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Tip Sheet: Evaluation & Management Services *updated 10-12-23*

::::::::EFFECTIVE JANUARY 1, 2023

Instructions: This tip sheet covers Outpatient, Inpatient, Observation and Emergency Department Evaluation & Management services for the non neonate. The below codes may be used for in-person or video visits. **Other Tip Sheet Links:** Provider E/M Tip Sheet | Inpatient Obs Pocket Card | Guide to Attestation Statements | Critical Care | All other

JUMP TO PAGE: MDM Leveling Steps | Data Usage Table | Using Time | Using MDM | Prolonged Time | Top Attestations | Definitions

E/M Service	Level	MDM	Time in minutes For prolonged time, see pg. 6
Office or Other Outpatient Visit - New ► *New = patient has not received any F2F services by anyone in the same specialty and group within the past 3 years*	• 99202 • 99203 • 99204 • 99205	• Straightforward • Low • Moderate • High	• 15-29 • 30-44 • 45-59 • 60-74 n/a for Primary Care Exception
Office or Other Outpatient Visit—Established ► *Established = patient has previously received F2F services by anyone in the same specialty and group within the past 3 years* *CPT 99211 may not require the presence of a physician or other qualified health care professional.	• 99211* • 99212 • 99213 • 99214 • 99215	• N/A • Straightforward • Low • Moderate • High	• N/A • 10-19 • 20-29 • 30-39 • 40-54 n/a for Primary Care Exception
Initial Hospital Care (Inpatient or Observation) ► *Use when patient has not received F2F services anyone in the same specialty & group during the admission and stay* For Inpatient admissions, Admitting Provider use "**Modifier AI**" "principle physician of record"	• 99221 • 99222 • 99223	• Sfwd or Low • Moderate • High	• 40 • 55 • 75
Subsequent Hospital Care (Inpatient or Observation) ► *Use when patient has received F2F services by anyone in the same specialty & group during the admission and stay* Transitions from Observation to Inpatient on a subsequent day do not constitute a new stay, report Subsequent 99231-99233	• 99231 • 99232 • 99233	• Sfwd or Low • Moderate • High	• 25 • 35 • 50
Consultation (Inpatient or Observation) ► *Requires request from another physician/QHCP. Report consult once during stay, thereafter report Subsequent 99231-99233.*	• 99252 • 99253 • 99254 • 99255 • f/up use 99231-99233	• Straightforward • Low • Moderate • High	• 35 • 45 • 60 • 80
Discharge Management (Inpatient & Observation) ► *Used by practitioner responsible for discharge or who did death announcement; all others use Subsequent 99231-99233*	• 99238 • 99239 *Same Day Adm/DC:* • 99234 • 99235 • 99236	• MDM is N/A • MDM is N/A *Same Day Adm/DC:* • Sfwd or Low • Moderate • High	• 30 min or less • More than 30 min *Same Day Adm/DC:* • 45 • 70 • 85
Outpatient—Consultation ► *Follow-up visits initiated by the consultant or patient report 99212-99215.*	• 99242 • 99243 • 99244 • 99245	• Straightforward • Low • Moderate • High	• 20 • 30 • 40 • 55
Emergency Department *CPT 99281 may not require the presence of a physician or other qualified health care professional, and does not have an MDM level	• 99281* • 99282 • 99283 • 99284 • 99285	• N/A • Straightforward • Low • Moderate • High	Time is N/A for ED Services

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Calculating Medical Decision Making: Follow steps 1-4 to determine the level of MDM and CPT code.

(Note: definitions for key terms are listed here)

Step 1: Calculate Number and Complexity of Problems Addressed at the Encounter - Select all bulleted elements that apply. The furthest right column in which an element is selected represents the final complexity . For example, if a patient has 1 stable chronic illness (Low) and 1 chronic illness with severe exacerbation and progression (High), the overall complexity level is High.

