Dermatology Coding Alert

E/M Coding: Take Steps to MDM Determination Success -- Every Time

This system will help you correctly calculate each piece of the MDM puzzle.

Are you increasing your odds for an Office of Inspector General (OIG) audit or payer review because you're foggy on how to calculate the medical decision making (MDM) portion of an encounter? Follow our three-step process to determine each component level and ensure your MDM calculations don't set you up for additional payer scrutiny.

Refresher: To figure the right MDM, you assign points to each of the three MDM components that your physician performs. The number of points in each category, in turn, can help determine the final MDM level.

There are three elements that contribute to the complexity of your provider's medical decision making, according to **Suzan Berman, CPC, CEMC, CEDC,** manager of physician auditing and compliance for West Penn Allegheny Health Systems in Pittsburgh: number of diagnoses/management options, amount and/or complexity of data reviewed/ordered, and the risk of complications and/or morbidity or mortality. To qualify for a given type of medical decision making, two of the three elements must be met or exceeded.

1. Understand Each Level of Diagnosis

Start your MDM level assessment by tackling the first category: number of diagnoses/management options. For this category, ask questions such as, "What's wrong with the patient?", "Is this a new problem, and does the patient need additional workup at the end of the office visit?" and "What is the total number of medical diagnoses that the patient has that the provider addressed during the encounter?"

For each diagnosis, assign a point and score the diagnosis level as follows:

- Self-limited/minor problem 1 point each, with a maximum of 2 points
- Established problem, improving/stable 1 point each
- Established, worsening 2 points each
- New problem, no planned additional workup 3 points each, maximum of 3 pts
- New problem, additional workup 4 points each.

No or one point represents "minimal." Two points are "limited, and three points are "multiple." Finally, four points are "extensive."

"The point system has been adopted by most insurance carriers; however, it is officially the 'Marshfield system,'" Berman explains. "Novitas, for example, uses a different point structure."

2. Classify Your Data Complexity

The second component to consider when deciding on your provider's MDM complexity is the amount and/or complexity of the encounter's data to be reviewed. For this piece of the MDM puzzle, you need to determine if your provider's work included the following classes of data:

- Review/order of clinical lab services such as WBC tests (80000 codes) (1 point maximum)
- Review/order of radiology services such as X-rays (70000 codes) (1 point maximum)
- Review/order of medicine services such as an EKG (90000 codes) (1 point maximum)

- Discuss results with test-performing physician (1 point)
- Independent review of image, tracing or specimen, such as such as reading X-ray films brought in by the patient to the office visit (not a written report) (2 points)
- Decision to obtain old records/ obtain history from someone other than patient (1 point) and/or
- Review and summarize old patient records from an outside source or obtaining history from someone other than the patient and/or discussion of case with another health care provider (2 points).

Score the complexity of data in the same manner as the diagnoses: minimal (0-1), limited (2), moderate (3), and extensive (4+).

Remember: No matter how many tests your dermatologist orders, you can only assign one point for ordering and reviewing all of the data in each of those two classes.

"In the Marshfield system, you can also get 2 additional points for independently visualizing," Berman states. "However, a maximum of 2 points is permitted for such activity."

3. Weigh the Risk

The final of the three MDM categories, level of risk, can be the most difficult part to determine.

"This is the most confusing component of the MDM section," Berman says. "We really need to be in tune with our physicians and the disease processes for which we code. This helps. It also helps when the physician is thorough and complete in the documentation, so we can determine patient specific risks, therapies ordered, etc."

Level of risk involves three subcategories: presenting problem(s), diagnostic procedures ordered, and management options selected. Comorbidities, the need for diagnostic testing, the plan of care, and so on, may complicate the medical decision making. The highest score from only one of the three subcategories (not from each category) determines the patient's overall risk level (minimal, low, moderate, or high).

Learn more: The Centers for Medicare and Medicaid Services' 1995 and 1997 guidelines for MDM contain a "Table of Risk" with examples of what constitutes each level of the three subcategories.

View the "Table of Risk" online on page 15 of the 1995 E/M Guidelines (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf) or page 47 of the 1997 Guidelines (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf).

Future planning pointer: Tell your physicians to clearly indicate when they're taking an intermediate step that they don't believe will solve the patient's problem. For example, they may try antibiotics before a more aggressive treatment, says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** audit manager for CHAN Healthcare in Vancouver, Wash.

"Explaining that they're trying the more conservative treatment, but that the patient may require a more aggressive approach, can boost the level of MDM," she adds. "Documenting the extra step shows that the physician considered more management options (one element of MDM)."

Final note: Keep in mind that E/M codes aren't based on the patient's general health. Don't code a higher level of decision-making than the documentation supports. Often, providers and coders will boost the MDM because they know the patient is really sick. But you have to code based on what your provider puts into the documentation and nothing more.

Don't miss: If your physician must consider the patient's co-morbidities and they have an impact on the treatment plan, patient compliance and resolution of the problem, get this documented on paper, warns **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in

Clearwater, Fla. "I always tell my physicians when I train them on this most important component of an E/M 'Think in Ink.' Get it on paper tell us the status of the current condition and the status of co-morbidities don't just list them without telling the complete story," she says. "This paints a clearer picture of the medical decision making that was necessary for the patient."

If you are using an electronic medical record system to record MDM, make sure you have a free text area to provide the needed information that a drop down box doesn't allow, Mac says. "I cannot emphasize enough that the MDM is the most important component of the E/M to support medical necessity and overall code level assignment," Mac says.