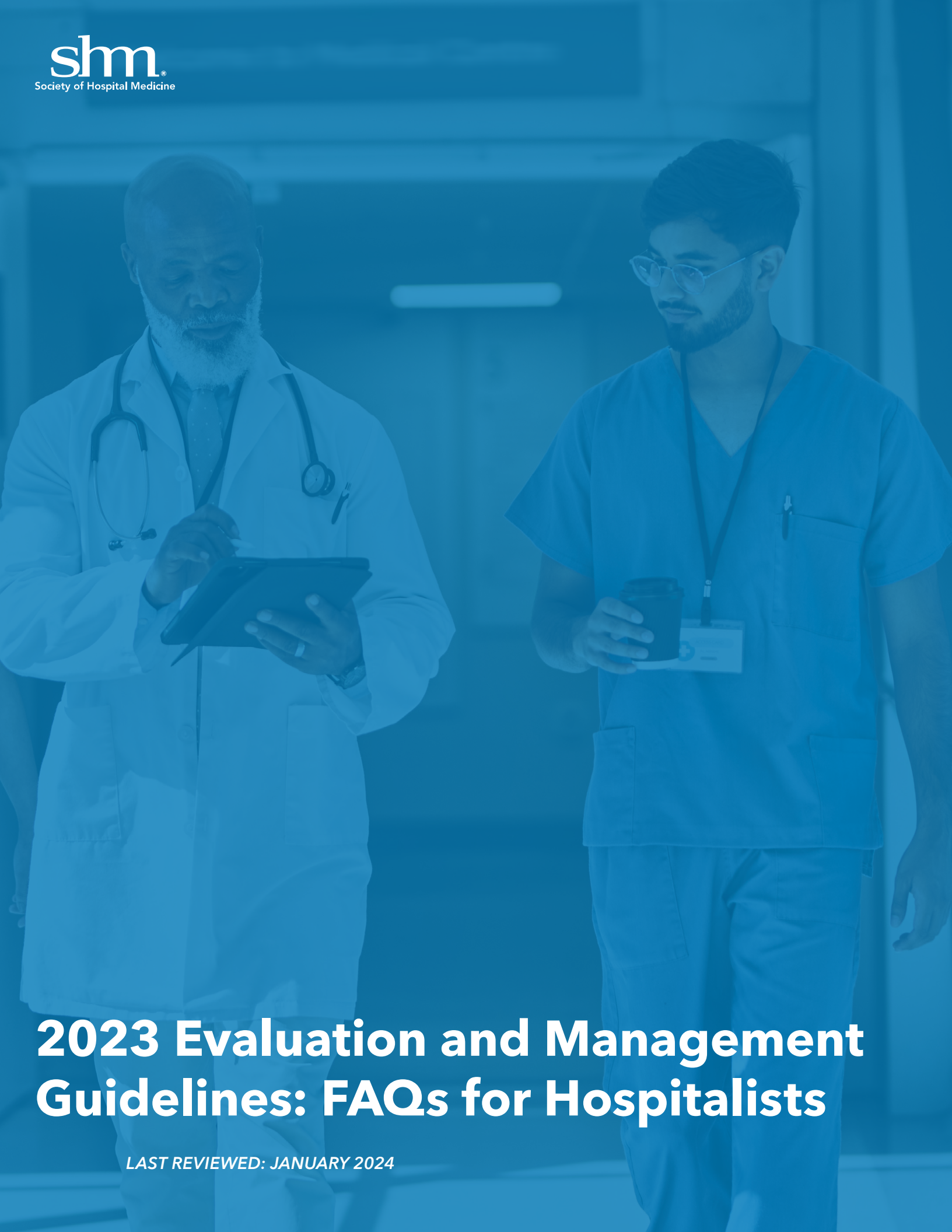
Society of Hospital Medicine



# 2023 Evaluation and Management Guidelines: FAQs for Hospitalists

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# Table of Contents

## MDM Table, Column 2 – Amount and/or Complexity of Data to be Reviewed and Analyzed ..... 13



## MDM Table, Column 3 – Risk of Complications and/or Morbidity or Mortality of Patient Management ..... 17

## Acknowledgement:

SHM received permission from ACEP to adapt its award-winning 2023 Documentation Guidelines FAQ list for use by hospitalists. This document, along with the American College of Emergency Physicians (ACEP) FAQ set, are living documents that may evolve as CPT™ or various payers change their policies over time.

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# General FAQs

## 1. How do the 2023 E/M Guidelines differ from the 1995 E/M Documentation Guidelines?

The most significant revisions to the 2023 E/M Guidelines are:

- A medically appropriate history and exam, while still clinically appropriate, are no longer a component for code selection.
- E/M code selection is based on Medical Decision Making (MDM) or Total Time.
- Revisions to the rules for using Time to assign an E/M code.
- Significant modifications to the criteria for determining the level of Medical Decision Making (MDM).
- Conceptually, CPT® wanted to give credit for mental work, not just physical orders.

## 2. Do these changes mean I am no longer required to document a history or exam?

The nature and extent of the history and physical examination are determined by the treating physician/qualified healthcare professional (QHP). However, the MDM table measures the complexity of problems addressed with expressive statements such as acute, uncomplicated illness or injury, undiagnosed new problem with uncertain prognosis; acute illness with systemic symptoms; chronic illnesses with severe exacerbation. While the history and exam elements are not "counted," a descriptive history and exam will ensure the coder or auditor will understand the complexity of problems addressed to the extent necessary to determine medical decision making accurately and support the selected and/or appropriate code.

## 3. Do I still need to document or import the patient's entire past, family, and social history from the nurse's notes or prior medical records?

Only when they are clinically relevant to the current E/M service. CPT® suggests reducing links embedded in documentation templates that automatically pull in data from other parts of EHR, contributing to "note bloat" but adding little, if any, true clinical value. Reducing note bloat and increasing the relevance of documentation were key reasons cited for making the 2023 changes.

## 4. If E/M codes are selected based on Medical Decision Making or Total Time, do I need to document my time for hospital visits?

