2024

E&M Coding Tips Guidebook

YOUR ESSENTIAL GUIDE FOR 2024

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2024 E&M Coding Tips Guidebook Introduction

Evaluation and management (E&M) services are utilized for problem focused visits performed in all healthcare settings. These are cognitive services in which a physician or other qualified healthcare professional diagnose and treat illnesses or injuries.

Code selection in most E&M categories is based on either time or medical decision making. It is truly important for providers, coders, auditors, educators and template developers to understand the E&M guidelines to maintain compliance with coding and documentation.

Panacea's experts compiled this guidebook as an easy reference for coding professionals. In it, you'll find tip sheets and reference articles for several different categories of E&M coding.

Included in the Guidebook:

2024 E&M Coding Tip Sheets

- Consultation Visits
- Emergency Department Visits
- Hospital Inpatient and Observation Care
- Office or Other Outpatient Services
- Critical Care

Critical Care Documentation and Examples Tip Sheet

Split Shared Services Reference Sheet

Medical Decision Making Guidelines

2024 Medical Decision Making Table

2024 Evaluation and Management Consultation Visits
Medical Decision Making (MDM)

Using Medical Decision Making (MDM) as the determining factor:

Code (level) selection requires two of the following three elements be met:

- Number and complexity of problem(s) addressed during the encounter
  - Count only diagnoses receiving active treatment during the encounter
  - See Medical Decision Making Table for examples for each level*
- Amount / Complexity of data to be reviewed and analyzed
  - Changes reflect specific combinations of work to score MDM*
- Risk of complications, morbidity / mortality of patient management decisions made at the visit
  - See Medical Decision Making Table for examples for each level*

Levels of MDM for Outpatient Consultations*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward	99242	Straightforward	Minimal / None	Minimal
Low	99243	Low	Limited	Low
Moderate	99244	Moderate	Moderate	Moderate
High	99245	High	Extensive	High

Levels of MDM for Inpatient Consultations*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward	99252	Straightforward	Minimal / None	Minimal
Low	99253	Low	Limited	Low
Moderate	99254	Moderate	Moderate	Moderate
High	99255	High	Extensive	High

**Refer to the Medical Decision Making Table (page 21) for detailed requirements for each level of MDM.*

2024 Evaluation and Management Consultation Visits – Time

Using Time as the determining factor:

- Includes total time spent by the physician or other qualified healthcare professional (face-to-face and non-face-to-face on the same date of service)

Activities Included in Total Time:

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

Activities NOT Included in Total Time:

- Time spent on separately reported services such as minor procedures, diagnostic studies, or any service reported on the same date of service
- Activities performed by clinical staff such as vital signs, recording history, etc.

Time Ranges for Outpatient and Inpatient Consultation Visits

Outpatient Consultations	
Code	**Time Threshold**
99242	20 min meet or exceed
99243	30 min meet or exceed
99244	40 min meet or exceed
99245	55 min meet or exceed

Inpatient Consultations	
Code	**Time Threshold**
99252	35 min meet or exceed
99253	45 min meet or exceed
99254	60 min meet or exceed
99255	80 min meet or exceed

Prolonged Services Codes

- May only be used when time is the determining factor
- May only be used with Level 5 codes – 99245 and 99255
- Fifteen-minute increments

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Time Ranges for Prolonged Service Codes

Time Ranges for Prolonged Service Codes*

Total Duration of Outpatient Consult	Code(s) Reported
<70 minutes	Report appropriate E&M code 99245
70 – 84 minutes	99245 x 1 and 99417 x 1
85 – 99 minutes	99245 x 1 and 99417 x 2
100 + minutes	99245 x 1 and 99417 x 3 + 1 for ea add'l 15 min

Total Duration of Inpatient Consult	Code(s) Reported
<95 minutes	Report appropriate E&M code 99255
95 – 109 minutes	99255 x 1 and 99418 x 1
110 – 124 minutes	99255 x 1 and 99418 x 2
125 + minutes	99255 x 1 and 99418 x 3 + 1 for ea add'l 15 min

