FAQ 1: How is Medical Decision Making (MDM) defined by CPT?

The AMA Current Procedural Terminology (CPT) states:

“Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;

- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed;

- The risk or significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options”.

FAQ 2: What is Medicare’s Take on Medical Decision Making (MDM)?

The Medicare 1995 E/M Documentation Guidelines essentially reiterates the CPT essentials regarding MDM and adds some illustrations, in part encompassing the following:

I. The ancillary studies considered and those ordered such as laboratory studies, x-rays, Special Studies and EKGs.
II. Any medications considered and those ordered for therapy. This encompasses a broad list including IV, IM, subcutaneous, oral, rectal, topical, eye, ear and other medications including those administered by nebulizers.
III. IV fluid administration.
IV. Documentation of the presence or absence of relevant findings upon review of old records, including prior admissions and discharge summaries, surgeries, EKGs, lab results, x-ray interpretations, procedures such as cardiac catheterizations, and Special Studies including echocardiograms, CT scans, Ultrasounds, and MRIs.
V. Conversations with physicians performing diagnostic studies.
VI. Communications with other healthcare providers including the patient’s PCP, the admitting or consulting physician, Poison Control professionals, mental health professionals, and EMS or other First Responders.
VII. Communication with family members about medical decisions.
VIII. Direct visualization and independent interpretation of images, tracings, or specimens such as EKG’s or X-rays.
IX. Patient re-evaluations to determine the patient’s response to treatments and interventions and guide further therapy or testing.
FAQ 3: What factors should be considered when determining the number of possible diagnoses and/or management options?

The Medicare 1995 Documentation Guidelines for Evaluation & Management Services, Number of Diagnoses or Management Options (page 11) state (emphasis added):

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

FAQ 4: What is the Marshfield Clinic Scoring Tool?

In the early 1990’s the Marshfield Clinic was a 600 physician multi-specialty, primarily office-based practice in 32 sites throughout Wisconsin. Medicare’s 1995 Evaluation & Management Documentation Guidelines were beta-tested at Marshfield Clinic before HCFA released them. As part of that process, Clinic staff helped their regional Medicare carrier to develop an audit worksheet that included a scoring system for Medical Decision Making (MDM). The score sheets never made it into the official Documentation Guidelines, but are commonly used by physicians, professional coders, and payers to evaluate the complexity of MDM. Below is an excerpt from the Marshfield Clinic Tool:

**Marshfield Scoring- Number of Diagnoses/ Treatment Options**

<table>
<thead>
<tr>
<th>Problems to Examining Physician</th>
<th>A</th>
<th>B</th>
<th>X</th>
<th>C</th>
<th>= D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or Minor (stable, improved or worsening)</td>
<td>Max = 2</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem (to examiner) stable, improved</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem (to examiner) worsening</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New Problem (to examiner) no additional work-up planned</td>
<td>Max = 1</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New Problem (to examiner) additional work-up planned</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>D</strong></td>
</tr>
</tbody>
</table>

FAQ 5: How should the Marshfield Clinic Scoring Tool for the Number of Diagnoses/Treatment Options be applied to the Emergency Department setting?

“Established Problem” vs. “New Problem”
In the Marshfield Clinic’s audit worksheets, a “new problem” is defined as new to the examining physician. “The decision making guidelines were designed to give physicians credit for the complexity of their thought processes. Giving a physician more credit for handling a problem he or she is seeing for the first time, even when that problem has been previously identified or diagnosed, is within the spirit of the guidelines”. (Bart McCann, MD, former Executive Medical Director HCFA)

“No Additional Work-up Planned” vs. “Additional Work-up Planned”

There has been some confusion regarding what is meant by “additional work-up planned”. “Additional work-up planned” refers to information (including diagnostic testing results and consultations) which can be obtained, either during or following the initial E/M encounter, in order to sift through the number of possible diagnoses and/or management options.

The Marshfield Clinic scoring tool is a method for assessing the underpinning CPT and Medicare E/M Documentation Guidelines Medical Decision Making criteria. (See FAQ3.) Neither CPT nor Medicare specify “additional work-up planned” be performed after the Evaluation & Management service. Certainly any additional work-up planned needed for patient care should be performed as soon as practical.

In an office setting, the patient visits the practitioner, who may determine that more in-depth information, including diagnostic testing, is necessary. The patient may provide samples right then (same day) and/or arrange for testing (e.g., radiological services) to be performed on a later date, and a follow-up appointment scheduled to review the results and further delineate the diagnosis. The patient may even require a consultation. The usual result is two patient visits with the practitioner over a 1 to 2 week interval, with the interim work-up credited in the initial visit. Sometimes a patient may fail to complete the additional testing and might not even keep the follow-up visit. Even so, the “additional work-up planned” would still be counted because during the initial visit the physician considered multiple diagnoses, management options, and actually ordered additional testing to be done.

In the Emergency Department, because of the ready availability of comprehensive diagnostic testing, assessments are frequently shortened to a single E/M encounter, with the work-up performed on the same day. It would make no sense to penalize an ED physician for efficiently assessing and managing the patient’s presenting medical condition, and assuring the work-up is performed in a timely manner. With regards to Medical Decision Making, the key concept and actual language from the Marshfield Clinic Scoring Tool is that additional work-up was “planned”, not whether it was performed on the same day or a later date.

Since the 1990’s, the Marshfield Clinic Scoring Tool has been adapted to create audit tools. Over time, modifications have been promulgated by different payers that deviate from the original tool. You are advised to check your local carrier and payer policies with regards to how Medical Decision Making is scored. Most local carrier scoring tools can be found on their local web pages.

FAQ 6: Where can I get more information about preparing for payer audits?

The American College of Emergency Physicians developed a document to provide members basic guidance on preparing for payer audits. Due to differences in regional/state/and jurisdictional precepts, rules and regulations, legal guidance should be
sought from a qualified attorney in the relevant locality as early in the payer audit process as possible.

www.acep.org/uploadedFiles/ACEP/practiceResources/issuesByCategory/reimbursement/Preparing%20for%20Payer%20Audits.pdf

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