E/M Services Blunders

PRESENTED BY

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Agenda

- EM audit refresher/overview
- The blunder areas:
  - Column 1 Number & Complexity of Problems Addressed at Encounter
  - Column 2 Amount and/or Complexity of Data to be Reviewed & Analyzed
  - Column 3 Risk of Complications and/or Morbidity/Mortality of Patient Management

Let’s Do Something Fun!

I’m going to give you some details describing something.

I want you to draw a picture of what I am describing.

It has legs
It does not have long hair
It may be found in groups or alone
You cannot put it in your pocket
It will show signs of age when not cared for
It comes in different sizes
There are many different colors

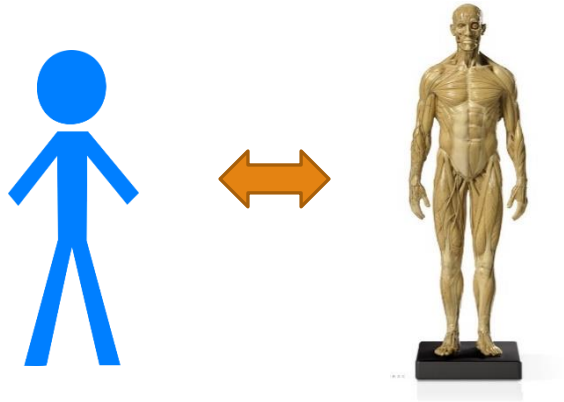
What Am I?

What Was the Point of This?

Without specific details, you cannot determine what the item was that I described.

Without specific details, medical record documentation may not contain enough information to clearly identify the service(s) rendered or the condition(s) the patient may have.

Which is more descriptive?



We'll look at examples of this on slide 12…but for now you'll have to wait!

EM Audit Refresher

True or False
1995 and 1997 Guidelines can still be used.
HPI, ROS, and PFSH must still be documented.
Credit is given once regardless of number of labs performed.
Credit is given when discussion of management or tests occurs with internal provider.
Risk is that of complications/morbidity/mortality of patient management.
Prescription drug management is only for long-term prescriptions.

	MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity/Mortality of Patient Management
99202, 99212 99242, 99252 99282	Straightforward	Minimal ° 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99221, 99231 99203, 99213 99243, 99253 99283	Low	Low (1 or more bullets below) ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
99222, 99232 99204, 99214 99244, 99254 99284	Moderate	Moderate (1 or more bullets below) ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
99223, 99233 99205, 99215 99245, 99255 99285	High	High (1 or more bullets below) ° 1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment; ° 1 acute or chronic illness or injury that poses a threat to life or bodily function	High (must meet requirements of at least **2 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: ° Drug therapy requiring intensive monitoring for toxicity ° Decision regarding elective major surgery with identified patient or procedure risk factors ° Decision regarding emergency major surgery ° Decision regarding hospitalization or escalation of hospital-level care ° Decision not to resuscitate or to de-escalate care because of poor prognosis ° Parenteral controlled substances

Considerations

Medical decision making may be impacted by role and management responsibility.

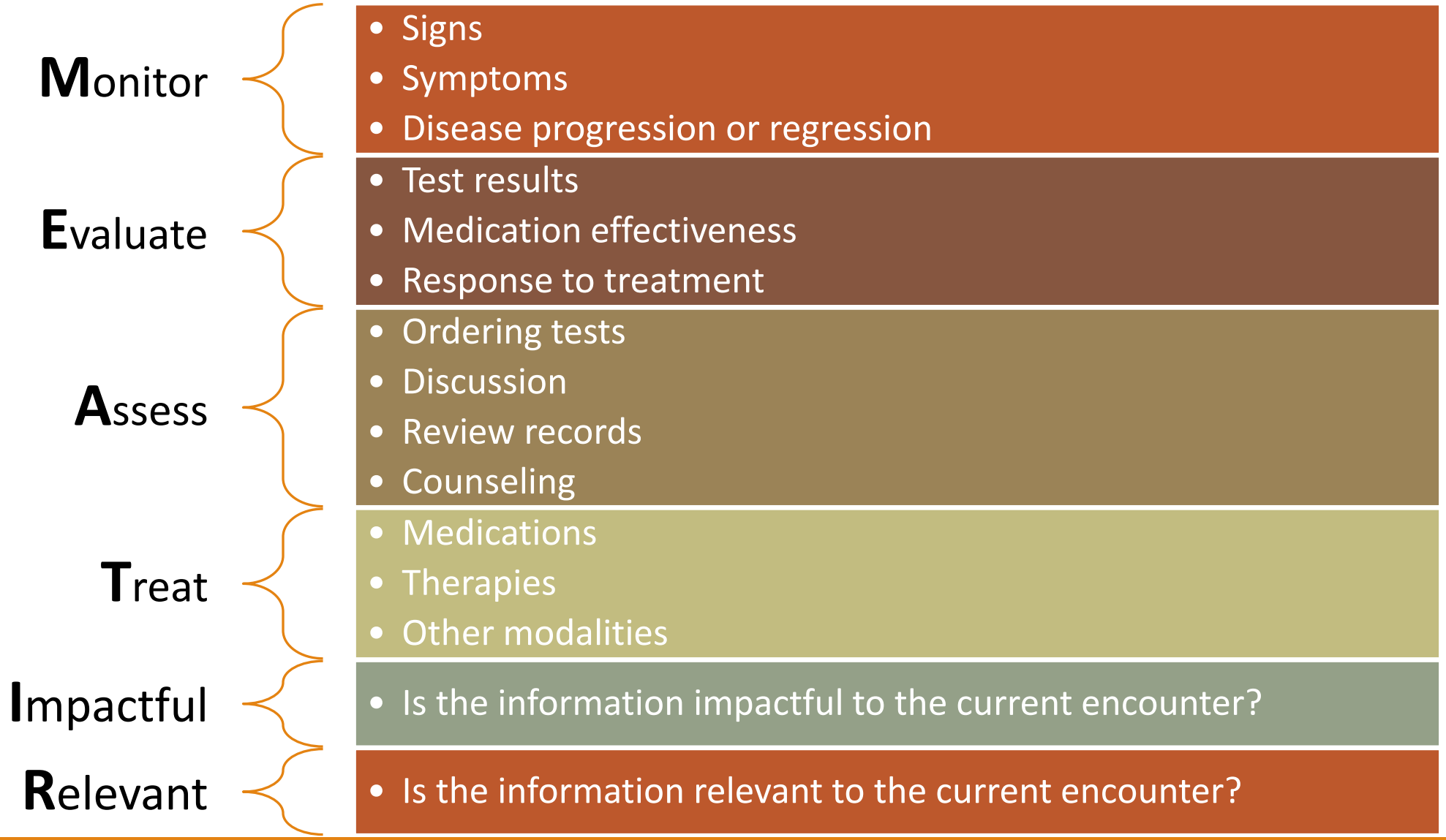
Any service reported with a separate CPT® code that includes interpretation and/or report **should not** be counted in the medical decision making when selecting the level of service.

Shared medical decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Consider what would happen to the patient if they left the appointment without any further work-up

MEAT (meatier) Principle

Documenting “MEAT” for co-existing conditions will help to support medical necessity in treatment of the presenting problem.



Best Practices

- ✓ Perform *necessary* history and examination.
- ✓ Document what is medically appropriate.
- ✓ Use MEAT when determining if a condition was addressed.
- ✓ Indicate any diagnosis or treatment changes.

MDM Examples

Patient with increased nasal congestion for 3 weeks and is worse when outside. OTC meds and saline nasal flushes.

Patient with season allergies and recurrent sinus infections. Has had five sinus surgeries and has recurring nasal polyps. Prescription for nasal steroids and OTC saline nasal flushes.

Patient presented to office with reaction after eating shellfish. Severe reaction and patient was sent by ambulance to ED for further treatment.

Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity/Mortality of Patient Management
Minimal ° 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low (1 or more bullets below) ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment OTC Medication
Moderate (1 or more bullets below) ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
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Low vs. Moderate

Chronic
1 stable

2 or more stable
1 or more with exacerbation…

MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity/Mortality of Patient Management
Straightforward	Minimal ° 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low (1 or more bullets below) ° 2 or more self-limited or minor problems; ° **1 stable, chronic illness;** ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment **OTC Medication**
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Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- Acute vs chronic condition.
- Uncomplicated vs complicated illness or injury.
- Severe exacerbation, progression, side effect or treatment.

	MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter
Level 2	Straightforward	Minimal ° 1 self-limited or minor problem
Level 3	Low	Low ° 2 or more self-limited or minor problems; ° 1 stable, chronic illness; ° 1 acute, uncomplicated illness or injury; ° 1 stable, acute illness; ° 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Level 4	Moderate	Moderate ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury
Level 5	High	High ° 1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment; ° 1 acute or chronic illness or injury that poses a threat to life or bodily function

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Acute vs. Chronic

Without considering the AMA definitions, what makes acute and chronic problems different?

Three main characteristics of an acute problem?

- Rapid onset
- Need for timely intervention
- Relatively short lived

Three main characteristics of a chronic problem?

- Gradual onset over a long duration
- Recurrent and persistent symptoms
- Impact of quality of life

1 **acute**, uncomplicated illness or injury
1 stable, acute illness
1 acute, uncomplicated illness or injury requiring hospitalization
1 acute illness with systemic symptoms
1 acute, complicated injury
1 **stable**, chronic illness
1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
2 or more stable, chronic illnesses
1 or more chronic illnesses with severe exacerbation, progressions, or side effects of treatment
1 **acute or chronic** illness or injury that poses a threat to life or bodily function

MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications and/or Morbidity/Mortality of Patient Management
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- A problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service.
  - Notation in patient medical record that another professional is managing the problem without additional assessment or care coordination does not qualify as being ‘addressed’ or managed by provider reporting the service.
- Stable, acute illness
  - A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.
- Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care
  - A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. **The treatment required is delivered in a hospital inpatient or observation level setting.**

Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1	Risk of Complications and/or Morbidity/Mortality of Patient Management
Moderate (1 or more bullets below) ° 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ° 2 or more stable, chronic illnesses ° 1 undiagnosed new problem with uncertain prognosis; ° 1 acute illness with systemic symptoms; ° 1 acute, complicated injury	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health

- Undiagnosed new problem with uncertain prognosis
  - A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
- Acute illness with systemic symptoms
  - An illness that causes systemic symptoms and has a high risk or morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system.

