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CDI IN BLOOM | acdis 2023
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Medical Decision-Making in CDI: What's in It for Them?

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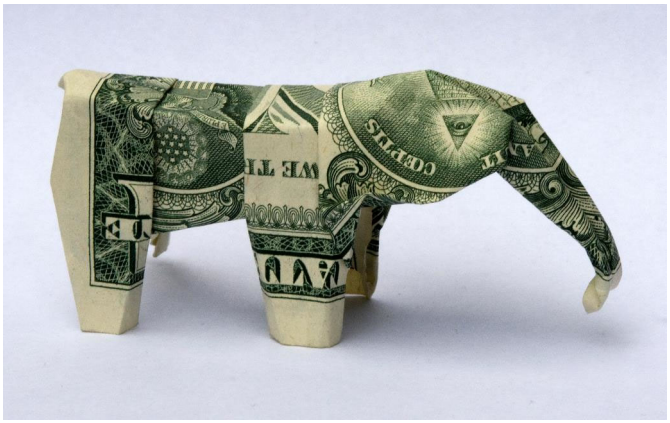
Erica E. Remer, MD, CCDS, is the president of Erica Remer, MD, Inc., based in Beachwood, Ohio. A practicing emergency physician for 25 years, Remer is a nationally known expert in coding, clinical documentation, CDI, and E/M. She has written numerous articles, serves as the co-host of the weekly podcast *Talk Ten Tuesdays*, and has been a frequent guest on the *ACDIS Podcast*. She is the chair of the American College of Physician Advisors' (ACPA) CDI Committee and on their Board of Directors. She is also on the National ACEP Coding and Nomenclature Advisory Committee and a past member of the ACDIS Advisory Board. She designed "Dr. Remer's Documentation Modules With CME" for remote learning by providers. Her passion is educating CDI specialists, coders, physician advisors, and healthcare providers with engaging, case-based presentations and the goal of putting MENTATION back into documentation.

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Describe the elements of medical decision making (MDM) for the professional fee
  - Identify the opportunities for CDI to improve provider documentation of MDM
  - Outline plan to employ MDM improvement in CDI education to align provider's needs with CDI team's needs

The Elephant in the Room



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Historical Billing: Pro vs. Technical

Facility/Technical	Professional
• Diagnosis Related Group (DRG) • Tiered with comorbid conditions and complications • Based on principal diagnosis and secondary diagnoses • The more comprehensive the diagnosis list, the more favorable the reimbursement	• Current Procedural Terminology (CPT®) • E/M Levels of Service • Based on key components (history, physical, complexity of medical decision making) or time, > 50% counseling and/or coordination of care • One good diagnosis demonstrating medical necessity and good to go

American Medical Association and CMS

- Overhaul of E/M office visit, 2021
- Overhaul of just about everything else, 2023
- “Intent is to reduce physician burden and improve patient care”
- Previous guidelines had been from 1995/1997
- **After this talk, some of you will be informing and educating your providers who will still have no idea that this seismic shift has occurred!**

Medical Decision-Making or Total Time

Changes Include:

- Hospital inpatient and observation care merged from separate code sets
  - **Initial** hospital inpatient or observation care: 99221-99223
  - **Subsequent** hospital inpatient or observation care: 99231-99233
  - Hospital inpatient or observation care admission and **discharge services in same day:** 99234-99236
  - Hospital inpatient or observation care **discharge day management**: 99238-99239
- Emergency department, nursing facility, home or residence services
- (Office and other outpatient services, 99202-99205, 99212-99215 transitioned in January 2021)

Why Should You Care?

WIIFM: What's in It for Me?

Facility and Professional Interests Are Now Aligned

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Opportunity Knocks

https://commons.wikimedia.org/wiki/File:Door_knocking_for_Jody_Wilson_Raybould_%2848910897596%29.jpg

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MDM as the Only Component

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Medical Necessity Supersedes All

If there is no medical necessity, there is no billable service.

History and Physical Examination

- Not eliminated…E/M mandate: “Include(s) a medically appropriate history and/or physical examination, when performed”
- Medicolegal implications
- May still be required by state code, conditions of participation, and institutional bylaws

History

- History is still very important!
  - How they diagnose acute problems
  - How they determine status of chronic conditions (are they at goal or not?)
  - PFSH – don’t have to tick off boxes anymore, but:
    - Social history is always relevant
    - Social determinants of health
  - Review of systems as indicated
- Interval history – never needed to rehash entire HPI
  - What is going on now? Why is the patient still here?

Physical Examination

- No longer have a mandatory number of organ systems or body parts
- Physical examination *as appropriate*
  - E.g.:
    - Heart failure…general, JVD, heart, lungs, pedal edema
    - Problem oriented – examine the offending body part!
    - Post surgical – at least look at the incision, is the area functioning as expected?
- Best practice medicine (QUALITY, not for billing purposes)
- Avoid creation of internal inconsistency
  - *Nontoxic…diagnosis of sepsis*
  - *Paralyzed and on sedation…A+O x 3*
  - *Skin intact…Stage 3 sacral decub*

MDM

- Three elements
  1. Number and complexity of problems addressed
  2. Amount and/or complexity of data to be reviewed and analyzed
  3. Risk of complications and/or morbidity or mortality of patient management
- Office…two out of three elements defines level
- Hospital based…two out of three elements as well for this code set
- ED…Only MDM; can't bill on time

Breakdown of MDM

Level of MDM	Number and complexity of problems addressed	Amount/complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient treatment
Straight-forward	Minimal	Minimal or none	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Number and Complexity of Problems *Addressed*

- Comorbidities and underlying diseases are not considered UNLESS they are **addressed**
  - Their presence may increase the complexity of data or increase risk
- Ultimate diagnosis does not define complexity or risk (e.g., chest pain which turns out to be costochondritis)
  - Signs and symptoms may require extensive evaluation to rule out serious pathology
  - Multiple problems of lower severity may aggregate to create higher risk or require more data

Number and Complexity of Problems *Addressed*

- **Addressed**
  - Some consideration or action is required (i.e., a legitimate secondary diagnosis)
    - MEAT paradigm: Monitor, Evaluate, Assess, Treat
    - Impactful or relevant (e.g., immunocompromised due to long-term steroid use) [MEATIeR]
  - If other professional is managing without provider doing any type of assessment, action, etc., not considered "addressed"
  - If referred without any evaluation or action, not "addressed"
  - Evaluation can be by history, physical examination, or diagnostic studies which usually leads to some assessment

Number and *Complexity* of Problems Addressed

- **Self limited or minor:** Runs a course, transient, won't permanently alter health status
- **Chronic** illness: Expected duration of at least a year or until death
  - **Stable:** At treatment goal, well-controlled
  - **Exacerbation, progression, or side effects** from treatment: Requires attention but no consideration of hospital level of care
  - **Severe** exacerbation, progression, or side effects: Significant risk of morbidity and/or consideration of hospital level of care
- **Undiagnosed new problem with uncertain prognosis:** High risk of morbidity without treatment

Chronic

- Can be newly diagnosed (e.g., hypertension) with the expectation of at least a year's duration or until death
- First consider, is it stable?
- Important to specify "not at goal" or "not adequately controlled." This is lumped in with exacerbation/progression/side effects as opposed to "stable."
- Exacerbation **severe** or not?
- Impress on them that they can't rely on the reader to make the leap for them – Think in Ink!

Number and *Complexity* of Problems Addressed

- Acute illness or injury:
  - **Acute, uncomplicated:** Recent or new short-term problem with low risk of morbidity or mortality. Expectation of full recovery (e.g., acute bronchitis, ankle sprain). May have general systemic symptoms like fever, fatigue, or myalgias.
  - Acute illness with **systemic symptoms:** High risk of morbidity without treatment. Systemic symptoms may be generalized or a single system (e.g., acute pyelonephritis, simple pneumonia).
  - Acute **complicated** injury: Requires evaluation of body systems that are not directly injured, extensive but not life-threatening injury/ies, treatment options are multiple and/or may have risk (e.g., concussion, quadriceps tendon rupture).

