CHAPTER 3 – UNDERSTANDING EVALUATION AND MANAGEMENT (E/M) CODES

CPT codes can be practically divided into 2 groups: E/M service codes and the rest (anesthesia, surgery, radiology, pathology/lab, medicine). CPT codes in the second group are only used by a subset of providers. Codes under urology are mostly used by urologists; the code for C-section is exclusively used by obstetricians. In contrast, codes under the E/M section are used daily by all physicians, and this group therefore contains the most commonly used CPT codes. Given their frequent use, these codes are of utmost importance.

E/M service codes typically exist in groups or code sets based on their usage setting. There are code sets for office, ER, hospital floor, and ICU care. Although there are many E/M codes, most physicians need to learn only a handful to report their services.

For practical use, E/M codes can be grouped into MDM based codes and others. Most MDM-based codes also based on time, but we'll refer to them simply as MDM based codes for simplicity. MDM reflects patient complexity: higher MDM means a more complex or sicker patient. These codes have strict rules; you must meet all requirements before using them.

1- MDM-based E/M codes

This group is composed of codes for office, hospital, consult, and ER services.

Let's take a look at CPT code 99213 to better understand an MDM-based code.

99213: *office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*

This is an MDM-based code because a certain level of MDM was required for its use. The CPT code book has 9 pages that explain the terms used in these codes, including MDM.

Starting in 2022-2023, these codes were significantly simplified to reduce documentation burden. ***Currently, these codes share the same basic structure.*** One example is given for each group.

Office or other outpatient services

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215

99211 differs from the rest of the office codes and is not an MDM-based code. (*99211: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).* There used to be 99201, similar to 99211, but it was deleted several years ago. The rest of the code set is MDM-based. An example of an office code (99213) is given above.

Hospital inpatient and observation care services

Initial	99221	99222	99223
Subsequent	99231	99232	99233

All the codes in this code set are MDM-based. An example of a hospital code is given below.

99233: *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.*

Consultations

Office/Outpatient- ER	99242	99243	99244	99245
Inpatient/Observation	99252	99253	99254	99255

All the codes in this code set are MDM-based. An example of a consultation code is given below.

99253: In patient or observation consultation for a new or established patient*, which requires a medically appropriate history and/or examination and low level medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*

Emergency department services

ED services	**99281**	**9982**	**99283**	**99284**	**99285**

99281 differs from the rest of the ER codes and is not an MDM-based code. 99281: Emergency department visit *for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional.* The rest of the code set is MDM-based. An example of an MDM-based ED code is given below.

99284: Emergency department visit *for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level medical decision making.*

These MDM based codes share certain common features.

Place: *specifies the setting for the code: office/other outpatient, hospital inpatient/observation, emergency department*

Usage frequency: *specifies how often a code can be used: per visit, per day. Hospital code 99233 can be used only once per day because the code descriptor states "per day."*

Patient type: *new or established patient. This distinction only applies to office patients. A new patient, as defined by CPT, is a patient who has not been seen by the provider in the last 3 years.*

Care type: *initial or subsequent. Only used in hospital setting.*

A Common similar sentence: *for the evaluation and management of a patient, which requires a medically appropriate history and/or examination*

MDM level: *straightforward, low, moderate, high*

Time/Total time: *required time, only when time is used for code selection. Time is not included in ER codes.*

Except for 99211 and 99281, within each subgroup, the wording of the codes is identical, except for the level of MDM and time. For example, the only difference among the codes 99212-99213-99214-99215 is the level of MDM and the specified time; the rest is exactly the same. For simplicity, some providers

refer to these codes as levels. For example, codes 99212-99213-99214-99215 are called level-2, level-3, level-4, level-5 respectively. The selection of an appropriate level is complex and at times may be a challenge, which will be covered in the coming sections.

There used to be very strict criteria on the required level of history or examination. Because these requirements were a significant burden to clinicians' daily workload, they were removed in 2022/2023. Now, there is no requirement for how much history or examination needs to be documented. Whatever the physician considers medically appropriate is enough. Your claim will not be denied because you haven't documented a specific number of examination or history findings.

2-Non-MDM-based E/M Codes – The rest

The codes in this group are not as complex as MDM-based codes and do not have strict requirements. Examples of the most commonly used non-MDM-based E/M service codes are given below and include preventative care (well child check, WCC), normal newborn care, hospital discharge care, delivery room attendance, and resuscitation care codes. A higher level in well child check code set does not imply a higher level of care or more time, but only means older age group.

