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Internal Medicine Coding Alert

How to Assess Medical Decision-making for High-level E/M Visits

Reimbursement for an office visit increases dramatically when going from a level-four (99204, 99214) to a level-five (99205, 99215) evaluation and management (E/M) service. With an established patient office visit, for example, the transitioned, non-facility relative value unit (RVU) for 99214 is 2.06 versus 3.06 for 99215.

To distinguish what level of office visit the service qualifies as, internists need to look carefully at the complexity of medical decision-making (MDM) involved in the visit. In many cases, increased medical risk to the patient separates the high complexity of medical decision-making required in a level-five E/M visit from the moderate complexity required in a level-four visit.

MDM, according to the CPT manual, refers to the complexity of establishing a diagnosis and/or selecting a management option. It should be the driving force behind the E/M encounter, says **Janet Leinke, CCS, CPC-H,** senior outpatient consultant for Laguna Medical Systems, a health information consulting, outsourcing and education services company headquartered in San Clemente, Calif. If a patient has a minor problem and the medical decision-making is straightforward or of low complexity, the history and examination will be simple and noninvasive. If the problem is more significant or life-threatening, the medical decision-making will be of moderate to high complexity.

HCFA has stated that medical decision-making should be measured according to the following three components:

1. The number of possible diagnoses and/or number of management options that must be considered. A moderate level of medical decision-making (as required for a level-four E/M service) calls for multiple diagnoses and/or treatment options to be involved, while a high level of medical decision-making (as required for a level-five E/M service) calls for an extensive number.

2. The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patients presenting problem(s), the diagnostic procedure(s) and/or the possible management options. A moderate level of medical decision-making calls for a moderate amount of medical risk, while a high level of medical decision-making requires a high amount of risk.

3. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed. A moderate level (four) of medical decision-making calls for a moderate amount of data to be reviewed while a high level (five) of medical decision-making requires an extensive amount.

Decision-making must meet or exceed two of these three components.

Risk of Significant Complications Is Key

The risk of significant complications from the patients presenting problem(s), the diagnostic procedure(s) and/or the possible management options selected establishes the level of MDM. Both HCFAs 1995 and 1997 Guidelines for Documentation of Evaluation and Management Services categorize and define the level of risk involved in the following manner:

Minimal One minor problem. Diagnostic procedures ordered include laboratory tests requiring venipunctures, chest x-rays, EKG/EEG and urinalysis. Management options include rest, elastic bandages and superficial dressings.

Low Two or more minor problems, one stable chronic illness or an acute, uncomplicated illness (such as allergic rhinitis). Diagnostic procedures ordered include superficial needle biopsies, skin biopsies and physiologic tests not under stress

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(such as pulmonary function tests). Management options include minor surgery with no identified risk factors, over-the-counter drugs, IV fluids without additives and physical/occupational therapy.

Moderate One or more chronic illnesses with mild exacerbation, two or more stable chronic illnesses, an undiagnosed new problem, acute illness with systemic symptoms or an acute complicated injury. Diagnostic procedures ordered include physiologic tests under stress, cardiovascular imaging studies with contrast and no identified risk factors (such as a cardiac catheter) to obtain fluid from the body (such as thoracentesis). Management options include prescription drug management, minor surgery with identified risk factors, elective major surgery with no identified risk factors and IV fluids with additives.

High One or more chronic illnesses with severe exacerbation or progression, acute or chronic illnesses or injuries that may pose a threat to life or bodily function or an abrupt change in neurologic status (such as a seizure, TIA, weakness or sensory loss). Diagnostic procedures ordered include cardiovascular imaging studies with contrast with identified risk factors and cardiac electrophysiological tests. Management options include elective major surgery with identified risk factors, emergency major surgery, parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity and a decision not to resuscitate or to de-escalate care.

The highest level of risk from among the presenting problem, diagnostic procedure(s) ordered or management options selected represents the overall level of medical risk.

What Happens If Problem Is Untreated?