MDM (2 of 3 elements of MDM)	Number & Complexity of Problems Addressed at Encounter	Amount and/or Complexity of Data to be Reviewed & Analyzed	Risk of Complications and/or Morbidity/Mortality of Patient Management
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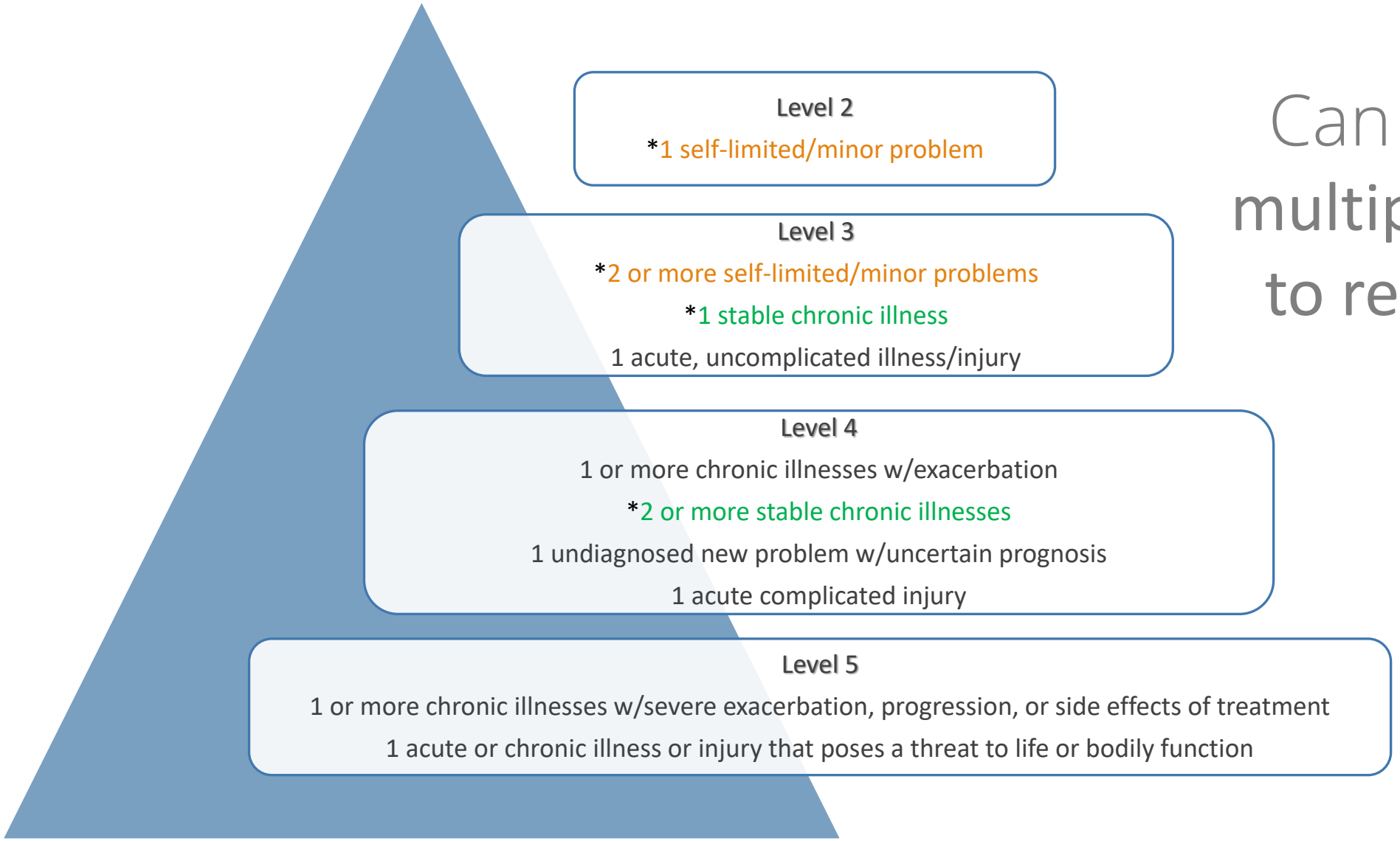
Acute or chronic illness or injury that poses a threat to life or bodily function

- An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

Number & Complexity of Problems Addressed at Encounter



Can you "stack" **multiple conditions** to reach a higher level?

No *

Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- Review and/or order of each unique test
- Independent historian
- Independent interpretation of tests

	MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
Level 2	Straightforward	Minimal or none
Level 3	Low	Limited (must meet requirements of at least **1 out of 2** categories) **Category 1**: Tests and documents Any combination of 2 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* **Category 2**: Assessment requiring independent historian(s) (For categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
Level 4	Moderate	Moderate (must meet requirements of at least **1 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)
Level 5	High	High (must meet requirements of at least **2 out of 3** categories) **Category 1**: Tests and documents Any combination of 3 from the following: ° Review of prior external note(s) from each unique source*; ° Review of result(s) of each unique test*; ° Ordering of each unique test* ° Assessment requiring independent historian(s) **Category 2**: Independent interpretation of tests ° Independent interpretation of a test performed by another MD/OQHP (not separately reported); **Category 3**: Discussion of management or test interpretation ° Discussion of management or test interpretation with external MD/OQHP (not separately reported)

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Limited must meet Category 1 or 2 - Level 3 Visits

Category 1 Tests and Documents (any combo of 2)

- Review prior external note(s) each unique source
- Review results of each unique test
- Ordering each unique test