Preventative Care/WCC – New Patient	99381	99382	99383	99384
Preventative Care/WCC – Established Patient	99391	99392	99393	99394

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Normal newborn care codes	99460	99461	99462	99463

99238: *Hospital inpatient or observation discharge day management. 30 minutes or less on the day of the encounter.*

99391: *Periodic comprehensive preventative medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, infant (age younger than 1 year)*

99460: *initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant.*

Please note that no MDM level was specified in the above codes; hence, these are non-MDM-based codes with less strict usage requirements. This distinction is important because code selection and medical documentation differ from MDM-based codes. Unlike MDM-based codes, selecting non-DMD codes is a very simple and straightforward process, such as selecting well-child check codes based on patient age alone.

3- RELEVANT E/M SERVICE CODE SETS FOR INDIVIDUAL PHYSICIANS

Most physicians only need to learn a handful of codes, not more. For example, an outpatient physician will never use inpatient codes in the office, and a hospitalist will never use office codes while practicing inpatient. So, although there are thousands of CPT codes, for any given physician, only a handful are relevant, and the rest are irrelevant. This makes learning these codes much easier.

Most commonly used office, outpatient E/M service codes

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215
Consult - Office	-	99242	99243	99244	99245

Preventative Care/WCC – New Patient	99381	99382	99383	99384
Preventative Care/WCC – Established Patient	99391	99392	99393	99394

Most commonly used inpatient E/M service codes

Initial admission	99221	99222	99223
Subsequent day	99231	99232	99233
Same day	99234	99235	99236

Consult ER	99242	99243	99244	99245
Consult Inpatient/Observation	99252	99253	99254	99255

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Critical care codes –Time based/Adult	99291		99292	
Critical care codes – day based/Pediatric	99471	99472	99475	99476
Critical care codes – day based/Neonatal	99468		99469	

Neonatal intensive care codes	99477	99478	99479	99480

Normal newborn care codes	99460	99461	99462	99463

4-SELECTION OF MDM-BASED E/M CODES

Because MDM based codes come in different levels, one may ask how the appropriate level is selected. This question is important because the higher the level, the more the reimbursement. MDM-based codes can be selected in 2 ways. The first one is MDM-based, and the second is time based. Each of these codes contains a specific level of MDM and a specific amount of time. The only thing you need to do then is to align your patients' MDM level or total time spent with the patient with the appropriate code that matches it.

Code Set	CPT code	Code level	Time	MDM level
Office New Patient	99202	Level 2	15 minutes	Straightforward
	99203	Level 3	30 minutes	low
	99204	Level 4	45 minutes	Moderate
	99205	Level 5	60 minutes	High
Office Established	99212	Level 2	10 minutes	Straightforward
	99213	Level 3	20 minutes	low
	99214	Level 4	30 minutes	Moderate
	99215	Level 5	40 minutes	High
Office Consult	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	low
	99244	Level 4	40 minutes	moderate
	99245	Level 5	55 minutes	High

Code Set	CPT code	Code Level	Time	MDM level
Hospital Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Hospital Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Hospital Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Example: for an established patient in the office, if the MDM level for that patient is low, then the appropriate code to choose for billing is 99213. This exemplifies MDM-based code selection. For another established patient in the office: If you provided 40 minutes of care, then you can select the highest level, 99215, irrespective of MDM. This exemplifies time-based code selection.

It is clear that an MDM-based code can be selected via 2 different pathways. The question then arises, which pathway should I choose? Is one pathway better than the other? Answer is "it depends"! Use the pathway that will get you the highest level. For example, if you saw an established patient in the office with a simple URI, then this kind of patient typically qualifies for straightforward MDM, so you can only bill level 2 (99212). Now imagine a situation where the mother asked you too many questions about viral illnesses and how to manage them, and you spent a lot of time educating the mother about childhood viral illnesses and how to prevent or manage them, and you ended up spending 40 minutes of total time. If this is the case, you should bill the highest level of 5 based on time, although, based on complexity or MDM, the patient only qualifies for level 2.

On the hospital side, a similar example may be subsequent day care for a bronchiolitis/reactive airway patient who is doing well and improving. This patient typically qualifies for low level MDM, hence level 1 (99231), but if you provide asthma education for 50 minutes, then you can select the highest code level of 99233.

