Selecting an E/M Code Based on Medical Decision Making in 2021

As of January 1st, 2021, providers may select an evaluation and management (E/M) level for office and outpatient services based on either time or medical decision making (MDM).

Key changes of the MDM were made to assist providers with the selection criteria associated with CPT codes 99202-99215 which include three components:

1) Problem: The number and complexity of problems addressed during the encounter

2) Data: Amount and/or complexity of data to be reviewed and analyzed

3) Risk: Risk of complications and or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s) or treatment(s).

There are four levels of medical decision-making: straightforward, low, moderate, and high. In order to achieve a specific level of MDM, two out of the three elements (the number of complexity and problems addressed, the amount and/or the complexity of data reviewed and analyzed, and the risk of complications and/or morbidity or mortality of patient management) must be met or exceeded.

Key tip:

- The MDM for a 99212 is exactly equivalent to the MDM required for a 99202. Similarly, 99213 and 99203 have the same requirements, 99214 and 99204 have the same requirements, and 99215 and 99205 have the same requirements.

Additional revisions include the following:

- "Number of Diagnoses or Management Options" is changed to "Number and Complexity of Problems Addressed"
- "Amount and/or Complexity of Data to be Reviewed" is changed to "Amount and/or Complexity of Data to be Reviewed and Analyzed"
- "Risk of Complications and/or Morbidity or Mortality" is changed to "Risk of Complications and/or Morbidity or Mortality of Patient Management"

Changes to MDM Subcategories

CPT Year				Typical Time
2020	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Typical time (with summary of face-to-face counseling and/or coordination of care).
2021	Number and Complexity of Problems Addressed	Amount and/or Complexity to be Reviewed and Analyzed*	Risk of Complications and/or Morbidity or Mortality of Patient Management	Total Time

2021 Medical Decision-Making Table

A new medical decision-making table was created to provide guidelines for E/M code level selection in 2021. It is still important for documentation to support medical necessity of the E/M service chosen.

Refer to Table 2- CPT E/M Office Revisions Level of Medical Decision Making for the full grid.

- *Key guideline:* In order to select a level of an E/M service, two of the three elements of medical decision making must be met or exceeded.

Step 1: Problem- select the applicable number and complexity of problems addressed at the encounter.

The new guidelines provide updated definitions of the elements of medical decision making. It is important to understand these definitions to ensure selection of the most appropriate E/M level.

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.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered.

- '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.
- Stable is defined by the treatment goal. The meeting of the goal is not the "ideal" outcome but meeting the goal for that patient.
- A patient whose condition has not changed but is not at their treatment goal is not stable, even if the condition is the same as when last seen.

Rheumatology example: a patient who is satisfied that she feels much better from the standpoint of her RA, but the physician identifies significantly active disease and wants to escalate treatment. *The risk of morbidity* ***without*** *treatment is significant.*

Rheumatology example: a patient with systemic lupus erythematosus (SLE) who wants to stop or decrease medications, but the provider knows that could lead to a serious flare – that patient is at risk of being unstable.

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.

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.

- The key here is that the differential diagnosis includes a condition or illness with a high risk or morbidity without treatment.
- The condition would likely lead to empiric treatment or diagnostic testing.

Rheumatology example: a patient with rheumatoid arthritis (RA), SLE or progressive systemic sclerosis (PSS) complains of increasing muscle weakness, even though the underlying disease seems to be well controlled. Or, a patient with RA or SLE complains of chest pain or shortness of breath.

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 include pyelonephritis or pneumonitis.

- These are the same examples as in the original table of risk.
- Notice that general symptoms such as fever, body aches, or fatigue in a minor illness are not considered as an acute illness with systemic symptoms.

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 back pain for which a vertebral compression fracture must be considered.

- Multiple injuries, not life-threatening.
- Need to evaluate body systems not related to injury.
- Extensive injury.
- Multiple treatment options and/or treatment option associated with risk of morbidity.

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, that 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.**

Rheumatology example: a red, hot, swollen joint and systemic fever suggesting possible septic arthritis, or chest pain even in a young person with RA, SLE, or other inflammatory arthritis that puts the patient at increased risk.

- CPT® has added the words “may require hospital level of care” to this definition.
- May require is not the same as will require and is admitted to the hospital.

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 that 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.