OR

Category 2

- Assessment requiring an independent historian

MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
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Moderate (must meet 1 of these categories) - Level 4 Visits

Category 1 Tests and Documents (any count of 3)

- Review prior external note(s) each unique source
- Review results of each unique test
- Ordering each unique test
- Assessment requiring an independent historian(s)

OR

Category 2

- Independent interpretation of tests performed by another provider (not separately billable)

OR

Category 3

- Discussion of management/test interpretation with external provider (not separately billable)

MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
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Extensive (must meet 2 of these 3 categories) - Level 5 Visits

Category 1 Tests and Documents (any count of 3)

- Review prior external note(s) each unique source
- Review results of each unique test
- Ordering each unique test
- Assessment requiring an independent historian(s)

Category 2

- Independent interpretation of tests performed by another provider (not separately billable)

Category 3

- Discussion of management/test interpretation with external provider (not separately billable)

MDM (2 of 3 elements of MDM)	Amount and/or Complexity of Data to be Reviewed & Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below
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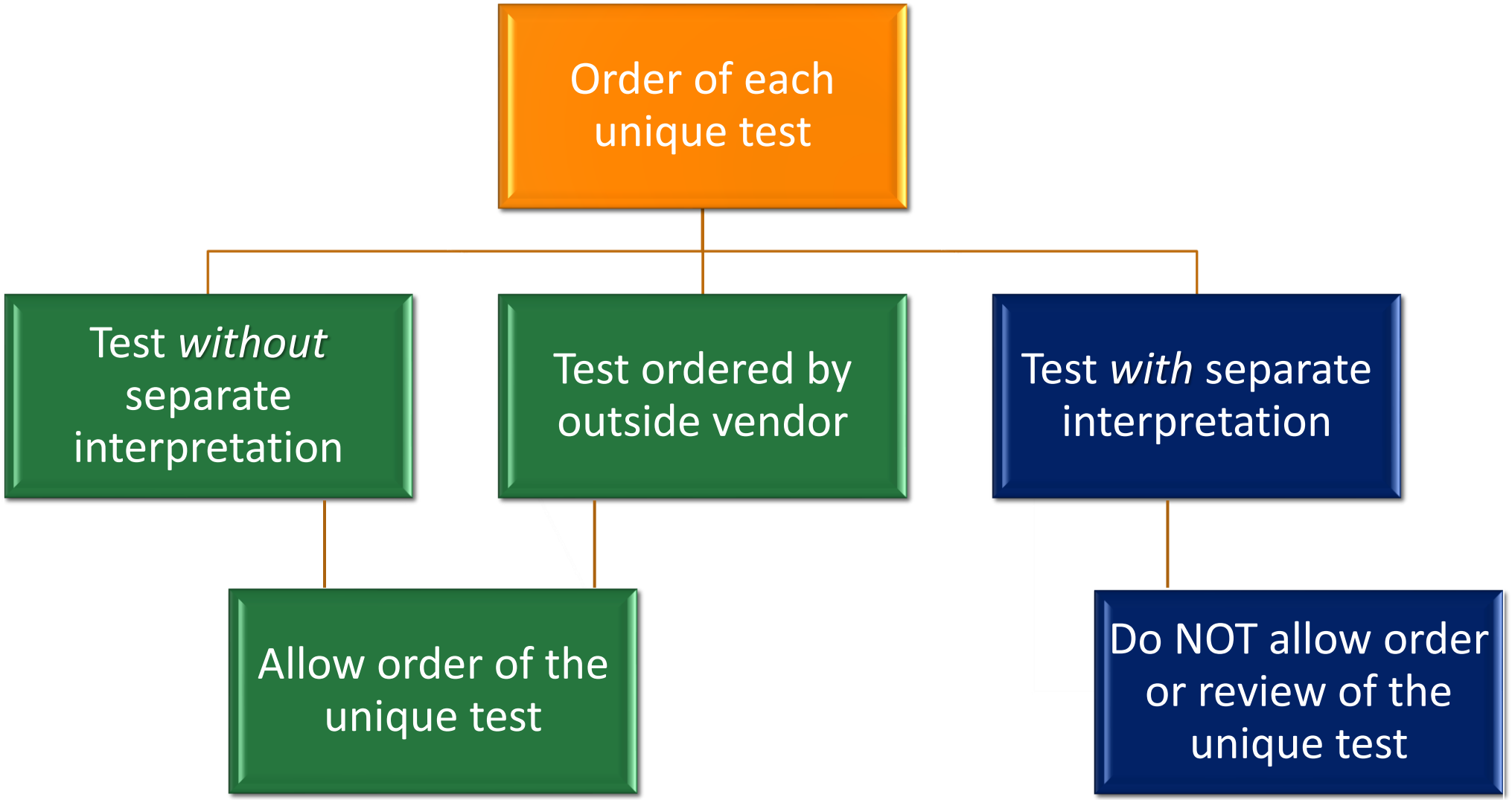
Review and/or Order of Each Unique Test

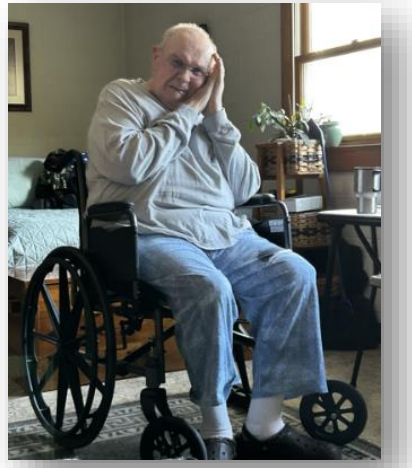


Independent Historian

AMA definition: An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

Independent Historian

- Adds information when the patient may not be able to provide a complete history.
- Documentation should include the independent historian's identity.
- The assumption may not be made without the provider's documentation.
- It is pertinent and relevant to be included to show complexity of patient's problem at this stage.
- An interpreter is not considered an independent historian.



