2023 EVALUATION AND MANAGEMENT SERVICE GUIDELINES – EMERGENCY MEDICINE CODER TRAINING – PART 3 OF 4

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TOPICS

- Medical Decision Making Component Two: Amount and/or Complexity of Data to be Reviewed and Analyzed (DATA)
  - Data Categories and Definitions
  - Data Levels and Documentation Consideration – Limited, Moderate, and Extensive

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED (DATA)

MDM CENTER COLUMN: AMOUNT OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED

Amount and/or Complexity of Data to be Reviewed and Analyzed (Chart B) *Each unique test, order, or document contributes to the combination of T&D category below
Tests & Documents (**T&D**) • Review of prior **external note(s)** from each unique source* • Review of the **result(s)** of each unique test* • **Ordering** of each unique test*
Assessment requiring an independent historian(s) (**IHX**) • An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to patient
Independent interpretation of tests • Independent **interpretation of a test performed by another** physician/other qualified health care professional (not separately reported)
Discussion of management or test interpretation (**DISC**) • Discussion of management or test interpretation **with external physician**/other qualified health care professional/appropriate source (not separately reported)

DATA CATEGORIES (1)

- "Data" is divided into three categories:
  - Category 1: Tests and documents independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
    - Includes order of labs, x-rays, and/or special studies, therapeutic interventions, and receipt of patient information from someone other than the patient (e.g., spouse, children of elderly patients, parents or grandparents of young children)

DATA CATEGORIES (2)

- "Data" is divided into three categories (cont.):
  - Category 2: Independent interpretation of tests (not separately reported).
    - Includes provider's independent interpretation of lab, x-ray, and special study results. Does not include CXRs, CT scans, Ultrasounds, and/or MRIs that are interpreted by a radiologist

DATA CATEGORIES (3*)

- "Data" is divided into three categories (cont.):
  - Category 3: Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).
    - Includes conversations with other providers who have performed various interpretations (e.g., cardiologists for review of a cardiac catheterization or ablation). May be related to a discussion of a prior surgical procedure that was performed by a general, orthopedic, or other surgeon.

DATA CATEGORY 1: TESTS, DOCUMENTS OR INDEPENDENT HISTORIAN (1)

Amount and/or Complexity of Data to be Reviewed and Analyzed (Chart B) *Each unique test, order, or document contributes to the combination of T&D category below
Tests & Documents (**T&D**) • Review of prior **external note(s)** from each unique source* • Review of the **result(s)** of each unique test* • **Ordering** of each unique test*

DATA CATEGORY 1: TESTS, DOCUMENTS OR INDEPENDENT HISTORIAN (2)

- Includes diagnostic tests, medical records, and/or other information that must be obtained, ordered, reviewed, and analyzed.
- Ordering a test is included in the category of test result(s) and is part of the encounter and not a subsequent encounter.

DATA CATEGORY 1: TESTS, DOCUMENTS OR INDEPENDENT HISTORIAN (3*)

- Ordering a test may include those considered but not selected after shared decision making.
- 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.

DATA CATEGORY 1: TESTS, DOCUMENTS, OR INDEPENDENT HISTORIAN – TERMS (1)

Analyzed:

- The process of using the data as part of the MDM.
- The data element itself may not be subject to analysis 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. When they are ordered during an encounter, they are counted in that encounter.

DATA CATEGORY 1: TESTS, DOCUMENTS, OR INDEPENDENT HISTORIAN–TERMS (2)

Analyzed cont.:

- 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. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.

DATA CATEGORY 1: TESTS, DOCUMENTS, OR INDEPENDENT HISTORIAN–TERMS (3)

Analyzed cont.:

- Any service for which the professional component is separately reported by the physician or other QHP 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.

DATA CATEGORY 1: TESTS, DOCUMENTS, OR INDEPENDENT HISTORIAN - TERMS (4*)

- External: External records, communications and/or test results are from an external physician, other QHP, facility, or healthcare organization
- Unique: A physician or QHP 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.

