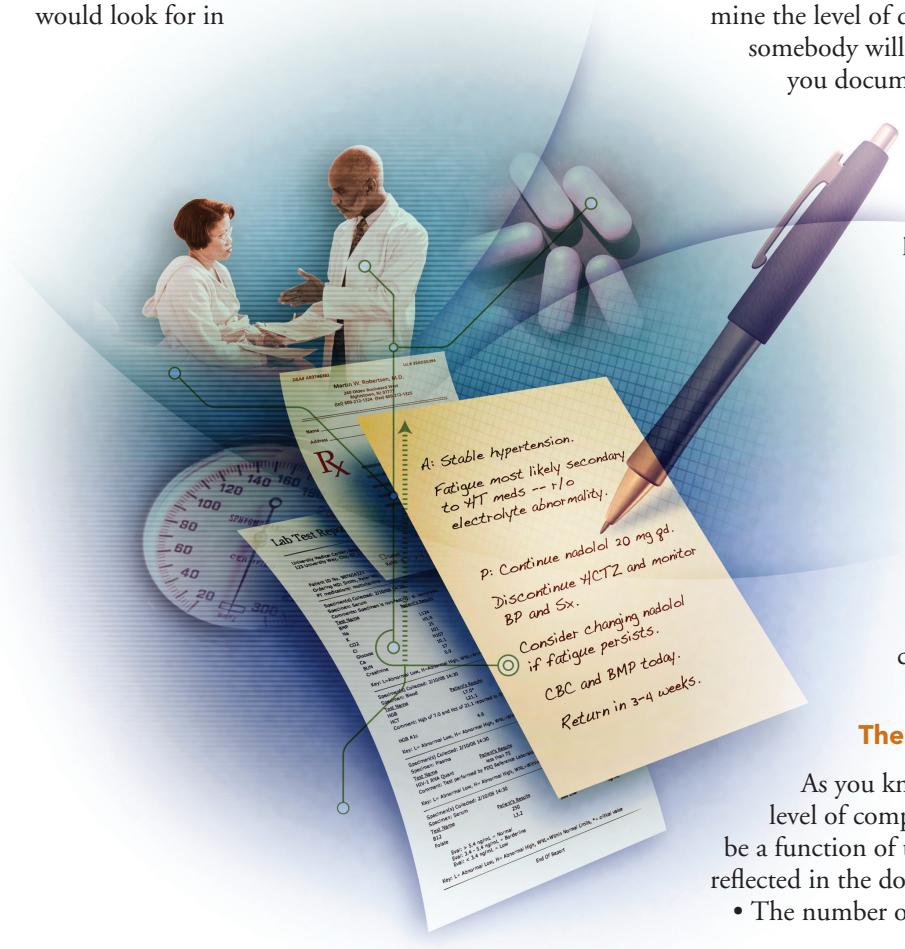
The third article in our series on Medicare's documentation guidelines will help you determine whether what's on your mind is what's on the patient's record.

THINKING ON PAPER: Documenting Decision Making

Robert L. Edsall and Kent J. Moore

Where medical decision making is concerned, Medicare's Documentation Guidelines for Evaluation and Management (E/M) Services are more striking for what they leave unsaid than for what they say. They do tell you what a reviewer would look for in determining the level of your decision making. However, unlike the guidelines for documenting history and exam, they don't tell you enough to figure out the level yourself, thereby leaving you to guess whether your documentation supports the claim you submit.

But *somebody* other than you has to be able to determine the level of decision making – and if you're audited, somebody will. The purpose of this article is to help you document and quantify what you're thinking about during patient encounters, so that you and a reviewer might reach the same conclusion about the level of decision making your note supports and so that you can confidently claim the payment you're entitled to. If you'd like to review the rest of the guidelines, see the articles on history documentation in our March/April 2010 issue (http://www.aafp.org/fpm/2010/0300/p22.html) and exam documentation in our May/June 2010 issue (http://www.aafp.org/fpm/2010/0500/p24.html). The table on the next page shows how medical decision making combines with history and exam to determine code selection.



The big picture

As you know, the CPT manual considers the level of complexity of medical decision making to be a function of three variables, and this division is also reflected in the documentation guidelines:

- The number of potential diagnoses and management

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options that must be considered during an encounter,

• The amount and complexity of data to be reviewed as a result of the encounter,

• The risk of complications, morbidity and mortality associated with the encounter.

