Where and How MDM is Indicated and What OP Can and Cannot Do

Last Modified on 04/01/2022 4:31 pm EDT

Version 20.16

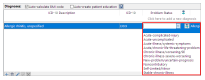
> **!** Important Note about the Development of these Features
>
> It is important to note that the details of what “should” and “should not” count are evolving and the developments in OP can only align with what we know to be true at the time of development. We expect that there will be modifications to the enhancements as more is learned from both the industry and our practices. All coding recommendations are **suggested** based on information that can be tracked in OP.

There are 3 **elements** of Medical Decision Making: Problems Addressed, Data Reviewed, and Risk of Complications. There are 4 **levels** of Medical Decision Making: Straightforward, Low, Moderate, and High. In order to qualify for a particular level of MDM, **two of the three elements** for that level of MDM must be met or exceeded. After reviewing where and how each element is indicated in OP, review the **definitions and some examples for each element**.

Problems Addressed: Number and complexity of problems addressed

OP Can	OP Cannot
• Count the number of problems/diagnoses in the Assessment • Count if they are 1 of the Problem Status options **if specified by the user at the template or Assessment level** • Default the MDM element level in the Coding section of note to Minimal	• Determine if the acute problem is self-limited or minor vs Acute- uncomplicated • Determine if an acute injury is "complicated" • Determine if an acute new problem has an "uncertain prognosis"

Where and How Problems Addressed are Indicated in OP *(Click thumbnail to enlarge image)*

Problem Status in Encounter Templates *Clinical tab > Encounter Templates*	Problem Status in Assessment Section of Note *Encounter Note > Assess/Plan*
Use the **Problem Status** drop-down located in the Diagnosis section of the Encounter Note tab in the Encounter Template Editor to set the default Problem Status for the diagnosis. This can be changed in the Encounter.  **Tip:** It may not be appropriate to assign a default Problem Status to *all* Encounter templates. Depending on the nature of the diagnosis, it may be best to determine Problem Status during the individual Encounter. When Problem Status *is* added to templates, it is the Provider's responsibility to verify it is appropriate when applied to an individual patient note and adjust if necessary.	Use the **Problem Status** drop-down located in the Diagnosis section of the Assessment section of the Encounter Note to select the Problem Status for each diagnosis. If the Problem Status is already populated because it was set at the template level, the provider should verify it is appropriate to the Encounter and adjust if necessary.  **Note**: "Reviewing" a Problem List has no relevance on the E/M coding level regardless of *who* does that work. It has to be a problem that is **addressed** in the Assessment/Plan of the Note and that by default, must be the Provider.

Data Reviewed/Analyzed: Amount and/or complexity of data reviewed and analyzed

OP Can

• Disregard the selection of "Self" for Independent Historian from the data review count.

• Count direct lab interface (DTI) orders and in-house labs by counting each unique lab in a requisition separated by a semi-colon.

• Count surveys reviewed on the date of the visit that do not carry their own CPT charge.

• Count each lab marked **reviewed today** on the date of the visit that was *not* counted as an ordered lab for the visit.

• Count each unique test ordered. Each order counts as a valid action. For example, if a provider orders 3 labs, then the provider has performed 3 actions.

Tip: There **must** be an order in the Diagnostic Tests tab with at least a status of **Pending**. This can happen directly if the provider orders tests from the Diagnostic Tests tab. Or, if providers create a task for the order, the task must have a status of **Completed**, and the order itself must be in at least a **Pending** status.

Note: You cannot double-dip and count a test that you ordered when that test is being separately reported and the work of interpretation and report is under that code descriptor. **Examples**: Developmental testing (96112-96113), Spirometry (94010, 94060), and EKG (93000 or 93010).

Some codes that do not include the terminology "interpretation and report" in the code descriptor: 84181, 84182, 85390, 86152, 86153, 88173, 88791, 88312, 88371, 88375, 89049.

Further guidance:

• AAP: New 2021 Office-Based E/M Updates from CPT Errata

OP Cannot

• Count paper copies of reports initialed.

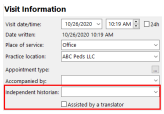
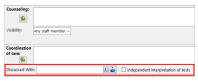
• Know which kind of scanned report someone is reviewing because users can label things any way they want. Providers are held accountable for their decision to label documents appropriately.

Valid Document Types	Invalid Document Types
:Chart	Disclosure*
:Chart-Med Hx	Photo ID
:Diagnostic Test	:Insurance
:Referral Letter	:Patient Consent
Miscellaneous	:CHADIS, :Questionnaire**
	:CDA***
	:Forms

** By definition, these are created by the practice*
*** This would double-count what you already have in Surveys*
**** These are always outgoing*

Where and How Data Reviewed/Analyzed is Indicated in OP *(Click thumbnail to enlarge image)*

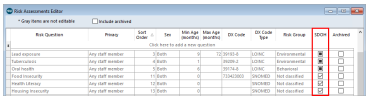
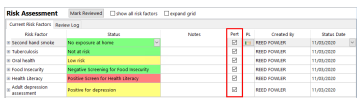
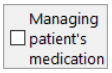
Document Management	Visit Info section of Note	Couns/CoC section of Note	Diagnostic Tests
Use the **Mark Reviewed** button. This now counts a re-review of the document if the date =	Use the **Independent Historian** drop-down list of the patient's Family Contacts or the free-text field to document who is providing	• Use the **Discussed with** field to select a name from Address Book or the patient's Clinical Contacts. Documentation of the	Use the **Reviewed Today** * button to indicate that a historical result was reviewed on the date of the Encounter, given it is relevant to the

today. 	information to the provider. The person responsible for entering this information should be decided on by the Practice. 	discussion must also be entered into the **Coordination of Care** field. • Use the **Independent Interpretation of Tests** checkbox to indicate such interpretation. Documentation of the interpretation must also be entered into the **Coordination of Care** field. 	patient's current visit/reason for seeking care.  * **Feature Development Notes**: - As of 11/30, the decision to exclude labs previously reviewed by you or another provider in the practice was made by the AMA, and OP plans to deliver the ability to filter these out in a future release.

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

OP Can	OP Cannot
• Count Risk Assessment items eligible to be counted as Social Determinants of Health (SDOH) that are marked pertinent for today's visit. • Count when a provider issues a prescription with a linked NDC. The prescription needs to have one of the following statuses to be counted toward MDM: - SENT - PRINTED - FAXED - PICKED UP - CALLED - DELIVERED - MAILED - PENDING	• Filter out ineligible OTC medications. The provider must decide whether or not to include an OTC medication when coding the Encounter. • Default to an element level of Risk. The user must select or perform requirements for Moderate Risk calculation. • Determine the complications of morbidity/mortality of patient management. For example, the decision to perform minor surgery and/or prescription management of chronic conditions. The provider must decide whether or not to adjust the Risk Level when coding the Encounter. • Support calculating Minimal, Low, and/or High Risk levels

Where and How Risk of Complication is Indicated in OP *(Click thumbnails to enlarge images)*

Risk Assessment Editor	Risk Assessment in an Encounter	Assess/Plan
Use the **SDOH** checkbox to mark Risk questions as eligible for SDoH. By default, Food Insecurity, Health Literacy, and Housing Insecurity are selected. 	Use the **Pert** (pertinent) checkbox to indicate which Risk Factors are pertinent to the visit. 	Use the **Managing patient's medication** checkbox located in the **Plan** section of the Encounter to document that prescriptions were created or managed on the date of the visit. 

Version 20.15

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OP Can	OP Cannot
• Count the number of problems/diagnoses in the Assessment • Count if they are 1 of the following 8 categories **if specified by the user at the template or Assessment level**: -Acute-minor, Acute-uncomplicated, Acute-complicated, Acute-severe, Chronic-stable, Chronic-unstable/increased, Chronic-recurring, Chronic-severe • Default the MDM element level in the Coding section of note to Minimal	• Determine if the acute problem is self-limited or minor vs Acute- uncomplicated • Determine if an acute injury is "complicated" • Determine if an acute new problem has an "uncertain prognosis"

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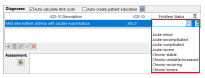
Use the **Problem Status** drop-down located in the Diagnosis section of the Encounter Note tab in the Encounter Template Editor to set the default Problem Status for the diagnosis. This can be changed in the Encounter.  **Tip:** It may not be appropriate to assign a default Problem Status to *all* Encounter templates. Depending on the nature of the diagnosis, it may be best to determine Problem Status during the individual Encounter. When Problem Status *is* added to templates, it is the Provider's responsibility to verify it is appropriate when applied to an individual patient note and adjust if necessary.	Use the **Problem Status** drop-down located in the Diagnosis section of the Assessment section of the Encounter Note to select the Problem Status for each diagnosis. If the Problem Status is already populated because it was set at the template level, the provider should verify it is appropriate to the Encounter and adjust if necessary.  **Note**: "Reviewing" a Problem List has no relevance on the E/M coding level regardless of *who* does that work. It has to be a problem that is **addressed** in the Assessment/Plan of the Note and that by default, must be the Provider.

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:Chart-Med Hx	Photo ID
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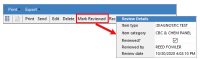
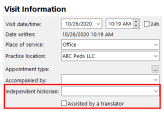
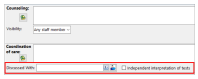
Use the **Mark Reviewed** button. This now counts a re-review of the document if the date = today. 	Use the **Independent Historian** drop-down list of the patient's Family Contacts or the free-text field to document who is providing information to the provider. The person responsible for entering this information should be decided on by the Practice.	• Use the **Discussed with** field to select a name from Address Book or the patient's Clinical Contacts. Documentation of the discussion must also be entered into the **Coordination of Care** field. • Use the **Independent Interpretation of Tests** checkbox to indicate such interpretation.	Use the **Reviewed Today** * button to indicate that a historical result was reviewed on the date of the Encounter, given it is relevant to the patient's current visit/reason for seeking care.  *** Feature Development Notes**:

		Documentation of the interpretation must also be entered into the **Coordination of Care** field. 	- As of 11/30, the decision to exclude labs previously reviewed by you or another provider in the practice was made by the AMA, and OP plans to deliver the ability to filter these out in a future release.

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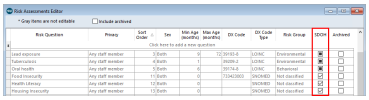
Use the **SDOH** checkbox to mark Risk questions as eligible for SDoH. By default, Food Insecurity, Health Literacy, and Housing Insecurity are selected. 	Use the **Pert** (pertinent) checkbox to indicate which Risk Factors are pertinent to the visit. 	Use the **Managing patient's medication** checkbox located in the **Plan** section of the Encounter to document that prescriptions were created or managed on the date of the visit.