On the other hand, if you admit a patient with severe asthma exacerbation, which typically qualifies for high MDM, then even if you have spent only 30 minutes with the patient, you can still select the highest level of code, 99223, based on the MDM pathway. In this example, if you base your code selection on time, you can only get the lowest level of 99221.

5-TOTAL TIME – DETAILED EXPLANATION

Prior to 2022/2023, you could only base code selection on time when the dominant part of the service was counseling and coordination of care. This is why old attestations universally stated "***more than 50% of my time spent in counseling and coordination of care***." Furthermore, only the time spent in the room, face-to-face with the patient, counted, not your 20-minute chart review before seeing the patient. It all changed in 2022/2023: now almost everything you do for patient care counts toward the total time, and you can base code selection on time at any time you like, regardless of counseling and coordination of care, so you no longer need the old attestation. You don't need to be on the patient's floor or office for the time to count.

1. Preparing to see the patient: **chart review, review of tests**.
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.

7. **Coordination** of care.

8. **Documenting** clinical information in the electronic or other health record ~ **writing notes.**

9. Independently **interpreting results** and communicating results to the patient/family.

Do not count time spent on the following: Performance of other services that are reported separately with another CPT code. Example: providing procedural sedation and billing an E/M service code such as 99233 on the same day. Because procedural sedation is reported with another CPT code, time spent on procedural sedation is not counted toward the total time for the code 99233. Do not also count the time spent on teaching that is general and not limited to the discussion that is required for the management of a specific patient.

The definition of time for critical care differs slightly from that for the rest of the E/M service codes. To deliver critical care, you should be immediately available to the patient. The practical result of this requirement is that when you are off the patient's floor, you cannot deliver critical care. If you are a hospitalist, you can count 30 minutes spent in the radiology department looking at MRI results with a radiologist, but the same thing doesn't count toward critical care time because you are not immediately available to the patient unless radiology happens to be next door to the ICU or you look at the MRI with the radiologist in the ICU. Another difference is that daily updates or time spent with caregivers do not count toward critical care unless these discussions affect evaluation and management. Apart from these 2 exceptions, everything you do for a patient also counts toward critical care time, as long as you are immediately available to the patient.

6- MEDICAL DECISION MAKING (MDM) - DETAILED EXPLANATION

MDM is an objective way to describe or report how complex or sick a patient is. The sicker or more complex the patient, the higher the MDM. CPT describes 4 different levels of MDM. Each level has strict requirements. **Understanding and choosing among different levels of MDM is the most complex billing topic.** The following is the detailed description of what exactly each level of MDM means.

MDM has 3 elements shown in table below. For simplicity, we use short names: problems, data, and risk.

	ELEMENTS OF MDM
Problems	Number and Complexity of **Problems** Addressed at the Encounter
Data	Amount and/or Complexity of **Data** to Be Reviewed and Analyzed
Risk	**Risk** of Complications and/or Morbidity or Mortality of Patient Management

Based on the complexity of its elements, MDM has 4 different levels: straightforward, low, moderate, and high. Accordingly, each element also has 4 levels, as shown in the table below. For instance, high-level MDM includes high acuity problems, extensive data, and high risk.

An important thing to know is that only 2 of 3 elements are required to qualify for a given MDM level. It is also important to note that any combination of 2 elements is enough. You do not need all 3 lined up. If the data element does not qualify for a given MDM level, you can still get to that MDM level by using risk and problems. If the problem element does not reach a certain MDM level, you can still get

that level by using data and risk elements. If the risk element does not reach a certain MDM level, you can still get that MDM level by using problem and data element.

Elements of MDM			
	Problems	**Data**	**Risk**
Straightforward MDM	Minimal	Minimal to none	Minimal
Low level MDM	Limited	Limited	Low
Moderate level MDM	Moderate	Moderate	Moderate
High level MDM	High	Extensive	High

Definition or explanations of the terms and conditions that are used to describe each element was given in the tables below. A clear understanding of these terms/conditions is very important in selecting the appropriate level of MDM.