We can call these three elements *diagnoses and management options, data* and *risk.*

The guidelines follow CPT in recognizing four levels of each of these elements, and four corresponding levels of medical decision making overall (see "The elements of medical decision making," page 12). The level of medical decision making for a given visit actually depends on the highest two out of these three elements. If you find that confusing, remember that the level of medical decision making is the same as either the *second-highest* of the three elements if they're all different or the *tied elements* if they're not. That's the easy part, though. The challenge lies in properly documenting diagnoses and management options, data and risk and in figuring out the level of each that a given note represents.

Diagnoses and management options

Determining the number of potential diagnoses and management options you have to deal with in an encounter is harder than it sounds. The guidelines suggest that this factor depends on each of the following:

• The number of problems you deal with in the encounter,

• How uncertain you are about the diagnosis,

• The number of management options you have,

• How uncertain you are about which management option to choose.

You can document the number of problems you deal with simply by listing them, as you probably do anyway. The guidelines do not require that you actually put down a number. The documentation of diagnostic uncertainty and management options is a little more involved, but it's also something you probably do already. If you understand what the guidelines are looking for in each of these areas, however, you may be more likely to cover all the bases.

Diagnoses. How good a handle you have on the diagnosis of each problem is the crux of the issue here; according to the guidelines, "decision making with respect to a diagnosed problem is easier than for an identified but undiagnosed problem." Actually, the guidelines suggest the following spectrum of diagnostic uncertainty, from least to most uncertain:

• An already-diagnosed problem that is now improved, well-controlled, resolving or resolved,

• An already-diagnosed problem that is now inadequately controlled, worsening or failing to change as expected,

• An identified but undiagnosed problem for which the history and physical are sufficient to establish a probable diagnosis,

• An identified but undiagnosed problem for which you need information beyond the history and physical (lab tests, for instance, or a consultation).

While almost anything you say about a problem will suggest where it falls on this spectrum, you may save yourself trouble in an audit if you keep these categories in mind and always make it clear which category a given problem falls into. As with most of their other recommendations, the guidelines do not insist that you identify the category explicitly, only that it be clearly implied. For instance, the fact that you document ordering lab tests or referring a patient for a biopsy should make it clear enough to any reader that you're dealing with an undiagnosed problem for which the history and physical don't provide enough information. Similarly, if your assessment says, "IDDM – controlled," it should be clear to any

SUBSECTIONS OF THE DOCUMENTATION GUIDELINES

Level	History	Examination	Medical decision making	Severity of presenting complaint	Time
1	–	–	–	Minimal	5 min.
2	Problem focused	Problem focused	Straightforward	Minor or self-limited	10 min.
3	Expanded problem focused	Expanded problem focused	Low complexity	Low to moderate	15 min.
4	Detailed	Detailed	Moderate complexity	Moderate to high	25 min.
5	Comprehensive	Comprehensive	High complexity	Moderate to high	40 min.

Table applies to established patient office visits.

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reviewer that you're dealing with a problem at the low end of the uncertainty spectrum.

When the history and physical aren't enough to pin down a probable diagnosis, it's important to document what you did to get more information, in part because it can help indicate the degree of uncertainty you're dealing with. As the guidelines say, "The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses," and "The need to seek advice from others is another indicator of complexity of diagnostic or management problems." The guidelines ask, reasonably enough, that when you refer a patient, request a consultation or ask for advice, you specify whom you referred the patient to, requested a consultation of or asked for advice.

A caution: While noting that you've ordered a lab test can imply something about the diagnosis or diagnoses you're considering, it's probably worth taking time to add an explicit comment to the assessment. Something as brief as "hypothyroidism vs. anemia" can be enough. You can't write "ECG and a Chem-21 profile" and expect a reviewer to know what you were thinking. A test you order may indeed help a reviewer determine the level of medical decision making if it really does indicate your line of thinking, but to do so, it has to be fairly specific.

The point is to convey that you have thought of a range of diagnoses and selected one based on the information above. This is what you tend to do in your head, but the guidelines require that it be indicated on paper.

Management options. In addition to implying that the need to seek advice about treatment suggests a higher level of medical decision making, the guidelines include one point about treatment: "The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies and medications."

The guidelines don't get directly at the issue of how many management options are open to you in a given situation – something you would expect to be important given that one element of the medical decision making guidelines is the number of diagnoses *and management options.* Still, saying what option you picked will presumably imply something about the options that were open to you.