Independent Interpretation of Tests

AMA definition: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified healthcare professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Use This for a Comparison…

This may be a stretch but think of it this way. You buy a cake and take it to a gathering. People talk about how delicious it is.

- If you made it yourself, you give yourself credit for your work.
- If somebody else made it, you are giving credit to them and sharing where it came from.

Independent Interpretation

- It's more than just a review, the provider claiming the independent interpretation must have their own, independent report.

Independent Interpretation of Tests

- The provider gives their own independent interpretation.
- Documentation should include why their interpretation was needed.
  - Have your provider add the why it was necessary.
- They are not receiving reimbursement for the interpretation.
- They must have a report, but that report does not need to be a typical complete report.
  - Narrative within the office visit would suffice.

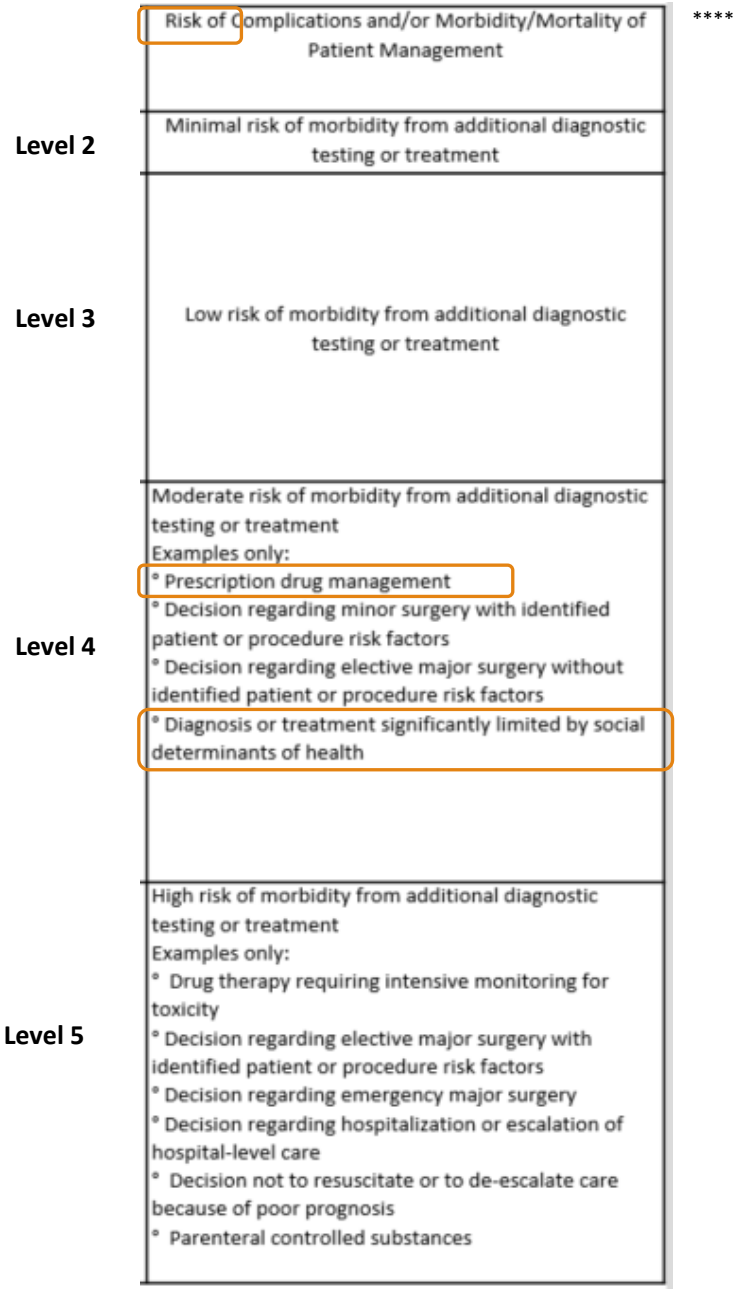
Elements of Medical Decision Making

Number and Complexity of Problems Addressed

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity of Patient Management

- What is risk?
- Prescription drug management
- SDOH



	Risk of Complications and/or Morbidity/Mortality of Patient Management ****
Level 2	Minimal risk of morbidity from additional diagnostic testing or treatment
Level 3	Low risk of morbidity from additional diagnostic testing or treatment
Level 4	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
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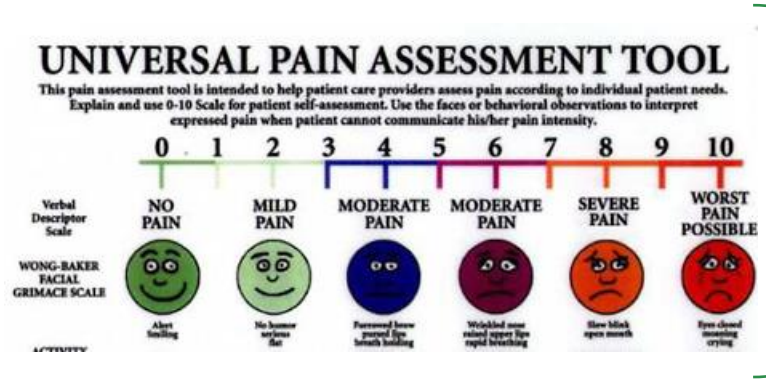
What is Risk?

