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Webinar

Medical Decision Making (MDM) Training

Based on 2023 Guidelines

Updated June 2023

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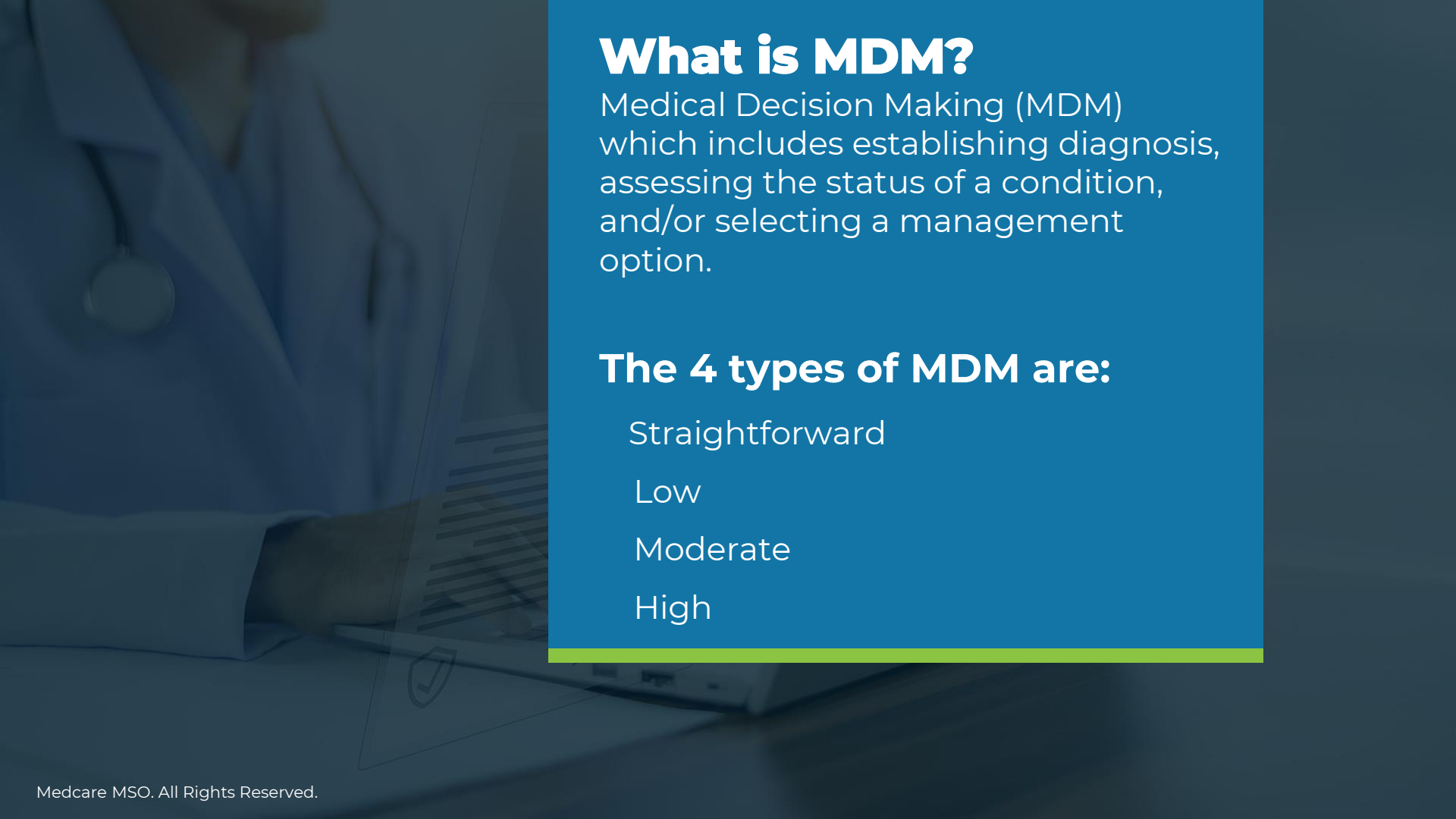


What is MDM?

Medical Decision Making (MDM) which includes establishing diagnosis, assessing the status of a condition, and/or selecting a management option.

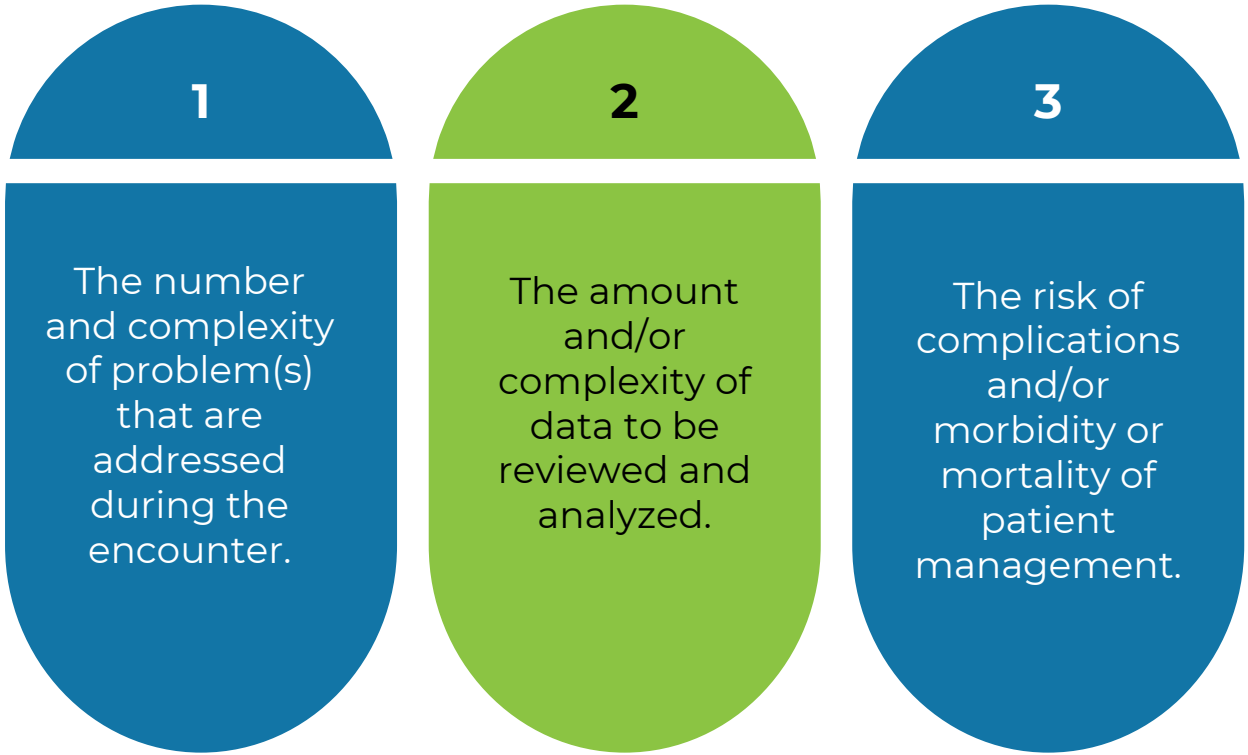
The 4 types of MDM are:

- Straightforward
- Low
- Moderate
- High

Medical Decision Making (MDM) Leveling Chart

Must meet or exceed 2 of 3 Medical Decision Making (MDM) Components to meet level of service.				
Updated: Feb 2021	99202 / 99212	99203 / 99213	99204 / 99214	99205 / 99215
MDM level	Straightforward	Low	Moderate	High
Number and Complexity of Problems Addressed	Minimal	Low	Moderate	High
Amount or Complexity of Data Reviewed and Analyzed	Minimal or None	Limited	Moderate	Extensive
Risk of Complications and/or Morbidity or Mortality	Minimal Risk	Low Risk	Moderate Risk	High Risk

MDM is defined by 3 elements:



Difference between Mortality And Morbidity

Mortality

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.

Morbidity

The state of being subject to death and/or the number of deaths that occur in a population.

1. Number & Complexity of Problems Addressed at the Encounter

Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

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.

The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Note:
The term "risk" as used in these definitions relates to risk from the condition.

While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

What is a problem? What does it mean to address a problem?

A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or QHP reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefits analysis or patient/parent/guardian/surrogate choice.

Additional Rules regarding problem addressed documentation:

Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or QHP reporting the service.

Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or QHP reporting the service.

For Hospital inpatient an observation care services the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or QHP and may not be the cause of admission or continued stay.

Types of Problems as defined in this element by the AMA

- **Minimal problem:** A problem that may not require the presence of the physician or QHP, but the service is provided under the physician's or other QHP's supervision. (E.g. 99211, 99281)

- **Self-limited or minor problem:** A problem that runs a definite and prescribed course, it 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 poor 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

Acute, uncomplicated illness or injury:

A recent or new short-term problem with 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 specific 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 observational setting.

Additional Problems

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.

Additional Problems

Acute illness with systemic symptoms:

An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms. Systemic symptoms may not be general but may be single system.

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.

Additional Problems

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 may have significant risk of morbidity and may require escalation in 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 severity.

2. The amount and/or complexity of data to be reviewed and analyzed.

These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.

Ordering a test is included in the category of test results(s) and the review of the test result is part of the encounter and not a subsequent encounter.

This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately.

Ordering a test may include those considered but not selected after shared decision making.

For Example:

These considerations must be documented

A patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a new test may normally be performed, but due to the risk for a specific patient it is not ordered.

Element #2
Data are divided into three categories:

Test, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)

Independent Interpretation of tests (not separately reported).

Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it was analyzed.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Tests: are imagining, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., BMP [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Unique:

is defined by the CPT code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count.

Unique Source:

A unique source is defined as a physician or other QHP is a distinct group or different specialty or subspecialty, or unique entity. Review of all materials from any unique source counts as one element toward MDM.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Combination of Data Elements:

A combination of different data elements. For example, a combination of notes reviewed, tests ordered, test reviewed, or 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.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

External:

External records, communications and/or test results from an external physician or other QHP, facility, or health care organization.

External physician or other QHP:

An external physician or other QHP who is not in the same group practice or is of a different specialty or subspeciality. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health agency.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Discussion: requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person) but it must be initiated and completed within a short time period (e.g., within a day or two).

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Independent historian(s)

An individual (e.g. parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g. due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case when there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. **It does not include translation services.** The independent historian does not need to be obtained in person but does need to be obtained directly from the historian providing independent information.

Terms for Amount and/or Complexity of Data to be Reviewed and Analyzed

Independent interpretation:

The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other QHP who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source:

Includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

3. The risk of complications and/or morbidity or mortality of patient management.

This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s).

This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family.

For example, a decision about hospitalization includes consideration of alternative levels of care. **Examples** may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

What does Shared decision-making mean?

involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Note: MDM may be impacted by role and management responsibilities:

When the physician or QHP is reporting separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or QHP is reporting a separate service for discussion of management with a physician or QHP the discussion is not counted toward the MDM when selecting a level of E/M services.

To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Terms for Risk of complications and/or morbidity or mortality of patient management

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. **For example**, a low probability of death may be high risk, whereas a high change of a minor, self-limited adverse effect of treatment may be a low risk. ***Definitions of risk*** are based upon the usual behavior and thought processes of a physician or other QHP in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (although quantification may be provided when evidence-based medicine has established probabilities). **For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.** Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other QHP as part of the reported encounter.

Terms for Risk of complications and/or morbidity or mortality of patient management

Social determinates of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery – Minor or Major: the classification of surgery into minor or major is based on the common meaning of such terms when used by training clinicians, like the use of the term “risk”. These terms are not defined by a surgical package classification.

Terms for Risk of complications and/or morbidity or mortality of patient management

Surgery – Risk Factors, Patient or Procedure	Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient procedure risk.
Surgery – Elective or Emergency	Elective procedures, emergent, urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. **An elective procedure is typically planned in advance** (e.g., scheduled for weeks later), while an **emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization**. Both elective and emergent procedures may be minor or major procedures.

Drug Therapy requiring intensive monitoring for toxicity:

A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.

They are drugs that have a narrow therapeutic window, and a low therapeutic index may exhibit toxicity at concentrations close to the upper limit of the therapeutic range and may require intensive clinical monitoring.

Drug Therapy requiring intensive monitoring for toxicity:

1. Therapeutic agent that has the potential to cause serious morbidity or death.
2. Monitoring is performed for assessment of adverse effects and not primarily for assessment of therapeutic efficacy.
3. May be patient-specific in some cases.
4. Long term or short term.
5. Not less than quarterly.
6. Lab test, physiologic test or imaging.
7. History and exam does not qualify.
8. Cytotoxic Chemotherapy treatment.

9. This table is a list of example drugs that are approved for monitoring for toxicity - when used for the specific treatment listed (This is not an all-inclusive list).

Drug Category	Drugs in the Category	Treatment Use
Cardiac	Digoxin, Digitoxin, Quinidine, Procainamide, Amiodarone	Congestive heart failure, angina, arrhythmias
Anticoagulants	Coumadin and Intravenous Heparin dip (Heparin must be provided in the hospital setting)	Prevention of Thrombosis and thromboembolisms
Antiepileptic	Phenobarbital, Phenytoin, Valproic Acid, Carbamazepine, Ethosuximide, sometimes Gabapentin, Lamotrigine	Epilepsy, prevention of seizures, sometimes to stabalize moods
Bronchodilators	Theophylline, Caffeine	Asthma, COPD, neonatal apnea
Immunosuppressant	Cyclosporine, Tacrolimus, Sirolimus, Mycophenolate Mofetil, Azathioprine	Prevent rejection of transplanted organs, autoimmune disorders
Anti-Cancer	All Cytotoxic agents	Multiple malignancies
Psychiatric	Lithium, Valproic Acid, some antidepressants (Imipramine, Amitriptyline, Nortriptyline, Doxepin, Desipramine	Bipolar disorder (manic depression), depression
Protease Inhibitors	Indinavir, Ritonavir, Lopinavir, Saquinavir, Atazanavir, Nelfinavir	HIV / AIDS
Antibiotics	Aminoglycosides (Gentamicin, Tobramycin, Amikacin) Vancomycin, Chloramphenicol, Cubicin, Zyvox	Infections with bacteria that are resistant to less toxic antibiotics
Insulin/Anti Diabetic	Intravenous Insulin Drip	Hyperglycemia
Erythropoiesis Stimulating Agents (ESA)	Procrit and Epogen (Epoetin Alfa) and Aranesp (Darbepoetin Alfa)	Anemia

Long-term intensive monitoring is not performed less than quarterly.

The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient

An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles.

Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annal electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Time Associated with the Encounter

(*Time spent on activities normally performed by clinical staff is not counted)	
Documentation must include TOTAL TIME SPENT ON DATE OF SERVICE to meet criteria for the level of service. Only the time of one individual is counted when the visit is shared between physician/other qualified healthcare provider.	
• Preparing to see the patient (e.g. review of tests).	• Ordering medications, tests, or procedures.
• Obtaining and/or reviewing separately obtained history.	• Independently interpreting results (when not separately reported).
• Performing a medically appropriate history, exam, and/or evaluation.	• Communicating results to the patient/ family/ caregiver
• Counseling and educating the patient/ family/ caregiver.	• Care coordination (when not separately reported)
• Documenting clinical information in the electronic or other health record.	• Referring and communicating with other healthcare record providers (when not separately reported)
**** All visits require a medically appropriate history and/or exam****	

Time Breakdown New Patient E/M

New Pt Code	Req Time	(+)99415	(+)99416 Start Time
99202	15-29 Min	59-103 Min	104 Min
99203	30-44 Min	64-108 Min	109 Min
99204	45-59 Min	71-115 Min	116 Min
99205	60-74 Min	76-120 Min	121 Min
		Direct F2F Time Only	
(+) 99417	< 75 Min	Not Eligible	
	75-89 Min	99417 x1	
	90-104 Min	99417 x2	
	105 Min >	99417 x3	
		Units go up each 15 min	

Time Breakdown Est Patient E/M

EST PT CODE	REQ TIME	(+)99415	(+)99416 START TIME
99212	10-19 Min	54-98 Min	99 Min
99213	20-29 Min	57-101 Min	102 Min
99214	30-39 Min	70-114 Min	115 Min
99215	40-54 Min	75-119 Min	120 Min
		Direct F2F Time Only	
(+) 99417	< 55 Min	Not Eligible	
	55-69 Min	99417 x1	
	70-84 Min	99417 x2	
	85 Min >	99417 x3	
		Units go up each 15 min	

