Focus On
Medical Decision Making

Chart Documentation
Medical Decision Making
Number of Diagnosis and Treatment Options
Amount and/or Complexity of Data Reviewed
Level of Risk
While seeing a patient, have you ever wondered how much History of Present Illness (HPI), Past Medical/Family/Social History (PFSH) or Review of Systems (ROS) should be documented for that particular visit in order to meet Medicare’s documentation requirements? Have you wondered if you need a complete ROS or HPI for a particular chart? Interestingly, it is the Medical Decision Making (MDM) score that ultimately determines how much History and Physical Exam are required, and if you understand MDM you will be able to document concisely and appropriately for the level of service that you provided.

*The Medical Decision Making involved in treating a patient is what drives the coding of a chart.* If a patient has a simple conjunctivitis, no matter how much history and exam is documented, it cannot be coded as 99285. However, if you see a patient for pneumonia that has labs, x-rays and is admitted, an example of MDM that is at a 99285 level, and only document enough HPI to support a level 3 then the chart will have to be downcoded.

*So how do you know how much History and Physical Exam will be required? In order for you to know “what level the chart could be” you need to know something about MDM. Additionally, there are important aspects of the patient’s care to communicate to the coder so they can fully understand the MDM associated with the case.*

The MDM determines the highest possible code a chart could be. For example, an admitted chest pain patient might maximally be coded at level 5 due to the high level of medical decision making, while a simple bee sting might be maximally a level 2 based on the straightforward medical decision making. Medical decision making determines what the charts could be, and the documentation of the 1) history and 2) exam determines if it will be downcoded for lack of sufficient documentation in these areas. According to Medicare’s most commonly cited audit tools, Medical Decision Making is calculated by first determining the highest E/M level of the following three components: 1) Number of Diagnosis and Treatment Options, 2) Amount and/or Complexity of Data Reviewed and 3) Level of Risk Table. Then, secondly, the final E/M level is determined by discarding the highest and lowest of the three levels.

### 1. Number of Diagnosis and Treatment Options

1. Self Limited Minor Problem (supports a level 99281)
2. Established Problem Stable (supports a level 99282)
3. Established Problem Worsening (supports a level 99283)

**Reimbursement Pearl:** These first three are typically more relevant for the office practitioner.

4. New Problem to Examiner No Additional Work Up Planned (supports 99283 and 99284)

**Reimbursement Pearl:** Since no distinction is made between new and established patients in the ED, and all ED visits can be considered new, “new problem to examiner” is a common description of the “diagnosis and treatment options” for an ED encounter. Thus, in conjunction with other areas of MDM, the number of diagnosis and management options, allows common ED patients to score as level 3 or 4.

5. New Problem Additional Work Up Planned

**Reimbursement Pearl:** This generally correlates with supporting a level 5 visit so make sure to document plans for admission, transfer, an in ED consult, or arrangements that are made by you for further additional workup after discharge.
2. Amount and/or Complexity of Data Reviewed

This is a very objective measure, which is done by counting up points as follows:

1 point each for:
- a) Ordering of: Clinical Lab tests, Radiology Tests, or Medicine Tests (e.g. EKG)

**Reimbursement Pearl:** Document all of the tests that you order.

- b) Discussing tests with performing physicians (such as radiologist or cardiologist)

**Reimbursement Pearl:** Document any discussions that you have with physicians performing supportive diagnostic tests.

- c) Decision to obtain history from additional source (such as family, old records, or EMS)

**Reimbursement Pearl:** Document (consider writing it as an order) when you are requesting history from another source, including an old record.

2 points each for:
- a) Review and Summarization of old records or obtaining history from someone other than the patient

**Reimbursement Pearl:** Briefly summarize your review of an electronic or old paper record or discussion with family, EMS, or nursing home records that contribute to the patient’s history. Of note, this adds an additional two points to the one point you get for documenting your decision to obtain history from another source.

- b) Independent Visualization of x-rays, EKG, or specimen

The points are added together to determine the E/M level supported.

**Reimbursement Pearl:** Document any fully independent review of the actual EKG or x-ray. Interpreting the EKG or x-ray yourself scores an additional 2 points in addition to the one point you get for ordering the test.

1 point supports 99281; 2 points supports 99282; 3 points support 99283 and 99284 and 4 points support 99285.

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**Data Under Your Control - Maximize Your Data Points and Your RVUs**

- 2 points for review of the old record
- 2 points for an independent interpretation

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### Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Diagnostic Tests</th>
<th>Management Options</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 self-limiting/minor problem</td>
<td>Lab w/venipuncture, CXR, EKG, U/A</td>
<td>Rest, gargle, Ace superficial dressing</td>
<td>Minimal</td>
</tr>
<tr>
<td>2 or more self-limiting/minor 1 stable chronic illness, acute uncomplicated</td>
<td>Lab w/ arterial puncture, superficial needle biopsies</td>
<td>OTC drugs, IV w/o additives</td>
<td>Low</td>
</tr>
<tr>
<td>1 chronic illness w/ exacerbation 2 or more stable chronic illnesses, new problem w/ uncertain progress, acute problem</td>
<td>LP, thoracentesis, culdocentesis</td>
<td>Prescription, IV w/ additives Tx of Fx w/o manipulation Minor surgery w/ identified risk factors</td>
<td>Moderate</td>
</tr>
<tr>
<td>1 or more chronic illnesses w/ severe exacerbation, life threatening illness/injury, suicidal/homicidal ideation, neurostatus change</td>
<td>Endoscopy w/ identified risk factors</td>
<td>Parenteral controlled drug therapy w/ monitoring Emergency major surgery</td>
<td>High</td>
</tr>
</tbody>
</table>

**Risk Table Reimbursement Pearls:**

1) Giving a prescription generally supports 99283.
2) Fracture treatment is recognized as supportive of level 3 or 4.
3) Treatment involving IV narcotics supports the risk criteria for level 5.
4) Suicidal/Homicidal ideation or neurological changes are indicative of level 5 risk.

Do yourself a favor by documenting the MDM components of a chart properly so the coder is empowered to recognize the full complexity of the case.