Number and *Complexity* of Problems Addressed

- Poses threat to **life** or **bodily function**
  - Acute or chronic
  - Illness or injury
  - Risk of mortality or significant permanent morbidity without rapid treatment
  - E.g., acute myocardial infarction, mesenteric ischemia, abrupt change in neurologic status (encephalopathy), psychiatric illness with suicidal or homicidal ideation, overdose
- Strong diagnoses support seriousness of condition
  - "low pulse ox" versus "acute hypoxic respiratory failure"
  - "urosepsis" versus "sepsis due to UTI with acute sepsis-related organ dysfunction as evidenced by metabolic encephalopathy and AKI"

Number and Complexity of Problems Addressed

- **Number** of problems
  - Matrix with number of problems figured in
  - Two or more stable chronic illnesses…moderate (e.g., 99204/99214)
  - Severe exacerbation or life/limb threat…high (e.g., 99205/99215)
- Comorbidities and underlying diseases must impact the MDM regarding the visit to affect the level of service (MEATIeR)
- Conversely, comorbidities, and underlying diseases which impact the MDM must be DOCUMENTED to enter into the calculation of level of service
- This can be used to your advantage – comorbidities are important to them too now

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

- Three categories
- **Category 1**
  - Number is dependent on level of MDM
  - Combination of:
    - Review of prior external note from unique source
    - Review of results of unique test(s)
    - Ordering of each unique test
    - Assessment requiring an independent historian (Cat 1 or 2)

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

- **Category 1**
  - Each unique test counts as one unit; e.g., CBC, CMP, and urinalysis count as three tests
  - Trending or comparing multiple results of same test only counts as one (e.g., serial glucose)
  - Pulse oximetry doesn't count as a test
- **Can only count once!** Copy and pasting day to day doesn't permit counting every day.

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

- Order presumes will be resulted, reviewed, and analyzed
- If test ordered and done elsewhere by an external HCP, can count if reviewing and analyzing
- If professional component is separately reported and billed, can't count as data point (e.g., provider does EKG and bills for it, can't double dip as category 1 test)
- External document (reviewing your own records doesn't count as a data point)
- Best practice, data should be **interpreted** (analyzed).

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

- Three categories
- **Category 1 or 2** (cont.)
  - Assessment requiring an independent historian
    - **Independent historian:** An individual who provides a history in addition to a patient who cannot provide a complete or reliable history (e.g., parent, spouse, witness, caregiver in context of minor age, dementia, or psychosis)
    - Language translation is not included

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

- **Category 2**
  - **Independent interpretation** of a test performed by another physician/other qualified healthcare professional
    - Document “personally reviewed” or “I reviewed…”
    - **Interpret**.
      - Can’t say, “CXR looks good to me.” Need to say something like, “No infiltrate seen” or “No signs of overt heart failure like fluid in fissure or pulmonary vascular redistribution.” **Not** held to formal “report” standard, however.
      - Can pull diagnoses from independent interpretations
    - If provider bills for procedure/test, can’t claim independent interpretation in category 2

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

- **Category 3**
  - **Discussion** of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)
    - Interactive exchange with professional (not through intermediaries). Can be healthcare provider, person from facility, case manager, lawyer, teacher (involved in management of patient). Not family or informal caregiver.
    - Does not need to be in-person
    - Initiated and completed within a short time period (day or two)
    - Doesn’t have to be on the day counted but can only be counted once
    - Best practice to give some points of discussion (as opposed to “Discussed with Dr. So and So.”)
    - Perfect opportunity to incorporate consultants’ diagnoses into own documentation

Data Pitfalls to Avoid

- Copying and pasting results of same unique tests into subsequent notes – can only count a test **once**, in one visit/encounter/day
- Importing results of a study done by another provider without independent interpretation or discussion with the performing individual does not count in data complexity calculation
- Inpatient coders are permitted to pick up certain details from imaging/studies (e.g., laterality of pathology), if the clinician has documented an associated relevant condition. They are not allowed to code straight from report, even if imported into the note. Clinician must assert clinical significance.

