Medical Decision Making

1. **When a patient arrives for scheduled chemotherapy, and a physician performs a Detailed exam, (including evaluation for drug toxicity and medication adjustment) can the physician bill an E&M service, since the hospital bills for the chemo administration? The physician is not an employee of the hospital.**

   Answer: A physician may perform an E&M service in a hospital outpatient setting (POS 22) and may bill that service, whether employed by the hospital or practicing as an independent practitioner.

   If the patient presents for scheduled chemotherapy, the medical necessity for an E&M visit is based on a separately defined problem. A routine evaluation for evidence of toxicity and medication adjustment is included in the chemotherapy administration fee and would not support the need for a distinctly separate E&M service. This same guideline applies in the inpatient, outpatient and office settings. *Updated 10/17/2017*

2. **Would Coumadin be considered high on the table of risk as "drug therapy requiring intensive monitoring for toxicity"?**

   Answer: Patients receiving Coumadin therapy are routinely monitored via laboratory results, which are separately billed and then reviewed by the ordering provider. As such, Coumadin therapy is not classified as a drug requiring intensive monitoring for toxicity, but is considered within the context of prescription medication management. *Updated 8/29/2017*

3. **Does a decision to continue current medications qualify as medication management?**

   Answer: A decision to continue current medications is within the scope of medication management. *Updated 8/29/2017*

4. **The physician orders an X-ray and then personally reviews the X-ray and provides an interpretation in the medical record note. What points are allowed under MDM?**

   Answer: Under MDM "Data Reviewed", one point would

be allowed in this scenario for "Review/order X-rays". The 2 points allotted for independent visualization of an image are appropriate when another provider reviews previously obtained images during a subsequent episode of care. *Updated 8/29/2017*

5. **Please clarify whether credit for an "undiagnosed problem with uncertain prognosis" is limited to particular clinical scenarios associated with higher levels of risk.**

   Answer: The phrase "undiagnosed problem with uncertain prognosis" is not limited in application; it may be used for any circumstance in which the provider is ordering further diagnostic testing to determine a plan of care. *Updated 8/29/2017*

6. **If an established patient with an established chronic illness is having an exacerbation of their illness, is this considered a new problem again (3 points) or a worsening problem (2 points)?**

   Answer: An exacerbation of a previously established chronic illness is considered an established problem, worsening, with a 2-point value. *Updated 8/29/2017*

7. **Please define CMS's interpretation of the word "majority" in reference to time spent during an encounter, and how this should be documented?**

   Answer: When coding an E&M service based on >50% of time spent in counseling or coordination of care, time for the service should be documented to support the coded level of care. For example, when coding a service at 99215: "spent 45 minutes with patient, the majority of time spent counseling on newly diagnosed congestive heart failure and new medication regime". *Updated 8/29/2017*

8. **Office visit for follow up of one diagnosis requiring Rx dosage adjustment. Where would this fall on the Table of Risk?**

   Answer: Rx dosage adjustment falls under Moderate Risk on the Table of Risk. *Updated 8/29/2017*

9. **Doctors A and B are both members of a same-specialty Urology group. During a workup for renal calculi by Provider A, abnormal lab and imaging studies led to a renal biopsy that demonstrated malignancy. Doctor A refers the patient to Doctor B, who has particular expertise in surgery for renal malignancy. Is the patient considered "new" to Dr. B? Is the problem considered to be "new" to Dr. B?**

Answer: Since Drs. A and B are members of a same-specialty group, and Dr. A has performed a workup on this patient, neither the patient nor the renal malignance is considered new to Dr. B, who has full access to the patient's medical records relative to this problem. If Drs. A and B had been different specialty providers in a multi-specialty group, both the patient and the problem would have been considered new to Dr. B. *Updated 8/29/2017*

10. **Please define MDM credit for drug therapy requiring intensive toxicity monitoring. Is there a list of specific drugs requiring this monitoring and what are the documentation requirements?**

    Answer: Intensive monitoring for drug toxicity is medically necessary based on each patient's individual clinical status; the need for monitoring is based on the patient's age and overall tolerance for the drug(s) and on his/her renal, hepatic and hematologic status. When there is clinical evidence of the need for monitoring, and diagnostic studies as evidence of the monitoring, this may be a factor in calculating MDM for an E&M. CMS has not published a list of specific drugs relative to this issue. Documentation for this monitoring requires a description of the medical need for monitoring, along with evidence of appropriate testing and analysis of results. *Updated 8/29/2017*