**CMS guidelines differ from AMA guidelines. Use CMS guidelines when reporting to Medicare / Medicaid.*

2024 Evaluation and Management Emergency Department Visits
Medical Decision Making (MDM)

Using Medical Decision Making (MDM) as the determining factor:

Code (level) selection requires two of the following three elements be met:

- Number and complexity of **problem(s) addressed** during the encounter
  - Count only diagnoses receiving active treatment during the encounter
  - See Medical Decision Making Table for examples for each level*
- Amount / Complexity of **data to be reviewed** and analyzed
  - Changes reflect specific combinations of work to score MDM*
- **Risk** of complications, morbidity / mortality of patient management decisions made at the visit
  - See Medical Decision Making Table for examples for each level*

Levels of MDM for Emergency Department Visits

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward	99282	Straightforward	Minimal / None	Minimal
Low	99283	Low	Limited	Low
Moderate	99284	Moderate	Moderate	Moderate
High	99285	High	Extensive	High

**Refer to the Medical Decision Making Table (handout) for detailed requirements for each level of MDM.*

Time is not an element that may be used for code selection criteria with the Emergency Department Evaluation and Management category of codes.

2024 Evaluation and Management Hospital Inpatient and Observation Care Medical Decision Making (MDM)

Using Medical Decision Making (MDM) as the determining factor:

Code (level) selection requires two of the following three elements be met:

- Number and complexity of **problem(s) addressed** during the encounter
  - Count only diagnoses receiving active treatment during the encounter
  - See Medical Decision Making Table for examples for each level*
- Amount / Complexity of **data to be reviewed** and analyzed
  - Changes reflect specific combinations of work to score MDM*
- **Risk** of complications, morbidity / mortality of patient management decisions made at the visit
  - See Medical Decision Making Table for examples for each level*

Levels of MDM for Hospital Initial Hospital or Observation Care*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward or Low	99221	Straightforward or Low	None, Minimal or Limited	Minimal or Low
Moderate	99222	Moderate	Moderate	Moderate
High	99223	High	Extensive	High

Levels of MDM for Hospital Subsequent Hospital or Observation Care*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward or Low	99231	Straightforward or Low	None, Minimal or Limited	Minimal or Low
Moderate	99232	Moderate	Moderate	Moderate
High	99233	High	Extensive	High

Levels of MDM for Hospital Same Day Admit / Discharge Hospital or Observation Care*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward or Low	99234	Straightforward or Low	None, Minimal or Limited	Minimal or Low
Moderate	99235	Moderate	Moderate	Moderate
High	99236	High	Extensive	High

**Refer to the Medical Decision Making Table (page 21) for detailed requirements for each level of MDM.*

2024 Evaluation and Management Hospital Inpatient and Observation Care – Time

Using Time as the determining factor:

- Includes total time spent by the physician or other qualified healthcare professional (face-to-face and non-face-to-face on the same date of service)

Activities Included in Total Time:

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

Activities NOT Included in Total Time:

- Time spent on separately reported services such as minor procedures, diagnostic studies, or any service reported on the same date of service
- Activities performed by clinical staff such as vital signs, recording history, etc.

Time Ranges for Initial and Subsequent and Same Day Admit / Discharge

Code	Time Threshold
99221	40 min meet or exceed
99222	55 min meet or exceed
99223	75 min meet or exceed

Code	Time Threshold
99231	25 min meet or exceed
99232	35 min meet or exceed
99233	50 min meet or exceed

Code	Time Threshold
99234	45 min meet or exceed
99235	70 min meet or exceed
99236	85 min meet or exceed

Prolonged Services Codes

- May only be used when time is the determining factor
- May only be used with highest level code from the category – 99223, 99233 and 99236
- Fifteen minute increments

