Briefings on APCs

Make sense of medical decision-making

Medical decision-making (MDM) documentation tells the story of all the things the provider considered during an E/M visit, including the nature of the patient's problem, any test results or data they reviewed when they assessed it, and factors they considered when they set up a treatment plan.

The MDM table provides a system for measuring the clinician's brainwork that takes place during an E/M visit. The physician (or qualified clinician) must consider the patient's medical condition(s)—whether the problem is self-limiting or highly complex. Data from any recent diagnostic tests must be reviewed and analyzed. And decisions must be made for ongoing patient management, which the clinician makes while weighing the potential risks of any treatment or testing—or taking no action at all.

From a payer perspective, MDM documentation has gained increased importance in recent years to justify a visit's medical necessity. Prior to 2021, some payers required MDM to be one of the two out of three components documented for high-level established patient visits.

For payers, the MDM supports the reason for the visit, answering such questions as: How sick is the patient? How risky is the treatment plan? How did the visit serve to advance the patient toward better health?

2021 MDM update streamlines reporting

The overall purpose of updating the office visit guidelines is "to reduce administrative burden, improve payment accuracy and better reflect the current practice of medicine," CMS observed in the final 2020 Medicare physician fee schedule.

For MDM, that translates to a streamlined MDM table that removes some of the guesswork when establishing the appropriate level of complexity.

The 2021 MDM table merged components of the previous MDM table from the CPT manual with the Table of Risk from the 1995/1997 documentation guidelines. In the process, it revised some of the key elements.

For example, one problem practices had with the old MDM table was that the number of diagnoses and amount of data reviewed were not set for the various MDM levels. Coders were left to wonder: How many diagnoses are considered "minimal," "limited" or "multiple"?

In the past, auditors solved this problem by referring to the more specific terms in the Table of Risk.

They noted that that the "Number of Diagnoses" in the MDM table corresponded to the "Presenting Problem(s)" in the Table of Risk. For example, a minimal "Number of Diagnoses" corresponds to one self-limiting or minor "Presenting Problem."

Similarly, the "Amount and/or Complexity of Data to be Reviewed" in the old MDM table matched up with "Diagnostic Procedure(s) Ordered" in the Table of Risk.

With the 2021 guidelines, there is no longer a need for such comparisons because all that information is integrated into the updated office visit MDM table.

Note that MDM will continue to apply only for Levels 2-5 E/M codes. Code 99201 (New patient level 1) was deleted as of Jan. 1, 2021. Code 99211 is considered a nursing code, so the concept of clinician MDM does not apply to it.

The 3 columns: What they mean and how to use them

When coding based on the new MDM table, practices will determine the MDM level of a visit based on two out of the following three elements, regardless of whether it's a new or established patient visit:

2021 MDM Elements	**Formerly Known As...**
Number and Complexity of Problems Addressed	Number of Diagnoses or Management Options
Amount and/or Complexity of Data to be Reviewed and Analyzed	Amount and/or Complexity of Data to be Reviewed
Risk of Complications and/or Morbidity or Mortality of Patient Management	Risk of Complications and/or Morbidity or Mortality

Number and complexity of problems addressed: Definitions

The 2021 E/M guidelines define a problem as “a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.”

A problem is considered to be “addressed” if the clinician evaluates or treats it directly during the visit, or if testing or further treatment is considered, but the decision is made not to proceed because the risk is too high or the patient, parent, guardian, or surrogate declines it.

Note that “each symptom is not necessarily a unique condition,” the guidelines state. That might be the case when, for example, it is associated with a related problem the clinician is already addressing.

If a patient presents with potentially serious signs and symptoms, those presenting conditions “may ‘drive’ MDM even when the ultimate diagnosis is not highly morbid,” the guidelines state. That’s because during the course of the visit, the clinician must do the work of evaluating the patient’s condition to reach a conclusion about the severity of the diagnosis.

Comorbidities or underlying conditions may be counted as problems if they are addressed; they also may be counted if their presence affects the data being analyzed or increases the complexity of managing the patient. For example, a cardiologist might not manage a pregnant patient’s prenatal care, but the fact of the pregnancy must be taken into consideration when managing any maternal cardiac condition.

For hospital inpatients or those in observation care, the problem addressed is the problem status on the date of the encounter, which might be quite different than the patient’s problem when admitted. The reporting clinician should code based on the problem being managed at that encounter, which may not be the reason the patient was admitted.

The term “addressed” was added to the title of this element in part because “in electronic records today, people have extensive problem lists that may or may not be addressed at the encounter at all,” explained Peter Hollmann, MD, co-chair of the AMA’s CPT/RUC Workgroup on E/M, in a January 2020 instructional video on the guidelines posted on the AMA’s website.

The following scenarios may not be counted as addressing a problem, according to the guidelines:

- The clinician documents that another medical professional is managing the problem. The documenting provider makes no additional assessment or care coordination.
- The clinician refers the patient to another medical professional without evaluating the history, exam, or diagnostic tests and without considering treatment options.

A closer look at the 4 levels of problems addressed

Minimal problem: The patient is seen for a problem that may not require a physician to be present. The service is instead performed under the supervision of a physician or qualified health care professional. In the physician’s office, this service would be reported with 99211; in the emergency department it would be reported with 99281.

- Self-limited or minor problem: The guidelines define this as a transient problem that “runs a defined and prescribed course” and probably won’t change the patient’s permanent condition. Examples: Cold, insect bite, tinea corporis (rash), teething, or post-nasal drip.

Low number/complexity of problems is defined in the MDM table as any of the following:

- Two or more self-limited or minor problems.
- One stable chronic illness. The guidelines define a stable chronic illness as one expected to last from one year to the death of the patient. In addition, the patient is meeting treatment goals. Example: A patient diagnosed with type 2 diabetes who is managing the condition with diet and exercise and achieving the prescribed treatment goals.
- One acute, uncomplicated illness or injury. A new, short-term problem with a low risk of morbidity or mortality with treatment. A full recovery is expected. A problem that would normally be considered self-limited or minor but which is not resolving with prescribed treatment would be considered an acute, uncomplicated illness or injury.
- Stable acute illness. The patient has a recent problem and treatment has started. The patient’s condition is improving, though not fully resolved.
- Acute, uncomplicated illness or injury requiring hospital inpatient or observation-level care: A recent problem with a low risk of morbidity or mortality with treatment, but for which treatment in a hospital inpatient or observation setting is required.

Moderate-level problems addressed may include any of the following:

- One or more chronic illnesses with exacerbation or side effects of treatment. A chronic illness that has become

acutely worse or is uncontrolled or progressing. The problem may require additional supportive care or require treatment for side effects of treatment.
- Two or more stable chronic illnesses.
- One undiagnosed new problem with uncertain prognosis. Signs and symptoms point to a possible high risk of morbidity if the condition goes untreated. Example: Breast mass.
- One acute illness with systemic symptoms. A new problem causing systemic symptoms with a high risk of morbidity without treatment.
- One acute, complicated injury. The illness may be extensive and require evaluation of body systems unconnected to the injured organ. Treatment options may have a high risk of injury. Example: Head injury with brief loss of consciousness.

High numbers and complexity of problems addressed may include any of the following, according to the 2021 guidelines:

- One or more chronic illnesses with severe exacerbation, progression or side effects of treatment. The problem may pose significant risk of death and require an increase in the level of care the patient is receiving.
- One acute or chronic illness or injury that poses a threat to life or bodily function. This may include an acute illness causing systemic symptoms, an acute, complicated injury, side effects of treatment, a chronic illness or injury that has become severely worsened or progressed to the point where the patient's life or bodily function are in danger without treatment. Examples: Pulmonary embolism, severe respiratory distress, progressive, severe rheumatoid arthritis, psychiatric illness causing potential threat to self or others, acute renal failure, abrupt change in neurological status (e.g., stroke), peritonitis, or myocardial infarction.

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