CONDITIONS LISTED UNDER PROBLEMS – CPT DEFINITIONS *(in italic)*
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.* Examples: Simple URI, diaper rash, mosquito bite.
Stable, chronic illness *A problem with an expected duration of at least one year or until the death of the patient. A patient who is not at his or her 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.* Any chronic condition that is at target or goal management endpoints. Examples: well-controlled hypertension, diabetes, eczema, asthma. If the patient is not at the target or goal, it is classified as unstable, even if the status is long standing.
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 definite and prescribed course is an acute, uncomplicated illness.* The distinction between a self-limited or minor problem and an acute, uncomplicated illness or injury is not always clear cut. Any self-limited or minor problem that is not resolving as expected or not responding to treatment automatically becomes an acute, uncomplicated illness or injury. For example, a common cold that has not resolved after a week, for which you suspect a bacterial superinfection, may be considered an acute, uncomplicated illness. Unlike the common cold, an uncomplicated influenza infection may be considered in this group as well. Other examples: cystitis, allergic rhinitis, sinusitis, simple ankle sprain.
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. Example: UTI requiring hospital admission for IV antibiotic.
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.* Example: UTI improving but not resolved on antibiotic.
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.* Any chronic illness that is not in goal control range: poorly or not adequately controlled diabetes. Any chronic illness that is worsening or progressing: asthma exacerbation.
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.* Example: a patient with pancytopenia of unclear etiology.
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, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system.* Examples: pneumonia, pyelonephritis.
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. Examples: head injury with loss of consciousness
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 level of care.* Example: severe asthma or congestive heart failure exacerbation
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.* Examples: severe anaphylaxis, septic shock

Having one subheading in the problem section is good enough to meet the requirement for that level.

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. As an example, a patient with hypertension, diabetes and hypothyroidism. Hypothyroidism does not count in MDM selection as long as it is not addressed or its presence affects the medical decision making. Take home message: The mere presence of multiple conditions does not automatically make a patient complex unless these problems are addressed or affect decision making.

ELEMENTS OF DATA – CPT DEFINITIONS *(in italic)*
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 (eg, 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 is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.* No double counting/dipping: If you order a CBC in an encounter and subsequently review the CBC result during the same encounter, this cannot be counted as two elements—one for ordering and one for reviewing. It must be counted as a single unit. You can't also count a test if you report it with a CPT code. If you run a urine analysis in your office, you cannot count either the order or the review of the UA, as you will request reimbursement for UA with a specific CPT code.
Minimal or none Minimal or no data. Self-explanatory, no explanations were given by CPT. Only used in straightforward MDM.
Ordering of each unique test ***Test:*** *Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test.* ***Unique****: A unique test is defined by the CPT code set. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes.*
Review of the result(s) of each unique test Order and review of a test considered as one unit. Typically, this element applies when you review a test result from a standing/recurring order outside the encounter, or when you review a test result ordered by other providers.
Review of prior external note(s) from each unique source ***External:*** *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. 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 care agency.*
A unique source *is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM*

Other than physician assistants and advanced nurse practitioners, there is no universally accepted list of who is included in the term 'qualified health care professional'. It is basically a trained and licensed healthcare worker who can report healthcare services independently of physicians, and also includes physical therapists, dietitians, clinical social workers, pharmacists, respiratory therapists, but not nurses. So, if you review a note from a nurse practitioner or dietitian that counts, but reviewing a note from a nurse does not count.
For example, for a pediatric hospitalist, any other specialty, such as surgery, ER, or another pediatric subspecialty, is an external source, even within the same hospital or department. Only notes considered internal would be those from the physicians within the same hospitalist group. So if you are a pediatric hospitalist and review the ER resident note, then that counts.

Assessment requiring an independent historian(s)

Independent historian(s): *An individual (eg, 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 (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.*
For pediatrics, we almost always use independent historians. So this element is almost always automatically checked.

Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

Independent interpretation is described by CPT as "The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test."
If you look at a CXR yourself and document what you see, that counts; but if you copy paste a radiologist's note or never interpret the CXR yourself and rely only on the CXR report, that does not count. You should document this in your note as "My independent interpretation of CXR: ……..or I personally reviewed the EKG, which shows…."

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

Discussion: *Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.*
Appropriate source: *For the purpose of the discussion of management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregiver.*

Examples: Discussion of MRI findings on the phone with radiologist or pathology findings with pathologist. Management discussions with any other consulting services/physicians. Discharge planning discussions with a case manager.

Data element is the most regulated or demanding element of MDM.

RISK ELEMENT- CPT DEFINITION

*One element used in selecting the level of service is the **risk of complications and/or morbidity or mortality of patient management** at an encounter. This is distinct from the risk of the condition itself.*

***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 chance of a minor, self-limited adverse effect of treatment may be low risk. 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. **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.** For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.*

Based on the above definition, the risk element is about the complications, morbidity, and mortality from our interventions (or lack of interventions), not necessarily the risk of the condition itself.

Unlike problem or data element, there is no quantification of risk element. It has no subheadings. Some conditions were listed only as an example. This is the least regulated element of MDM, and appropriate level selection is largely left to physicians, as described above.

Examples

■ ***Prescription drug management.***

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of a service. Simply listing current medications is not considered prescription drug management. At its core, this element just requires documentation from the provider stating that the medication was evaluated for the patient's condition. This may involve discussions on efficiency, tolerance, side effects, etc.

• Starting, stopping, modifying, refilling, or deciding to continue a prescription medication and documenting your thought process are all included in prescription drug management. "*stable hypertension, continue valsartan 10 milligrams, will refill for 4 months until the next follow up visit." is enough documentation.* Just listing the medication is not enough. This risk even applies when a prescription medication is considered but not started yet, or not started based on patient preferences. Documentation of the thought process is all that is needed.

Although this risk category typically applies to prescribed medications, Over the counter medications may also be included. An example may be the use of NSAIDs in a patient with chronic kidney disease. NSAIDs may have significant side effects in this patient and may count toward the risk, as long as clear documentation is made in the chart about the rationale of usage or avoidance of these agents.

■ ***Diagnosis or treatment significantly limited by social determinants of health***
Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. This is when patients' lack of finances, insurance, food, housing, etc., affects your ability to diagnose, manage, and care for them as you normally would.*

■ ***Drug therapy requiring intensive monitoring for toxicity.***
This term is self-explanatory. A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed to assess these adverse effects, not primarily to assess therapeutic efficacy. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. Example, monitoring CBC for cytopenia during chemotherapy. Another example would be vancomycin levels.

■ ***Decision regarding hospitalization or escalation of hospital-level care.***
Self-explanatory. Anytime you are admitting a patient from ER or sending a patient from floor to ICU.

■ ***Decision not to resuscitate or to deescalate care because of poor prognosis.***
Self-explanatory.

■ ***Parenteral controlled substances***
Self-explanatory. Include iv opioids, iv benzodiazepines or any other iv controlled substance.

Now that we are comfortable with terminology, let's take a detailed look at each MDM level.

Straightforward is the first and simplest level of MDM.

Straightforward MDM	**Problems**	Minimal • 1 self-limited or minor problem
	Data	Minimal or none
	Risk	Minimal risk of morbidity from additional diagnostic testing or treatment

Examples of straightforward MDM are a simple URI, mild diaper rash, or clean bug bite. All of these conditions involve **only one** self-limited or minor problem. There are typically no prior notes from an external source to review, no tests to order or review, and the risk is minimal. If you obtain the history from a parent, then data elements qualify for one higher level of low MDM, but you would still have 1/3 elements fulfilled for low level MDM, and hence cannot reach the low level MDM, as you need 2/3 elements.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with Straightforward MDM	99202 99212	99221 99231 99234	99242 99252	99282

Next level of MDM is low.

Low MDM	**Problems**	**Low** *(must meet the requirement of only one of the subheading below)* ■ 2 or more self-limited or minor problems or ■ 1 stable, chronic illness or ■ 1 stable, acute illness or ■ 1 acute, uncomplicated illness or injury or ■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care.
	Data	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **<u>Category 1: Tests and documents</u>** **Each unique test, order, or document contributes to the combination of 2* ■ Any combination of 2 from the following ● Review of prior external note(s) from each unique source* ● Review of the result(s) of each unique test* ● Ordering of each unique test* or **<u>Category 2: Assessment requiring an independent historian(s)</u>**
	Risk	Low risk of morbidity from additional diagnostic testing or treatment

As shown in the table, there are 2 ways to meet the data element requirement at this level. The first pathway is meeting Category 1 requirements by reviewing test results or other providers' notes or ordering tests. Only 2 items are needed. Examples: looking at a CBC result and reading a note from an ER doctor. Looking at the CBC result and ordering BMP or CXR. The second pathway is meeting category 2 requirement by having an independent historian. In pediatrics, we almost always have an independent historian (parents/caregivers), so from the data element perspective, our patients at least qualify for low level MDM.

Examples of low-level MDM are simple UTI, sinusitis, AOM, influenza infection, ankle sprain.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with low level MDM	99203 99213	99221 99231 99234	99243 99253	99283

Next level of MDM is moderate.

	Problems	**Moderate** *(must meet the requirement of only one of the subheading below)* ■ 2 or more stable, chronic illnesses, or ■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment, or ■ 1 undiagnosed new problem with uncertain prognosis, or

		■ 1 acute illness with systemic symptoms, or ■ 1 acute, complicated injury
Moderate **MDM**	Data	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **<u>Category 1: Tests, documents, or independent historian(s)</u>** **Each unique test, order, or document contributes to the combination of 3* ■ Any combination of 3 from the following: ● Review of prior external note(s) from each unique source* ● Review of the result(s) of each unique test* ● Ordering of each unique test* ● Assessment requiring an independent historian(s) or **<u>Category 2: Independent interpretation of tests</u>** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or **<u>Category 3: Discussion of management or test interpretation</u>** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
	Risk	Moderate risk of morbidity from additional diagnostic testing or treatment. Examples only: ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

1st and 2nd data categories in the low level MDM data element merge together and become the 1st data category in moderate and high level of MDM. Moderate and high levels then add two more categories: (2nd) independent interpretation of tests and (3rd) discussion of management or test interpretation. Meeting the requirement of only one category is good enough. 3 items are needed for Category 1.

Examples of moderate level MDM: a patient with well controlled hypertension and DM. A patient with poorly controlled eczema or ADHD. Acute pneumonia or pyelonephritis. Asthma exacerbation.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with moderate level MDM	99204 99214	99222 99232 99235	99244 99254	99284

Last and highest level of MDM is high.

High MDM	**Problems**	**High** *(must meet the requirement of only one of the subheading 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
	Data	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **<u>Category 1: Tests, documents or independent historian(s)</u>** **Each unique test, order, or document contributes to the combination of 3* ■ Any combination of 3 from the following ● Review of prior external note(s) from each unique source* ● Review of the result(s) of each unique test* ● Ordering of each unique test* ● Assessment requiring an independent historian(s) or **<u>Category 2: Independent interpretation of tests</u>** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Or **<u>Category 3: Discussion of management or test interpretation</u>** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
	Risk	**High risk** of morbidity from additional diagnostic testing or treatment. Examples only: ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to deescalate care because of poor prognosis ■ Parenteral controlled substances

High level MDM data element has the same 3 categories as the previous moderate level MDM. In high level though 2/3 categories must be met not 1/3 as in the moderate level.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with high level MDM	99205 99215	99223 99233 99236	99245 99255	99285

Examples of high level MDM: severe asthma or CHF exacerbation, severe traumatic brain injury, septic shock.

Let's assume that as a hospitalist, you are consulted on a patient with an acute severe asthma exacerbation in the ER. The table below shows how you can plug the elements together to reach the high-level MDM. You don't need to fulfill all 3 elements, as in this example, 2/3 is enough. If you evaluated the patient and decided that the patient needed to be admitted to the ICU but not to the floor. In this situation, even if you spent only 15 minutes of care on this patient, you can still select the highest level of consult code (99245 = 55 minutes) because this patient's MDM qualifies for high level. You do not need to, and preferably should not, document how much time (15 minutes) you spend with the patient, as the patient clearly has a high level MDM.

High level MDM	Problem	Acute severe asthma exacerbation = 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment	
	Data	Category 1	Review of CBC ordered by ER physician Ordering BMP Reading ER physician note Taking history from the mother
		Category 2	Independent interpretation of CXR
		Category 3	Discussing management with ER attending
	Risk	High risk = Decision regarding hospitalization or escalation of hospital-level care.	

MDM based code sets typically have 3 to 5 levels.

Typically, last digit of the code set indicates the level.

4 or 5 level code sets

MDM	-	Straightforward	Low	Medium	High
Code Level	Level **1**	Level **2**	Level **3**	Level **4**	Level **5**
Office –New Patient	Code deleted	9920**2**	9920**3**	9920**4**	9920**5**
Office - established	9921**1**	9921**2**	9921**3**	9921**4**	9921**5**
Consult outpatient	Code deleted	9924**2**	9924**3**	9924**4**	9924**5**
Consult inpatient	Code deleted	9925**2**	9925**3**	9925**4**	9925**5**
ER	9928**1**	9928**2**	9928**3**	9928**4**	9928**5**

Level of MDM and level of code set may be quite confusing, as seen above, because the first code level is either nonexistent or a non MDM based code. The first MDM level of straightforward correlates with the second level in the above code sets. Codes 99201, 99241, and 99251 were deleted in recent years. You may be tempted to think that 99242 is the level 1, but it is still considered level 2 because of historical usage.

3 level code sets.