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Confusing verbiage ↑
- From American Medical Association presentation: “Risk of complications and/or morbidity, or mortality of patient management decisions made at the visit, associated with the patient’s problem(s), treatment(s).”
- This is an assessment of the **management**, not the disease process or work-up.
- **Decision** may be where risk lies. Decision to perform (or not perform) emergency major surgery, hospitalize, or to deescalate care.

Risk of Complications and/or Morbidity or Mortality of Patient Management

- **Drug therapy requiring intensive monitoring for toxicity**
  - Therapeutic agent that has potential to cause serious morbidity or death. Often narrow therapeutic window.
  - Monitoring is to assess for adverse effects, not therapeutic efficacy
  - Monitoring by lab test, physiologic test, or imaging (not history/physical)
- NOT: Monitoring glucose levels, annual electrolytes, renal function on diuretic.
- YES: Short term intensive monitoring of electrolytes and renal function in case of acute kidney dysfunction; monitoring for cytopenia during chemotherapy; aminoglycoside levels for toxicity. E.g., immunosuppressants, antiarrhythmics, antiepileptics, psychiatric meds, anticoagulants requiring level monitoring.
- At least quarterly testing

Parenteral Controlled Substances

- Must meet medical necessity
- **High risk** of morbidity from treatment

Risk of Complications and/or Morbidity or Mortality of Patient Management

- **Prescription drug management**
  - **"Management"** is the operative word. They are making a decision about the medication.
  - Initiate, continue, discontinue, change dosing. Must document name of medication and dosage.
  - NOT: "See med list." NOT: "Medications refilled."
  - However, could probably document "Reviewed current medications -see med list. Assessed for efficacy and side effects. Will continue medications at current dosage – refills provided for 1 month."

Risk of Complications and/or Morbidity or Mortality of Patient Management

- **Diagnosis or treatment significantly limited by social determinants of health (SDOH)**
- SDOH are found in Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances (https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65)
- Examples of SDOH:
  - Literacy
  - Unemployment
  - Occupational exposure
  - Problems related to living alone
  - Military deployment, alcoholism and drug addiction in family
  - Homelessness
  - Poverty
  - Housing instability

Risk of Complications and/or Morbidity or Mortality of Patient Management

- **Consider templating**
- Would explicitly document, “diagnosis or treatment significantly limited by social determinants of health”
- Make the SDOH additional diagnoses (Z55-Z65)
  - SDOH diagnoses can be picked up from others’ documentation (e.g., medical assistant, nurse, social worker), but they can’t determine the increased risk posed by SDOH diagnoses

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Possible management choices discussed and considered
- Conversations regarding hospitalization, resuscitation, comfort care, hospice
- Whether the patient chooses the treatment or not!
- They should document the conclusion (“family has decided to make the patient comfort care”), not just the fact that the discussion occurred

Risk

Risk of complications and/or morbidity or mortality of patient management	Level of risk in MDM matrix
Straightforward	Minimal or no risk from treatment or even opting out of treatment
Low	Low risk from treatment or choosing not to treat with minimal consent/discussion required
Moderate	Must review with patient and/or surrogate, obtain consent and/or monitor for adverse effects, social considerations complicating care and increasing risk
High	High risk of bad outcome requiring discussion/consent and significant monitoring. Significant risk factors identified impacting major elective surgery or decision regarding any emergency surgery. Admission or escalation of care. Risk of bad outcome from not undergoing treatment as recommended or DNR/deescalation of care due to poor prognosis.