DATA CATEGORY 1: INDEPENDENT HISTORIAN (1)

Amount and/or Complexity of Data to be Reviewed and Analyzed (Chart B) *Each unique test, order, or document contributes to the combination of T&D category below
Assessment requiring an independent historian(s) (IHX) • An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to patient

WHAT IS AN INDEPENDENT HISTORIAN? (1)

- An individual (e.g., parent, guardian, surrogate, spouse, witness, caregiver) 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.

WHAT IS AN INDEPENDENT HISTORIAN? (2)

- 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
- It does not include translation service.

WHAT IS AN INDEPENDENT HISTORIAN? (3*)

- The independent historian should provide additional information and not merely restate information that may have already been provided by the patient. In cases in which the patient cannot provide any information (e.g., developmental age), the independent historian may provide all the required information.

DATA CATEGORY 2: INDEPENDENT INTERPRETATION OF TESTS (1)

Amount and/or Complexity of Data to be Reviewed and Analyzed (Chart B) *Each unique test, order, or document contributes to the combination of T&D category below
Independent interpretation of tests • Independent **interpretation of a test performed by another** physician/other qualified health care professional (not separately reported)

CATEGORY 2: INDEPENDENT INTERPRETATION OF TESTS (2)

- 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 QHP 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.

CATEGORY 2: INDEPENDENT INTERPRETATION OF TESTS (3*)

- For proper code choice, providers will need to vastly improve documentation with special emphasis on the following:
  - Independent interpretation of a test performed by another physician/other qualified health care professional. Tests performed by another provider may consist of the following: Special Studies such as CT scans, Ultrasounds, MRIs, x-ray series by radiologist and EKGs interpreted by cardiology.

DATA CATEGORY 3: DISCUSSION OF MANAGEMENT OR TEST INTERPRETATION (1)

Amount and/or Complexity of Data to be Reviewed and Analyzed (Chart B) *Each unique test, order, or document contributes to the combination of T&D category below
Discussion of management or test interpretation (**DISC**) • Discussion of management or test interpretation **with external physician**/other qualified health care professional/appropriate source (not separately reported)

DATA CATEGORY 3: DISCUSSION OF MANAGEMENT OR TEST INTERPRETATION (2)

- 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.
  - It may be asynchronous (i.e., does not need to be in person).

DATA CATEGORY 3: DISCUSSION OF MANAGEMENT OR TEST INTERPRETATION (3)

- **Who qualifies as an external physician or appropriate source?**
  - External physician or other QHP who is not in the same group practice or is of a different specialty or subspecialty
  - The individual may also be a facility or organization provider such as from a hospital, nursing facility, or home health care agency

DATA CATEGORY 3: DISCUSSION OF MANAGEMENT OR TEST INTERPRETATION (4*)

- **Who qualifies as an external physician or appropriate source? cont.**
  - Appropriate source: 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.

MDM LEVELING USING CENTER COLUMN (DATA)

LOW = LIMITED DATA REVIEW

DATA LEVEL – LIMITED (1)

- Limited: Must meet the requirements of at least 1 of the 2 categories:
- Category 1: Tests and documents
  - Any combination of 2 from the following:
    - Review of prior external note(s) from each unique source;
    - Review of the result(s) of each unique test;
    - Ordering of each unique test.

OR

DATA LEVEL – LIMITED (2*)

- 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)*

LIMITED DATA REVIEW – DOCUMENTATION CONSIDERATIONS (1)

- "Review of prior external note(s) from each unique source.": Emphasizes the need for the provider to document old record review and what was found that helped with patient management.
- "Review of the result(s) of each unique test.": Provider should document review of normal studies and list abnormal findings.
- "Ordering of each unique test.": Provider should document any tests ordered unless orders are included in the patient record.

LIMITED DATA REVIEW – DOCUMENTATION CONSIDERATIONS (2*)

- Category 2 (Limited only): Assessment requiring an independent historian(s).
  - Provider should **document conversations with anyone other than the patient and why this was necessary** (e.g., **patient with diminished communications ability or the extremes of age).**

MODERATE = MODERATE DATA REVIEW

DATA LEVEL - MODERATE (1)

- Moderate (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:
    - Review of prior external note(s) from each unique source;
    - Review of the result(s) of each unique test;
    - Ordering or each unique test;
    - Assessment requiring an independent historian(s).

OR

DATA LEVEL – MODERATE CONT. (2*)

- OR Category 2: Independent interpretation of tests
  - Independent interpretation of a test performed by another physician/other QHP (not separately reported)

OR

DATA LEVEL – MODERATE CONT. (3*)

- OR Category 3: Discussion of management or test interpretation
  - Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

MODERATE DATA REVIEW – DOCUMENTATION CONSIDERATIONS (1)

- Category 1: Tests and documents, or independent historian(s)
  - "Review of prior external note(s) from each unique source.": Emphasizes the need for provider to document review of old records, what was found that was helpful in managing the case.
  - "Review of the result(s) of each unique test.": Provider should document review of normal studies and abnormal findings.
  - "Ordering of each unique test.": Provider should document any tests ordered unless clearly listed in record for the coder to see.
  - "Assessment requiring an independent historian(s).": Provider should document conversations with anyone other than the patient and why this was necessary (e.g., patient with diminished communications ability or the extremes of age).

MODERATE DATA REVIEW – DOCUMENTATION CONSIDERATIONS (2)

- "Category 2: Independent interpretation of a test performed by another physician/other QHP (not separately reported)."
  - Provider should look at (visualize) and independently interpret all x-rays and special studies after other physicians have done the initial interpretation and billed for these services (radiologist).

MODERATE DATA REVIEW – DOCUMENTATION CONSIDERATIONS (3*)

- "Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)."
  - Provider should document discussion of a case with another external physician (e.g., patient's PCP, the referral physician, or another specialist).
  - Documentation should include who was called and what was discussed.

HIGH = EXTENSIVE DATA REVIEW

DATA LEVEL - EXTENSIVE (1)

- Extensive (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:
    - Review of prior external note(s) from each unique source;
    - Review of the result(s) of each unique test;
    - Ordering or each unique test;
    - Assessment requiring an independent historian(s).

AND/OR

DATA LEVEL– EXTENSIVE CONT. (2*)

- AND/OR Category 2: Independent interpretation of tests
  - Independent interpretation of a test performed by another physician/other QHP (not separately reported)

AND/OR

DATA LEVEL– EXTENSIVE CONT. (3*)

- AND/OR Category 3: Discussion of management or test interpretation
  - Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

HIGH DATA REVIEW –DOCUMENTATION CONSIDERATIONS (1)

- Category 1: Tests, documents, or independent historian(s)
  - "Review of prior external note(s) from each unique source.": Emphasizes the need for provider to document review of old records and what was found that was helpful in managing the case.
  - "Review of the result(s) of each unique test.": Provider should document review of normal studies and abnormal findings.
  - "Ordering of each unique test.": Provider should document any tests ordered unless orders are included in the patient record.
  - "Assessment requiring an independent historian(s).": Provider should document conversations with anyone other than the patient and why this was necessary (e.g., patient with diminished communications ability or the extremes of age).

HIGH DATA REVIEW – DOCUMENTATION CONSIDERATIONS (2)

- Category 2: Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)
  - Provider should look at (visualize) and independently interpret all x-rays and special studies after other physicians have done the initial interpretation and billed for these services.

HIGH DATA REVIEW –DOCUMENTATION CONSIDERATIONS (3*)

- Category 3: Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)
  - Provider should document discussion of a case with another external physician (e.g., patient's PCP, the referral physician, or another specialist.
  - Documentation should include who was called and what was discussed.

QUESTIONS:

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REFERENCES

- AMA *CPT® Evaluation and Management (E/M) Code and Guideline Changes.* July 1, 2022. American Medical Association.