URGENT CARE ASSOCIATION®

UCA Coding Task Force Publication – March 2021
Medical Decision Making (MDM) Resources

The following is a compilation into "quick reference" format of multiple guidance documents issued by the AMA as of March 26, 2021.

The information sources are on the final page and referenced in the article 2021 Coding Impacts for Urgent Care published March 26.

Both resources represent our best understanding at the time and are published for UCA Member reference only. Members should continue to consult with certified professional coders and legal counsel to ensure their organization is following the new rules appropriately.

Within this grid are also relevant Action Steps UCA will be taking on members' behalf to further clarify ambiguous areas or those highly problematic for urgent care.

Disclaimer: Please understand and accept that this Resource and the accompanying Coding Impacts article is merely our best collective interpretation of the rules as published as of mid-March 2021. These resources in no way are meant to direct provider coding toward a particular level of service or away from appropriate documentation of a visit. All members should consult with their own Coding and Legal experts for formal advice or recommendations as needed.

Medical Decision Making (MDM)

Overview and Notes				
	Level of MDM is based on 2 out of 3 Elements	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Additional Notes	Baseline Level descriptions in this column unchanged from 2020 except removal of 99201 and removal of requirements for 99211	See Definitions page for further info on minor vs. acute, etc. in the Elements descriptions below	Data are divided into 3 Categories and each Level requires certain #'s of Categories of data: Level 2=none, Level 3=one, Level 4=one, Level 5=two The contents of Categories and requirements within them then also escalate by Level.	Includes possible management options selected AND those considered but not selected. Addresses risks associated with social determinants of health. The AMA notes on 3/9 that presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. They further note that the term "risk" in their Definitions relates to risk from the condition.

		ELEMENTS OF MEDICAL DECISION MAKING		
Code	Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed (each unique test, order or document contributes to the combinations of 2 or 3 data in the Category 1 elements below)	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))
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward (self-limited)	Minimal problems - 1 self-limited or minor problem	Minimal data or None	Minimal risk of morbidity from additional diagnostic testing or treatment (including no treatment). Effectively no risk.
99203 99213	Low (stable, uncomplicated, single problem)	Low problems - 2 or more self-limited or minor problems OR; - 1 stable chronic illness OR; - 1 acute, uncomplicated illness or injury	Limited data (must meet the requirements of at least 1 of the 2 Categories) Category 1: Tests & Documents - Any combination of 2 from the following: o Review of prior external note(s) from each unique source*; o Ordering of each unique test* o Review of the result(s) of each unique test* OR Category 2: Assessment requiring an independent historian(s) (for the categories of independent interpretation of tests and discussion of management or test interpretation, see Moderate or High below)	Low risk of morbidity from additional diagnostic testing or treatment (i.e. very low risk of anything bad, minimal consent/discussion)

		ELEMENTS OF MEDICAL DECISION MAKING (cont)		
Code	Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate (multiple problems or significantly ill)	Moderate problems - 2 or more stable chronic illnesses OR - 1 or more chronic illnesses with exacerbation, progression or side effects of treatment OR - 1 undiagnosed new problem with uncertain prognosis OR - 1 acute illness with systemic symptoms** OR - 1 acute complicated injury **See Definitions page(s) (below) for new exclusions from "systemic symptoms".	Moderate data (must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, Documents or Independent Historian(s) - Any combination of 3 from the following: o Review of prior external note(s) from each unique source* o Ordering of each unique test* (note: FLU A/B test is now considered 1 test vs. 2) o Review of the result(s) of each unique test o Assessment requiring an independent historian OR Category 2: Independent interpretation of tests - Independent interpretation of tests by another physician or qualified health care professional (not separately reported) OR Category 3: Discussion of management or test interpretation - Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment (would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management) Examples only: - Prescription drug management (note: does not require a written prescription. Saying "no" to a medication [ex. antibiotic] or offering a medically indicated prescription the patient ultimately declines both count toward MDM) - Decision regarding minor surgery with identified patient or procedure risk factors - Decision regarding elective major surgery without identified patient or procedure risk factors - Diagnosis or treatment significantly limited by social determinants of health

		ELEMENTS OF MEDICAL DECISION MAKING (cont)		
Code	Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	High (very ill)	High problems - 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment OR - 1 acute or chronic injury or illness that poses a threat to life or bodily function	Extensive data (must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, Documents or Independent Historian(s) - Any combination of 3 from the following: o Review of prior external note(s) from each unique source* o Ordering of each unique test* o Review of the result(s) of each unique test o Assessment requiring an independent historian(s) OR Category 2: Independent interpretation of tests - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) OR Category 3: Discussion of management or test interpretation - Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment (need to discuss some pretty bad things that could happen for which physician/QHP will watch or monitor) Examples only: - Drug therapy requiring intensive monitoring for toxicity - Decision regarding elective major surgery with identified patient or procedure risk factors - Decision regarding emergency major surgery - Decision regarding hospitalization - Decision not to resuscitate or to de-escalate care because of poor prognosis

* Note on Utilization and Counting of Testing (please see below and also Coding Impacts Article)

From Coding Grid 99203/99213 above
Category 1: Tests & Documents

- Any combination of 2 from the following:
  - Review of prior external note(s) from each unique source*;
  - Ordering of each unique test*
  - **Review of the result(s) of each unique test***

March 9 clarifications from the AMA (see Sources, emphasis within added) noted that "the ordering and performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining E/M levels when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (e.g. tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered OR reviewed for selecting an MDM level. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM."

"The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter."

"Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented."

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* Note on Utilization and Counting of Testing (cont. from above)

In plainer language (from UCA's Task Force):

If the professional interpretation of a test/study is reported separately (see box below), you should not count the ordering, performance and/or interpretation toward the E/M Level.

> *The key question here is whether "professional interpretation" is considered to be "reported separately" only when there is a Professional Component modifier available for a test.*

If not reporting a test/study separately, you can count ordering OR reviewing in-house tests toward the MDM (in Category 1 of Data), but neither count as "independent interpretation" (Category 2 of Data).

Each test with a specific CPT code may be reported separately in addition to the appropriate E/M code following the guidelines above. That is, for each test you order (Category 1 in Data) you count each one separately.

Action Item: UCA intends to follow up with the AMA to clarify whether professional components were considered included in urgent care test charges, which likely only include technical component charges. If not, then professional interpretation is not reported separately and can count toward the E/M Level. If tests are billed globally there is automatic inclusion of the professional component and they are not able to be separated. This "mixed-use" of this rule per payer contract is confusing and problematic for providers to implement.

DEFINITIONS

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. (see Problem columns, Levels 2 and 3)

Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently, poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well- controlled hypertension, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia. (See Problem columns, Levels 3 and 4)

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self- limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain. (See Problem column, Levels 3 and 4)

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care. (See Problem column, Levels 4 and 5)

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast. (See Problem column, Level 4)

DEFINITIONS (cont.)

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

****Acute illness with systemic symptoms**: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis. (See Problem column, Level 4)

> Action Item: UCA intends to clarify with AMA re: exclusion of certain systemic general symptoms and intent to "carve out" these symptoms from Moderate (Level 4) E/M Levels.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness. (See Problem column, Level 4)

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status. (See Problem column, Level 5)

DEFINITIONS (cont.)

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM. (See UCA Action Item above). (See Data column headings)

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test. (See Data columns, all Levels)

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM. (See Data columns, all Levels)

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements. (See Data columns, all Levels)

DEFINITIONS (cont.)

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization. (See Data columns, Category 1, all Levels)

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency. (See Data columns, Category 1, all Levels)

> UCA Action Item: clarify with AMA whether providers from other urgent care locations or who typically practice in separate shifts from the treating provider meet the definition of “external”. This question also applies to records and results.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). 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 it 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 (eg, within a day or two). (See Data columns, Category 3, Levels 4 and 5)

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information. (Independent historian (IH) is counted differently in Level 3 vs. 4/5. Level 3 counts IH in Category 2. Levels 4 and 5 count IH in Category 1).

DEFINITIONS (cont.)

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

Independent interpretation: The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test. (See Data column. Level 4 and 5 Category 2).

Appropriate source: For the purpose of the discussion of management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers. (See Data column. Level 4 and 5 Category 3).

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. (See Risk column definition)

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. (See Risk column definition)

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. (See Risk columns)

DEFINITIONS (cont.)

(based on AMA sources listed and updated guidance from March 9, 2021 where noted)

Surgery–Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification. (See Risk column, Levels 4 and 5)

Surgery–Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures. (See Risk column, Level 5)

Surgery–Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk. (See Risk column, Levels 4 and 5)

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold. (See Risk column, Level 5)

Sources:

Original AMA presentation late 2020
https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf

CMS E/M Guide February 2021
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf (Table of Risk used as source document for AMA changes begins on page 18)

Updated AMA Guidance with technical corrections March 9, 2021
https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf