COFFEE & CODING

Monday, December 9, 2024

The Challenge of Documentation for Prescription Drug Management

Prescription drug management documentation continues to be a hot topic. It's a major reason why Medicare and other payors have been down-coding E/M services. And to better understand why that is happening, we need to examine a question posed during an American Medical Association webinar about 2023 E/M coding updates:

Here's the question:

> "Related to MDM: It was discussed and understood that it was intended for clinical judgment by clinicians. [The] problem is, coders/auditors/coding educators are trying to use the tool for consistency. We need a way to insightfully apply the guidelines. Please elaborate on what constitutes Prescription Drug Management—is it enough to simply review a medication list, [or] does there need to be management of the condition, etc.? Also, does a provider stating, "There is a moderate risk for an over-the-counter medication" [include] enough to justify a moderate level of risk re: patient management?

And here is the AMA's response:

> There is no "blanket" guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed, including medicine management, (prescription or OTC), based on a specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on an anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management. The E/M workgroup will continue to monitor questions and consider clarifications and education to refine the guidance.

And now here's our assessment:

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of an E/M visit. There is a mindset that because it says prescription (Rx) management, if a provider prescribes, then the risk level qualifies as moderate.

Physicians and QHPs need to adjust their documentation to include the medication risk for the patient based on the “probability and/or consequences of an event.” They need to specify:

- What are the risks to the patient?
- Is the prescription something that could be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?

The guidelines for risk state, “Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification.”

- Document using the terms minimal, low, moderate, or high to correlate the risk of PDM.

The takeaway:

Documenting fully is the best strategy for ensuring providers receive payment for all the prescription drug management services they provide.

Got a question about E/M coding? We’d love to hear from you.
Submit your questions by emailing us at coders@calmwatersai.com!

Angela Jordan
CPC, CPMS, COBGC
Executive Vice President, ChartPal/Education