Time Breakdown Home E/M Visits

Home New Pt Code	Req Time	Home Est Pt Code	Req Time
99341	15 Min or More	99347	20 Min or More
99342	30 Min or More	99348	30 Min or More
99344	60 Min or More	99349	40 Min or More
99345	75 Min or More	99350	60 Min or More
NP services >90 min +99417		EP services >75 min +99417	

MDM Leveling Chart Review

Must meet or exceed 2 of 3 Medical Decision Making (MDM) Components to meet level of service.				
Updated: Feb 2021	99202 / 99212	99203 / 99213	99204 / 99214	99205 / 99215
MDM level	Straightforward	Low	Moderate	High
Number and Complexity of Problems Addressed	Minimal	Low	Moderate	High
Amount or Complexity of Data Reviewed and Analyzed	Minimal or None	Limited	Moderate	Extensive
Risk of Complications and/or Morbidity or Mortality	Minimal Risk	Low Risk	Moderate Risk	High Risk

Level of MDM (Based on 2 out of 3 Elements of MDM)				
Updated:	Jun-23	**Elements of MDM**		
Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and/or Morbidity or Mortality of Patient Management
99202 (15-29 Min) 99212 (10-19 Min)	See Below	• 1 self-limited or minor problem	• Minimal or none	• Minimal risk of morbidity from additional diagnostic testing/treatment
"	**Straightforward MDM**	**Minimal**	**Minimal or Low**	**Minimal Risk**
99203 (30-44 Min) 99213 (20-29 Min)	See Below	• 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury	**Category 1:** Tests and Documents *Any combination of 2 from the following: •Review of prior external note(s) form each unique source •Review of the result(s) of each unique test •Ordering of each unique test **OR** **Category 2:** Assessment requiring an independent historian(s) *i.e., parent, guardian, spouse, etc). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	• Low Risk of morbidity from additional diagnostic testing or treatment
"	**Low MDM**	**Low**	**Limited (Must meet at least 1 of the 2 categories above:)**	**Low Risk**

Level of MDM (Based on 2 out of 3 Elements of MDM)				
Updated:	Jun-23	**Elements of MDM**		
Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and/or Morbidity or Mortality of Patient Management
99204 (45-59 Min) 99214 (30-39 Min)	See Below	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment OR • 2 or more stable chronic illnesses OR • 1 undiagnosed new problem with uncertain prognosis OR • 1 acute illness with systemic symptoms OR • 1 acute complicated injury	**Category 1:** Tests, Documents, or Independent historian(s) *Any combination of 3 from the following: •Review of prior external note(s) form each unique source •Review of the result(s) of each unique test •Ordering of each unique test •Assessment requiring an independent historian(s) *i.e., parent, guardian, spouse, etc). **OR** **Category 2**: Independent Interpretation of tests • Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported). **OR** **Category 3**: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separetly reported)	**Examples**: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risks factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinations of health
"	**Moderate MDM**	**Moderate**	**Moderate (Must meet at least 1 of the 3 categories above:)**	**Moderate Risk (of morbidity from additional diagnostic testing or treatment)**

Level of MDM (Based on 2 out of 3 Elements of MDM)

Updated:	Jun-23	**Elements of MDM**		
Code	Level of MDM	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and/or Morbidity or Mortality of Patient Management
99205 (60-74 Min) 99215 (40-54 Min)	See Below	• 1 or more chronic illnesses with severe exacerbation/progression, or side effects of treatment OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Category 1:** Tests, Documents, or Independent historian(s) *Any combination of 3 from the following: •Review of prior external note(s) form each unique source •Review of the result(s) of each unique test •Ordering of each unique test •Assessment requiring an independent historian(s) *i.e., parent, guardian, spouse, etc). **OR** **Category 2:** Independent Interpretation of tests • Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported). **OR** **Category 3**: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Examples:** • Drug therapy requiring intensive monitoring for toxicity • Decision regarding major surgery with identified patient or procedure risks factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis
"	**High MDM**	**High**	**Extensive (Must meet at least 2 out of 3 categories above:)**	**High Risk (of morbidity from additional diagnostic testing or treatment)**

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THANK YOU!

Empower your clinical decisions with our evidence-based strategies.

Take the next step towards optimal healthcare management - Connect with us today!

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Any Questions?