SAVVY CODER

E/M Nuances: Determining the Level of Medical Decision-Making

Which level of evaluation and management (E/M) code should you use? There are two ways to determine this: One is physician-time based and the other is based on the level of medical decision-making (MDM) that is required. The MDM level is dependent on the 1) problems, 2) data, and 3) risk that the physician must contend with (see "E/M Rules for Office Visits: What Level of Medical-Decision Making?" Savvy Coder, June).

Some clarifications. Although new E/M rules have been in force for eight months, practices are still getting to grips with the nuances of the new system. Here is a refresher on two of MDM's components, including responses from the American Medical Association (AMA), which maintains the Current Procedural Terminology (CPT) codes, including the E/M codes.

MDM's Data Component

The "amount and/or complexity of data to be reviewed and analyzed" helps to determine the MDM level.

Q. What does analyzed mean?

AMA's response. "It is the process of using and anticipating using the test in the MDM process. If a test is ordered outside of an encounter, the ordering has not yet been part of the MDM level determination, so the results will be included in the subsequent E/M visit, if analyzed in the MDM of that encounter. For a test that is recurring, and ordered once for multiple future dates, a new result may be used in determining MDM level if it is analyzed in a subsequent encounter."

Q. If an ophthalmologist reviews a test by a referring source on one date and then reviews that same test at a subsequent encounter, can that second review count as a data item?

A. No. Each unique test performed by the referring source can be counted only once.

Q. If the ophthalmologist orders a computed tomography (CT) scan and blood work, do they both count?

A. Yes. The CT scan would contribute one data point and, depending on the individual CPT/HCPCS code(s), at least one more would be added for the blood work. With two data points, the exam would be considered to involve a "limited" level of data, which would help to support a "low complexity" level of MDM.

Q. One way to meet the requirements of a moderate level of data review would be to have a "discussion of management or test interpretation with external physician/QHP*/appropriate source (not separately reported)." What does that mean?

AMA's response. "Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries such as clinical staff. Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two)."

MDM's Risk Component

MDM's risk component is defined as the "complications and/or morbidity or mortality of patient management."

Q. The AMA gives several examples of scenarios that would be considered moderate risk. These include the "decision regarding minor surgery with identified patient or procedure risk factors" and the "decision regarding elective major surgery without identified risk factors." Are these determined by the global period of zero, 10, or 90 days of post-op care?

AMA's response. "An elective procedure is typically planned in advance (e.g., scheduled for weeks later). An emergent procedure is typically performed immediately or with minimal delay. Both elective and emergent procedures may be minor or major." Note: For MDM purposes, the terms minor and major surgery are not determined by the global period.

* QHP = qualified health care professional.

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