Time Ranges for Prolonged Service Codes*

Duration of Initial Hospital Visit	Code(s) Reported
< 90 minutes	Report appropriate E&M code 99223
90 – 104 minutes	99223 x 1 and 99418 x 1
105 + minutes	99223 x 1 and 99418 x 2 + 1 for ea add'l 15 min
Duration of Subsequent Hosp Visit	**Code(s) Reported**
< 65 minutes	Report appropriate E&M code 99233
65 – 79 minutes	99233 x 1 and 99418 x 1
80 + minutes	99233 x 1 and 99418 x 2 + 1 for ea add'l 15 min
Duration of Same Day Admit / DC Visit	**Code(s) Reported**
< 100 minutes	Report appropriate E&M code 99236
100 – 114 minutes	99236 x 1 and 99418 x 1
115 + minutes	99236 x 1 and 99418 x 2 + 1 for ea add'l 15 min

**CMS guidelines differ from AMA guidelines. Use CMS guidelines when reporting to Medicare / Medicaid.*

2024 Evaluation and Management Office or Other Outpatient Visits Medical Decision Making (MDM)

Using Medical Decision Making (MDM) as the determining factor:

Code (level) selection requires two of the following three elements be met:

- Number and complexity of **problem(s) addressed** during the encounter
  - Count only diagnoses receiving active treatment during the encounter
  - See Medical Decision Making Table for examples for each level*
- Amount / Complexity of **data to be reviewed** and analyzed
  - Changes reflect specific combinations of work to score MDM*
- **Risk** of complications, morbidity / mortality of patient management decisions made at the visit
  - See Medical Decision Making Table for examples for each level*

Levels of MDM for Office or Other Outpatient Services – New Patient*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward	99202	Straightforward	Minimal / None	Minimal
Low	99203	Low	Limited	Low
Moderate	99204	Moderate	Moderate	Moderate
High	99205	High	Extensive	High

Levels of MDM for Office or Other Outpatient Services – Established Patient*

MDM	Code	Problems Addressed	Data to Review	Risk
Straightforward	99212	Straightforward	Minimal / None	Minimal
Low	99213	Low	Limited	Low
Moderate	99214	Moderate	Moderate	Moderate
High	99215	High	Extensive	High

**Refer to the Medical Decision Making Table (page 21) for detailed requirements for each level of MDM.*

2024 Evaluation and Management Office or Other Outpatient Services – Time

Using Time as the determining factor:

- Includes total time spent by the physician or other qualified healthcare professional (face-to-face and non-face-to-face on the same date of service)

Activities Included in Total Time:

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

Activities NOT Included in Total Time:

- Time spent on separately reported services such as minor procedures, diagnostic studies, or any service reported on the same date of service
- Activities performed by clinical staff such as vital signs, recording history, etc.

Time Ranges for Office or Other Outpatient Visits

New Patient	
Code	Time Threshold
99202	15 minutes met or exceeded
99203	30 minutes met or exceeded
99204	45 minutes met or exceeded
99205	60 minutes met or exceeded

Established Patient	
Code	Time Threshold
99212	10 minutes met or exceeded
99213	20 minutes met or exceeded
99214	30 minutes met or exceeded
99215	40 minutes met or exceeded

Prolonged Services Codes

- May only be used when time is the determining factor
- May only be used with Level 5 codes – 99205 and 99215
- Fifteen-minute increments

Time Ranges for Prolonged Service Codes*

Total Duration of New Patient Visit	Code(s) Reported
<75 minutes	Report appropriate E&M code 99205
75 – 89 minutes	99205 x 1 and 99417 x 1
90 – 104 minutes	99205 x 1 and 99417 x 2
105 + minutes	99205 x 1 and 99417 x 3 + 1 for ea add'l 15 min
Total Duration of Established Patient Visit	**Code(s) Reported**
<55 minutes	Report appropriate E&M code 99215
55 – 69 minutes	99215 x 1 and 99417 x 1
70 – 84 minutes	99215 x 1 and 99417 x 2
85 + minutes	99215 x 1 and 99417 x 3 + 1 for ea add'l 15 min

**CMS guidelines differ from AMA guidelines. Use CMS guidelines when reporting to Medicare / Medicaid.*

Critical Care Coding

99291: Critical care for the first 30–74 minutes
99292: Each additional 30 minutes beyond the first 74 minutes