Office and Outpatient (Other Than Observation)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99202/ 99212	Straightforward	Minimal • One self-limited or minor problem	Minimal or none	Minimal
99203/ 99213	Low	Low • Two or more self-limited or minor • One stable chronic illness • One acute, uncomplicated illness/injury	Limited • Category 1: Any combination of two tests • Category 2: Assessment requiring independent historian	Low

- 99201/99211 deleted from code set
- New and established have same MDM requirements (time requisites are different)

Office and Outpatient (Other Than Observation)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99204/ 99214	Moderate	Moderate • One or more chronic illnesses with exacerbation, progression, or side effects • Two or more stable chronic illnesses • One undiagnosed new problem with uncertain prognosis • One acute illness with systemic symptoms • One acute, complicated injury	Moderate (one of the three) • Category 1: Any combo of three tests • Category 2: Independent interpretation • Category 3: Discussion	Moderate (e.g.:) • Prescription drug management • Decision for minor surgery with risk factors, elective major surgy without risk factor • SDOH

Office and Outpatient (Other Than Observation)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99205/ 99215	High	High • One or more chronic illness with severe exacerbation, progression, or side effects • Life or bodily function threat	High (two of the three) • Category 1: Any combo of three tests • Category 2: Independent interpretation • Category 3: Discussion	High (e.g.:) • Intensive monitoring for toxicity • Decision re: elective major surgery with risk factors or emergency surgery • Decision re: hospitalization • Decision not to escalate or to deescalate care because of poor prognosis

Hospital Inpatient and Observation Care (Initial and Subsequent)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99221/ 99231	Low	Low • One acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited • Category 1: Any combination of two tests • Category 2: Assessment requiring independent historian	Low

- Is there medical necessity for patient to still be in the hospital?

Hospital Inpatient and Observation Care (Initial and Subsequent)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99222/ 99232	Moderate	Moderate • One or more chronic illnesses with exacerbation, progression, or side effects • Two or more stable chronic illnesses • One undiagnosed new problem with uncertain prognosis • One acute illness with systemic symptoms • One acute, complicated injury	Moderate (one of the three) • Category 1: Any combo of three tests • Category 2: Independent interpretation • Category 3: Discussion	Moderate (e.g.:) • Prescription drug management • Decision for minor surgery with risk factors, elective major surgy without risk factor • SDOH

Hospital Inpatient and Observation Care (Initial and Subsequent)

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99223/ 99233	High	High • One or more chronic illness with severe exacerbation, progression, or side effects • Life or bodily function threat	High (two of the three) • Category 1: Any combo of 3 tests • Category 2: Independent interpretation • Category 3: Discussion	High (e.g.:) • Intensive monitoring for toxicity • Decision re: elective major surgery with risk factors or emergency surgery • Decision re: hospitalization • Decision not to escalate or to deescalate care because of poor prognosis • Parenteral controlled substances

Emergency Department Services

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99282	Straightforward	Minimal • One self-limited or minor problem	Minimal or none	Minimal
99283	Low	Low • Two or more self-limited or minor • One stable chronic illness • One acute, uncomplicated illness/injury	Limited • Category 1: Any combination of two tests • Category 2: Assessment requiring independent historian	Low

- 99281 doesn't require a physician or other qualified healthcare professional

Emergency Department Services

Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of treatment
99284	Moderate	Moderate • One or more chronic illnesses with exacerbation, progression, or side effects • Two or more stable chronic illnesses • One undiagnosed new problem with uncertain prognosis • One acute illness with systemic symptoms • One acute, complicated injury	Moderate (one of the three) • Category 1: Any combo of three tests • Category 2: Independent interpretation • Category 3: Discussion	Moderate (e.g.:) • Prescription drug management • Decision for minor surgery with risk factors, elective major surgery without risk factor • SDOH

Emergency Department Services

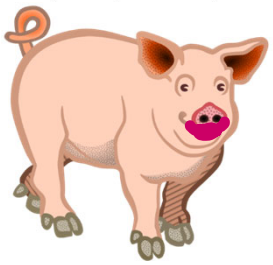
Code	Level of MDM	Number/complexity problems addressed	Amount/complexity data	Risk of Treatment
99285	High	High • One or more chronic illness with severe exacerbation, progression, or side effects • Life or bodily function threat	High (two of the three) • Category 1: Any combo of three tests • Category 2: Independent interpretation • Category 3: Discussion	High (e.g.:) • Intensive monitoring for toxicity • Decision re: elective major surgery with risk factors or emergency surgery • Decision re: hospitalization • Decision not to escalate or to deescalate care because of poor prognosis

Examples of Good Documentation

- Despite high risk of rebleeding, must continue anticoagulation due to history of stroke and newly placed drug eluting stent.
- Discussed acute kidney injury (AKI) with Dr. Kidney. We both agree that the cause is acute tubular necrosis. Will avoid contrast and other nephrotoxins, will hydrate and monitor creatinine carefully.
- According to antibiogram, will initiate therapy with vancomycin and cautiously monitor levels to avoid toxicity.
- Discussed risks and benefits of prompt I&D of perirectal abscess. Patient has risk factors of being a diabetic and prone to sepsis. Recommended surgical intervention, but patient and family prefer to try antibiotics and observation for 48 hours.

Alternative to MDM

- Time-based billing is the alternative
- There are ranges, but the documentation should have a precise whole number
- Emergency department does not bill on time unless they are claiming critical care time
- Documentation should still support the level of service – if there is no medical necessity for a level 5 service, they can spend all day, but…



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Copy and Paste is NOT Their Friend!

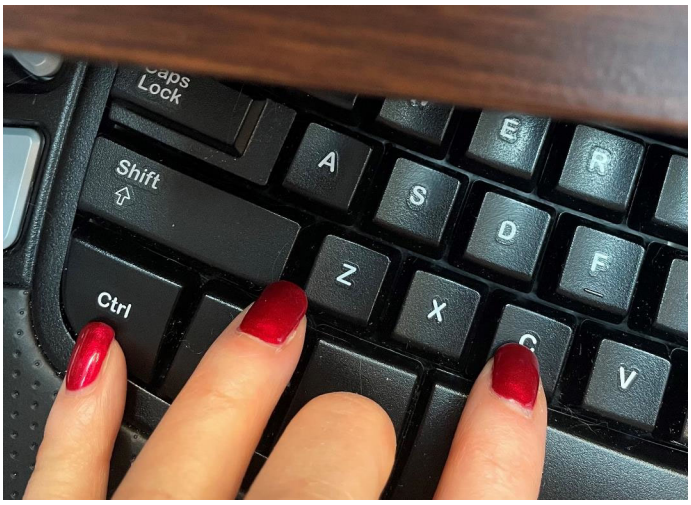

Photo by Erica Remer. Permission granted.

MDM

- Think in ink (Put **MENTATION** back into documentation)
  - **Analyze data**
  - Independent **interpretation**
  - **Discussion** with consultant and incorporation of their diagnoses
- Repeat exams or assessments
- Make the narrative count—don't just perpetuate prior thought process (excessive copy and paste)
- Differential diagnosis belongs here, as appropriate
- Diagnoses are key (comorbidities, strong diagnoses as opposed to signs and symptoms, chronic at goal?, exacerbation severe?)

Feedback and Education

- You are in the record reviewing documentation. You can provide valuable input.
- Someone (CDI, compliance, professional coders, physician advisor) needs to give the providers formative feedback and education.

Benefits of Good Clinical Documentation

- Take better care of patients
- Improve quality metrics by demonstrating good care of patients
- Appropriate reimbursement for facility
- Appropriate compensation for provider
- Avoid note bloat
- Avoid queries
- Avoid denials
- Protection from medicolegal jeopardy
- Avoid compliance risk

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Describe the elements of medical decision making (MDM) for the professional fee
  - Identify the opportunities for CDI to improve provider documentation of MDM
  - Outline plan to employ MDM improvement in CDI education to align provider's needs with CDI team's needs

References

- CPT Evaluation and Management (E/M) Code and Guideline Changes:
  - https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- ACEP on 2023 Changes:
  - https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggs-articles/regs--eggs---october-13-2022/
- E/M Coding Changes for 2023, The Hospitalist, December 13, 2022.
  - https://www.the-hospitalist.org/hospitalist/article/33857/business-of-medicine/e-m-coding-changes-for-2023/

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Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

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