Evaluation and Management

Medical Decision Making

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What's he thinking?

What Is the Table of Risk?

- 1 of 7 tables in the 1995 and 1997 E/M Documentation and Coding Guidelines.

- 1 of 3 preliminary tables that you can use along with the problem categories table and the type of data table, to determine the level of decision-making

3. Medical Decision Making

MEDICAL DECISION MAKING

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and duration of time is not specified. In that case, enter 3 in the total box.

Number of Diagnoses or Treatment Options

A	B	X	C	=	D
Problem(s) Status	Number		Points		Result
Self-limited or minor (stable, improved or worsening)	Max=2		1		
Est. problem (to examiner); stable, improved			1		
Est. problem (to examiner); worsening			2		
New problem (to examiner); no additional workup planned	Max=1		3		
New prob. (to examiner); add. workup planned			4		
			TOTAL		

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Bring total to line C in Final Result for Complexity (table below)

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Risk of Complications and/or Morbidity or Mortality

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g. pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Table of Risk

Why Should I Use the Sheets?

- support for your physician's code selection
- check your physicians' levels

- Watch out: You might have to use a different audit tool for some carriers.
  - TrailBlazer (Medicare Part B carrier for Texas, Virginia, Maryland and Delaware) has developed its own counting system

3 MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using Tables A.1 and A.2. Use the larger of the two "Totals" for Section D. Final Assignment of Medical Decision Making Type.

Table A.1 Number of Diagnoses

A "problem" is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		**Points**
Each new or established problem for which the diagnosis and/or treatment plan is evident with or without diagnostic confirmation		**1**
Each new or established problem for which the diagnosis and/or treatment plan is not evident	**2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation**	**2**
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	**3**
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	**4**
	Total Points	

Table A.2 Management Options

Important Note:	**These tables are not all inclusive.** The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended quantifications. Many other treatments exist and should be counted when documented.	**Points**
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it).		**0**
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required; however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes.	≤3 new or current medications per problem	**1**
	>3 new or current medications per problem	**2**
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		**1**
Physical, occupational or speech therapy or other manipulation		**1**
Closed treatment for fracture or dislocation		**1**
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making and was not standard facility "protocol"		**1**
Complex insulin prescription (SC or combo of SC/IV), hyperalimentation, insulin drip or other complex IV admix prescription		**2**
Conservative measures such as rest, ice/heat, specific diet, etc.		**1**
Radiation therapy		**1**
Joint, body cavity, soft tissue, etc injection/aspiration		**1**
Patient education regarding self or home care		**1**
Decision to admit to hospital		**1**
Discuss case with other physician		**1**
Other		**1**
	Total Points	

How Does Risk Tie Into MDM?

- Medical decision-making (MDM) is comprised of:
  1. Number of diagnoses or management options
  2. Amount and/or complexity of data to be reviewed
  3. Risk of complications and/or morbidity or mortality

- physician must meet or exceed 2 of the 3 elements

How Should I Evaluate Type?

- You can't read your physician's mind
- They can help you see what was involved by completely documenting the process
  - include all diagnoses and any suspected problems or concerns, including rule-outs
- Don't overlook: You won't code the rule-outs, but documenting them shows a more involved MDM type.

What Should I Look For?

- To weigh the type of risk, zoom in on:
  1. Diagnosis
  2. Status
  3. Risks, treatments or management

  - Map these to the CMS medical point-making system.

E/M Documentation Auditor's Instructions

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY

HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions OR		☐ Status of 1 2 chronic conditions		☐ Status of 3 chronic conditions
HPI (history of present illness) elements: ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms		☐ Brief (1-3)		☐ Extended (4 or more)
ROS (review of systems): ☐ Constitutional (wt loss, etc) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovasc ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymph ☐ All/immuno ☐ All others negative	☐ None	☐ Pertinent to problem (1 system)	☐ Extended (2-9 systems)	☐ *Complete
PFSH (past med ical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of medical events in the patient's family including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities)		☐ None	☐ Pertinent (1 history area)	☐ **Complete (2 or 3 history areas)
	PROBLEM FOCUSED	EXP.PROB. FOCUSED	DETAILED	COMPREHENSIVE

*Complete ROS: 10 or more systems, or some systems with statement "all others negative".

**Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care, b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care, b) Consultations, c) Initial hospital care, d) Hospital observation, e) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	COMPREHENSIVE EXAM

EXAM

Body areas: ☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Neck ☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity	☐ 1 body area or system	☐ Up to 7 systems	☐ Up to 7 systems	☐ 8 or more systems
Organ systems: ☐ Constitutional (e.g., vitals, gen app) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm				
	PROBLEM FOCUSED	EXP.PROB. FOCUSED	DETAILED	COMPREHENSIVE

Example

- An ENT sees a patient with a diagnosis of otitis media (OM) and decides the patient requires tubes. The physician orders no tests and reviews no records. The patient is scheduled for tympanostomy (69436, Tympanostomy [requiring insertion of ventilating tube], general anesthesia).