Risk may be thought of as the threat a presenting problem poses to a patients mortality if he or she goes untreated, says **Catherine Brink, CMM, CPC,** president of Healthcare Resources Management Inc. a physician practice management consulting firm in Spring Lake, N.J. If the patient has a bad cold, there is some risk that it could develop into pneumonia if untreated by a doctor, but that risk is probably minimal, she explains.

With moderate risk, the patient definitely needs to see the doctor for treatment, continues Brink, who cites cutting a finger on a rusty nail or having uncontrolled hypertension as two examples of moderate medical risk. High risk is usually a life-threatening situation. Gunshot wounds, extremely high fever or a patient in need of major surgery would qualify as high risk.

Consider Multiple Diagnoses and Treatment Options

The risk of significant complications, however, is not the only component of medical decision-making. The number of diagnoses and/or treatment options involved should also be considered when evaluating the level of medical decision-making.

Internists tend to forget to write down all of the relevant diagnoses, says Brink. Secondary diagnoses, if they contribute to the overall medical decision-making, should be documented and included in the consideration of the level of medical decision-making.

Because these components can be difficult to quantify, many internal medicine practices use the method employed by Medicare auditors. This method, summarized in the E/M Documentation Auditors Worksheet compiled by the Medical Group Management Association (MGMA), assigns a point system to the remaining two components of medical decision-making and then arrives at a score to determine the overall level of decision-making.

The worksheet quantifies the number of diagnoses or treatment options in the following manner:

Each self-limited or minor problem 1 point (maximum 2 points)

Each established problem (to the internist) that is stable or improved 1 point

Each established problem (to the internist) that is worsening 2 points

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A new problem (to the internist) where no additional workup is planned 3 points (maximum 3 points)

Each new problem (to the internist) where additional workup is planned 4 points

The number of diagnoses or treatment options is then totaled. One point is a minimal number of diagnoses or treatment options, and a total of two points is limited. A total of three points qualifies as a multiple number of diagnoses or treatment options, while four or more points qualifies as extensive.

Dont Neglect the Amount and Complexity of Data

The amount and/or complexity of data to be reviewed should also be considered when determining the level of medical decision-making. The auditors worksheet assigns points in this category as follows:

Review and/or order of clinical lab tests 1 point

Review and/or order of tests in the radiology section of CPT 1 point

Review and/or order of tests in the medicine section of CPT 1 point

Discussion of test results with a performing physician 1 point

Decision to obtain old records and/or obtain history from someone other than the patient 1 point

Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider 2 points

Independent visualization of image, tracing or specimen itself (not simply a review of the report) 2 points

One point represents a minimal amount and/or complexity of data to be reviewed; a total of two points is considered limited. A total of three points is necessary to qualify for a moderate level in this category; four points are needed to qualify as an extensive level.

There should be a notation of the review in the patients medical record that the internist signs or initials and dates, says **Stephanie Jones, CPC,** a multispecialty coding consultant in Boca Raton, Fla. In addition, the date of the review or date when the test was ordered should match the date when the E/M service was reported.

Two of Three Subcomponents Determine MDM

To determine the overall level of MDM, look at the chart titled Final Results for Complexity of MDM at the end of this article. Circle the results for each of these three subcomponents on this chart. If a column contains two or three circles, choose that level of MDM. If no column contains two or three circles, choose the level of MDM in which the second circle from the left appears. For example, a minimal number of diagnoses and treatment options combined with a low risk of complications and/or morbidity or mortality and an extensive amount and/or complexity of data, you would choose limited or low MDM.

Although medical decision-making is not the only component to be considered when determining the level of E/M service performed, there is generally a link between it and the history and/or examination that also occurred.

Most internists will end up having a diagnosis that correlates to the chief complaint of the patient and the systems that were examined during the visit, says Brink.

Note: Copies of the complete E/M Documentation Auditors Worksheet can be ordered from the Medical Group Management Association by calling (877) ASKMGMA. More examples of medical decision-making for a level-four and -five office visit can be found in Appendix D (Clinical Examples) of the CPT Manual. HCFAs 1997 Guidelines for the

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Documentation of Evaluation and Management Services are available online at www.hcfa.gov/audience/planprov.htm.

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