Part B Insider (Multispecialty) Coding Alert

Documentation: Utilize MDM Notes to Assist With Coding E/M Charts

Concise documentation is a boon to long-term treatment planning.

If your outpatient E/M coding is still a work in progress, you are not alone. The 2021 changes to outpatient E/M codes (99202-99215) were dramatic, and many coders are still adjusting to the policies.

Remember: Although history and examination should still be performed and documented as the visit dictates, they are no longer deciding components in the code choice for office/ outpatient E/M services. Instead, you've been basing your office visit coding levels this year exclusively on either time spent or medical decision making (MDM). And when it comes to MDM, many practices have expressed confusion about how to arrive at the correct level.

If you're looking for some solid advice about evaluating your MDM level, check out these quick tips from **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, CMCS**, of CRN Healthcare in Tinton Falls, New Jersey. Cobuzzi recently shared answers to several of the most common questions that Medicare providers have about calculating MDM levels.

Tip 1: 2 Out of 3 Elements Can Dictate MDM Level

As most coders know, the MDM table includes three elements that can help you select the MDM level:

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

If you're poring over charts and reports to try to pinpoint an MDM level because you want to meet all three criteria, keep in mind that you must only meet two of the three to justify a particular MDM level, Cobuzzi said.

"This means that if one area is weak, we are able to drop it - and counting the data elements can be a challenge. There are a lot of variables that you can have arguments with payers about in terms of collection of data, and it's my recommendation that, when possible, you concentrate on the number and complexity of problems being addressed during your encounter rather than the amount of complexity of data being reviewed. And then also focus on the risk of complications and morbidity or mortality of patient management," Cobuzzi advised.

Tip 2: Understand What a 'Problem' Is

When you're evaluating the number and complexity of problems addressed, remember that if you see a patient with a high number of differential diagnoses, you should be listing them all to justify MDM, even though you're ultimately going to assign just one diagnosis to the patient's claim for the day, Cobuzzi said.

Why? The reason is because you need to count all of the problems the provider addresses, she said. "Let's talk about what a problem is," she noted. "A problem is a disease, a condition, an illness, an injury, a symptom, a sign, a finding from a lab, a complaint, or other matters that are being addressed during the visit, with or without a diagnosis being established at the time of the visit." For example, consider dizziness, where many differential diagnoses are evaluated. Now, a physician can count all of the possible diagnoses considered for a dizzy patient, which increases the complexity of problems addressed for the MDM.

Additionally, a patient can give you a sign or symptom, but you may not establish a diagnosis for that problem during the

visit, Cobuzzi acknowledged. However, evaluating it still adds complexity to that visit.

Tip 3: Think in Ink

The point of documenting all the problems you addressed during a visit is to make sure a payer would be able to visualize the thought process you used while analyzing a patient's problems (and managing them), Cobuzzi said.

"You want to think in ink," she said. "Take everything you're thinking and record it as part of the medical decision making."

Tip 4: Record Your Treatment Goals

When you're reviewing the number and complexity of problems addressed, you'll note that you have the option of evaluating what the MDM table refers to as "stable, chronic illnesses." For most practices, "chronic" means that the illness will last at least one year or until the death of the patient. But for the "stable" part of the definition, it may be a little bit more challenging to evaluate.

"Stable means that the patient is at their specific treatment goals," Cobuzzi explained. "For instance, let's say the patient has chronic sinusitis, and you set a goal that they will only get one sinus infection or fewer in a year. If they only get one acute sinus infection that year, then that's considered a stable, chronic illness. But if you had set your goal indicating that they would get no sinus infections and they end up getting one, then you cannot consider them stable."

To ensure that you can determine when a patient is considered stable, you should add a line to your templates so when a patient has a chronic illness, you have a place to enter a treatment goal. "The physician should be wanting to add examples for the patient, and there can be interim general treatment goals," Cobuzzi said. "For instance, in the beginning, you might want the patient to get down to three sinus infections in the year, and then you want them to get down to one infection in the year, and then you want them to get down to no infections in the year - this way, you don't want to make it so that your treatment goals are impossible, that they'll never get out of into a stable illness."

Resource: To review the AMA's MDM chart, visit www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.