MDM level	Straightforward or low	Medium	High
Code Level	Level **1**	Level **2**	Level **3**
Admission	9922**1**	9922**2**	9922**3**
Subsequent	9923**1**	9923**2**	9923**3**
Same day	99234	99235	99236

7- PRACTICAL TIPS ON CODE SELECTION

Tips on office and consultation code selection

Level 1 (~99211) is easy to decide as it is for a visit that does not require physician attention. Like a weight check by a nurse. The remaining 4 codes can be selected based on either time or MDM. If the code selection is based on time, it is still a very clear and straightforward process. Just match the total time you spend with the patient to the appropriate code. Difficulty and confusion may arise when MDM is used for code selection, because you cannot open a cheat sheet and plug in MDM elements each time you see a patient. Below are some tips to make MDM based code selection easier.

Focus on the patient's problem first when selecting the MDM level. This fulfills the first MDM element; you then need only one more: data or risk.

Simple problems, like a common cold or a diaper rash, are easy to code because they only qualify for level 2 (~99212). This level is not very difficult to decide. Typically, these patients have very simple, self-resolving illnesses; there is minimal to no data to review, and the risk from management is minimal. From the documentation perspective, there is not much to document other than the simple problem and your recommendations.

Most complex problems, such as severe asthma exacerbation or septic shock, qualify for level 5 (~99215). These patients are typically very sick, carry a high risk of morbidity and mortality, and require review of multiple data elements.

The rest of the problems are in between, either level 3 (~ 99213) or level 4 (~99214). Separating level 3 from level 4 becomes the most difficult task.

Although one self-limited problem qualifies for level 2, if you address 2 self-limited problems, it universally qualifies for level 3 in pediatrics because of the independent historian of data element. For example, if you see a child with a common cold, you can only report level 2; but if the same patient has diaper rash and you address it during the same visit, you can then bill level 3. Take home point is that you should always look for additional simple problems to address to bring level 2 to level 3 in pediatrics.

Because we almost always have an independent historian who fulfills the low-level MDM data element that aligns with level 3, any of the following conditions automatically qualify for level 3: any stable/well-controlled chronic illness, such as well-controlled hypertension, or any acute, uncomplicated illness, such as a UTI. From the documentation perspective, it’s important to document that history is obtained from the caregiver.

Level 4 (~99214) codes require moderate MDM, which has a detailed data element. So it may be easier to get to level 4 using the problem and risk element. Anytime you prescribe a medication (prescription drug management) then risk element of the moderate MDM is fulfilled then you only need a qualifying condition and not worry about data. 2 stable/well controlled chronic condition, any one chronic condition that is not well controlled or with progression or exacerbation, one acute illness with systemic symptoms like pneumonia or undiagnosed new problem with uncertain prognosis. All of these problems qualify for moderate MDM, and if you happen to write a prescription, then you have 2/3 elements fulfilled and can easily report level 4 code.

Example, *"8 years old with ADHD on 10mg amphetamine. Caregivers report frequent issues at school and home. Physical exam and vitals, including blood pressure, were within normal limits. ADHD is not well controlled with 10 mg, and we will increase amphetamine to 20mg and reevaluate in 3 months".* This very short note is perfectly enough to report the level 4 code of 99214. It has a medically appropriate history and examination, and moderate level MDM, including a chronic problem that is not well controlled, and moderate risk given prescription drug management. You do not need any data as 2/3 elements are fulfilled.

In 2022, Medicare had 98 million paid claims for 99214 and 76 million paid claims for 99213. From the above example, it's easy to see why level 4 overtakes level 3 because it is not very difficult to get it. Anytime you see any chronic condition that is not in the target goal range and prescribe/continue a medication, then it's a level 4 claim.

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Anytime you order a CXR and prescribe an antibiotic, level 4 can be selected because you can document your independent interpretation of CXR, which takes care of the data element, prescription takes care of the risk element, and you do not need to worry about the problem element; 2/3 fulfilled.

Another way to reach level 4 is to use "diagnosis or treatment significantly limited by social determinants of health under risk element" instead of a prescription when social factors limit your ability to diagnose or treat a patient's condition.

Typically, level 5 is reached through problems like severe exacerbation of a chronic condition or a life threatening illness, but if you evaluate patient for hospital admission (Decision regarding hospitalization under high risk element) then you can still report level 5 if you have enough data elements like independent interpretation of a test, management discussions with another physician or review of labs, notes.

