

Medical Decision Making

If coding and billing is the core of a practice's life, medical decision making is one of those apple seeds that can really annoy you bite into one. Good knowledge of medical decision making can provide a solid basis for proper coding, but the lack of such knowledge keeps most optometrists' coding at a guesswork level.

For coding general ophthalmological services, the 92000's, medical decision making (MDM) "cannot be separated from the examining techniques used" (from CPT 2006), while MDM directly relates to which code is chosen with evaluation and management codes, the 99000's. In the 1995 and then 1997 Documentation Guidelines for Evaluation & Management (E&M) Services provided by the AMA and HCFS, MDM was clarified to assist in determining which 99000 code could be justified.

MDM was one of three major areas that were broken down for the doctor to consider. The others, history and physical exam, were also delineated by the E&M Guidelines, and were quite clearly spelled out. But the MDM portion has been generally viewed as quite complicated and is definitely the most subjective area of the three.

In most E&M coding choices, the case history is the direct driving force behind the level of visit that a doctor can code. I have had the opportunity to perform chart reviews as a practice consultant, and documentation is often lacking for a complete case history. Of course, doctors can also have problems documenting their examination, either by not including all pertinent findings especially tests done that had normal results, or by writing legibly (if it isn't written clearly, the test is considered not done!)

In MDM, the Guidelines give three areas of consideration: 1) Number of Diagnoses or Management Options, 2) Amount and/or Complexity of Data to be Reviewed, and 3) Risk of Complications and/or Morbidity/Mortality. Each area has four levels: Minimal, Limited, Moderate/Multiple, or Extensive/High. At first glance, you can see that there is a lot of subjectivity here, and that's where the Documentation Guidelines lose the casually-interested optometrist. One might ask, for example, what differentiates a "limited" or "moderate" amount of data to be reviewed?

Without thorough understanding of the Guidelines, it might be tough to determine the MDM for a patient of yours with primary open angle glaucoma, mild visual field loss with some field defects showing intertest variability, stable IOP treated with one therapeutic agent, needing to be seen every six months. Even if the Guidelines are somewhat understood, it's still not easy: for example, for the area of "risk," an extensive table is published with examples for various health care specialties to address the fact that the choices are "not readily quantifiable."

In the nine years since the last guidelines were published, no definitive outline has been provided for eye care MDM. So, there is no cookbook to help you decide if your glaucoma patient has risk described as: "one self-limited or minor problem" (probably not),

OcularCommons.com

"one stable chronic illness" (plausibly), or "one... chronic illness with mild exacerbation or progression" (probably this one!) It seems evident that the case does not have the highest level of risk, "one... chronic illness with severe exacerbation or progression."

It's a tough game, so simplify it by using available resources and applying common sense. The advice that I have given doctors is to create an MDM decision matrix and stick to it. In the spirit of EyeCodeRight's commitment to collaboration within optometry, we share with you the following matrix that could very easily be applied to your daily practice to ensure you are properly considering MDM as part of your determination of E&M coding:

A) Number of Diagnoses + Number of Management Options = TOTAL
1 = Minimal 2 = Limited 3 = Multiple 4 = Extensive

B) Amount & Complexity of Data
Minimal Limited Moderate Extensive

C) Risk of Complications/Morbidity/Mortality in Rx, Dx, Mx
Minimal = one self-limited or minor problem
Low = two or more self-limited or minor illnesses; one stable or chronic illness; one acute illness or injury; uncomplicated illness or injury
Moderate = one chronic illness with mild complication(s); two stable chronic illnesses; an undiagnosed new problem (uncertain prognosis); acute illness with systemic symptoms; acute complicated injury
High = one or more chronic illness(es) with severe complications; acute or chronic illness or injuries posing a threat to life; abrupt change in neurological status

To choose your level of MDM, you need to find the two highest levels attained of the three subcategories, and you use the middle-most level as the determinant of the MDM. Since "Amount & Complexity of Data" is the most subjective of the three, I recommend that doctors consider the middle-most level as the LOWER OF (A) and (C) as their choice for MDM:

MDM LEVEL Straightforward Low Complexity Moderate Complexity High Complexity

A) TOTAL # Dx/Mx Minimal Limited Multiple Extensive

B) Amount/Compl. Data Minimal Limited Multiple Extensive

C) Risk Minimal Low Moderate High

Now that it's thoroughly confusing, let's finish with three examples:

1) 80 year old patient, cataracts and PVD OU, slightly reducing BVA, visited for a six month follow-up today with good documentation of services, recommended follow-up in six months for complete exam and change in spectacle lenses, also noted mild risk to RD from PVD and instructed to call with any new onset flashes/floaters:

OcularCommons.com

A) TOTAL Dx/Mx = 4/Extensive (CAT, PVD, Rx change, PVD f/u is six months vs. ASAP with fl/fl)

B) Data = ?? (too subjective)

C) Risk = Moderate (one chronic illness - CAT - with mild complications)

Overall MDM shows that the Risk is the lower of the two and so the level of MDM is MODERATE COMPLEXITY

2) 56 year old patient, subconjunctival hemorrhage, mild symptoms and straightforward documentation with reassurance as the only plan:

A) 2/Limited

B) ??

C) Minimal

Overall MDM shows that Risk is the lower of the two and so the level of MDM is STRAIGHTFORWARD.

3) 10 month old patient, leukocoria as presenting sign, examination reveals no retinoscopic reflex and no Bruckner image, dilated assessment reveals retinoblastoma requiring immediate referral to pediatric oncology and ophthalmology:

A) 2/Limited

B) ??

C) High

Overall MDM shows that Total Dx/Mx is the lower of the two. In this case, the "amount and complexity of data" should be factored in because there may be extensive documentation and the doctor may perform a great deal of data comparison to help determine the seriousness of the case. Therefore, the MDM which is limited to LOW COMPLEXITY by the number of diagnoses and management options may in fact move up to MODERATE or even HIGH COMPLEXITY if the "amount and complexity of data" justifies the higher level of MDM overall.

Granted, this is the most difficult subject to be cookbooked for any health care providers, and eye care is no exception. Don't get frustrated with this analysis... digest it in reasonable parts and make your best effort to analyze your MDM as part of determining your coding for E&M services. And later in 2006, look into EyeCodeRight's coding engine as part of its new EMR to take the challenges out of this part of practice. Thanks for your patience with this lengthy subject!