Data

When the guidelines talk about "the amount and complexity of data to be reviewed," they refer to information gathered from sources other than the history and physical – lab tests, imaging, other diagnostic services, old records and history from sources other than the patient. Generally speaking, the guidelines ask that you record the decision to seek additional information and, if you have obtained the information, the results of your review of it.

Medicare's documentation guidelines describe how to assess the level of complexity of medical decision making.

With history and exam notes, medical decision making documentation supports CPT code selection.

The three elements of medical decision making – diagnosis and management options, data and risk – each have four levels.

THE ELEMENTS OF MEDICAL DECISION MAKING

Type of decision making	Diagnoses or management options	Data to be reviewed	Risk
Straightforward	Minimal	Minimal or none	Minimal
Low complexity	Limited	Limited	Low
Moderate complexity	Multiple	Moderate	Moderate
High complexity	Extensive	Extensive	High
	At least two criteria must be met or exceeded.		

The rationale is that any such step implies an increase in the complexity and volume of the data you need to winnow. Specifically, they ask that you make sure the documentation reflects the following:

- The nature of any diagnostic service you order, plan, schedule or perform at the time of the encounter.
- Any review of diagnostic test results that you perform. "An entry in the progress note such as 'WBC elevated' or 'chest x-ray unremarkable' is acceptable," as is your simply initialling and dating the reports of test results.
- Any decision to review old records or obtain history from sources other than the patient.
- Relevant findings from any review of old records or from any additional history you obtain – or a note to the effect that you carried out such a review but found no additional relevant information. "Old records reviewed" or "additional history obtained from family" is *not* enough. You need to give relevant findings or say explicitly that there were none.
- The results of any discussion you have with the physician who carried out or interpreted a diagnostic test or service. That the guidelines talk about "discussion of *contradictory or unexpected* test results" (emphasis added) at least suggests the possibility that carriers might question such a discussion of results unless they were contradictory or unexpected.
- Your "direct visualization and independent interpretation of an image, tracing or specimen" that has been or will be interpreted by another physician. Again, the guidelines suggest that such independent checking is not expected to be a regular thing, but rather something that happens only "on occasion."

Risk

The guidelines consider risk to the patient in determining the level of medical decision making – risk of significant complications, morbidity and mortality – and they recognize three gauges of this risk: the presenting problems, any diagnostic procedures you choose and any management options you choose.

The guidelines include only a few points under documenting risk, but much of the information needed for assessment of the level of risk is already called for in other parts of the guidelines. These are the additional points:

- Comorbidities, underlying diseases and other factors that increase risk should be documented.
- All surgical procedures and invasive diagnostic procedures performed or planned should be documented as specifically as possible. That is, if you perform such a procedure during the E/M encounter, you should document "the specific procedure," and if you request, plan or refer for such a procedure, you should document "the type of procedure, e.g. laparoscopy."
- If you refer for or decide to perform such a procedure urgently, that urgency should be clearly communicated by the record.

Quantifying diagnoses and management options, data and risk

The guidelines give no help in defining what *minimal, limited, multiple* and *extensive* mean when applied to the number of diagnoses and management options, or what constitutes *minimal*, *limited*, *moderate* or *extensive* review of data. Since the guidelines were first introduced, a number of worksheets have emerged that auditors, coders and physicians use to help fill this gap by assigning points for documentation elements and defining each level of diagnosis and management options and data in terms of point ranges. Today Medicare contractors use a variety of such worksheets to audit claims. Because there is no standard, you should check with the contractor in your region to find out what system to measure your medical decision making against. (This isn't the only area where Medicare contractors differ in their application of the documentation guidelines; see "Is Your Medicare Payer Playing by the Rules?" on page 27 to learn about others.)

The guidelines do provide a useful table for quantifying the four levels of risk (see "Quantifying the risk of complications, morbidity and mortality," page 14). The table lists common examples of problems, diagnostic procedures and management options classified by level of

The elements map to four levels of overall medical decision making.

Your documentation should convey the diagnoses you considered, your diagnostic uncertainty, and the management options that you considered.

For data, the guidelines suggest that you record the decision to seek additional information and, if you have obtained the information, the results of your review of it.

About the Authors

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risk. It is intended as a ruler against which to loosely measure the risk inherent in problems and procedures not listed.

Clearly, the quantification of risk is not an exact science, any more than the quantification of uncertainty. The guidelines do attempt to contain the problem by specifying limited periods over which to estimate risk. Where risk is related to presenting problems, you are to assess the amount of risk the patient will be subjected to "between the present encounter and the next one." When risk is related to your decisions and actions – that is, when it is related to diagnoses and management options – the guidelines ask you to assess the risk "during and immediately following any procedures or treatment."

To use the table, find the categories in which the

QUANTIFYING THE RISK OF COMPLICATIONS, MORBIDITY AND MORTALITY

Level of risk	Presenting problems	Diagnostic procedures	Management options selected
Minimal	One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest X-rays Urinalysis Ultrasound (e.g., echocardiography) KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness (e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH) Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)	Physiologic tests not under stress (e.g., pulmonary function tests) Non-cardiovascular imaging studies with contrast (e.g., barium enema) Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) Acute complicated injury (e.g., head injury with brief loss of consciousness)	Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test) Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization) Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis)	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss)	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiologic tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Remembering that any visit that involves a prescription is at least a moderate-risk visit can simplify establishing a risk level.

patient's presenting problems and your diagnostic and therapeutic actions seem to fit best. The highest individual level of risk determines the overall level. Consider this encounter with a hypertensive patient:

S: A 55-year-old male established patient returns today for follow-up of hypertension. Has done well since last visit w/o Sx consistent w/ angina or CHF. His only complaint is increased fatigue over past 1-2 months w/o DOE or other constitutional Sx. Current meds include nadolol 20 mg qd, HCTZ 25 mg qd.

O: BP 126/86, P 82, Wt 190, HEENT: PERRLA. EOMs intact, TMs nl, oropharynx benign. NECK: supple w/o JVD, bruits or thyromegaly. CHEST: BS clear to percussion and auscultation. EXT: w/o edema, pulses intact.

A: 1. Stable hypertension.
2. Fatigue most likely secondary to hypertensive meds – rule out electrolyte abnormality.

P: 1. Continue nadolol 20 mg qd.
2. Discontinue HCTZ and monitor BP and Sx.
3. Consider changing nadolol if fatigue persists.
4. CBC/SMA 7 today.
5. Return for follow-up in 3-4 wks.

The presenting problem, hypertension with fatigue probably resulting from antihypertensive therapy, seems to fit in the *moderate* risk level as "one or more chronic illnesses with mild exacerbation, progression or side effects of treatment."

The diagnostic procedures seem to fall into the *minimal* risk level as "laboratory tests requiring venipuncture."

The management option, modifying a prescription drug, falls into the *moderate* risk category as "prescription drug management."

Since the highest risk identified is *moderate,* that is the risk associated with the visit.

You may find it useful to examine the table for patterns and characteristics that will help impress the categories in your mind. For instance, under diagnostic procedures, note the four-step progression of imaging studies from chest X-rays and ultrasound to noncardiovascular studies involving contrast, to cardiovascular studies involving contrast and no identified risk factors, to cardiovascular studies involving contrast with identified risk factors.

One remarkable characteristic of the table is that it puts prescription drug management on a par with elective major surgery as a moderate-risk intervention. Remembering that any visit that involves a prescription is at least a moderate-risk visit can simplify the process of establishing a risk level.

Medical necessity

Medical decision making seems to have a special role in determining the level of a patient encounter, even though it's supposed to be weighted evenly with the history and exam.

Indeed, reviewers are likely to regard the medical decision making component as a reality check on the other two key elements. While any two of the three can determine the overall level for an established patient visit, the physician who consistently documents a high-level history and a high-level exam on a patient with a minor problem is asking for trouble.

But even if the obvious ethical considerations did not militate against subversion of the guidelines, good sense argues against it. A claim supported by documentation that obeys the letter of the guidelines while violating their spirit can still be challenged by the carrier on the grounds of medical necessity. The trick is to push the guidelines exactly as far as accuracy requires – no more, no less. FPM

Send comments to **fpmedit@aafp.org**

Editor's note: To enrich our online archive with some particularly useful "pre-web" articles, we are publishing updated versions of them. This article first appeared in 1995.

The guidelines don't help you to quantify diagnosis and management options or data; they do include a table for assessing risk.

Prescription drug management qualifies as moderate risk.

Medical decision making documentation helps to convey the medical necessity of the service.