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6 Questions Ensure E&M Compliance

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Using MDM to code office visits in 2021 from an auditor's perspective

There are four distinct portions of an auditor's tool: diagnoses, data, risk, and calculation of medical decision making (MDM). Providers should ask themselves the following six questions to ensure their progress notes are complete and will pass each portion of an audit with flying colors:

1. Does my progress note contain a medically appropriate history and examination?
2. Did I address the diagnoses appropriately?
3. Did I document all orders and data reviewed?
4. Did I work with other professionals?
5. Did I use an independent historian?
6. Does the documentation support the level of risk I chose?

History and Exam

Even though the focus has shifted to using either time or MDM to choose office visit levels, it is still important for providers to perform and document what they consider to be a medically appropriate history and physical examination. Make sure your providers understand that, while these are no longer key elements in choosing an E/M level, they are still included in the descriptors for codes 99202–99205 and 99212–99215 (i.e., "… which requires a medically appropriate history and/or examination") and should be fully documented when performed.

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Addressing Diagnoses

Providers must consider the number and/or complexity of problems addressed during the encounter when calculating the overall level of MDM. The term "addressed" is important: The clinician reporting the service must identify, evaluate, and manage or treat the patient's problems for the issue to be considered addressed. As evidence, the documentation must reflect a complete evaluation — history, exam, diagnostic measures, and treatment.

Only after identifying which problems have been truly addressed can a provider choose a level based on the specific definitions provided in the audit tool. For example, an issue, such as a lump in the breast, meets the definition of an "undiagnosed new problem with uncertain prognosis," which falls into the moderate level for the number/complexity of problems addressed portion of the audit tool. This is then combined with the data and risk portions to determine an overall MDM level. When addressing multiple problems during the same visit, the provider may base their decision on the problem with the highest level.

Data – Records, Tests, and Interpretations

The second portion of the audit looks at data — medical records, tests, and other information — that must be obtained, ordered, reviewed, and analyzed during the encounter. Each unique test (panels count as one **test), order, and/or document is counted. Interpretations of tests that are not separately reported also count.**

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Data – Other Professionals

Also included in the data portion of the audit tool is the discussion of management or test interpretation with an appropriate source. This includes an external physician or other qualified healthcare professional, which is defined in the AMA guidelines as an individual who is not in the same group practice or is a different specialty or subspecialty, including licensed professionals practicing independently. This may also be a facility or organizational provider such as a hospital, nursing facility, or home healthcare agency. Appropriate sources include non-healthcare professionals who are involved in the management of the patient (for example, lawyers, parole officers, case managers, and teachers). Discussions with family or caregivers are not included.

Data – Independent Historians

Providers may rely on an independent historian, such as a parent, spouse, guardian, surrogate, or witness, to provide a history in addition to what was obtained from the patient. This may occur in cases where the patient is unable to provide a complete or reliable history (for example, due to developmental stage, dementia, or psychosis) or because a confirmatory history is deemed necessary.

In the audit tool, the data elements described above in numbers three through five are counted and/or categorized, and the combination is used to determine a level for the data portion of the tool.

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For example, if the provider documents in the progress note that they used an independent historian, ordered a metabolic panel, and discussed care management with the patient's social worker, the provider's documentation would support moderate level amount and/or complexity of data reviewed and analyzed. This would be combined with the diagnosis level and the risk level to determine the overall MDM level for the visit.

Risk Level

The third section of the audit tool takes into consideration the morbidity risk. Morbidity is defined as a state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. For MDM purposes, the level of risk is based upon the consequences of the problem(s) addressed at the encounter when appropriately treated.

Risk levels are defined as minimal, low, moderate, and high. Examples of moderate risk include prescription drug management and diagnosis/treatment significantly limited by social determinants of health such as housing and food insecurities. Examples of high risk include drug therapy requiring intensive monitoring for toxicity and decisions regarding hospitalization. Auditors will look in the documentation for content that supports the level of risk.

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Calculating Overall MDM

After determining individual levels for the categories of diagnoses, data, and risk, the final MDM level depends on the visit documentation meeting or exceeding two out of three elements for a particular level of MDM. For example, a low diagnostic level, high data level, and moderate risk level result in an overall moderate MDM level.

An audit is simply a review of documentation to see if providers are taking proper credit for all the MDM work they perform and to verify that the CPT® code assigned is correct and supported by the documentation. By asking the six questions above, providers will ensure their progress notes reflect their work and support the visit levels assigned.