Classify Problem's Status - Table 1

- Follow these rules:
  - If the ENT has previously treated the patient for OM, CMS considers the problem established and awards 2 points for an established problem that is inadequately controlled, worsening or failing to progress as expected
  - If this is the first time the ENT is treating the patient for OM, you should consider the diagnosis a new problem, which is worth three points

Table 1 – con't

- Why is there a point difference?
  - CMS expects that the decision-making for a known problem is less than that of a new problem

- Who is the problem new to?
  - The sheet indicates "to the examiner". The problem has to be new to that provider. The increased score for a new problem is given because working up a new problem involves more work than assessing a problem that is established or familiar to the physician.

Self-Limited or Minor

- Examples on Table of Risk:
  - Cold
  - Insect Bite
  - Tinea Corporosis

- assign 1 point

Self-Limited or Minor

- Definition:
  - "A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance."

Table 1 – cont'd

- CMS guidelines state,
  - "The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one."
- Risk measures the chance of the patient becoming worse from the time he leaves the physician's care to the next visit.
  - A common cold carries minimal risk, consistent with the definition of a minor or self-limited problem.

Example

- An established male patient previously diagnosed as a controlled-diabetic presents with complaints of a runny nose and congestion without any other symptoms.
- Ignoring the co morbidities and listing only the presenting problem diagnosis, will make the visit qualify for the lowest risk level.
- The physician should also consider the effect the patient's diabetes has on management options, and if the physician treats the condition, they should report 250.00 (Diabetes mellitus …) for addressing the underlying disease.
- Documentation guidelines state, "Co morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented."

Example

- An ENT sees a patient with a diagnosis of otitis media (OM) and decides the patient requires tubes. The physician orders no tests and reviews no records. The patient is scheduled for tympanostomy (69436, Tympanostomy [requiring insertion of ventilating tube], general anesthesia).

Calculate Reviewed Data

- The ENT did not review any data so he receives a 0 in this table.
- Remember to map your CPT® codes to the areas listed in the Amount and/or Complexity of Data Reviewed table.
- Give 1 point for clinical lab tests like urinalysis or a strep test. (80000 series codes)
- Don't miss: The table counts medicine tests (90000 codes) separately. If a physician reviews an x-ray and orders an ECG, give 1 point for each of these tests.

Don’t Double Dip!

- If the physician is coding the service like an x-ray, allergy testing, or an ENG at this service or another, they are already receiving credit for the review in the test code.
- Give points for work the physician could not otherwise get credit for.
  - ei: a strep test that an outside lab is reading or an x-ray that an outside radiologist reads
- “Do not report [E/M] services for test interpretation and report.”

Data – cont'd

- Poor historian
  - record who the historian is
  - why the patient is not giving the history.

Example

- A babysitter attempting to give the history for a small child. If time doesn't dominate these encounters qualifying them for time-based coding, consider giving a point in this table for "decision to obtain history from someone other than parent."

Select Risk Level

- based on the single **highest** element identified in the table of risk's three columns (1 of 3).
- Do **not** need one element in each column.

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clincal laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with addititives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Look to History

- OM Patient
  - Should you classify OM with a decision for tubes as a presenting problem that is stable chronic (low), acute uncomplicated illness (low), or acute illness with systemic symptoms (moderate)?
- If there is documented hearing loss, balance dysfunction, speech/language delay, tympanic membrane rupture, you could argue that it represents an acute or chronic illness that may pose a risk to loss of function, classifying the presenting problem as high.

Count Tests/Labs - Column 2

- To calculate the diagnostic procedures level, you'll focus on any workup the Otolaryngologist ordered.

- Because the physician in the OM case study did not order or review any diagnostic procedures, you have no circle in column two.

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
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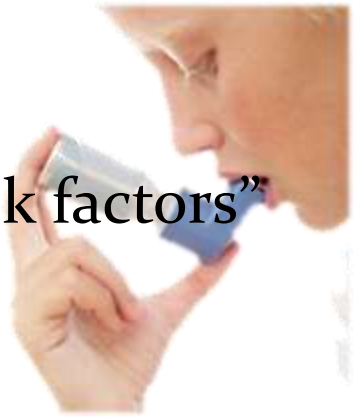
Tip: Check Hx

- check if the patient has any identified risk factors
- refers to the patient's unique medical history that might affect the outcome.
- Asthma example:
  - circle "minor surgery with identified risk factors"
  - ups level from low to moderate.