- Risk - The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.
  - For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
  - Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.
- Risk as it relates to Column 3 – the risk associated with the outcomes of what is or isn't being done for the patient at this encounter.

Risk

Consider if the patient were to leave today without any treatment – what is the risk to their well being?

The higher the risk to the patient, the higher the risk on the grid.



	Risk of Complications and/or Morbidity/Mortality of Patient Management
Level 2	Minimal risk of morbidity from additional diagnostic testing or treatment
Level 3	Low risk of morbidity from additional diagnostic testing or treatment
Level 4	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ° Prescription drug management ° Decision regarding minor surgery with identified patient or procedure risk factors ° Decision regarding elective major surgery without identified patient or procedure risk factors ° Diagnosis or treatment significantly limited by social determinants of health
Level 5	High risk of morbidity from additional diagnostic testing or treatment Examples only: ° Drug therapy requiring intensive monitoring for toxicity ° Decision regarding elective major surgery with identified patient or procedure risk factors ° Decision regarding emergency major surgery ° Decision regarding hospitalization or escalation of hospital-level care ° Decision not to resuscitate or to de-escalate care because of poor prognosis ° Parenteral controlled substances

Noridian PDM

Evaluation and Management: Prescription Drug Management

The American Medical Association (AMA) owns the CPT codes and CMS has an agreement with the AMA to use these codes. When CMS does not develop separate policy, Noridian will follow the AMA Evaluation and Management (E/M) guidelines.

Prescription drug management may be part of the Medical Decision Making (MDM) element when choosing the level of E/M code supported by documentation. The variables involved when determining the risk will depend on the patient's condition(s), age, co-morbidities, lifestyle, and other medications. One patient with Coronary Obstructive Pulmonary Disease (COPD) will have different risks when compared to other patients with COPD. One may be older, one may have diminished health, or one may have cancer with COPD.

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of an E/M visit. There is a mindset that because it says prescription (RX) management, if a provider prescribes, the risk level qualifies as moderate. A prescription being written or discontinued, or a decision to maintain a current medication or dosage would need to be supported in documentation that the provider evaluated the medications.

Note: Simply listing current medications is not considered "prescription drug management."

Documentation for prescription drug management would need to show the work and/or risk involved by the billing provider when managing a prescription.

- Is the prescription something that could be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?
- Is the prescription a non-complex drug for a patient with no allergies or complications? Example – a patient taking anticoagulants.
- Did the patient have a stroke and is there a risk they may sustain a subsequent hemorrhage?

Additional considerations for prescription drugs that may support risk management when included in the documentation:

- Ability of a patient to self-administer the medication. Education to the patient on performing injectables or ability to open a pill bottle and take a pill out.
- Caregiver or family member at home to monitor the effects of the drug.
- Any concern about the patient's understanding with taking their medication.

Adding new or deleting drug(s) should include narrative in the medical note to explain why the change was made.

If determining the level of E/M code based on total time, the MDM elements would not apply.

***WPS does not appear to have a document like this on their webpage.*

Noridian PDM

AMA Publication

Appropriate documentation of prescription drug management continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate. Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided. Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: "Stable hypertension; continue valsartan 10 milligrams, will refill for 4 months until next follow-up visit." Simply stating that the medication list was reviewed will not meet the definition of prescription management.

AMA 2023 Webinar Questions and Answers

There is no "blanket" guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management.

Additional Resource

- AMA Evaluation and Management (E/M) Guidelines 2023

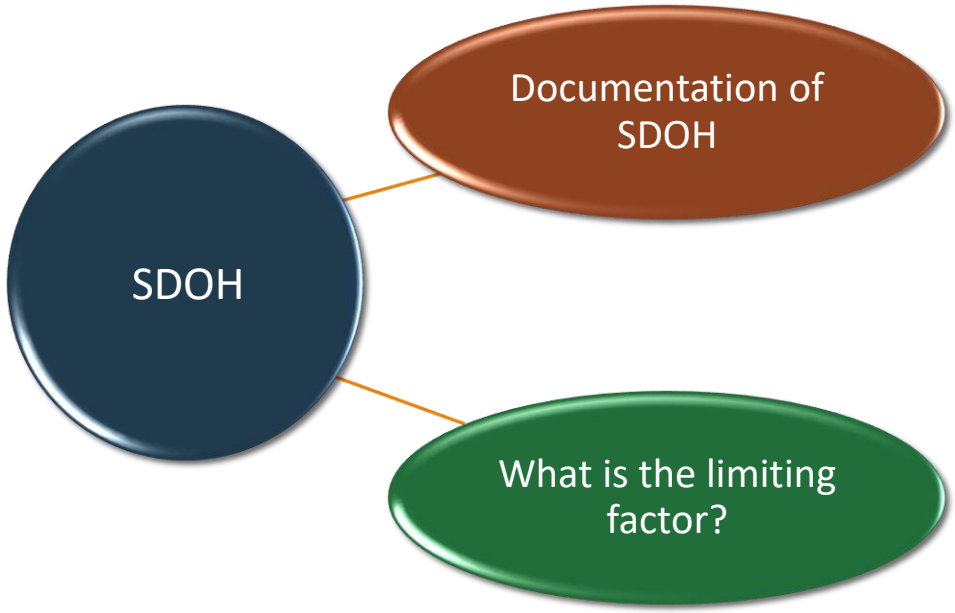
This article is written at the suggestion of the Provider Outreach and Education Advisory Group.

