Training Session Handouts

Get More E/M Money with New 2021 Medical Decision-Making Rules

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Complexity of Medical Decision Making

Make the Right Decision to Optimize Reimbursement while Maintaining Compliance

DECIPHERING MDM

Office and Other Outpatient Services
99202-99215

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OBJECTIVES

- Review the new office and other outpatient billing requirements
- Review the 3 MDM elements
- Discuss how to quantify data
- Discuss how to qualify risk
- Review MDM example

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MDM & TIME

Medical Decision Making (MDM):

- Number and Complexity of Problem(s) Addressed During the Encounter
- Number and Complexity of Data Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management Decisions…

Time:

- Total Visit Time

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MEDICAL DECISION MAKING

1. What is included in formulating MDM?

MDM includes establishing a diagnosis, evaluating the status of a condition, and/or identifying management option(s).

2. What are the MDM levels?

Straightforward (level 2), Low (level 3), Moderate (level 4), and High (level 5).

3. How is MDM calculated?

To qualify for a MDM level, two of three MDM elements for that level of MDM must meet or exceed.

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NUMBER & COMPLEXITY OF THE PROBLEM(S)

- Must be addressed on the encounter.
- Symptoms may cluster around a specific diagnosis & each symptom is not necessarily a unique condition. ICD-10-CM guidelines prohibit coding signs/symptoms when a definitive dx exists.
- Comorbidities in and of themselves do not increase the service level unless addressed and their presence increases the amount/complexity of data reviewed or increased risk to patient.
- Risk is the probability and/or consequences of an event. Ultimately, the provider is responsible for determining risk. The level of risk is based upon consequences of the problem(s) addressed at the encounter when treated.
- Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

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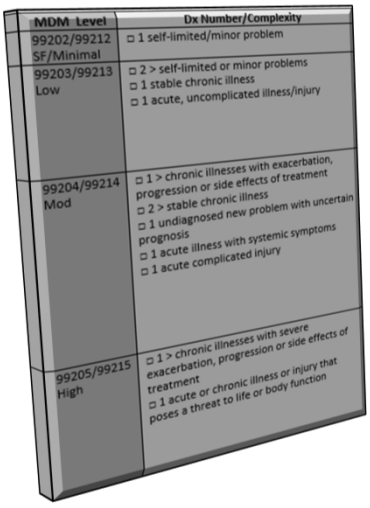
MEDICAL DECISION MAKING TABLE



MDM Level	Dx Number/Complexity
99202/99212 SF/Minimal	▫ 1 self-limited/minor problem
99203/99213 Low	▫ 2 > self-limited or minor problems ▫ 1 stable chronic illness ▫ 1 acute, uncomplicated illness/injury
99204/99214 Mod	▫ 1 > chronic illnesses with exacerbation, progression or side effects of treatment ▫ 2 > stable chronic illness ▫ 1 undiagnosed new problem with uncertain prognosis ▫ 1 acute illness with systemic symptoms ▫ 1 acute complicated injury
99205/99215 High	▫ 1 > chronic illnesses with severe exacerbation, progression or side effects of treatment ▫ 1 acute or chronic illness or injury that poses a threat to life or body function

This chart is for illustrative purposes only.

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NUMBER & COMPLEXITY OF THE PROBLEMS

- A **self-limited** or **minor problem** runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
- A **stable, chronic illness** has an expected duration of at least 1 year or until death.
  - ❖ Conditions are considered chronic whether or not stage or severity changes (e.g. uncontrolled DM and controlled DM are a single chronic condition).
  - ❖ *'Stable' for the purposes of categorizing MDM is defined by the specific tx. goals for the patient.*
  - ❖ A pt. not at treatment goal(s) is not stable.
- An **acute, uncomplicated illness/injury** is a recent or new short-term problem with low risk of morbidity. There is little to no risk of mortality with treatment and full recovery is expected.

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NUMBER & COMPLEXITY OF THE PROBLEMS

- A **chronic illness w/exacerbation, progression or side effect of tx**. is a chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression; requires additional care/attention to side effects, but does not require consideration of hospital level care.
- A chronic illness **with severe exacerbation…** has significant risk of morbidity and may require hospital level care.
- An **acute or chronic illness that poses a threat to life or bodily function in the near term without intervention/treatment.** Examples may include a new cancer diagnosis, new PE/DVT, acute MI, severe RA, psychiatric illness, acute renal failure, etc.

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DATA

- Data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
- Examples: Medical records from external sources, diagnostic tests, communication with external providers (e.g. inter-professional consult), etc.
- Data is divided into 3 categories:
  - Tests, documents, orders , or independent historian(s).
  - Independent test interpretation
  - Discussion of management or test interpretation with external physician/QHP or appropriate source.

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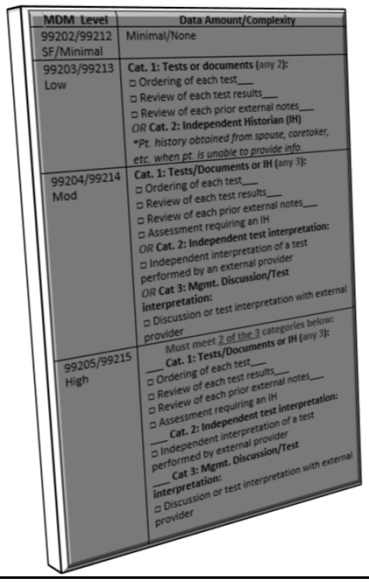
DATA



MDM Level	Data Amount/Complexity
99202/99212 SF/Minimal	Minimal/None
99203/99213 Low	**Cat. 1: Tests or documents** (any 2): □ Ordering of each test___ □ Review of each test results___ □ Review of each prior external notes___ *OR* **Cat. 2: Independent Historian (IH)** **Pt. history obtained from spouse, caretaker, etc. when pt. is unable to provide info.*
99204/99214 Mod	**Cat. 1: Tests/Documents or IH** (any 3): □ Ordering of each test___ □ Review of each test results___ □ Review of each prior external notes___ □ Assessment requiring an IH *OR* **Cat. 2: Independent test interpretation:** □ Independent interpretation of a test performed by an external provider *OR* **Cat 3: Mgmt. Discussion/Test interpretation:** □ Discussion or test interpretation with external provider
99205/99215 High	Must meet 2 of the 3 categories below: ___ **Cat. 1: Tests/Documents or IH** (any 3): □ Ordering of each test___ □ Review of each test results___ □ Review of each prior external notes___ □ Assessment requiring an IH ___ **Cat. 2: Independent test interpretation:** □ Independent interpretation of a test performed by external provider ___ **Cat 3: Mgmt. Discussion/Test interpretation:** □ Discussion or test interpretation with external provider

This chart is for illustrative purposes only.

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DATA AMBIGUITIES

1. How do I calculate numerous tests?

Each unique test is defined by CPT code. A group of tests in a panel that has a unique CPT code counts as 1 test.

2. How do I credit review of tests?

Ordering a test **is included** in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.

3. What if a provider needs to review notes from a previous encounter 2 years ago, can that be counted towards review of medical records?

A provider cannot receive credit for reviewing their own records.

4. Can a parent be an independent historian when the patient is a child?

If the child is an infant or young enough where they cannot give a history. Also acceptable in cases where an adolescent is unable to recount or recall information and the parent has to "fill in gaps."

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DATA AMBIGUITIES

From the AMA:

Thank you for contacting the AMERICAN MEDICAL ASSOCIATION with your coding inquiry.

Although, this topic was discussed during the CPT Symposium, there are still some unresolved issues regarding the "unique" test definition - and whether ordering and reviewing should be separated. The below information may change in the near future.

For now, it is correct that one cannot get credit for INDEPENDENT interpretation if the test has a "PC" and is reported. But it is also true that one cannot get credit on an order or review of any test that is billed. The goals was to not reward ordering services that are also paid.
There is language in "Separately Reported" section of CPT that may be of assistance to you. Notice "performance and/or interpretation".

Services Reported Separately
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...

Question: Our employed physician or other QHP receive no compensation for labs performed in their clinic. The wording of "separately reported" typically indicates reimbursement, but that isn't the case with our physician or QHPs. This includes point of care labs. May all labs be counted as data when ordered? May they be counted as reviewed when the patient returns to the office, or do we need to choose counting it as ordered or reviewed, but not both?