11. **Please clarify points for follow-up of two stable chronic conditions, when the provider's plan indicates a continuation of the current prescriptionf medication regime.**

    Answer: The two chronic conditions would be coded separately, with one point allotted for each as "established problem, stable" and a moderate level of risk associated with prescription medication management. *Updated 8/29/2017*

12. **When a condition is described as "uncontrolled" (e.g., hypertension or diabetes), does this qualify the problem as high-risk?**

    Answer: The term "uncontrolled" generally signifies a higher level of risk; each clinical situation merits its own individual assessment. For example, "uncontrolled hypertension" bears more risk than "uncontrolled facial acne". *Updated 8/29/2017*

13. **Please define appropriate coding for an NPP discussion with an MD in the office setting. Are points appropriately allotted for this as effort to obtain additional history?**

Answer: When a NPP discusses a case with a physician in the same group, and the service is being billed by the physician under incident to guidelines, the physician is providing supervision for the NPP and sharing his/her knowledge of the patient. Discussion related to this supervision is not considered as additional history. *Updated 8/29/2017*

14. **Does a new patient problem apply more than once in a multi-specialty group?**

    Answer: The guideline does not apply to different specialties, whether within a group practice or in different practices. When a provider of a different specialty sees the patient for the first time, the problem is considered new to that specialty physician. *Updated 6/9/2017*

15. **If a patient has a known problem (not "new") and the problem returns or worsens, is this considered "new" or known?**

    Answer: If a patient has been treated for a problem in the past (e.g., asthma) and has been successfully stabilized, and that problem recurs or presents as an exacerbation, it is considered to be an established problem which is worsening. There may be unusual circumstances in which a former problem recurs after many years, and may be considered a new problem. For example: a 65 year old patient presents during an acute asthmatic attack, and reports a history of a similar attack 20 years prior. The asthma is now considered a new problem, based on the wide gap in time during which the patient had no evidence of this problem. *Updated 6/9/2017*

16. **When a patient is seen in the ED, does the concept of "new" vs. "established" problem apply?**

    Answer: The concept of a "new" or "established" problem does not apply to patients seen in the ER. All patient problems are considered "new" in the ER setting, except those for which the patient presents on multiple visits on the same date of service. *Updated 6/9/2017*

17. **In family history does "family history noncontributory" meet?**

    Answer: Family history which is described as "non-contributory" would not qualify for a detailed or comprehensive level of coding, but may be referenced in a service billed at a lower level of service, for which family history is not required. *Updated 6/9/2017*

18. **Could family history of breast cancer be used for a diagnosis management point when adding up points for medical decision making?**

    Answer: A family history of breast cancer is a factor within the patient's PFSH. Unless the provider has included this factor as part of his/her medical decision making, it is not included as a diagnosis/management option. *Updated 6/9/2017*

19. **Does time define billing if a provider documents 15 minutes but the documented MDM and exam meet a 99214 level?**

    Answer: Time is only used as a level-setting factor for an E&M service in which 50% or more of the visit was spent in counseling and coordination of care. When documentation of history, exam and MDM meet the 99214 level, the service can be billed as such regardless of time spent. *Updated 6/9/2017*

20. **Can complex MDM become the determining factor in assigning a level of visit? For example, a subsequent hospital visit with documentation of a PF physical exam and complex MDM – can this score at 99233 instead of 99232?**

    Answer: For E&M services requiring 2/3 components, the level of service is set by the lowest-ranking element. In order to bill a 99233, a detailed examination and high level of complexity in MDM is required. *Updated 6/9/2017*

21. **Is the MDM one of the required elements for an established patient?**

    Answer: MDM is a required element for all new patient visits which require 3/3 elements. For subsequent visits requiring 2/3 elements, visits that do not include MDM will be assessed individually. Providers must bear in mind that it is difficult to determine medical necessity for a visit in which a history and examination have been documented, but no plan of care has been established. *Updated 6/9/2017*

22. **When an EKG is ordered and interpreted in the office on the same DOS, what points are assigned in MDM under "Data Reviewed"?**

    Answer: One point is allotted for ordering and reviewing an EKG. The interpretation of the EKG is a separately payable service. *Updated 6/9/2017*

23. **Please clarify E&M data points assigned for provider referrals. How are points assigned when a provider refers a patient to a specialty provider?**

    Answer: A referral to another specialty provider is included under “new problem- additional workup planned” and would be allotted 4 points under Problem Points within the MDM table. *Updated 6/9/2017*

24. **How does Medicare determine conditions that qualify for "undiagnosed new problem with uncertain prognosis"? Can this be applied for cases where physician is ordering bloodwork to determine the next course of action? As an example, patient presents with abdominal pain, hair loss and hematuria.**

    Answer: If a patient presents with a problem that is yet undiagnosed, and which is associated with potentially serious prognostic outcome, this would merit a moderate level of risk. The problems noted in your question appear to qualify on this level; each set of clinical circumstances must be individually interpreted in this regard. *Updated 6/9/2017*

25. **When there is an administration of parenteral medications, does this need to be documented in provider note? If the provider documents "See Nurses notes", is it applicable to use information from the nurse notes?**

    Answer: Administration of parenteral medications is included in MDM risk assessment for the E&M service. As such, the billing provider’s note for the DOS should reflect the administration (including drug, dosage and route). Nurses’ notes, while corroboratory, are not assessed in determining the MDM or level of coding for a service. *Updated 6/9/2017*

26. **A patient presents to the emergency room for chest pain, and the provider documents several chronic conditions in the ROS (HTN,CHF,CAD,COPD). The MDM only includes reference to the chest pain and a diagnosis of “Atypical chest pain”. In assessing risk for the MDM, would the chronic conditions be included?**

    Answer: In order to include consideration of a chronic condition(s) in the MDM risk assessment, the provider must include the chronic condition(s) within the MDM portion of the record. In this scenario, if only the atypical chest pain was considered, a chronic condition mentioned in the ROS or HPI will not count in assessing the complexity of the MDM. *Updated 6/9/2017*

27. **What does NGS consider prescription drug management under management options for MDM? If a patient is currently stable on medication and the prescription is refilled, is this considered prescription drug management?**

    Answer: All prescription drug management, including prescription renewal, is associated with moderate risk, as per the CMS Table of Risk. *Updated 6/9/2017*

28. **Is it appropriate to assign MDM data points for reviewing and summarizing history obtained from parents/guardian, when obtaining history on a pediatric patient?**

    Answer: Credit for obtaining history from someone other than the patient represents the provider's decision and extra effort to elicit an HPI when the patient is unable to provide an HPI due to his/her clinical condition (e.g., patient is unconscious, disoriented or intubated). The concept does not apply to babies and small children, since no actual provider decision is implied. Babies and children, due to their age and state of intellectual development, are not capable of providing an accurate HPI in most, if not all, clinical circumstances. *Updated 6/9/2017*

29. **A provider sees a patient for an acute uncomplicated illness (i.e.. acute upper respiratory infection) no other chronic illness is noted. The provider writes a prescription for an OTC medication, such as Mucinex D; would the Medical Decision Making be assigned as low or moderate based on this prescription alone?**

    Answer: Prescription and management of OTC medication, along with management of an acute, uncomplicated illness is associated with a low level of MDM. *Updated 6/9/2017*

30. **If a physician sees a patient presenting with an acute complaint, such as shoulder strain, and the provider does a complete HPI, ROS and exam and addresses any non-related chronic conditions in his/her plan, should these chronic conditions be taken into consideration when assigning the E&M or should only the acute condition and related care be used for the calculation of the E&M level of service?**

    Answer: The level and scope of an E&M service is determined by the medical necessity for each element of history, examination and MDM. If non-related chronic conditions do not impact the patient's clinical status relative to the presenting complaint, and are not being evaluated in the context of the visit, they should not be

included as a means of achieving a higher level of coding. *Updated 6/9/2017*

31. **Could chest pain be considered a moderate level of risk in the MDM?**

    Answer: The level of risk for chest pain would be based on the history and exam findings, and particularly the context in which the pain was reported. Chest pain from recent external trauma or a physical finding such as a skin abscess or dermatological condition would probably score as a low risk, while chest pain of suspected cardiac nature might score as moderate if the patient was clinically stable or high if chest pain was accompanied by other symptoms such as diaphoresis or shortness of breath. *Updated 6/9/2017*

32. **What makes a surgery in MDM covert from a Moderate risk to a High risk?**

    Answer: Elective major surgery is considered as either moderate or high risk based on many factors that include (but are not limited to) the specific nature of the surgery (e.g., aortic aneurysm repair carries more risk than knee replacement), the patient's age, comorbid conditions, prior surgical and anesthesia problems and the patient's actual clinical status at the time of the surgery. *Updated 6/9/2017*

33. **Where can I find a list of drugs that are considered high risk "drug therapy requiring intensive monitoring for toxicity"?**

    Answer: The CMS website list of high risk medications does not apply to the MDM risk assessment, since it includes drugs that do not require intensive toxicity monitoring. CMS has not published a specific list of such drugs. *Updated 6/9/2017*

34. **Please clarify MDM credit granted for problems considered "new" to the examiner. Does this apply for each provider who sees the patient for the first time, including same-specialty group members? Are the rules the same in both the inpatient and outpatient environment?**

    Answer: NGS medical directors have reconsidered this standard and authorized a change that will be effective for services on and after 2/1/2017. The NGS Medical Review tool will also be modified to reflect this new standard. *Updated 6/9/2017*

    The reference to a problem as "new to examiner" is being changed to a problem as "new to patient". This reference

is changing to clarify the issue for same-specialty provider groups, many of whom have submitted questions on this issue. Providers in a same-specialty group are considered by CMS as one entity, and this concept applies in both the inpatient and outpatient setting. As such, a patient's problem can only be "new" to members of a same-specialty group practice **on one occasion**, and is considered to be a known problem beyond initial presentation and documentation. If a problem has been recognized and addressed by one group provider, it is not considered new to another group provider who sees the patient on a subsequent basis. This is especially true because the first provider should have documented the problem, plan of approach and diagnostic findings, which should now be available to the second provider.

When a patient presents with a new problem, not previously addressed within a same-specialty group practice, this factor of MDM may be appropriately assessed, based on whether additional workup is or is not being planned. *Updated 6/9/2017*

35. **Please provide clarification on the changes effective 2/1/2017 to the MDM for a new problem to provider vs. new problem to patient. Does this reconsideration by NGS include Emergency Department visits? As an example, if a patient comes to the ED for an asthma exacerbation that has been previously diagnosed by their primary care doctor (family practice specialty group) and has never seen anyone at the ED for this same problem, would the problem be new to the ED because the ED is a different specialty group practice?**

Answer: The concept of "new" vs. "established" patients does not apply in the ED. All ED patients, and their presenting problems, are considered as new, regardless of the patient's history or the examiner's prior experience with the patient. *Updated 6/9/2017*

36. **Please explain NGS's interpretation of medication prescription management as it relates to MDM. Does renewal of a prescription for long-term medication(s) differ from a prescription for a new medication?**

Answer: NGS refers to the CMS E&M guidelines in assigning moderate risk to prescription drug management. The guidelines do not differentiate between newly ordered and renewed medications, nor do they classify any particular prescription medication as being more or less risk-associated than others. Since risk is one element in assessing the complexity of medical decision making (the others being the scope/duration of conditions and the scope of diagnostics and medical

records), all factors are included by reviewers in calculating the complexity of MDM. *Updated 6/9/2017*

37. **For emergency room visits, we take into consideration all the potential diagnoses the provider needs to consider when evaluating medical decision making when using the TOR. Is this in line with NGS guidance?**

    Answer: Consideration for other possible diagnoses is factored into MDM, and may increase complexity based on the number of possibilities (or "rule outs"), and the clinical risks associated with the potential diagnoses. The complexity of decision making is seen within the context of the choices; differentiating between a fractured versus sprained risk carries a different level of risk than differentiating between a myocardial infarction versus pulmonary emboli. *Updated 6/9/2017*

38. **Please clarify NGS's process for crediting the amount and complexity of data reviewed as part of MDM.**

    Answer: NGS uses the following table for crediting amount and complexity of data: *Updated 6/9/2017*

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

39. **Please clarify this interpretation: "Direct visualization and independent review/interpretation of an image, tracing or specimen previously or subsequently interpreted by another MD" (e.g., CT, MRI, ultrasound) - not simply review of report - regardless of items viewed, count as two points.**

    Answer: As per the chart above, this independent visualization would be associated with two points. *Updated 6/9/2017*

40. **E&M and EKG done on the same day, should we count EKG under Amount & Complexity of Data, Review and/or order tests in Medicine section**.

Answer: An order for EKG and review of the results would be counted under review and/or order tests in the Medicine section of CPT. *Updated 6/9/2017*

41. **When an E&M level requires 2/3 components, does one of the 2/3 have to be MDM?**

    Answer: When a service requires 2 of 3 components, it may be payable with documentation of the history and physical examination, but this would be unusual. Medical necessity is the over-arching determinant for all Medicare claim approvals. When documentation does not reflect the provider's decision relative to the patient's complaint, or a plan of care based on clinical assessment, the medical necessity for the visit is often not evident. This is especially true for higher levels of E&M services, usually associated with clinical presentations or problems that demand more complicated decision making by the provider. *Updated 6/9/2017*

42. **Do your auditors use a point system to quantify the MDM and, if so, can you provide me with the rules and your auditing form so I can incorporate the rules correctly into my compliance plan?**

    Answer: Yes, please refer to our NGS E&M auditing tool, available on our website at Evaluation & Management Documentation Training Tool . *Updated 6/9/2017*

43. **In the NGS tool under "Number of Diagnoses or Treatment Options", the chart references "workup planned" and "no additional workup planned". Some MACs consider tests performed during the same encounter and others consider it to be tests scheduled following the encounter. How does NGS interpret "additional work up"?**

    Answer: The MDM Problem Points lists "new problem, additional workup planned": workup that is accomplished during an office visit is not "planned", since it's already been performed. The concept of "additional workup planned" applies to diagnostic testing or consultative opinion(s) planned beyond the office visit. An exception to this rule applies to emergency room (ER) visits; diagnostic studies which are ordered and completed during an ER visit, and included in medical decision making, may be credited as additional workup. *Updated 6/9/2017*

44. **When reviewing and auditing documentation for an established patient, if the auditor finds a comprehensive history, comprehensive exam and a low MDM:**

    Would you allow the visit to be billed as a level 99215

because of the two out of three factor?
or
Would you drop the visit down to a level 99213 due to the low MDM?

Answer: In the situation described above, 2/3 components are required and, while three are documented, 2/3 met the comprehensive level. As such, the service could be approved at the higher level of 99215, but this would depend on the nature of the presenting complaint and the medical necessity for a comprehensive level of care. Two examples:

a. A patient with no significant health history and/or comorbidities presents with a URI, for which the provider ultimately prescribes an OTC medication. The medical necessity for a comprehensive history and examination is unlikely.

b. A patient with known COPD and history of prior lung cancer presents with a URI. Given the patient's history, the provider may elect to perform a comprehensive history and examination, followed by a request for chest X-ray and OTC medication. The comprehensive history and examination would likely be seen as medically necessary in this circumstance. In this case, the MDM scores as low risk, but the patient's health history conveys a need for a comprehensive history and examination, supporting the higher level billing. *Updated 6/9/2017*

45. **How is "medical necessity" for the level of E&M determined for established patients?**

Answer: Generally, the patient's presenting complaint sets the framework for medical necessity of care rendered during an encounter, which is then reflected in the coding level. For example: A patient who presents for follow-up to medication adjustment will probably require a lower level of history, exam and MDM than a patient who presents with recent onset of chest pain. *Updated 6/9/2017*

46. **Would prescription for antibiotics be considered moderate on the TOR under prescription management?**

Answer: Ordering and renewing prescription medications, including antibiotics, is assigned a moderate level of risk, as per CMS guidelines. *Updated 6/9/2017*

47. **Please define how NGS interprets the term "prescription drug management."**

Answer: Prescription drug management includes:

a. Management and/or renewal of current prescription medications, including review of tolerance, side effects, dosage changes and medication termination

b. New prescriptions issued as a result of the current encounter

c. Discontinuation of current medication(s) *Updated 6/9/2017*

46. **Does "additional workup" include request for consultation with a specialty provider?**

Answer: Additional workup includes all requests by the provider to obtain further diagnostic information to help establish a final diagnosis and plan of care. This includes orders for diagnostic tests and requests for consultative input from other specialty providers. *Updated 6/9/2017*

47. **When a provider personally reviews image(s), tracing(s) or specimen(s), are two points allowed for each image, tracing or specimen, if documented in the note?**

Answer: Two points are allowed for review of image(s), tracing(s) and specimen(s); the points are inclusive of all reviewed materials and the maximum allowance for this work is two points. *Updated 6/9/2017*

48. **What drugs are designated as "requiring intensive monitoring" for toxicity?**

Answer: Drugs in this category generally include certain cardiac drugs (e.g., Digoxin), specific antibiotics (e.g. Vancomycin and Gentamycin), anti-seizure agents, bronchodilators, immunosuppressant drugs, chemotherapeutic agents, certain psychiatric drugs and drugs used to treat HIV/AIDS. *Updated 6/9/2017*

49. **Do the sign and symptoms or complaints in the HPI count in the Diagnosis and Management options if not included in the POC?**

Answer: Signs and symptoms not addressed in the POC do not count under diagnosis and management options, since they are not among those being considered by the provider as relevant to the POC. *Updated 6/9/2017*

[Return to Top]

[Return to E&M FAQ Index]