Last Updated Nov 08 , 2024

https://med.noridianmedicare.com/web/jfb/article-detail/-/view/10534/evaluation-and-management-prescription-drug-management

Social Determinants of Health (SDOH)

- Economic and social conditions that influence the health of people and communities.
- Examples may include food or housing insecurity.
- Not simply including the patient has a SDOH but identifying how does it impact the problem.



Minor or Major

AMA

The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

CMS

0 /10 days global period = Minor surgical procedure
90 days = Major surgical procedure

Surgery Definitions

- Elective or Emergency
  - Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
- Risk Factors to Patient or Procedure
  - Risk factors are those that are relevant to the patient and procedure.

Drug Therapy Requiring Intensive Monitoring for Toxicity

When monitoring is performed for assessment of adverse effects
Therapeutic levels do not fall into high risk category.

Examples of monitoring that **may** qualify

- Toxicity level in the use of an antineoplastic agent between dose cycles
- Short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis
- Pulmonary function tests in a patient with RA, SLE, or PSS who is at risk of pulmonary disease as part of the rheumatic disease.

Examples of monitoring that ***does not*** qualify

- Monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern)
- Annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold
- Annual assessment of thyroid function in a patient with hypothyroidism.

Parenteral Controlled Substances

Which medications qualify as parenteral controlled substances in the high section of the risk column?

Controlled Substance – a schedule I, II, III, IV, or V drug or other substance.
Parenteral – substance administered/given by a route other than the alimentary canal.

It is not just the medication; it is the route of administration plus the medication.

Buprenorphine (Suboxone)	Morphine
Diazepam (Valium)	Nubain (nalbuphine)
Fentanyl (Sublimaze, Duragesic)	Pentobarbital
Hydromorphone (Dilaudid)	Phenobarbital
Ketamine	Stadol (butorphanol)
Lorazepam (Ativan)	Sufentanil
Meperidine (Demerol)	Talwin (pentazocine)
Methadone (Dolophine)	Thiopental
Methohexital	Versed (midazolam)
Midazolam (Versed)	

https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs

Parting Words on Medical Decision Making

MDM = more than just the plan

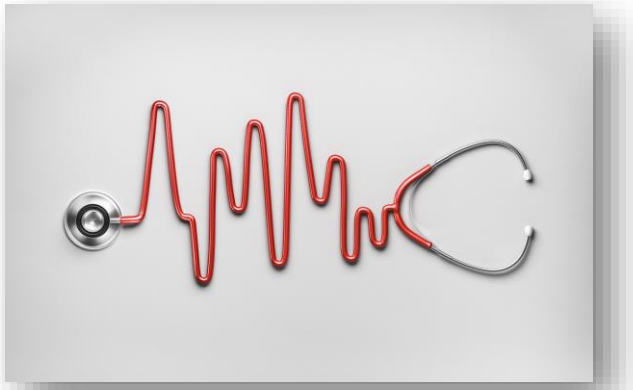
MDM = a composite of problem complexity, data review, and risk analysis

The "substantive portion" = majority of the work across these elements—or majority of time

Documentation = individualized proof of that work—not a copy-paste shortcut

When we teach and apply it this way, the ambiguity fades—and so does much of the frustration around shared visit documentation and billing.

Effective Provider Education And Communication



Understanding Your Provider

Providers maintain a busy and stressful schedule

- Be respectful of his or her time.

Providers want to care for patients

- Explain that you are looking at from an objective point of view to help reduce risk and protect the provider.

Why a Physician Thinks That Way

Coding doesn’t influence patient outcome.

Coding is low priority.

No margin for error in caring for patient.

May not recognize coder’s work as a major priority.

It is never about YOU (coder) unless you make it that way!

Understanding the Provider

Unclear Documentation

Example: Physician documents an excisional biopsy of forearm.

- Physician was trained to refer to “excisional biopsy” or “shave excision”

CPT has a code for:

Excision

Biopsy

Shave

BUT NOT ONE FOR ALL OF IT!

Table – Types of biopsy and indications

Type of biopsy	Indications
Punch	Most superficial inflammatory diseases (eg, erythema multiforme major) Papulosquamous disorders (eg, psoriasis) Connective-tissue disorders (eg, SLE) Most superficial bullous diseases (eg, pemphigus) Benign tumors Granulomatous diseases (eg, sarcoidosis) Nonmelanotic malignant tumors (eg, infiltrating squamous cell carcinoma)
Shave	Raised lesions (eg, skin tags) Lesions that separate easily from deeper skin (eg, seborrheic keratoses) Dome-shaped nevi and benign tumors Nonmelanotic malignant tumors (eg, superficial basal cell carcinoma)
Excision	Subcutaneous or deep dermal tumors Deep inflammatory diseases (eg, erythema nodosum) Malignant melanoma Atypical pigmented lesions

Don’t Panic! It’s OK!