Some codes can only be billed by time, such as critical care codes 99291-99292, discharge codes 99238-99239, and advance care planning codes 99497-99498.

For more HM-typical initial visits and subsequent visits for hospitalized patients, they may be billed by Total Time or MDM.

CPT's® view is that typical visits should be billed by MDM, but some visits are appropriate for billing total time, such as patients who require prolonged services (see below).

## 5. Can I bill by time?

Billing can be based on MDM or total time spent on an encounter during that date of service.

CPT® generally recommends billing by MDM but there may be instances where time, with supporting documentation, may permit billing at higher levels. For example, if an admission included the review of extensive records that took 30 minutes, and the total time for all allowed time-based activities (see below) exceeded what the charge would be for a lower MDM level, it is permissible to use time as a justification for a higher level.

| Initial Hospital Inpatient or Observation Code | MDM | Time Range (must be met or exceeded) | Subsequent Hospital Inpatient or Observation Code | MDM | Time Range (must be met or exceeded) |
|---|---|---|---|---|---|
| 99221 | Straight-forward or low | 40 minutes | 99231 | Straight-forward or low | 25 minutes |
| 99222 | Moderate | 55 minutes | 99232 | Moderate | 35 minutes |
| 99223 | High | 75 minutes | 99233 | High | 50 minutes |
| **Hospital Inpatient or Observation Code (Same Date)** | **MDM** | **Time Range (must be met or exceeded)** | **Hospital Inpatient or Observation Discharge Day Management Code** | **MDM** | **Time Range (must be met or exceeded)** |
| 99234 | Straight-forward or low | 45 minutes | 99238 | N/A | 30 minutes or less |
| 99235 | Moderate | 70 minutes | 99239 | N/A | >30 minutes |
| 99236 | High | 85 minutes | | | |

## 6. What are allowable activities for time-based billing?

Time includes face-to-face time, time reviewing records, speaking to qualified healthcare professionals and reviewing/interpreting/ordering labs, documentation, and time spent on discussing the patient's care plan with supporting documentation in the note. Other allowable activities include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Excluded activities include travel time and general teaching time, as well as any other services that are reported separately.

## 7. As of 2023, how is Medical Decision Making determined?

MDM level is selected by the highest two of the three MDM columns.

| Level of MDM | | Medical Decision Making (MDM) | | |
|---|---|---|---|---|
| **E/M Code** | **Level** | **Number and Complexity of Problems Addressed** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** | **Risk of Complications/ Morbidity/ Mortality of Patient Management** |
| **99221/99231** | **Low** | Low | Limited | Low |
| **99222/99232** | **Moderate** | Moderate | Moderate | Moderate |
| **99223/99233** | **High** | High | Extensive | High |

## 8. Can I still use the macros, templates, smart phrases, etc., included in our EHR to document hospital admissions, follow-up visits, and discharges?

CMS has no specific prohibition regarding macros or templates when documenting patient encounters. When the CP® E/M Workgroup set out to revise the E/M guidelines, one of the guiding principles was to decrease unnecessary documentation in the medical record and eliminate "note bloat."

There may be some elements of the 2023 E/M that could be satisfied with pre-built statements. However, it is important to ensure that the documentation accurately reflects the patient's condition and the services provided on that date of service.

Per CMS MLN 006347, *"You may use a documentation macro (a command in a computer or dictation application in an electronic medical record that automatically generates predetermined unedited user text) if you personally add it in a secured or password-protected system. Physicians or residents must provide enough patient-specific information to support a medical necessity determination."*

Different auditors may have different requirements that reflect differences in how Medicare Administrative Contractors (MACS) have interpreted these requirements. For example, certain MACs may require drug name and dosage for credit for "prescription drug management," which is moderate for the management risk column.

## 9. How do the new E/M Guidelines affect documentation and coding in academic settings where residents provide a portion of the patient care?

CP® is silent on the issue of teaching physician services; CMS has a long-standing policy regarding the level of participation required from the teaching physician when a resident is involved in the E/M service. While recent CMS teaching policy changes have modified what documentation is required from the teaching physician to code for E/M services, the performance expectations have remained the same.

*(Continued...)*

Per CMS policy, E/M services billed by teaching physicians require that the teaching physician is physically present during the key or critical portions of the E/M service. The documentation must demonstrate the teaching physician's participation in the E/M service. What qualifies as the key or critical portion of the E/M service is the teaching physician's discretion. Depending on the circumstances dictated by the patient encounter, it may vary from one encounter to the next.

If the teaching physician has met their performance and documentation requirements, the E/M code is assigned by combining the work and documentation of the resident and the teaching physician to determine the appropriate E/M code.

## 10. How do the 2024 E/M Guidelines affect documentation and coding when a PA/NP has provided a portion of the patient care, and the attending physician will report the visit as a split or shared service?

The American Medical Association (AMA) CPT® Editorial Panel revised guidelines regarding "split or shared visits" for 2024. The definition of a "split or shared visit" now refers to the substantive portion of an Evaluation and Management (E/M) service. The revised definition states that the substantive portion is determined either by more than half of the total time spent by the physician and other qualified healthcare professional (QHP) performing the split visit or by a substantive part of the Medical Decision Making (MDM). These guidelines are intended to assist in determining which healthcare provider, the physician or QHP, may bill for the service.

For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM.

The CY 2024 Final Rule indicated that CMS would be adopting the CPT® definition of substantive portion for 2024 and beyond.

## 11. Does the attending physician have to document their medical decision making for PA/NP shared E/M services, or must their attestation indicate what elements of the E/M service they provided to support reporting a shared service?

The CPT® description of a shared service does not include a documentation standard for reporting a shared service. Per CMS, *"Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record. Signing and dating the MR and putting their name on the bill affirms that the individual performed the substantive portion, whatever they chose. We did not finalize anything about identifying what they used as the substantive portion."*

Beyond a date and signature from the billing provider, documentation and/or attestation requirements are an internal hospital or physician group decision.

It is recommended that the physician state that they made/approved the management plan and take responsibility for the patient management to abide by the CPT® definition.

For more information about the 2024 Medicare Policy on Split (or Shared) Billing, view SHM's fact sheet here.

