/Major Surgery

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.

Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Global Periods Merely a Guide – Not Absolute

2022 CPT

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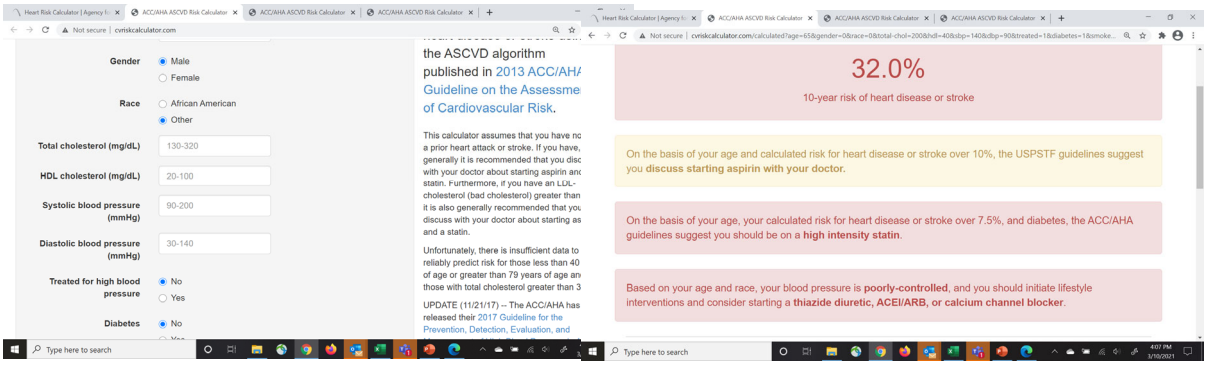
MDM – CPT Errata – "Risk Factors"

Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.



- Source: http://www.cvriskcalculator.com/ **Agency for Healthcare Research and Quality (AHRQ)**

MDM – Risk of Morbidity/Mortality

- Key Definitions
  - **Social determinants of health** – Economic and social conditions that influence the health of people and communities
    - Examples – Food insecurity or homelessness

Does NOT include Patient Noncompliance (Z53.-)

For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. **Patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the health record by either a clinician or provider.**

MDM – Risk of Morbidity/Mortality

99205 99215	High			**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 • Decision not to resuscitate or to de-escalate care because of poor prognosis

AMA

MDM – Risk of Morbidity/Mortality

- Key Definitions
  - **Drug therapy requiring intensive monitoring for toxicity** –A drug that must be monitored due to the potential to cause serious morbidity or death.
    - May be long term (at least quarterly) or short term
    - Monitoring may be by lab test, physiologic test, or imaging
      - Monitoring by history and exam is NOT counted!
    - Examples – Cytopenia in a patient undergoing chemo, INRs for a patient on anticoagulant

Do not use for monitoring Glucose levels during insulin therapy or annual electrolytes and renal function for patients on diuretics!

Documentation should include drug levels obtained at appropriate intervals.

Medical Decision Making – Drug Therapy and Monitoring

- CPT defines drug therapy requiring intensive monitoring for toxicity as the following:
  - *"A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and **not primarily for assessment of therapeutic efficacy**. The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient….*

<Source: 2022 CPT Manual>

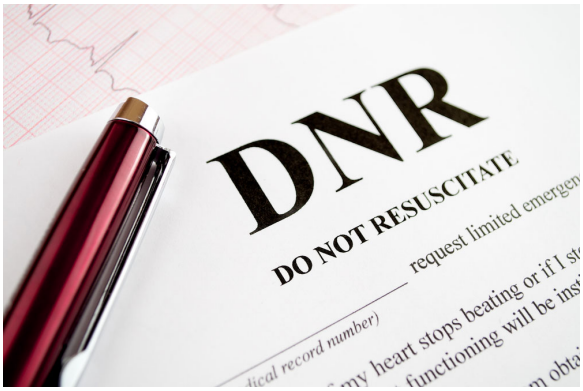
MDM – Risk of Morbidity/Mortality

- Decision for hospitalization
  - Discussion of possible hospitalization is also included, even if the decision ends up being no. *<WPS Medicare>*

Does NOT include merely sending a patient to the Emergency Room <WPS Medicare>

MDM – Risk of Morbidity/Mortality

- Do not resuscitate (DNR)
  - Does not automatically equate to a high level of risk
  - Documentation should support that the patient has a poor prognosis or can be inferred from the note. <*palmettogba.com*>



MDM – Risk of Mortality/Morbidity

- To qualify for a given type of medical decision **TWO OF THE THREE** elements (# diagnoses, amount of data reviewed, and risk of mortality) must be met or exceeded.
  - For example:
    - Patient is seen for one stable chronic illness (Hypertension) → Number of problems addressed = **Low**
    - Provider obtains medically necessary history and exams the patient and takes the patient's BP → Amount of data to review = **Minimal or none**
      - There is no unique CPT code for taking the patient's BP
    - Provider determines that the patient has good control over their hypertension with their current prescription Bumex® and documents to continue at current dosage. → Risk of mortality = **Moderate**

Medical Decision Making – Abbreviated Table

# and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Low ✓	Limited	Low	Low complexity
Moderate	Moderate	Moderate ✓ ✚	Moderate complexity
High	Extensive	High	High complexity

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Using MDM – The Advantage

- Established definitions
- Similar to "key component" methodology
- Complex patients with short visit times (ENT, Dermatology)
  - Patients with separately reportable procedures during same session
- Patient encounters with multiple tests ordered especially ones including radiology, pathology – Independent interpretation
- Patient encounters resulting in major surgical procedures
- Patients requiring medication related visits (Rx management, monitoring)

A visit can be assigned based on time OR MDM - Choose most advantageous <WPS Medicare>

BEST PRACTICE- DOCUMENT BOTH

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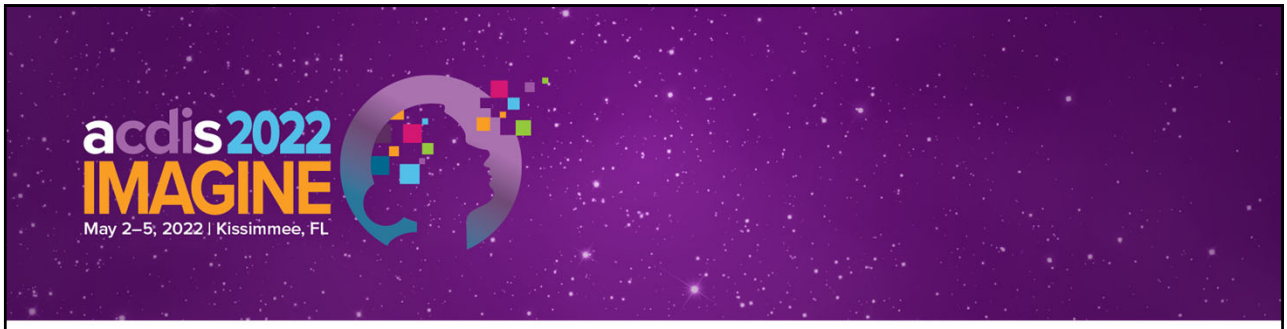
What's (Possibly) New for 2023?

- Deletion of 99241, 99251 (consult codes)
- "Mystery" revisions to Emergency Department services (99281-99285)
- Deletion of observation care codes (99217-99226) and incorporating into the initial and subsequent inpatient services codes (99221-99223 and 99231-99233)
- Deletion of prolonged outpatient services codes (99354-99357) since they can't be used with office visit codes anyway
  - Replacing with 2 new codes (TBD)
- Revision of +99417 (will they concede to CMS's "maximum time"??)



Good medical decision making in E/M is not whether the provider HAS the knowledge… it is whether the documentation SUPPORTS that knowledge accurately!