Element	• 1 self-limited or minor problem *(runs a definite or prescribed course, is transient in nature, and is not likely to permanently alter health status)*	• 2 or more self-limited or minor problems; *or* • 1 stable chronic illness *(chronic illness which is at treatment goal for the specific patient);* or • 1 acute, uncomplicated illness or injury *(full recovery w/out functional impairment is expected)*; or • Stable, acute illness *(treatment newly or recently initiated, resolution may not be complete, but condition stable);* or • Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care *(little to no risk of mortality with treatment, but treatment required is delivered in inpt or obs setting)*	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment *(requires supportive care or attention to treatment for side effects);* or • 2 or more stable chronic illnesses; *or* • 1 undiagnosed new problem with uncertain prognosis *(likely to result in high risk of morbidity w/out tx);* or • 1 acute illness with systemic symptoms *(illness that causes systemic symptoms and has high risk of morbidity without treatment);* or • 1 acute complicated injury *(eval of body systems not part of injured organ, extensive injury, or multiple tx options are multiple and/or associated with risk of morbidity)*	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment *(significant risk of morbidity; may require escalation in level of care);* or • 1 acute or chronic illness or injury that poses a threat to life or bodily function *(in the near term without treatment e.g. AMI, pulmonary embolus, severe respiratory distress psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)*
Complexity	**Minimal**	**Low**	**Moderate**	**High**

Step 2: Calculate Amount and/or Complexity of Data to be Reviewed and Analyzed—Select all of the elements that apply to the service. To reach a certain complexity level, one must meet the required number of elements for the level as described below. Data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources, inter-professional communications, or interpretation of tests not separately reported.

ATTN: See NEW DATA TABLE (page 4) for appropriate usage

Complexity → Must meet category requirements specified here	Minimal MINIMAL	Limited MEET CATEGORY 1 BELOW	Moderate MEET 1 OF 3 CATEGORIES BELOW	Extensive MEET 2 OF 3 CATEGORIES BELOW
CATEGORY 1 **1.** Review of prior external note(s) from each unique source (each unique source) **2.** Review of the result(s) of each unique test **3.** Ordering of each unique test (includes review of result, do not count in #2) **4.** Assessment requiring an Independent historian	Minimal or No Data Reviewed	**Category 1:** Meet any combination of 2 from items 1-3 **Or** Meet item 4 (independent historian)	**Category 1:** Meet any combination of 3 from items 1-4	**Category 1:** Meet any combination of 3 from items 1-4
CATEGORY 2: independent interpretation of tests performed by another physician/other qualified healthcare professional *(not separately reported)* *Do not count independent interpretation for a test billed or ordered by colleague in same specialty*			**Category 2:** Independent interpretation of test	**Category 2:** Independent interpretation of test
CATEGORY 3: Discussion of management or test interpretation—with external physician/other qualified health care professional/ appropriate source *(not separately reported)* *Requires direct interactive exchange (not via intermediaries or notes)*			**Category 3:** Discussion mgmt., or test interpretation (external)	**Category 3:** Discussion mgmt., or test interpretation (external)

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Step 3: Calculate Risk of Complications and/or Morbidity or Mortality of Patient Management Decisions Made at the Visit (associated with diagnostic procedures and treatments) - Select the risk associated with the management decisions made by the reporting physician/QHCP on the date of encounter. This risk is distinct from the risk associated with the condition alone. This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

The below examples are provided by AMA. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk.

Description	Minimal risk of morbidity from additional diagnostic testing or treatment ***Examples only*** • Rest • Gargles • Elastic bandages • Superficial dressings	Low risk of morbidity from additional diagnostic testing or treatment ***Examples only*** • OTC drugs • Minor surgery w/no identified risk factors • Physical/Occ therapy	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	High risk of morbidity from additional diagnostic testing or treatment ***Examples only*** • Parenteral controlled substances (DEA controlled substance given by route other than digestive tract) • 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 (i.e. transfer to ICU) • Decision not to resuscitate or to deescalate care because of poor prognosis
Complexity	**Minimal**	**Low**	**Moderate**	**High**

Step 4: Calculating Level of Medical Decision Making - Select the corresponding complexity level below that was calculated for Elements 1-3. To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded.

If a column has 2 or 3 selections, draw a line down the column and select the code. For example, Moderate Problems, Limited Data, Moderate Risk = ***MODERATE (2 of 3 met Moderate)***. Otherwise, draw a line down the column with the center selection and select the code. For example, Moderate Problems, Limited Data, High Risk = ***MODERATE (the center column was Moderate).***

ELEMENTS	**COMPLEXITY**				
1. Number and Complexity of Problems Addressed	N/A	Minimal	Low	Moderate	High
2. Amount and/or Complexity of Data to be Reviewed and Analyzed	N/A	Minimal or None	Limited	Moderate	Extensive
3. Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	Minimal Risk	Low Risk	Moderate Risk	High Risk
LEVEL of MDM *→ See Table Page 1 for CPT codes*	**N/A**	**STRAIGHTFORWARD** ***2 of 3 Minimal***	**LOW** ***2 of 3 Low (or S,L,M)***	**MODERATE** ***2 of 3 Moderate (or L,M,H)***	**HIGH** ***2 of 3 High***

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DATA TABLE APPROPRIATE USAGE

Data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

Category 1 Tests & Documents	**Review of Prior External note(s) from each unique source**	▪Review of notes from external source (count once each source, no matter how many notes reviewed) ▪Review of notes from another specialty or subspecialty (count ounce for each specialty, no matter how many notes reviewed) ***Note:*** noting simply "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient (MLN Medicare DG documentation guidelines).
	Review of the results of each unique test	▪Review of each unique lab or diagnostic test (diagnostic test interpreted or billed by a different specialty) ***Note:*** you may get credit for the order or review of a single test, but not both
	Ordering of each unique test (includes review)	▪Ordering of each unique lab or diagnostic test (includes review of test) ***Note:*** Tests ordered include the eventual review of the result. Therefore, tests ordered during an encounter are counted in that encounter. Additionally, per AMA: "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."
	Independent Historian	History taken from an independent historian (i.e. due to patient's developmental stage, psychosis, dementia etc.) ***Note:*** Translated history does not count as an independent history
Category 2 Independent Interpretation	**Independent Interpretation**	Independent interpretation of a test/images performed by another physician or QHCP (not separately reported)
Category 3 Discussion of Management	**Discussion of management or test interpretation (external)**	Discussion of management or test interpretation with external physician/QHCP or appropriate source (not separately reported) ▪ discussion with external physician, QHCP, or appropriate source (i.e. parole officer, teacher, case manager) ▪ discussion with physician/QHCP of another specialty or subspecialty Document who discussion was with, and discussion specific to patient, i.e. "Discussed with Dr. Marks whether the patient is stable enough to operate given episode of low HBP yesterday, he agreed it would be safe to proceed as planned" ***Note:*** Requires direct interactive exchange. Discussion via chart notes or written exchanges, or intermediaries (e.g. clinical staff or trainees) does not qualify. Discussion may occur within a short time frame of the visit (e.g. a day or two).

Data Inappropriate to Count:

- Reviewing own prior notes
- Discussion with patient or family
- Discussion with own care team (including resident)
- Pulse Oximetry
- Independent interpretations for which a report is not customary

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Selecting a Level of Service

Method of level selection is MDM or Time, except for Primary Care Exception & Emergency Department services which may only use MDM.

- **All Services except PCE & ED**:
  1. The total Time for E/M services performed on the date of the encounter (n/a for PCE); ***or***
  2. The level of the Medical Decision Making as defined for each service.

"All Services" Includes resident (non-PCE) services (Mod GC).

- **Primary Care Exception (Mod GE):** In qualified primary care centers, residents may be seen without the presence of a teaching physician. As of Jan 1st 2022:
  1. Only the level of Medical Decision Making may be used to level regular or video services.

- **Emergency Department:** The concept of time does not apply to the leveling of Emergency Department services.
  1. Only the level of Medical Decision Making may be used to level services, except CPT 99281.

History and/or Examination

E/M services include a medically appropriate history and/or physical examination, when performed. However, history/exam elements are not required for level selection. The nature and extent of the history and/or exam is determined by the treating physician/qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire). The provider should indicate that such information has been reviewed.

Selecting Level of Service Using Medical Decision Making (MDM)

The four level of MDM are straightforward, low, moderate, and high. MDM is defined by three elements:

1. The number and complexity of problem(s) that are addressed during the encounter;
2. The amount and/or complexity of data to be reviewed and analyzed; and
3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

Documenting M.E.A.T. to Support the Encounter

A problem list of diagnoses alone is not sufficient to support problems addressed or medical necessity of the encounter. Documentation of M.E.A.T. within the history, exam and the assessment & plan helps support a problem is being addressed:

- **M**onitoring signs, symptoms, disease progression or regression, ongoing surveillance of the condition
- **E**valuating current state of condition, physical exam findings, review of results, medication effectiveness, treatment response
- **A**ssessing ordering further testing, ordering diagnostic studies, review of records, discussion of management, care coordination
- **T**reating medication management, therapy or other modalities, treatment or care plan, decision for surgery, decision for admission, etc.

Documentation of MDM

To support the level of MDM, the provider's note should include:

- A clear description of all problems managed, evaluated and/or treated on the date of service, as well as the severity and acuity of those problems.
- A description of the data ordered, reviewed or interpreted plus any relevant analysis (i.e., "Reviewed CBC from 10/20 and (insert analysis here)."
- If an assessment requiring an independent historian (e.g., parent, spouse, guardian) is obtained because the patient is unable to provide a complete or reliable history (i.e., due to developmental stage, dementia, or psychosis).
- Possible management options that were considered but ruled out, after shared medical decision making with the patient/ family. These considerations must be documented.
- Any social determinants of health and their impact on the provider's ability to diagnose or treat the patient.

Social Determinants of Health Examples (ICD: Z55-Z65)

Document the type of SDOH impacting/complicating care, for ex.:

- **Illiteracy and low-level literacy —>** Low health literacy may require different or more extensive efforts with patient education (i.e. all verbal instruction because patient can't read written instructions)
- **Inadequate housing** —> Patient may lack refrigeration in their home so can't be prescribed cold storage medications, so you have to prescribe something else. May have mold infestation so have to intensify management of their asthma.
- **Extreme poverty or Low income** —> May not be able to afford medications or other over-the-counter type therapies/devices.
- **Disappearance and death of family member** —> May decide to defer addressing some medical issues to prioritize providing emotional support for bereavement.
- **Child in welfare custody.** —> May have to spend extra time educating new foster parent on medical management or on how to provide support care for medical condition

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TIME (not applicable for Primary Care Exception & ED)

Selecting Level of Service Using Time

- Time increments for each code are in the table above.
- A face-to-face encounter with the physician/qualified health care professional (QHCP) is required.
- Note: The concept of time does not apply to code 99211.
- ***Time that may not be counted:***
  - Time spent on a Primary Care Exception service
  - Time spent on a previous or subsequent day
  - Activities performed by clinical staff (i.e., RNs, MAs)
  - Time spent on separately reportable services such as procedures, diagnostic tests, professional interpretation (when the E&M is warranted and separately identifiable)
  - Overlapping time spent between an NPP and Physician for the purpose of split-shared billing
  - Time spent on travel
  - Time spent on teaching that is general
  - Resident/trainee time
- ***Time that may be counted***
  - Both face-to-face and non-face-to-face time personally spent by the Physician/QHCP or Teaching Physician on qualifying activities the day of the encounter,
  - Time the Teaching Physician is present when the resident is performing qualifying activities on the DOS

  List of qualifying activities:
  - ⇒ Preparing to see the patient (e.g., review of tests)
  - ⇒ Obtaining/reviewing separately obtained history
  - ⇒ Performing a medically appropriate examination and/or evaluation
  - ⇒ Counseling/education of the patient/family
  - ⇒ Ordering medications, tests, or procedures
  - ⇒ Referring and communicating with other health care professional (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)

Split– Shared Time Requirements (Facility settings)

N/A for Physician Office settings POS 11

- Time personally spent by the Physician and Non-Physician Practitioner (NPP) on the date of the service is summed to define total time. Only distinct time is summed.
- If the Physician and NPP see the patient together, or discuss the patient together, time is counted once.
  - Example 1: Physician & NPP jointly spend 15 mins on a split-shared visit with a patient. Time Allowed = 15 mins (not 30).
  - Example 2: NPP personally spends 15 mins of time related to the patient visit; Physician personally spends 10 minutes of time on the visit. Time Allowed = 25 (15 + 10).

⇒ Billing practitioner uses .**SPLITSHAREDNPPVISIT**

⇒ Non-billing practitioner may use **.TIMEATTEST**

Counting Time with Teaching Physicians & Housestaff (e.g., Residents & Fellows)

- **Primary Care Exception (PCE):** Time may **not** be used to level Primary Care Exception services as of Jan 1, 2022.
- **Non-Primary Care Exception:** Housestaff's time may not be counted. Count only the Teaching Physician's time, which may include time TP is present with resident while performing qualifying activities.
  - ⇒ Do not count time spent in educating the Housestaff (i.e., on teaching that is general and not limited to mgmt. for specific patient)

Time Documentation

- If time is used to select the E/M code, the provider (e.g. APP, Attending) must document total time in the note. Use the smart phrase below to capture total time.
- **.TIMEATTEST**—"I spent a total of *** minutes (excluding separately reportable procedure time) in care of this patient on @ED@.
- Teaching Physicians can use the Attestation Statements below to record total time.

* Housestaff in non-PCE settings do not have to record time since their time cannot be counted by the Teaching Physician.

Common Attestation Statements

- Split-Shared (Billing Provider) —> **.splitsharednppvisit**
- MD/APP not supervising **.MDMORTIME (new)** or **.TIMEATTEST**
- Outpatient Telehealth **.ATTTELEHEALTHOUTPATIENT**
- Inpatient Telehealth **.ATTTELEHEALTHINPATIENT**

Outpatient Teaching Physician

- Teaching Physician alone **.ATTESTNOTPRESENTINP**
- Teaching Physician with Housestaff **.ATTESTPRESENTINP**

Inpatient Teaching Physician

- Teaching Physician alone **.ATTESTNOTPRESENTAMB**
- Teaching Physician with Housestaff **.ATTESTPRESENTAMB**

See the guide to attestation statements for a list of UCM standard attestations and smartphrases with statement detail.

EPIC Level of Service Calculator (Wizard)

- The EPIC Level of Service (LOS) calculator can provide a suggested office/outpatient E/M code based on MDM criteria or time the provider enters into the calculator.
- Caution: The calculator captures the approximate time the provider had the patient's chart open. This time may not accurately reflect the provider's actual face to face, and non face to face time on the service.
- See the OCC tip sheet for instructions on how to access and use the calculator (LINK).

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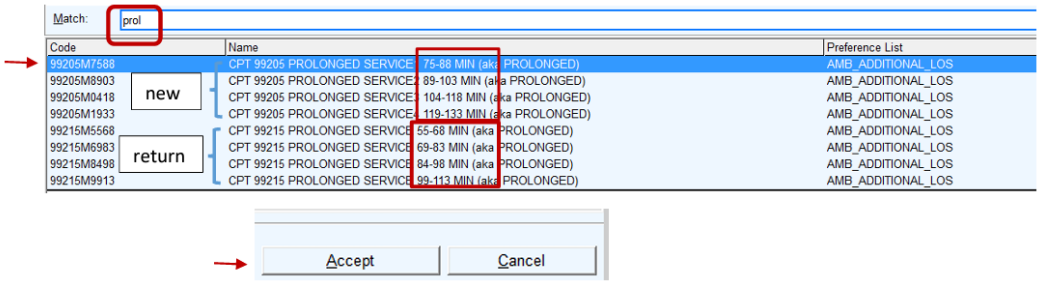
PROLONGED E/M SERVICES

A prolonged service add-on code may be used when :

- Primary E/M service is leveled by time,
- Minimum time requirement is met to report prolonged service,
- Total time spent on approved activities is documented

Outpatient

- In the LOS area go to Additional E/M Codes: "Click to Add" and search using "prolonged" to find new or return codes with time ranges. See Prolonged Services **tip sheet** for step by step.



Time Required to Report Base Code	Prolonged Add-on Minimum Time	AMA/CMS Prolonged HCPCS codes
99205 Initial Hosp/Obs,75 min	***meet 89 mins***	See CPT 99205 Prolonged Service codes above
99215 Subs Hosp/Obs, 50 min	***meet 69 mins***	See CPT 99215 Prolonged Service codes above

Inpatient

- Locate codes in Charge Capture. If not present use Help 99 or ask your coding/billing contact for assistance.

Time Required to Report Base Code	Prolonged Add-on Minimum Time	AMA/CMS Prolonged HCPCS codes
99223 Initial Hosp/Obs,75 min	***meet 90 mins***	99418 each 15 mins (G0316 bills to Medicare)
99233 Subs Hosp/Obs, 50 min	***meet 65 mins***	99418 each 15 mins (G0316 bills to Medicare)

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I. Definitions for the elements of medical decision making

Acute or chronic illness or injury that poses a threat to life or bodily function (Updated): 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.

Acute, complicated injury (Updated): 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.

Acute illness with systemic symptoms (Updated): 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.

Acute, uncomplicated illness or injury (Updated): 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.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care (NEW): 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.

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 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.

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 (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

Chronic illness with exacerbation, progression, or side effects of treatment (Updated): 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.

Chronic illness with severe exacerbation, progression, or side effects of treatment (Updated): 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.

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests 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.

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Definitions for the elements of medical decision making

Drug therapy requiring intensive monitoring for toxicity (Updated): A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. 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 annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Discussion: 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 it 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)

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 healthcare professional: An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

Independent historian(s) (Updated): 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 where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met. It does not include translation services. 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 Interpretation (Updated): 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 qualified health care professional 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.

Minimal problem (Updated): A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

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.

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.

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Definitions for the elements of medical decision making

Problem addressed (Updated): A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. 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 other qualified health care professional 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 other qualified health care professional reporting the service. For hospital inpatient and 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 other qualified health care professional and may not be the cause of admission or continued stay.

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 (Updated): 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 (though 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 qualified health care professional as part of the reported encounter.

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.

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

Stable, acute illness (NEW): 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

Stable, chronic illness (Updated): 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 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. The risk of morbidity without treatment is significant.

Surgery (minor or major, elective, emergency, procedure or patient risk):

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

Surgery–Elective or Emergency: Elective procedures and emergent or 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. *Surgery definitions continued next page...*

Definitions for the elements of medical decision making

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 and procedure risk.

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

Undiagnosed new problem with uncertain prognosis (Updated): A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Unique: A unique test 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. A unique source is defined as a physician or qualified heath 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.

II. Resources

A. AMA CPT E/M Code and Guideline Changes 2023: https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf 2021: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

B. MLN Booklet Evaluation and Management Services Guide, ICN 006764: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

C. CMS CY23 Physician Fee Schedule Final rule: https://public-inspection.federalregister.gov/2022-23873.pdf

D. NGS E&M FAQ's: here

DISCLAIMER: information in this guidance document has been provided to the best of our knowledge and interpretation at the time of publication, and may be subject to revision upon release of further guidance and clarifications.

Questions? compliance@bsd.uchicago.edu