## 12. Where can I find the complete set of guidelines?

They can be found in the Evaluation and Management (E/M) Services Guidelines section of the 2023 CPT® Manual. They can be downloaded here.

## 13. Where can I download a copy of the 2023 MDM grid?

The only official source for the MDM grid is the 2023 CPT® Manual. A modified version of the grid to specifically address the hospital medicine E/M codes can be downloaded here.

# MDM Table, Column 1 – Number and Complexity of Problems Addressed (COPA)

## 14. How are the Number and Complexity of Problems Addressed (COPA) measured?

When assigning a value to the Number and Complexity of Problems Addressed (COPA), there are several factors to consider.

The problem has been addressed when it is evaluated or treated by the physician/QHP, with or without a diagnosis established during the encounter. This can include diagnoses being "ruled-out" for example.

- This includes consideration of further testing or treatment that may not be performed by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.
- Comorbidities and underlying diseases can contribute to the MDM if addressed during the encounter.
- The final diagnosis does not determine the complexity or risk.

The MDM grid from CPT® divides COPA into four levels: Minimal, Low, Moderate, or High; Minimal MDM does not have a corresponding code in hospital medicine and involves no medical decision making.

| Number and Complexity of Problems Addressed (COPA) | |
|---|---|
| **Low** | **2 or more** self-limited or minor problems |
| | **1** stable, chronic illness |
| | **1** acute, uncomplicated illness or injury |
| | **1** stable, acute illness |
| | **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care |
| **Moderate** | **1 or more** chronic illnesses with exacerbation, progression, or side effects of treatment |
| | **2 or more** stable chronic illnesses |
| | **1** undiagnosed new problem with uncertain prognosis |
| | **1** acute illness with systemic symptoms |
| | **1** acute complicated injury |
| **High** | **1 or more** chronic illnesses with severe exacerbation, progression, or side effects of treatment |
| | **1** acute or chronic illness or injury that poses a threat to life or bodily function |

## 15. Are there definitions for the bulleted items in the Complexity of Problems Addressed (COPA) column?

Yes, the E/M guidelines offer these definitions for each of the elements:

- **Self-limited or minor problem:** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
- **Stable, chronic illness:** A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition).
    - "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.
        - For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant.
- **Acute, uncomplicated illness or injury:** A recent or new short-term problem with a low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
    - A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.
- **Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care:** A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.
- **Stable, acute illness:** A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.
- **Chronic illness with exacerbation, progression, or side effects of treatment:** A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.
- **Undiagnosed new problem with uncertain prognosis:** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
    - **Morbidity:** A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- **Acute illness with systemic symptoms:** An illness that causes systemic symptoms and has a high risk of morbidity without treatment.
    - Systemic symptoms may not be general but may affect a single system.
    - For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury.
- **Acute, complicated injury:** An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

- **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 escalation in the level of care.
- **Acute or chronic illness or injury that poses a threat to life or bodily function:** An acute illness with systemic symptoms, 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.
    - Some symptoms may represent a condition that is significantly probable and poses a **potential** threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of **potential**.

## 16. Are there clinical examples for the bulleted items in the Complexity of Problems Addressed (COPA) column?

CPT® has not published clinical examples for the COPA elements. The SHM E/M Technical Advisory Panel has reviewed available CPT® guidelines, CPT® clarifications published in CPT® Assistant, and common practices in hospital medicine to offer some guidelines when assessing the Complexity of Problems Addressed.

### Minimal

One self-limited or minor problem

It is improbable that many patients that require hospitalization clinically fit into this category, given the severity of illness required to establish medical necessity for hospital-level services. CPT® stipulates that "a problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness," which would be "Low."

### Low

| MDM COPA Element | Additional Description |
|---|---|
| Two or more self-limited or minor problems | See the above description of a self-limited or minor problem. |
| One stable chronic illness | The CPT® definition of "Stable" makes it doubtful that patients requiring hospitalization fit into these categories.<br><br>*"Stable," for the purposes of categorizing MDM, is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. It does not refer to hemodynamic stability.* |
| One stable, acute illness | |
| One acute, uncomplicated illness or injury | Hospital presentations in this category will be limited to localized complaints that do not include additional signs or symptoms.<br><br>Uncomplicated illnesses are minor illnesses with no associated systemic symptoms and can be evaluated without testing or imaging (e.g., isolated URI symptoms). Most of these patients can be reasonably treated with over-the-counter medications. Illnesses that have developed associated signs or symptoms, or require testing or imaging, or necessitate treatment with prescription strength medications have progressed beyond an uncomplicated illness. |
| One acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care | |

Patients that require hospitalization seem out of place in the Low COPA category. CPT® personnel have said that this bullet was added to provide a mechanism to score Low MDM as required for the inpatient hospital/observation E/M codes. This bullet is not typically used when calculating the MDM for patients in the hospital.

### Moderate

| MDM COPA Element | Additional Description |
|---|---|
| One or more chronic illnesses with exacerbation, progression, or side effects of treatment. | |
| Two or more stable chronic illnesses. | See the above explanation of stable chronic illness. It is unlikely that patients with stable, chronic illnesses will have medical necessity for hospitalization. |
| One undiagnosed new problem with uncertain prognosis. | |
| One acute illness with systemic symptoms. | There are many presenting problems, chief complaints, and associated signs and symptoms that could fit into these three categories. |
| One acute complicated injury. | As indicated by the CPT® definition, these are injuries that require an evaluation of organ systems or body areas beyond just the injury site (e.g., musculoskeletal injuries where an assessment of distal neurovascular function is indicated).<br><br>A patient's mechanism of injury can also be an indication of an acute complicated injury. Presentations prompted by a fall, MVA, etc. require the physician/QHP to evaluate multiple organ systems or body areas to identify or rule out injuries. |

In response to a reader's question, CPT® Assistant indicated that abdominal pain would likely represent "at least" Moderate COPA. This could be a patient with chronic abdominal pain, so the presentation would be considered a *chronic illness with exacerbation*. It may be a patient with no history of abdominal pain that would be an *undiagnosed new problem with uncertain prognosis*. Or it might present as abdominal pain with vomiting and diarrhea, so it would score as an *acute illness with systemic symptoms*.

- At the time of admission as part of an evaluation a physician/QHP may order or review an advanced laboratory test or other complex diagnostic study (e.g., Troponin, BNP, D-Dimer, Lactate, CT, US, MRI, etc.). Such evaluations are typically for a patient presenting with complaints or symptoms consistent with a potential condition that poses a threat to life or bodily function. In such cases, the encounter has likely surpassed a moderate COPA presentation.

### High

| MDM COPA Element | Additional Description |
|---|---|
| One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment | Presenting problems in these High COPA categories are high-risk presentations where the physician/QHP is evaluating or ruling out a condition with a significant risk of morbidity or one that poses a threat to life or bodily function. These are patients with symptoms that potentially represent a highly morbid condition and therefore support high MDM even when the ultimate diagnosis is not highly morbid. |
| One acute or chronic illness or injury that poses a threat to life or bodily function | |

*(Continued...)*

The final diagnosis for a condition, in and of itself, does not determine the complexity of the MDM. The presenting problem, or diagnostic evaluation, or treatment or management, or differential diagnoses, may indicate that an extensive evaluation is required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.

## 17. Why didn't SHM include diagnosis examples?

CPT® believes that clinicians caring for each individual patient are best positioned to assess that patient's COPA. Hospitalists care for patients from admission through discharge, and during the course of hospitalization, it would be common for COPA to be highest at the time of admission, and lower at the time of discharge, though the diagnoses may be the same. The above descriptions provide guidance on, for example, what constitutes an acute or chronic illness or injury that poses a threat to life or bodily function.

## 18. Can I use the application of evidence-based risk calculators as an indicator of the complexity of problems addressed?

Yes, the physician/QHP may employ risk stratification tools to ascertain the significance or severity of a presentation and/or help determine appropriate diagnostic or therapeutic interventions. Some tools that may be relevant to hospital medicine are:

- HEART score – for major cardiac events and to determine between discharge or admit/observe from the ED
- Pneumonia Severity Index / PORT score (or CURB-65) – Estimates mortality for adult patients with community-acquired pneumonia and determines between discharge or admit/observe from the ED
- Well's Criteria for DVT – Calculates risk of DVT based on clinical criteria
- Well's Criteria for Pulmonary Embolism – Objectifies risk of pulmonary embolism
- MELD/MELD-Na for three-month mortality in patients >12 years old with end stage liver disease
- qSOFA for mortality in hospitalized patients with suspected infection outside the ICU based on bedside findings
- TIMI Risk Scores for 30-day mortality in patients with acute coronary syndrome
- NIHSS NIH stroke scale for patients with suspected or confirmed stroke

Documentation that the physician/QHP used a risk calculator to determine the need for additional testing or treatment is an indicator of the complexity of problems addressed.

When a risk calculator score has suggested that a diagnostic test is not indicated, the Data Category 1 element should be scored the same as if the test had been ordered, as indicated by the CPT® statement, *"Ordering a test may include those considered but not selected."*

## 19. Do the comorbidities need to be noted in the MDM, or does mentioning them in the HPI or PMH count?

Simply listing the comorbidity does not satisfy the CPT® definition of "problems addressed." The documentation should reflect how the comorbidities impacted the MDM for the patient encounter. Per CPT®, *"Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management."*

# MDM Table, Column 2 – Amount and/or Complexity of Data to be Reviewed and Analyzed

## 20. How is the Amount and/or Complexity of Data to be Reviewed and Analyzed measured?

Amount and/or Complexity of Data to be Reviewed and Analyzed (Data) is divided into three categories:

- Category 1: Tests, documents, orders, or independent historian(s).
- Category 2: Independent interpretation of tests (not separately reported).
- Category 3: Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source.

The MDM grid in the E/M section of CPT® assigns value to components of the Data categories. For each encounter, elements from each category are counted to determine if the Data is Minimal, Limited, Moderate, or Extensive.

| **Amount and/or Complexity of Data to be Reviewed and Analyzed** | |
|---|---|
| **Limited –** Satisfy at least one category. | **Category 1: Tests and documents**<br>• At **least 2** from the following:<br>  • Review of prior external note(s) from each unique source; (each note counts as 1)<br>  • Review of the result(s) of each unique test; (each test counts as 1)<br>  • Ordering of each unique test (each test counts as 1)<br>**Category 2: Assessment requiring an independent historian(s)** |
| **Moderate** – Satisfy at least one category. | **Category 1: Tests, documents, or independent historian(s)**<br>• At **least 3** from the following:<br>  • Review of prior external note(s) from each unique source; (each note counts as 1)<br>  • Review of the result(s) of each unique test; (each test counts as 1)<br>  • Ordering of each unique test (each test counts as 1)<br>  • Assessment requiring an independent historian(s)<br>**Category 2: Independent interpretation of tests**<br>**Category 3: Discussion of management or test interpretation** |
| **Extensive –** Satisfy at least two categories. | **Category 1: Tests, documents, or independent historian(s)**<br>• At **least 3** from the following:<br>  • Review of prior external note(s) from each unique source; (each note counts as 1)<br>  • Review of the result(s) of each unique test; (each test counts as 1)<br>  • Ordering of each unique test (each test counts as 1)<br>  • Assessment requiring an independent historian(s)<br>**Category 2: Independent interpretation of tests**<br>**Category 3: Discussion of management or test interpretation** |

## 21. How do I "score" the bulleted items in Category 1?

Each unique test, order, or document is individually counted to meet the indicated requirement for each level of Data. A combination of different data elements – for example, a combination of notes reviewed, tests ordered, tests reviewed, or use of an independent historian – allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian, would be a combination of three elements.

- Review of prior external note(s) from each unique source.
    - External notes are any records, communications, test results, etc., from an external (not your same specialty or same group) physician/QHP, facility, or healthcare organization. For hospitalists, these will be any notes that come from outside their group, e.g., ED or EMS notes, nursing home records, PCP notes, charts from another facility, etc. Notes from prior hospitalizations only count if they are not from your group.
    - A unique source is defined as a physician/QHP in a distinct group, different specialty, subspecialty, or unique entity.
    - Review of external notes from each unique source counts as one element when calculating the Data, e.g., a review of a cardiology consult from a prior inpatient stay and review of nursing home records would each count as 1, for a total of 2 "points" for Category 1. However, review of multiple notes from a nursing home would count as 1 point, as there is only one unique source.
- Review of the result(s) of each unique test:
    - Tests are imaging, laboratory, psychometric, or physiologic data.
    - The CPT® code set defines a unique test.
    - A standard clinical laboratory panel, e.g., BMP (80047), is a single test.
    - When the same test is performed multiple times (e.g., serial blood glucose, repeat EKG), count it as one unique test for each date of service.
    - For data reviewed and analyzed, pulse oximetry is not a test. Pulse oximetry is now considered a vital sign.
    - When labs are automatically imported into clinical documentation, this is not assumed to indicate that a physician/QHP has reviewed the results. While there is no direct guidance on documentation from CPT®, documentation should directly reflect what labs were reviewed.
- Ordering of each unique test:
    - It is assumed that ordering a test includes the review of the results. A single unique test ordered or reviewed is a data point, but a single unique test ordered and reviewed is not 2 points.
    - It is assumed that the physician/QHP will review the results of a test ordered; therefore, the physician/QHP does not receive dual credit in Category 1 for both ordering and reviewing the same test.
    - Credit can also be granted for documented consideration of tests not ordered.
    - Review of a test ordered by another physician counts as a review of a test. For example, a review of tests performed in the ED or prior to hospitalization would qualify.
- A combination of different Category 1 elements is summed to determine the total:
    - A lab test ordered, plus an external note reviewed and an independent historian would be a total of three for Category 1 under moderate or extensive data.
    - All the Category 1 values can come from a single bulleted element.

- Ordering an EKG (93010), a CBC (85027), and a CMP (80053) is a total of three for Category 1, even though they are all from the same element (Ordering of each unique test).
- Ordering a CBC, CMP, and cardiac troponin is a total of three for Category 1, even though they are all lab tests, as each test has a unique CPT® code.

## 22. What documentation is required to count "review of prior external note" in Category 1?

The physician/QHP should document any information they feel is clinically relevant to the evaluation and management of the patient. Neither CPT® nor CMS policy indicates a documentation standard for counting Category 1 data elements.

In response to a reader question regarding using "outside records reviewed" without any analysis or summary to qualify for data, the December 2022 issue of CPT® Assistant indicated that the notation "outside records reviewed" should be counted as Category 1 data credit, with the provision that the review is used in the MDM during the current E/M service.

## 23. What qualifies as an independent historian?

- Any individual (e.g., parent (or adult child), caregiver, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient.
- The independent historian should provide additional information and not merely restate information already provided by the patient unless confirmation is necessary.
- The physician/QHP may query an independent historian when the patient is unable to provide a complete or reliable history for any reason, e.g., encephalopathy/dementia, clinical urgency, etc.
- The physician/QHP may query an independent historian when a confirmatory history is judged to be necessary.
- In cases in which the patient cannot provide any information (e.g., advanced dementia), the independent historian may provide all of the required information.
- 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.
- Independent historian does not include translation services.

## 24. What documentation is required to count "Assessment requiring an independent historian" as part of the MDM?

2023 CPT® Evaluation and Management (E/M) Code and Guideline Changes indicates the physician/QHP may utilize an independent historian when they cannot get reliable history from the patient or need to confirm the accuracy of the history obtained from the patient. The physician/QHP may involve an independent historian in the E/M service when clinically appropriate during patient treatment. CPT® does not require the physician/QHP to document the reason that an independent historian was utilized during the evaluation of the patient. Nor does CPT® require that the physician/QHP document which elements of the history were obtained from the independent historian.

CPT® Assistant November 2020 / Volume 30 Issue 11 does indicate that all of the history may be obtained from the independent historian in cases where the patient cannot provide any information. At a minimum, the physician/QHP should document the source of any history obtained from anyone other than the patient. The documentation style or format in which the independent historian is identified (e.g., "history per the mother," "Additional history from spouse", etc.) is at the discretion of the treating physician/QHP or may be determined by health record format or hospital/physician group policy.

## 25. What qualifies as an independent interpretation of a test for Category 2?

Any personal interpretation of a test for which there is a CPT® code, and an interpretation or report is customary. Even if formally interpreted/billed by another clinician, this can be counted toward data elements.

Typical hospitalist examples include X-ray/CT scans, EKG or rhythm strip interpretations, etc.

A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

If the CPT® code for the independent interpretation is separately reported (i.e., billed) by the clinician or group, it cannot also be counted in Category 2.

## 26. Can I count Category 2 for interpreting a CBC or BMP and documenting "CBC shows mild anemia, no elevated WBC" or "BMP with mild hyponatremia, no hyper K"?

No, lab tests do not have a separate interpretation component. Category 2 only applies for interpreting a test where an interpretation or report is customary, e.g., EKG, X-ray, ultrasound, rhythm strip.

Per CPT®, *"Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level."*

## 27. If I order a chest X-ray and compare it to a chest X-ray performed six months ago, does this review and comparison constitute an independent interpretation?

Yes, comparing recent X-ray findings to a previous X-ray would be considered an independent interpretation if appropriately documented as your personal interpretation. However, merely comparing radiology reports would not be considered an independent interpretation.

## 28. What qualifies as "discussion" for Category 3 - Discussion of management or test interpretation with external physician/other appropriate source?

Discussion requires an interactive exchange (i.e., two-way).

- The exchange must be direct and not through nonclinical intermediaries.
- Sending chart notes or written exchanges within progress notes does not qualify as an interactive exchange.
- It may be asynchronous; it does not need to be in person or verbal.

## 29. What is an external physician or another appropriate source for Category 3?

- Any external physician/QHP (qualified health professional) who is not in the same group practice or is of a different specialty or subspecialty within the same group.
    - QHPs are distinct from clinical staff, such as RNs. CPT® assumes that discussion will occur with clinical staff as part of the patient's care, and it is not separately counted.
    - Possible QHPs include:
        - Physician assistant (PA), nurse practitioner (NP) or certified nurse specialist (CNS) if outside your group
        - Pharmacist
        - Certified registered nurse anesthetist (CRNA)
        - Clinical social worker (CSW) or care manager
        - Physical therapist (PT)/Occupational therapist (OT)
- It may also be the staff of a facility or organizational provider such as a hospital, nursing facility, or home health care agency.
- An appropriate source is professionals who are not healthcare professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher).
- Appropriate source does not include discussion with family or informal caregivers.

## 30. What documentation is required to give MDM credit for Category 3 - Discussion of management or test interpretation with an external physician/other appropriate source?

For the purposes of determining medical decision making, the chart should indicate that the hospitalist physician/QHP had an interactive exchange (e.g., in-person or via telephone, text, secure electronic messaging, etc.) with another physician/QHP from a different practice or specialty or other professional involved in the management of the patient. Category 3 discussions may be asynchronous, but they should be completed in a timely manner (e.g., within a day or two) and contribute to the MDM of the current E/M service.

The documentation style or format in which the external physician/other appropriate source is identified (e.g., *"discussed with cardiology"* vs. *"discussed with Dr. Smith,"* etc.) and the discussion details (e.g., *"recommended a repeat troponin and EKG in two hours"* or *"will accept admission"*) are at the discretion of the treating physician/QHP. Documentation content requirements are an internal hospital, physician group, or MAC (Medicare Administrative Contractor) decision.

# MDM Table, Column 3 – Risk of Complications and/or Morbidity or Mortality of Patient Management

## 31. Can I count Category 1 for the order of an X-ray or CT and also count Category 3 when the test is discussed with the radiologist or surgeon?

Yes, the decision to order the test (Category 1) is a separate and distinct element from discussing the films/images with the radiologist (Category 3).

| Risk of Complications and/or Morbidity or Mortality of Patient Management | |
|---|---|
| **Minimal** risk of morbidity from additional diagnostic testing or treatment | |
| **Low** risk of morbidity from additional diagnostic testing or treatment | |
| **Moderate** risk of morbidity from additional diagnostic testing or treatment | *Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| **High** risk of morbidity from additional diagnostic testing or treatment | *Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization or escalation of hospital level of care<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis<br>• Parenteral controlled substances |

## 32. How are the Risk of Complications and/or Morbidity or Mortality of Patient Management measured?

- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.
- For the purpose of MDM, the level of risk is based upon consequences of the treatment of the problem(s) addressed at the encounter.
- The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.
- **Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.**

The MDM grid in the E/M section of CPT® assigns value levels of management risk. For each encounter, patient management decisions made by the physician/QHP are assessed as Minimal, Low, Moderate, or High.

## 33. Are there additional examples of risk that would be applicable to hospital medicine, or can we establish additional risk elements within our practice?

When asked for clarification or additional examples, CPT® indicated that it would be impossible to list all the possible patient management decisions in the MDM grid, and that the examples listed in the risk column are not exhaustive. Furthermore, they may not be the only patient management decisions to be taken into account when establishing the level of risk when calculating the E/M service. SHM created a modified version of the MDM grid with additional risk examples for HM.

The 2023 E/M Guidelines indicate that physicians/QHPs have a common understanding of how diagnostic and therapeutic decisions made in the patient management process can be categorized as high, medium, low, or minimal risk. And while they are not required to quantify their definition, the assignment of risk should be based on the usual behavior and thought processes of a physician/QHP from the same specialty.

## 34. What qualifies as prescription drug management in moderate risk?

Prescription drug management is based on documentation that the physician/QHP changed, added, or stopped a medication, or contemplated such a change during the E/M visit. This may be ordering any new prescription strength medication for a hospitalized patient (e.g., oral meds, IM injections, or IV injection/infusion), discontinuation or modifications to the patient's existing medication dosages, or after consideration of the current medications, the decision to maintain the current medication regimen. It can also include medications prescribed at hospital discharge. MACs may have specific documentation requirements, such as including drug and dose. Reference MAC policies for further clarification.

## 35. Can prescribing a prescription dosage of an over-the-counter medication qualify as prescription drug management?

Yes, when assigning risk for medications, the risk level is determined by the medication given, the dosage prescribed, and patient-specific risk factors.

Per CPT®, there is no blanket guidance categorizing medications into specific levels of risk. While the MDM grid lists prescription drug management as a moderate risk element, multiple CPT® citations indicate that a medication can be low, moderate, or high management risk, depending on patient-specific factors and the associated risks typically seen with the medication. The CPT® webinar E/M 2023: Advancing Landmark Updates explained, "An OTC NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs."

## 36. Are there examples of minor surgery with patient or procedure risk factors frequently performed by hospitalists that could be considered at least moderate risk?

The determination that a procedure is minor vs. major or has risk factors is at the discretion of the physician/QHP performing the service. Risk for any procedure depends on the specific patient-risk factors and circumstances as they are assessed by the physician/QHP. While a procedure may be

deemed high risk for a patient because of their specific circumstances, the same procedure may be assessed as moderate or low risk for a different patient.

Examples of patient risk factors that would be considered at least moderate risk may be a patient with a chronic condition (e.g., diabetes mellitus), or a patient taking medication.

## 37. What is the difference between elective and emergency surgery in the risk column?

- An elective procedure is typically planned in advance, e.g., scheduled for weeks later.
- An emergent procedure is typically performed immediately or with minimal delay.
- Both elective and emergent procedures may be minor or major procedures.

## 38. What qualifies as a risk factor for surgery in the risk column?

- Risk factors associated with a procedure may be specific to the procedure or specific to the patient.
- An otherwise low-risk procedure on a patient with an underlying condition that increases the risk of a poor outcome could be considered moderate or even high risk.
- The physician/QHP may use evidence-based risk calculators when assessing patient and procedure risk, but it is not required.

## 39. What are social determinants of health (SDOH) that may indicate moderate risk?

Any economic or social condition such as food or housing insecurity that may significantly limit the diagnosis or treatment of a patient's condition (e.g., inability to afford prescribed medications, unavailability or inaccessibility of healthcare). Common social determinants of health (SDOH) in the hospital may include homelessness/undomiciled, unemployed, uninsured, financial insecurity, alcohol or polysubstance abuse, lack of transportation, food insecurity, lack of social or family support, and poor health literacy. The medical record should reflect how the diagnosis or treatment is significantly limited by social determinants of health.

## 40. Can treating non-English-speaking patients and/or using a translator be considered a social determinant of health (SDOH)?

No, a language barrier is not included on the list of SDOH conditions published by the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), or International Classification of Diseases (ICD-10).

## 41. Would it be appropriate to count the order for a CT scan in the data category and then consider the performance of a CT as a risk element?

Yes, the decision that the patient needs a CT scan (and the independent interpretation when applicable) are elements of the amount and complexity of data. The risk associated with the performance of the test would be considered in the risk column when choosing the E/M level of service. This is supported by CMS MAC references at the following links: Noridian and FCSO.

## 42. Would the risk associated with the performance of a CT scan be consistent with at least moderate risk in the risk column?

Yes. CT scans are a common diagnostic tool in hospitalized patients for the evaluation of traumatic injuries, abdominal pain, and other serious and potentially life-threatening medical conditions. However, ionizing radiation in CT scans poses a potential risk to patients. The most significant risk associated with radiation exposure from CT scans is the potential for increased cancer risk. Ionizing radiation can cause damage to DNA and other cellular structures, which can lead to the development of cancer over time.

The risks associated with radiation exposure from CT scans are higher in children than adults, and the risk increases with the number of CT scans a patient receives. The potential risks include an increased risk of cancer, particularly leukemia and brain tumors. In addition, radiation exposure can also cause damage to the thyroid gland, leading to thyroid cancer or other thyroid disorders. In rare cases, radiation exposure from a CT scan can cause skin damage, including redness, blistering, and peeling. Pediatric patients are more susceptible to radiation exposure than adults due to their developing organs and tissues. The ED physician must weigh the risks and benefits of each scan, consider alternative diagnostic tools, and take steps to minimize radiation exposure to patients, particularly in pediatric patients.

When compared to the published examples of Moderate Risk, the radiation exposure and other potential complications seem consistent with Moderate Risk.

## 43. Would it be appropriate to consider administering IV fluids to be at least a moderate risk management decision?

Yes, assuming the fluid rate is greater than that required simply to maintain IV access. Additionally, some patients may have medical conditions that increase the risk further (such as severe heart failure, CKD, etc.) or the IV fluid may include additives that reflect a higher degree of risk.

Administering IV fluids is a common and necessary intervention during many hospitalizations, and must be ordered by a physician/QHP. However, there are some risks associated with this procedure that need to be taken into account.

One of the most common risks is infection. IV fluids are administered through a catheter inserted into a patient's vein, which can introduce bacteria into the bloodstream and cause infections. Another risk associated with IV fluids is fluid overload. In some cases, patients may receive too much fluid too quickly, leading to fluid overload and potentially life-threatening complications such as pulmonary edema. In rare cases, patients may also experience allergic reactions to the fluids or medications administered through the IV. To prevent this, it is important to monitor patients closely and adjust the rate of fluid administration as needed. Incorrect IV fluid concentration and rate choice can lead to life-threatening under- or over-correction of electrolyte abnormalities or acid-base status (e.g., sodium, chloride, potassium, calcium, and lactate).

*(Continued...)*

The benefits of administering fluids usually outweigh the risks, and this intervention can be lifesaving in many cases.

Compared to the published examples of moderate risk, the risks associated with IV access and administering fluids, which require a physician/QHP order, seem consistent with other examples of moderate risks, such as prescription drug management.

## 44. What is needed to satisfy "Drug therapy requiring intensive monitoring for toxicity"? Has CPT® or CMS published examples of qualifying medications?

These are encounters where the patient has been given a medication that has the potential to cause serious morbidity or death and must be monitored for adverse effects.

Monitoring for adverse effects should be a generally accepted practice for the medication and may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. For example, Noridian, the MAC for California, Nevada, and Hawaii (Jurisdiction JE) may require that the documentation contain not only a specific drug name but also the dosage and route.

It is worth noting that just because a patient may be on a medication that is often considered "high risk," does not mean that it always requires monitoring for toxicity, or that the physician/QHP is doing so. It is recommended that documentation explicitly state when a patient is on a drug for which they are being monitored for toxicity.

CPT® has not published a list of "high-risk" medications. The CPT® position is that trained clinicians understand specific patient and drug factors and know when a medication is high risk depending on the patient situation. CPT® expects the physician/QHP to rely on their clinical judgment to determine which medications are at higher risk of morbidity or, in some cases, mortality for a particular patient.

The CMS MAC for Jurisdiction J (Palmetto) has published a list of examples, but many of the medications listed are not typically used in the hospital. Their list can be found here.

## 45. When working with a pharmacist, for example with warfarin or vancomycin dosing, can the physician/QHP receive credit for monitoring for toxicity?

Yes, if the physician/QHP is actively participating in the monitoring for toxicity.

## 46. How are "minor" and "major" surgeries defined?

CPT® believes that physicians/QHPs are best suited to define whether a procedure is minor or major based upon the procedure itself as well as the risk factors pertaining to a specific patient. Ultimately, it is up to the physician/QHP, but would have to be supported by appropriate documentation, particularly if there is some judgment involved. For example, a CABG would always be a major surgery, but procedures such as a laparoscopic cholecystectomy could be minor or major, depending on patient factors.

## 47. Are there examples of emergency major surgery or high-risk procedures performed by hospitalists that qualify as high in the risk column?

CPT® describes emergent procedures as "typically performed immediately or with minimal delay to allow for patient stabilization." Procedures frequently performed by hospitalists that may be considered major surgery or high risk could include but are not limited to:

- Chest Tube Insertion
- Cardioversion
- Endotracheal Tube Insertion
- Lumbar Puncture
- Thoracentesis
- Paracentesis
- Emergent Central Venous Catheterization
- Arterial Catheterization
- Cardiopulmonary Resuscitation (CPR)

## 48. For the high-risk example "Decision regarding emergency major surgery," does the hospitalist/QHP have to perform the procedure, or does it include the hospitalist/QHP referring the patient to the surgeon or admitting the patient for surgery?

It includes both. Regardless of whether the decision is to perform the procedure themselves, refer the patient to a surgeon, or admit the patient for surgery, the risk is determined by the decision that the surgery is necessary. This is supported by CMS MAC references at the following links.

- Noridian
- FCSO

## 49. Does "Decision regarding hospitalization…" only apply when the patient is hospitalized?

Decision regarding hospitalization involves consideration of an escalation of care. This may include escalation from the ED, such as to Observation Services or Inpatient admission, but CPT® clarified that it does not refer to conversion from Observation to Inpatient (CPT® Symposium, November, 2023). Additionally, the determination of risk also includes decision Making when the outcome is to forego further testing, treatment, and/or hospitalization. For example, a decision about hospitalization includes consideration of alternative levels of care. An example would be the decision not to hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment and is sent home. If a hospitalist is called to evaluate an emergency room patient for hospitalization but concludes that they may safely be discharged, for example, this would meet the requirements indicating participating in the decision regarding hospitalization.

This is meant to be a one-time decision to hospitalize and does not count for subsequent days. It also does not apply when discharging patients to a lower or equivalent level care setting as compared to the current acute care setting.

## 50. What counts as escalation of hospital level of care?

Examples of escalation of hospital-level care include initial hospitalization, medically necessary transfer to a telemetry unit or intensive care unit, etc. Escalation of hospital-level care could include transfer to a facility offering medically necessary services such as acute cardiac intervention, if unavailable at your facility. Similar to the decision to admit, the escalation can only apply to the encounter in which the escalation occurred or was documented to be considered. It does not apply when downgrading or discharging to a lower-level care setting, such as a skilled nursing facility.

## 51. Which medications qualify as parenteral controlled substances in the high section of the risk column?

It is not just the medication; it is the medication, the dose(s), and route of administration plus other clinical factors that create risk. Not all patients, for example, with a PRN order for morphine would be considered high risk.

- Parenteral, administered by means other than the alimentary tract.
- Controlled Substance – a schedule II, III, IV, or V drug or other substance.

## 52. Does consideration of a test, treatment, or management option (e.g., admission vs. discharge) not ordered or performed contribute to the complexity of the medical decision making?

Yes, the need to initiate or forego further testing, treatment, and/or hospitalization/escalation in care can be a factor in the complexity of medical decision making. Examples in which the physician/QHP may elect not to order a test, treatment, or management option include but are not limited to a clinician's risk/benefit analysis or use of evidence-based risk calculators, or shared decision making.

## 53. Could the risk associated with using IV contrast for a CT scan be considered high risk in the risk column?

Yes. Using contrast with a CT can be a valuable tool in diagnosing certain conditions; it can cause adverse reactions in some patients. One of the main risks associated with using contrast is an allergic reaction. An allergic reaction can lead to anaphylaxis, a potentially life-threatening condition in severe cases. In addition, the contrast material can be harmful to the kidneys, especially in patients with pre-existing kidney problems. In certain cases, this can lead to contrast-induced nephropathy, which can cause kidney damage and even kidney failure in some cases.

The additional risk that IV contrast adds to a CT scan is evidenced by the American College of Radiology (ACR) requirement that a physician or PA/NP trained in and capable of managing an acute hypersensitivity reaction provide direct supervision of intravenous contrast administration. The provider of direct supervision must be immediately available to furnish assistance and direction throughout the performance of the procedure. While this does not mean that the supervising provider or radiologist must be present in the room where and when the procedure is performed, there should be at least one person who can recognize adverse events related to contrast media administration in attendance (in the room or in an adjacent control room) to observe the patient during and immediately after the injection and summon medical assistance as needed.

Due to the higher risk associated with a CT with contrast, considering these as a high-risk management decision may be appropriate.

## 54. Could the use of physical restraints or placing a patient under watch (e.g., Line of Sight Observation or equivalent) for patients with altered awareness, mental status changes, agitation, or other behavioral issues be considered high risk in the MDM grid?

Yes, using physical restraints for patients in the hospital can pose several risks.

- Physical injury: Patients may injure themselves while struggling against the restraints, leading to bruises, cuts, urethral trauma from forcefully removed Foley catheters, or even broken bones.
- Psychological trauma: Being restrained can be a traumatic experience for patients, especially those already vulnerable due to their mental health condition. This trauma can lead to long-lasting psychological effects.
- Respiratory compromise: Restrained patients may experience difficulty breathing, especially if the restraints are too tight or in a position that restricts their breathing.
- Circulatory compromise: Patients restrained for extended periods may experience decreased blood flow to certain body areas, which can lead to serious medical complications.

While physical restraints may be necessary in certain situations, their use is limited to extraordinary situations. The decision to restrain a patient is not taken lightly and should be considered a high-risk patient management option.

Similarly, placing a patient under "security watch" or equivalent can be poorly perceived by the patient and cause a significant behavioral decompensation which may manifest as increased agitation and aggressive behavior toward the hospital staff, themselves, or others.

## 55. Could anticoagulant therapy initiated in the hospital or ED (e.g., warfarin, enoxaparin, therapeutic dose heparin) or direct-acting oral anticoagulants (DOACs) qualify as a high-risk management decision on the MDM table?

Yes, initiating enoxaparin, heparin, DOACs, or other anticoagulant medication to treat patients with conditions such as deep vein thrombosis, atrial fibrillation, pulmonary embolism, stroke, or other conditions that require immediate anticoagulation is a high-risk management decision.

These medications can increase the risk of bleeding and other life-threatening side effects. The risk is particularly high in patients with a history of bleeding disorders or those taking other medications, such as aspirin or nonsteroidal anti-inflammatory drugs. These drugs also have significant drug-drug interactions, further adding to their management complexity and risk.