November 3, 2017

Auditing Medical Decision Making

With CMS looking to gradually revise its E/M documentation requirements to reduce the burden and complexity they pose to providers, it's a great time to review the trickiest E/M component: medical decision making (MDM).

Remember: CMS is considering several tweaks to its E/M guidelines, and suggest that it could reduce the emphasis on the history and exam components in favor of MDM (or in the case of counseling - dominated visits, the amount of face time spent with the patient). In the 2018 Medicare Physician Fee Schedule (PFS) final rule, the agency says it will make no changes for next year, but will consider all feedback received for future rulemaking.

What is MDM and is it different from medical necessity?

The history and exam components are easy to understand in principle; history is about collecting information from the patient and/or records, while the exam is just that - a physical (or more limited) exam of the patient's body.

MDM is a more complex concept: It represents CMS' best effort to quantify the amount of cognitive labor required to evaluate and treat the patient's

problems. It is often seen by payers as the most important key component, more so than the history

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or exam, particularly in an era where EHR templates can allow providers to easily document the highest level of history and exam with just a few clicks.

However, MDM is not the same concept as "medical necessity" - the latter is seen as the one overarching criterion for supporting any level of service. Medical necessity is often confused with MDM or used interchangeably, but it is actually a distinct concept, and the difference is significant:

- MDM is more relevant to CPT than to insurance payers because it is referenced in all CPT code descriptors for E/M services as a way to describe providers' cognitive labor.
- Medical necessity is the requirement that a service is "reasonable and necessary."
- Medical necessity is not quantified via any grid or tool, but is either met or not met; it is met when a service (any service, not just E/M) "is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition," according to the Medicare Program Integrity Manual (chapter 13, section 5.1).
- Thus medical necessity is more relevant to payers than CPT because it answers the crucial question of whether the cost of the service was a justifiable use of resources given the patient's condition.

While medical necessity has no numerical metric like a point system, the closest proxy for medical necessity would be one of the three subcomponents of MDM: the "number and nature of presenting problems." Managing multiple problems whose nature is severe would support a higher code level based on medical necessity, as long as all the other E/M components are also met.

Number and nature of problems
This first element of MDM may be the simplest to understand, at least in principle. It asks how many problems does the patient have that will be evaluated and managed during this specific visit, and what is the nature of these problems? This element is scored on a point system, from 1 to 4 points maximum.

- **Self-limited/minor**. These are minor problems or those that will resolve on their

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own without the need for intervention. Worth 1 point, capped at 2 points total.

- **Established problem, stable/improved**. These problems are established (already known/previously evaluated) to the provider, not the patient. Worth 1 point and without any cap.
- **Established problem, worsening**. Established problems that have worsened, or are failing to respond as expected to treatment. Worth 2 points, no cap.
- **New problem, no additional workup**. These problems are new to the provider (have not been previously evaluated), but no additional workup is planned to address them. Worth 3 points, capped at 3 points total.
- **New problem, additional workup planned.** New problems that have additional workup documented in the note. Worth 4 points, no cap. Additional workup would be any work (tests, labs, studies, specialist referrals) that are expected to occur outside the current visit. Procedures do not count as additional workup unless diagnostic in nature.

Amount and complexity of data review
This element accounts for any diagnostic data that the provider reviews during the visit, including ordering diagnostic tests, discussing results with other providers, or digging up old records. It is also scored on a 1-4 point system, with a maximum of 4 points.

- **Review/order clinical labs.** Clinical labs include analysis of specimens such as blood, urine, feces, synovial fluid, semen, etc. For easy reference, clinical labs will refer to the ***CPT code range 80047-89398***. Worth 1 point for review or order.
- **Review/order radiology tests**. Radiology tests include imaging studies such as X-rays, CT scans, MRIs, etc. For easy reference, radiology tests will refer to the ***CPT code range 70010-79999***. Worth 1 point for review or order.
- **Review/order medicine tests**. Medicine tests include EKGs, EEGs, ECGs, audiometry tests, speech or swallow studies, allergy testing, etc. For easy reference, medicine tests will refer to the ***CPT code range 90700-99199***. Worth 1 point for review or order.
- **Discuss test with performing physician**. Requires that the provider discuss the

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patient's case with the physician who performed and/or interpreted the test. The note must state the discussion occurred and summarize the findings; worth 1 point.

- **Independent review of image, tracing, or specimen**. Requires the provider to personally review a diagnostic test result, whether an image, tracing, or specimen, and document his/her takeaways (i.e. summarize the results). This may be done regardless of whether there is already an interpretation or report by another physician (so long as another provider has or will eventually perform an interpretation), but it must be based on a personal review of the test result itself rather than an existing interpretation or report. Worth 2 points.
- **Decision to obtain old records**. Deciding to obtain a patient's prior records, and documenting that this decision was made, is worth 1 point. Also credited for obtain history from someone other than the patient.
- **Review and summarization of old records**. This requires reviewing a patient's past records (whether progress notes or lab results) *and* summarizing them. The summary can be a concise 1-2 sentence description but it should be specific and unique to that patient (generic statements such as "old records were reviewed" cannot be credited). Typically a total 3 points is credited if the note states a decision to obtain old records was made, and then those records are reviewed and summarized. Also credited for review and summary of history from someone other than the patient.

Overall risk to the patient
This last element of MDM is often the murkiest, because the official guidance consists only of the CMS Table of Risk, a document that is not intended to be all-encompassing. From an ENT standpoint, the most difficult cases will often a one-level difference in E/M code, such as whether to report 99213 or 99214 for a patient, based on MDM.

Example: An established patient comes in with worsening pain in the right ear. He has a history of Eustachian tube dysfunction and tinnitus. He was previously seen a week prior with minor right ear pain, diagnosed as acute otitis media. Today the problem is identical, just with worsening pain that has evidently not responded to the previous treatment of applying a warm washcloth over the ear and taking over-the-counter pain relievers. The physician prescribes Augmentin in response.

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Should this be reported as 99213 or 99214, assuming the history and exam supports either code?

Answer: Following E/M guidelines, we see one established problem that is worsening (2 points for number and nature of problems) and an overall risk that would be moderate (established problem with mild exacerbation, prescription medication management). This is only sufficient to support 99213 because 2 points for number and nature of problems is consistent with low complexity MDM. However, 99214 could be supported based on medical necessity, given the patient's past history of ear issues. The overall clinical picture suggests a case of otitis media that is more complex than typical, and thus warrants greater care than what would otherwise be an acute but uncomplicated problem.

A more conservative practice might choose to report 99213 anyway, because according to the E/M guidelines (often captured using a grid tool such as the Marshfield Clinic Scoring Tool), 99213 is the only code that can be supported without any data reviewed during the visit. This is an example where the practice must consider its risk tolerance and whether it would be comfortable making the argument outlined above to support 99214.

This Week's Audit Tip Written By:

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Grant is the Director of Content for our parent organization, DoctorsManagement

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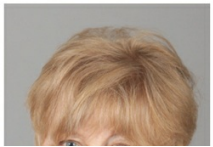

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Speaker: Betty Stump
November 14, 2017
2pm EST

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November 21, 2017
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