Answer: If your physician or other QHP are not billing for the labs, ordering and review of a lab test may be counted as a single component towards medical decision-making when the test is ordered. Per CPT Assistant, November 2020, E/M Changes 2021, "it is assumed that the physician or QHP will review the results of the test ordered; therefore, the physician or QHP would not receive dual credit toward MDM for service level selection for both ordering and reviewing the test. Ordering and reviewing a test are considered a single component for MDM when ordered even if ordering the test and subsequent review are performed on different days. The 2021 guidelines state that "ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter."

Thank you for your inquiry and we hope this information is of assistance to you.

CPT Education and Information Services

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RISK

- The risk of complication and/or morbidity or mortality of patient management decisions **made at the visit,** associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).
- Includes the possible management options selected, and those considered but not selected.
  - **Low:** Risk of morbidity w/o treatment is low; there is little to no risk of mortality w/o treatment; full recovery is expected w/o functional impairment.
  - **Moderate:** Risk of morbidity w/o treatment is moderate; there is moderate risk of mortality w/o treatment; uncertain prognosis **OR** increased probability of prolonged functional impairment.
  - **High:** Risk of morbidity w/o treatment is high to extreme; there is moderate to high risk of mortality w/o treatment **OR** high probability of prolonged functional impairment.

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RISK

MDM Level	Risk of Morbidity Examples
99202/99212 SF/Minimal	**Minimal:** Rest; Gargles; CXR; UA; lab test requiring venipuncture; US/ECHO
99203/99213 Low	**Low:** OTC drug; Rx antibiotic; Skin biopsy; Minor surgery w/no identified risk factors; PT/OT; IV fluids w/o additives; CT w/contrast
99204/99214 Mod	**Mod:** Deep needle/incisional biopsy; Elective major surgery w/no identified risk factors; LP/Thoracentesis; Rx drug (excludes short-term antibiotics); Therapeutic nuclear med; IV fluids w/additives; Treatment limited by SDOH
99205/99215 High	**High:** Elective or emergent major surgery; Parenteral controlled drug (i.e. Morphine); Drug therapy requiring intensive toxicity monitoring via test; Decision not to resuscitate or to de-escalate care because of poor prognosis (hospice)

This chart is for illustrative purposes only.

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CPT (2021) RISK DEFINITIONS

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social Determinants of Health: Economic and social conditions that influence the health of people and communities.

Drug Therapy Requiring Intensive Monitoring for Toxicity: Therapeutic agent that has the potential to cause serious morbidity or death.

- Monitoring is performed for assessment of these adverse effects and not to validate treatment efficacy.
- Intensive monitoring may be long-term or short-term. Long-term monitoring is not performed less than quarterly.
- Monitoring should be performed by lab or physiologic testing.
- If the primary reason for monitoring is therapeutic, it does not qualify.

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RISK

Risk examples where there isn't a new treatment or intervention documented:

- Think about how the condition is managed? What happens to the patient if not medically intervened on? For the below example, there is no intervention in terms of meds, biopsy, etc. There is also no order for diagnostic study, labs, record review, etc. A provider may consider what is the risk if the patient stops taking the meds? What is the probability of death for this patient? **The below would be audited as a 99213.**

CHIEF COMPLAINT:

The patient returns today for reevaluation of CLL.

Active *Problems:*

Assess: CLL (C91.10) -:

Status: Ongoing

Plan: Continue Calquence therapy. Continued mild improvement in lymphocyte count.

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A NOTE ABOUT TIME

PFS Payment for Office & Outpatient E/M Visits (01/11/2021 CMS Fact Sheet)

- Effective January 1, for Physician Fee Schedule (PFS) payment of office and outpatient Evaluation and Management (E/M) visits (CPT codes 99201 through 99215), Medicare generally adopted the new AMA coding, language, and interpretive guidance framework.
- PFS payment of Medicare's add-on codes for prolonged office and outpatient visits (G2212) ~~and visit complexity (G2211)~~
- **Medical review when time is used to select visit level**

MEDICAL REVIEW WHEN PRACTITIONERS USE TIME TO SELECT VISIT LEVEL

Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.

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QUESTIONS

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RESOURCE

- AMA. CPT 2021 Professional Edition. Pgs.12-15.
- CMS. Physician Fee Schedule (PFS) Payment for Office/Outpatient E/M Visits – Fact Sheet. 2021. https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

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