Tips on inpatient code selection

Inpatient code sets have 3 levels. There is not much to worry about the level 1 codes (~99231. This is the default level when patient complexity does not reach the moderate or high level of MDM.

Hospital level 2 codes (~99232) have moderate level MDM. You can reach the moderate level MDM as described above in the office section, primarily using the problem element. Two well controlled chronic illnesses or any chronic condition that is not well controlled or an acute illness with systemic symptoms or an undiagnosed new problem with unclear prognosis, plus medication prescription or socially limiting factors.

Any chronic condition that needs to be managed in the hospital is not well controlled by definition, and hence, a patient like this qualifies for at least level 2 because we will most certainly use some medications for that condition. This applies even if the patient is responding well to treatments and otherwise well. You just need to document it appropriately.

Example: *"6-year-old patient admitted with asthma exacerbation. No retractions this morning; end expiratory wheezing present; vitals within normal limits. Asthma exacerbation improving, given improvement in clinical status, we will wean albuterol to q4hr.* This note clearly qualifies for level 2. Note that both a chronic condition with exacerbation and medication management were documented.

Compared with the office, we order more labs, have plenty of external notes to review from different providers, and have more discussions with other physicians. Given this difference, using data elements is more common on the inpatient side. We almost always prescribe some medications in the hospital, so it may be easier to get to level 2 by using data and risk elements and not worry about the problem. Any prescription medication plus only one of the following: independent interpretation of a test (like CXR or EKG), management discussions with another physician, or a combination review of a lab, review of an external note, and history from a caregiver will get you level 2. Prescription can be swapped with limiting social factors.

Examples: a patient was admitted with concern for aspiration pneumonia. You documented your independent review of CXR and prescribed antibiotics. A patient was admitted with GER. You discussed management with the GI specialist and started or adjusted the PPI dose. A patient on IV antibiotics for soft tissue infection, and you had a combination of review of CBC, procalcitonin order, and history from the mother. All these patients qualify for hospital level 2.

Hospital/inpatient level 3 involves high level MDM. You can get to high level MDM primarily by using the problem element as described above. Any chronic illness with severe exacerbation or any life-threatening illness, plus enough data element. When a patient is this sick, there is typically an excess of labs to review and other physicians or providers to consult. Unlike moderate MDM, you need to fulfill 2 data categories.

Examples: a patient admitted with severe asthma exacerbation, plus independent interpretation of CXR and management discussion with a pulmonologist. A patient admitted with severe IBD exacerbation, plus a combination of CBC review, review of GI note, and history from caregiver and management discussions with GI. A patient with severe bronchiolitis, plus an independent review of CXR, and a combination of CBC review, review of an ER physician's note, and history from the caregiver.

Another way of getting hospital level 3 is by using risk factors listed under high risk. These include: drug therapy requiring intensive monitoring for toxicity, decision regarding hospitalization or escalation of hospital-level care, decision not to resuscitate or to deescalate care because of poor prognosis, and use of parenteral controlled substances. If you have one of these risk factors, then you only need to add appropriate data or problem element.

Examples of drug therapy requiring intensive monitoring for toxicity: checking daily electrolytes while on IV fluids to prevent electrolyte imbalances. Checking vancomycin levels to prevent toxicity. Checking daily creatinine while on Zosyn or Toradol to prevent AKI. *Example: a patient with hyponatremia on IV fluids, q12-hour BMP checks to prevent IV fluid toxicity, plus review of BMP, ER note, caregiver history,*

and independent interpretation of EKG. This patient's problem may not be severe enough for high level MDM, but you can still reach high level MDM using risk and data elements.

Decision regarding hospitalization or escalation of hospital-level care, plus enough data element. *Example: you saw a patient with bronchiolitis in the ER and decided to admit, plus an independent review of CXR and management discussion with the ER physician. You saw the same patient the next day on the floor and decided to transfer the patient to the ICU, plus independent interpretation of the new CXR and management discussions with intensivist.*

Decision not to resuscitate or to de-escalate care because of poor prognosis, plus enough data element. Example: *You saw a patient with terminal CF and placed a DNR order, plus independent interpretation of CXR and management discussion with pulmonologist.*

Parenteral controlled substances. *Example: a patient with acute pancreatitis and severe abdominal pain requiring IV morphine plus independent review of KUB and management discussions with GI.*

Data and risk elements may be very helpful in practical code selection for inpatient and ER consultation codes, because there will typically be plenty of labs, imaging, and notes to review, and consideration of hospital admission, escalation of care, or IV opioid therapy.