Jump to ‘High’ for Risk Exceptions

- “diagnostic endoscopies with no identified risk factors” = moderate risk
- “diagnostic endoscopies with identified risk factors” = high risk
  - Don’t increase the risk factor just because the patient’s undergoing a scope.

Jump to ‘High’ for Risk Exceptions

- Do this: Usually give a physician moderate risk credit for ordering a scope. All patients undergoing an endoscopy face a certain amount of risk, so the ordering of the endoscopy is always the same.

- Exception: If a patient has identified risk factors, increase the risk factor from “moderate” to “high”.

Weighing Medication = Moderate

- Giving samples involves this same process.

- How AMA Weighs Managing Drugs
  - The table of risk in the AMA-approved 1995 E/M guidelines lists prescription drug management as a common clinical example of moderate risk. The provider has to evaluate the suitability of the patient for the medication and weigh the benefits and risks.

Weighing Medication – cont'd

- What Counts as Prescription/Drug?
  - Giving samples with or without a prescription all falls under prescription drug management. The process of prescription drug management would include giving the patient the actual meds as samples, the thought process and risk would remain the same as writing it down on a piece of paper.
- Example:
  - A female patient has allergic rhinitis. The allergist gives her samples of Astelin to try as needed. He tells the patient to call in for a prescription if she feels the prescription helps. This case constitutes prescription management.

OTC

- = low risk
- Risk assessment relates to the disease process anticipated between the present encounter and the next one.

Identify Risk With Highest Circle

- chronic otitis media with effusion (381.3) and documentation support a chronic illness with progression,
- child who is new to the ENT has no comorbidities.

Level of risk	Presenting problem(s)	Diagnostic procedures ordered	Management options selected
Low			Minor surgery
Moderate	Chronic illness with progression		

- Assign the level based on the highest circle.
- The highest level is moderate.

Tally Final MDM

- enter the 3 tables' scores in the Final Result for Complexity table.
- Determine the final score using 2/3 elements.

Number of diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
Highest risk	Minimal	Low	Moderate	High
Amount and complexity of data	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making	Straight-forward	Low complex	Moderate complex	High complex

No Column Has 2 Circles

- draw a line down the column with the second circle from the left
- Example:
  - A patient has allergic rhinitis that's usually controlled with Allegra-D but weather changes trigger the patient's allergies, which precipitates her sinusitis. The patient's sinusitis is a new problem to the pediatrician and he plans no additional work-up and orders no tests. The patient, an adolescent, gives her own history. The pediatrician has previously treated the patient's allergies and writes her a prescription telling her to fill it if after she finishes the samples provided. She decides the Xyzal is decreasing her sinusitis and allergic rhinitis exacerbations.

No Column Has 2 Circles

Number of Diagnoses or Treatment Options	0- 1 Minimal	2 Limited	3 Multiple	4 or more Extensive
Highest Risk	Minimal	Low	Moderate	High
Amount and/or Complexity of Data Reviewed	0- 1 Minimal or low	2 Limited	3 Multiple	4 or more Extensive
Type of decision making	Straightforward	Low complexity	Moderate complexity	High complexity

Combining History, Exam, MDM

- Example:
- When a patient comes into the office complaining of chest pain, we often order lab work, an ECG, and send the patient to the hospital. These instances involve moderate to high risk but we do not perform a complete review of systems (ROS) due to the presenting problem's emergent nature.
- Will these be level 4 or 5 established patient office visits?

Answer:

- Choose level based on the medically necessary history, exam, and medical decision making (MDM) that is performed and documented at each encounter.
- Probable combos:
  - detailed history + detailed/comprehensive exam + mod/high MDM
- MDM, plus the amount of exam, ultimately determine whether 99214 or 99215.

MDM

- 4 points in the "Number of Diagnoses or Treatment Options" area for the new problem to provider with additional work-up planned
- total of 2 points in the "Amount and/or Complexity of Data to be Reviewed" section.
  - 1 point for ordering lab work
  - 1 point for ordering the ECG
- Because the diagnoses level puts you at a high level and the data amount is at a low level, the risk will determine whether the MDM is high complexity (if risk is high) or moderate complexity (if risk is moderate).

History

- Extended HPI - asking the patient about the severity, duration, quality, context, etc. of the pain
- Pertinent PFSH - any past personal or family history of heart disease
- Detailed ROS - questions about the constitutional and cardiac systems
  - Extended HPI + extended ROS + pertinent PFSH = detailed history.

Which Exam Level?

- Comprehensive exam - 8 or more systems -- such as constitutional, eyes, ENT, detailed cardio, respiratory, skin, neurological, and psychological
- Detailed exam - If the severity didn't allow for anything other than constitutional (vitals, general appearance) and detailed cardio, you may still be at a detailed exam.

AAPC April 1-4

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