Strategies for High-Level Medical Decision Making in Diagnosis Coding and Risk Analysis

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Who is Jaci?

Jaci J. Kipreos, is the President/Owner of Practice Integrity, LLC a consulting firm focused on audit and compliance for providers and their staff. She has over 35 years of experience working in the field of medical coding and auditing and has been a Certified Professional Coder (CPC) since 1994. She has acquired numerous certifications, and her experience includes a wide range of practice settings, with particular expertise in coding for OB/GYN, family care, urgent care, and general surgery. Jaci is also knowledgeable in Medicare Teaching Physician Guidelines and other Medicare policies.

Nationally acclaimed for medical coding, many have called on her expertise to assist their practice in the area(s) of physician office compliance, medical chart audits, and provider and staff education. Jaci was recognized as Coder of the Year for the State of Virginia in 2006.

Additionally, Jaci has been an instructor for over25 years for CPC, CPMA, and COC, and is a Certified ICD-10 Instructor through AAPC for both ICD-10 CM and ICD-10 PCS. Jaci is a past president of local chapters of AAPC and is also the previous president of the AAPC National Advisory Board.

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Purpose

- This presentation will aim to provide a deeper understanding of the clinical reasoning processes that make diagnostic decisions and risk assessments in healthcare. We will consider how providers extrapolate data and apply clinical guidelines to assist a deeper understanding of the documentation.
- We will consider risk analysis and its impact on documentation and coding. We will discuss how clinicians evaluate patient risk factors, stratify severity, and make decisions that influence coding for procedures, outcomes, and quality metrics. Real-world examples will illustrate how risk-based decision-making affects code selection, reimbursement, and compliance. Attendees will leave with practical strategies to enhance coding precision by aligning their work more closely with clinical intent and decision-making frameworks

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What is Not Covered

- Details of Risk Adjustment Coding and Methodologies
- Deep Dive into Evaluation and Management documentation and coding
- Time based coding

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Agenda

- The codes
- The grids
- The details of the definitions
- ICD10-CM, CDI and Risk Analysis
- Summary

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The Codes

High Level Complexity

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99205

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60 minutes of total time is spent on the date of the encounter.

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99215

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40 minutes of total time is spent on the date of the encounter.

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99223

Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, minutes of total time is spent on the date of the encounter.

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99233

Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 50 minutes of total time is spent on the date of the encounter.

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High Level Complexity Based on Medical Decision Making

Overview

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High (any two of the three categories must be met)

Number and Complexity of Problems Addressed	Amount or Complexity of Data to be Reviewed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complication and / or Morbidity or Mortality of Patient Management
High **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 of the 3 categories)* **Category 1: Tests and documents** • **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 of each unique test*; • 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** 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 or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis. • Decision regarding parenteral controlled substances

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Problems Addressed

- ***Chronic illness with severe exacerbation, progression, or side effects of treatment:*** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

- What is chronic and how is that documented?
- What is severe? How is that documented?
- Did the documentation clarify morbidity

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Level 5 problems addressed

An acute illness with systemic symptoms, or 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.

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MDM - Data

- ***Independent historian(s):*** An individual (eg, 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 (eg, 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(s) is needed, the independent historian(s) requirement is met.
- ***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 sho[illegible]nform to the usual standards of a

How will you know there was an independent historian?
How will you recognize an independent interpretation?

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Data

Discussion of management or test interpretation with external provider/appropriate source

- Discussion requires an interactive exchange
- The exchange must be direct and not through intermediaries
- Written exchanges do not qualify
- Does not have to be on date of service , but must be initiated and completed within a short period of time (eg, a day or two)

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

High - 99205/99215

- 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

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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 (even if 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.

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Diagnoses, CDI and Risk Analysis

How does it all fit together?

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Assessment and Plan

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. (Data)

assessment, clinical impression, or diagnosis; (Problems Addressed)

plan for care; (Risk)

Appropriate health **risk factors** should be identified.

The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

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Assessment and Plan of Care – Documentation Risks

Problem List versus Problems Addressed

List of medications or documentation to support medication management

Surgery - Risks identified

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ICD10-CM Missed Concepts

Hypertension

- Hypertension
- Congested Heart Failure
- Chronic Kidney Disease

Missed Concept = Missed Opportunity

- Each condition reported separately
  versus
- Combination codes to reflect complexity

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ICD10-CM Missed Concepts

Presentation

- Left side weakness
- Prior TIA

Correct Reporting

- Left side weakness
- TIA
- Late effect

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ICD10-CM Missed Concepts

Diabetes

- Type
- Status
- Type of treatment
- Complications

Diagnosis Mishaps

- E11.65 must have documentation to support hyperglycemia
- Not using combination codes
- Not reporting treatment type

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ICD10-CM Missed Concepts

Wounds

- Type
- Status
- Co-morbid conditions

ICD10- Mishaps

- Documentation does not support co-morbid conditions
- Sequencing of codes

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ICD10-CM Missed Concepts

Obesity

- Status
- Cause
- Medication

Documentation Concerns

- Risk not documented
- Incorrect coding
- BMI not related to a diagnosis

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In Summary



Documentation to support high complexity MDM related E/M code



Complexity in problems addressed, data, risk



Specificity and detail documented for each condition



ICD10-CM codes reported to reflect the accurate complexity

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Thank you



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