The easiest solution is **COMMUNICATION.**

Talk to your provider.

- Look at CPT, CDR and any other resources together.
- Explain
  - “CPT descriptions are not the same as what you are telling me”.
  - “Help me to understand what you did or what you meant”.

Use medical dictionaries and references.

Use credible internet searches for unfamiliar terms.

Communication

Communication

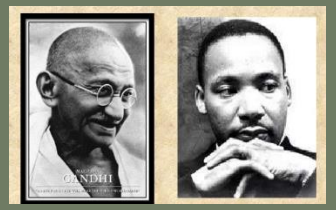
7% happens in spoken words

38% happens through voice tone

55% happens through body language

Few people are One Style
Don’t Label a Personality as BAD or GOOD

Passive



Passive-Aggressive

Aggressive

Assertive

Initiating a Difficult Conversation

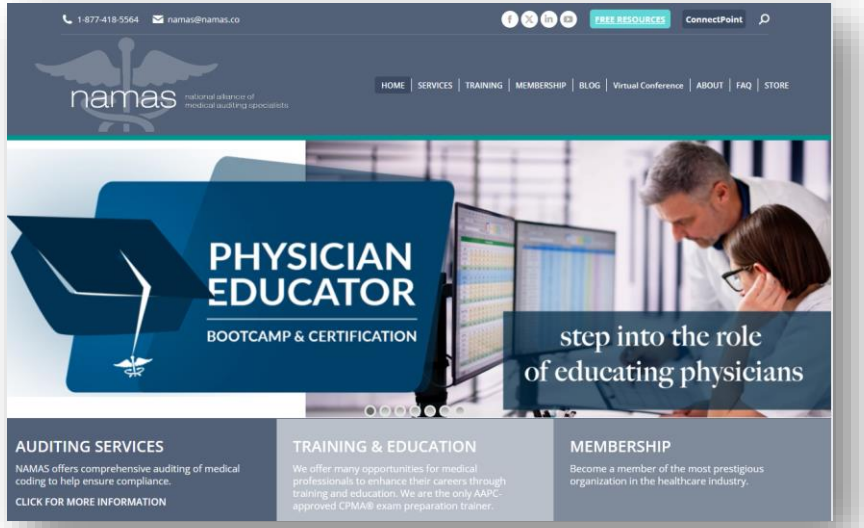
Ask	Is this a good time to talk?
Don't finger point	Use "I" phrases and avoid "you" statements
Be direct	Short statement that gets to the point
Use active listening	Allow person to respond completely, even if defensive
Sympathize	Understand their perspective and make the effort to show it
Empathize	Express you realize how hard it is, it's hard for you too
Assess	• Tell me more • Can you expand on this?
Detailed conversation	Explain rationale, reward, and risk

Communication Tips

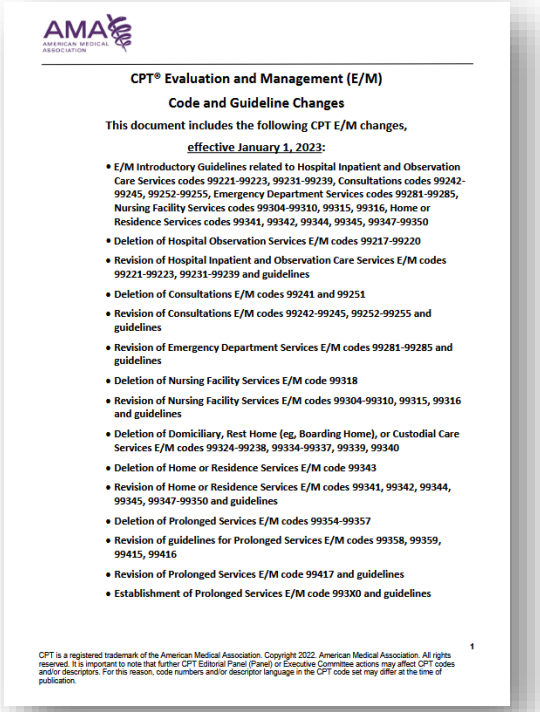
- Always use facts
- Show source documents on rules
- Use rationales
- Remain organized, detached and calm
- Professionally impersonal
- State facts concisely
- Be genuine
- Be personable
- Be pleasant

Credit Given

NAMAS for many references



AMA 2021 and 2023 Evaluation and Management Guidelines



AMA
AMERICAN MEDICAL ASSOCIATION

CPT® Evaluation and Management (E/M)

Code and Guideline Changes

This document includes the following CPT E/M changes,

effective January 1, 2023:

- **E/M Introductory Guidelines related to Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242-99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350**
- **Deletion of Hospital Observation Services E/M codes 99217-99220**
- **Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines**
- **Deletion of Consultations E/M codes 99241 and 99251**
- **Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines**
- **Revision of Emergency Department Services E/M codes 99281-99285 and guidelines**
- **Deletion of Nursing Facility Services E/M code 99318**
- **Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines**
- **Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340**
- **Deletion of Home or Residence Services E/M code 99343**
- **Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines**
- **Deletion of Prolonged Services E/M codes 99354-99357**
- **Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416**
- **Revision of Prolonged Services E/M code 99417 and guidelines**
- **Establishment of Prolonged Services E/M code 993X0 and guidelines**

Questions?

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