AMA Guidelines	
Total Duration	**Codes**
Less than 30 minutes	99232 or 99233 or other appropriate E&M code
30 > 74 minutes	99291 (1 unit)
75 > 104 minutes	99291 (1 unit) and 99292 (1 unit)
105 > 134 minutes	99291 (1 unit) and 99292 (2 units)
135 > 164 minutes	99291 (1 unit) and 99292 (3 units)
165 > 194 minutes	99291 (1 unit) and 99292 (4 units)
194 minutes or longer	99291–99292 as appropriate per above illustrations

CMS Guidelines	
Total Duration	**Codes**
Less than 30 minutes	99232 or 99233 or other appropriate E&M code
30 > 103 minutes	99291 (1 unit)
104 > 133 minutes	99291 (1 unit) and 99292 (1 unit)
134 > 163 minutes	99291 (1 unit) and 99292 (2 units)
164 > 193 minutes	99291 (1 unit) and 99292 (3 units)
194 minutes or longer	99291–99292 as appropriate per above illustrations

Critical Care is defined as:

- The critical illness or injury acutely impairs one or more vital organ systems, with a high probability of imminent or life-threatening deterioration in the patient's condition.
- Involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat vital organ system failure or to prevent further life-threatening deterioration of the patient's condition.
- Requires direct delivery of medical care for a critically ill or critically injured patient by a physician(s).
- Treatment and management of a patient's condition, in the threat of imminent deterioration, while not necessarily emergent, is required.
- Both the illness or injury and the treatment provided must meet the above requirements.
    - Providing medical care to a critically ill patient should not be automatically deemed a critical care service for the sole reason that the patient is critically ill or injured.

Critical Care Coding, Continued

- Time with family members may be counted towards critical care if:
  - Patient is unable to participate in giving a history or making treatment decisions and
  - Discussion is necessary for determining treatment
    - All other family discussions, no matter how lengthy may not be counted towards critical care

The following services are bundled into critical care and counted towards critical care time when performed by the physician and cannot reported separately:

CPT	Description
93561, 93562	Interpretation of cardiac output measurements
91010, 71015, 71020	Chest x-rays, Professional component
36415	Blood draw for specimen
99090	Blood gases, and information data stored in computers – e.g., ECGs, blood pressures, hematologic data
43752, 43753	Gastric intubation
94760, 94761, 94762	Pulse oximetry
92953	Temporary transcutaneous pacing
94002 – 92004, 94660, 94662	Ventilator management
36000, 36410, 36415, 36591, 36600	Vascular access procedures

Critical Care Documentation

Documentation should include the following:

- The critical and unstable nature of the patient's condition
- Complexity of medical decision making
- Aggregation of time spent by the billing provider, if applicable
- Patient assessment
- Family discussions – substance of discussion
- Total time spent

Note: Critical care services do qualify for shared/split care.

Critical Care Examples

Examples where medical condition(s) may warrant critical care services:

- A 69-year-old male patient is 4 days status post mitral valve repair. He develops hypotension, hypoxia and petechiae, required respiratory and circulatory support.
- A 71 year old admitted for an acute anterior wall myocardial infarction and continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Examples where medical condition(s) may not warrant critical care services:

- Daily management of patient on chronic ventilator therapy
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., overdose, drug toxicity)
- Patients admitted to a critical care unit because hospital rules require certain treatments to be administer in the critical care unit

Split / Shared Services

What is a Split / Shared service?

Defined by CMS as Evaluation and Management visits (only) provided in the facility setting and performed jointly by a physician and an NPP in the same group practice on the same calendar day. Patients may be new or established.

In what Places of Service (POS) are Split / Shared services allowed?

Allowed	POS
Provider-Based / Outpatient Clinics	19, 22
Hospital Inpatient (admission, follow-up, discharge)	21
Observation	22
Emergency Department	23
Skilled Nursing/Nursing Facility	31, 32, 54, 56
Critical Care	Any POS
Prolonged Services	Any POS **except** 11

Not Allowed	POS
Office visits	11
Consults	Any POS
Mandated Nursing Home visits	31, 32, 54, 56

CMS: How are Split / Shared services documented and billed?