	Level of	**Number and Complexity of**
99211	**N/A**	N/A
99202 **99212**	**Straight forward**	**Minimal** • **1** self-limited or
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or**
99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new
99205 **99215**	**High**	**High** • **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

A full list of definitions can be found in the “CPT® Evaluation and Management (E/M) Office or Other Outpatient Code and Guideline Changes”

Step 2: Data- select the amount and/or complexity of data to be reviewed and analyzed. *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1.

- Data are divided into three types:

1. **Tests**, documents, orders, or independent histories with each unique test, order, or document counted to meet a threshold number
   - A panel of lab tests is considered a single, unique test.
   - Lab tests with their own CPT® code are considered unique tests. A mono-spot and a quick strep test each have their own CPT® codes; if ordered, those would be two unique tests.
   - There is separate counting for ordering and for reviewing the unique test.
   - Tests included lab tests, in the 80000 series of codes.
   - Tests include diagnostic tests, in the 70000 series of codes
   - Tests include the medical tests in the medicine chapter, in the 90000 series of codes.

External: *External records, communications, and/or test results are from an external physician, other qualified health care professional, facility, or healthcare organization.*

- Records from another clinician or facility.

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.

When the data section discusses review of external records, records from a physician/NP/PA within your multi-specialty group but who has a different specialty are considered. Do not include records from your same specialty partners.

2. Independent interpretation of tests: 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 is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.
   - If the clinician interprets a diagnostic test but is not billing for that test, credit an independent interpretation, within these parameters:
     - There is typically an interpretation or report for that test, and
     - The clinician did not bill for the interpretation at a prior encounter.
   - A rheumatologist reviews an X-ray that was interpreted and billed by a radiologist.

3. Discussion of management or test interpretation with external physician or other QHP or appropriate source

- For 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.

Selecting the level of data using the new MDM chart for E/M services in 2021

The most difficult of the three elements to score is the data element which located in the middle column of the chart. Data are defined as

- minimal or none,
- limited,
- moderate, and
- extensive.

Except for minimal or no data, data are divided into three categories:

- Category 1: Tests and documents
- Category 2: Assessment requiring an independent historian
- Category 3: Discussion of management or test interpretation

Codes	Level of MDM	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.**
99211	**N/A**	N/A
99202 **99212**	**Straight forward**	**Minimal or none**
99203 **99213**	**Low**	**Limited** *(Must meet the requirements of at least 1 of the 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(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*
99204 **99214**	**Moderate**	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **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 tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
99205 **99215**	**High**	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **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 tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

99203/99213 requires one of the two categories (Category 1 or Category 2) to meet the data

99204/99214 requires one of the three categories (Category 1, Category 2 or Category 3) to meet the requirement of moderate.

99205/99215 requires two of the three categories (Category 1, Category 2 or Category 3) to meet the requirement of extensive.

Step 3: Risk- select the risk of complications and/or morbidity or mortality of patient management.

- ***Risk:*** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high 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 purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment, and/or hospitalization.
- ***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.
    - Social determinants of health (SDoH) are new criteria that appears in moderate complexity, for codes 99204 and 99214. Moderate complexity may be defined as "diagnosis or treatment significantly limited by social determinants of health."
    - A rheumatologist may indicate that the patient is living in a shelter and does not have access to a kitchen to follow a healthy diet needed for their condition. Or a patient who is homeless could have a minor skin tear, the type of problem that would not normally qualify as moderate complexity, but without the ability for frequent dressing changes may pose a problem.
- ***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 less than quarterly. The monitoring may be by a lab test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient.
    - Examples may include monitoring for toxicity level in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis or pulmonary function tests in a patient with RA, SLE, or PSS who is at risk of pulmonary disease as part of the rheumatic disease.
    - Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a

concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold; or annual assessment of thyroid function in a patient with hypothyroidism

Key tips

- The monitoring is performed for assessment of adverse effects and not primary for assessment of therapeutic efficacy. If the purpose of the monitoring is to adjust the dosage of the medication, that is not considered intensive monitoring.
- The monitoring should be typical for that medication, although may be patient specific. An individual patient may have co-morbidities or be taking another medication that affects the need for intensive monitoring.
- The type of monitoring may be a lab test, physiologic test, or imaging.
- Taking a history and doing an exam do not qualify as intensive monitoring.

For questions or additional information on the MDM criteria or guidelines, contact the ACR practice management department at practice@rheumatology.org.

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