

“Special Edition”

Charting for Medical Decision Making (MDM) 99204 and 99214

MDM is comprised of the top 2 of 3 considerations: Diagnosis, Data, and Risk. In the ambulatory setting, Diagnosis and Data are more likely to satisfy documentation requirements.

Many templates have time recorded as part of the office visit. Billing can be based on Time or on Medical Decision Making. This document describes the elements required for Medical Decision Making documentation. If the time spent on an office visit is appropriate for a 99213 but the medical decision making supports a 99214, then 99214 is the appropriate code for the encounter.

Diagnosis (For 99214 Multiple = 3)

Charting example: “This is a new problem.” This makes it easier for the coder.
 Second opinions and referrals (new problem) are considered additional work-up.

Problems	Points (per condition)
Self-limited or minor	1 (Max 2)
Established problem, stable or improving	1
Established problem, worsening	2
New problem with no additional work-up planned	3 (Max 1)
New problem, with additional work-up planned	4

Data (For 99214 Data = 3 points and can be derived from the following areas)

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed. Indications of data reviewed are based on the following point system:

Categories of Data to Be Reviewed	Points
Review and/or Order Clinical Lab Tests	1
Review and/or Order Radiology Tests (70010-79999) (No echocardiography and cardiac catheterization)	1
Review and/or Order Medical Diagnostic Tests (90281-99199) (e.g., EEG, cardiac cath, pulmonary function studies)	1
Discussion of Test Results with Performing Physician	1
Decision to Obtain Old Records	1
Review and Summarization of Old Records	2
Independent Visualization of Image, Tracing or Specimen Itself (no simply review of report)	2
Total	

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Clinical Lab Tests (1 point)

Lab tests refer to CPT codes 80002 - 89399 which include results of analysis of any specimen such as blood, urine, CSF, feces, synovial fluid, semen, etc. These may include routine chemistry tests, CBC, hormonal assays, microbiologic cultures, cytogenetic studies, gross or microscopic pathology results, or evocative testing such as a cosyntropic stimulation test.

Charting Examples:

- “WBC elevated”
- “Reviewed labs from (e.g. Inpatient, Emergency Dept, SNF) visit on xx/xx/xx “
- “Labs from last visit were reviewed and unremarkable”
- Can also import or copy the labs into the chart note

Radiology Tests (1 point):

X-rays, myelography, CT scans, MRIs, urography, angiography, venography, DEXA scans, diagnostic ultrasounds, nuclear medicine studies and PET scans.

Charting Examples:

- “Reviewed Radiology from (e.g. Inpatient, Emergency Dept, SNF) visit on xx/xx/xx”
- “Mammogram or CXR reviewed – unremarkable”
- Can also import or copy Radiology results into the chart note

Diagnostic Tests (1 point):

EKGs, EEGs, PFTs, echocardiograms, cardiac catheterizations, cardiac stress tests, audiometry, speech or swallow studies, pacemaker interrogations, arterial or venous doppler studies, plethysmography, non-invasive arterial studies (such as ABIs), transcranial doppler studies, allergy testing, sleep studies, EMGs, evoked potentials, tensilon testing and nutritional assessments.

Charting Examples:

- “Reviewed cath report – minimal disease”
- “Doppler study was normal”
- “Sleep study shows apnea”
- “EKG – tachycardia but otherwise normal”
- “Colonoscopy showed polyps” (Diagnostic only, screening tests do not qualify)

Discussion of Test Results w/ Performing MD (1 point):

You can receive one data point for discussing a test with the performing physician. A second opinion from another physician is part of the Diagnostic workup, not Data.

Charting Examples:

- “Spoke with Pathologist who confirmed the benign nature of the biopsy”
- “Spoke with the Radiologist who has concerns about metastasis”

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Decision to Obtain Old Records (1 point):

You can receive one data point for "deciding" to obtain old records. In order to claim this, point you must document your specific intentions in the chart. Receiving medical history from a family member also counts as one point for toward this goal.

Charting Examples:

- “Used Comm Management to order Colonoscopy results”
- “Sent record release to Ophthalmologist for Diabetic Eye Exam”
- “Sent pediatrician request for vaccination record”
- “Spoke to her daughter about her health history”

Review/Summarization of Old Records (2 points):

In order to claim these two data points, the findings **MUST** be summarized in the chart. “Old records reviewed” does not qualify.

Charting Examples:

- “Reviewed the PAMF records for exam, labs and treatments. The only lab of significance is a biopsy report showing”
- “Previous Pap Smear records show dysplasia treated with a LEEP”

Independent Visualization of Image, Tracing, or Specimen Itself (2 points):

A provider personally reviewing an image, tracing or specimen and providing an interpretation is worth 2 data points. It does not matter if there is an official report already in the record (for example an official interpretation from a radiologist for a chest X-ray).

Charting Examples:

- “Went to Radiology and reviewed the CT scan that shows a mass in the pancreas”
- “Reviewed the ultrasound images and agree that the baby is breech”

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Risk Moderate Risk 99214: (Requires any ONE of the following elements)

≥ 2 stable chronic illnesses
≥ 1 worsening chronic illness (mild exacerbation, progress or side effects of treatment)
New problem requiring workup with uncertain prognosis (Head injury)
Acute illness with systemic symptoms (pyelonephritis, colitis)
Prescription drug management (new or managing current prescriptions)

Charting Examples:

- “Flu syndrome with symptoms requiring Tamiflu”
- “New onset gestational hypertension requiring NST”
- “Postmenopausal bleeding that may indicate uterine carcinoma. Endometrial biopsy recommended”
- “Breast lump that needs diagnostic mammogram and biopsy”
- “Diabetes and hypertension both addressed, and medications adjusted for better control”
- Three stable chronic condition: hypertension, diabetes, dyslipidemia all addressed in the discussion, without medication changes
- COPD exacerbation requiring evaluation and treatment