- Documentation must identify the two practitioners who performed the visit
- Visit must be billed by the practitioner who provides the **substantive** portion of the visit
  - When both providers document time, the times will be added together and the provider with greater than 50% of the total time is the billing provider

    OR
  - The provider who performs and documents the MDM
  - The substantive component must be performed in full by the billing practitioner
  - The practitioner providing the substantive portion must sign and date
- CMS Guideline: Use **-FS modifier** to denote E&M visit split or shared between physician and non-physician provider in same group

CMS Indicates:

Coming in 2025

All Split / Shared E&M Visits will be based on time.

AMA differences from CMS:

- The substantive portion can be determined by the provider who spent more than 50% of the time ***OR*** who ***made or approved*** the MDM
- AMA does not provide any guidance on place of service where shared / split care can be provided
- Review CPT guidelines if utilizing data to support the level of service

Guidelines For Selecting Level of Service Based on Medical Decision Making

Medical Decision Making (MDM) includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements.

The elements are:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented. Data are divided into three categories:
  - Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
  - Independent interpretation of tests (not separately reported).
  - Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).
- The risk of complications and/or morbidity or mortality of patient management. This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options. MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E&M services. When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E&M services.

The Levels of Medical Decision Making (MDM) table is a guide to assist in selecting the level of MDM for reporting an E&M services code. The table includes the four levels of MDM (i.e., straightforward, low, moderate, high) and the three elements of MDM (i.e., number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (e.g., transfer to ICU) applies to the hospitalized or observation care patient. See also the introductory guidelines of each code family section.

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of service is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E&M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM are:

Guidelines

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.

Problem Addressed: 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, exam, 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.

Minimal Problem: 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).

Self-Limited Or Minor Problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, Chronic Illness: A problem with an expected duration of at least a 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 medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

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. Examples may include cystitis, allergic rhinitis, or a simple sprain.

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, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

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. An example may be a head injury with brief loss of consciousness.

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, but that does not require consideration of hospital level of care

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 hospital level of care.

Acute or Chronic Illness or Injury That Poses a Threat to Life or Bodily Function: An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, which poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

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. An example may be a lump in the breast.

Amount and/or Complexity of Data to Be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

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.

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 purpose of data reviewed and analyzed, pulse oximetry is not a test.

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 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.

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.

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.

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).

Independent Historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable

history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent 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: 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.

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.

Risk of Complications and/or Morbidity or Mortality of Patient Management

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 (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.

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.

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

Surgery (minor or major, 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—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.

Drug Therapy Requiring Intensive Monitoring for Toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. 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.

Source: ***CPT Professional 2024***

Table

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Code Selection Requires 2 of 3 Elements be Met (Complexity, Data to Review, Risk)

Complexity	Data to Review	Risk
Straightforward: 1 self-limited or minor problem	**Minimal:** No data	**Minimal** risk of morbidity from additional diagnostic testing or treatment
Low Complexity: 2 or more self-limited or minor problems **OR** 1 stable chronic illness **OR** 1 acute, uncomplicated illness or injury **OR** 1 stable, acute illness **OR** 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** (meet 1 of 2 categories) **Category 1: Tests and Documents** 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** **Category 2:** Assessment requiring an independent historian	**Low** risk of morbidity from additional diagnostic testing or treatment
Moderate Complexity: 2 or more stable chronic illnesses **OR** 1 or more chronic illness with exacerbation, progression of side effect **OR** 1 undiagnosed new problem with uncertain prognosis **OR** 1 acute illness with systemic symptoms **OR** 1 acute complicated injury	**Moderate** (meet 1 of 3 categories) **Category 1: Tests and Documents** 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** **Category 2: Independent Interpretation of test** (performed by another physician / not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician and/or appropriate source	**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 Complexity: 1 or more chronic illness with severe exacerbation, progression of side effect **OR** 1 acute or chronic illness or injury posing a threat to life or bodily function	**Extensive** (meet 2 of 3 categories) **Category 1: Tests and Documents:** 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** **Category 2: Independent Interpretation of test** (performed by another physician / not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician/appropriate source	**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 de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances