Office Visit Evaluation & Management (E/M) Coding Tool

Select appropriate Level of E/M service based on either: Level Of Medical Decision Making (MDM) OR Total Encounter Time*

All E/M services include a medically appropriate History and Exam

***Elements of Medical Decision Making:* To qualify for a certain Level of Medical Decision Making *TWO of THREE ELEMENTS of MDM* listed below *MUST BE MET* or exceeded.**

Level of Medical Decision Making (MDM)	1. Number & Complexity of Problems Addressed	2. Amount and/or Complexity of Data to be reviewed and Analyzed	3. Risk of Complications and/or Morbidity/Mortality of Patient Management
	A problem is addressed when it is evaluated or treated at the encounter by the qualified health care professional reporting the service. Notation that another professional is managing the problem w/o additional assessment or care coordination documented does not qualify as being addressed or managed. Referral w/o evaluation or consideration of treatment does not qualify as being addressed or managed.	Data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. 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 ordered outside of an encounter may be counted in the encounter in which they are analyzed. *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1.	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. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.
STRAIGHTFORWARD MDM **99202**: 15-29 minutes **99212:** 10-19 minutes	Minimal • 1 self-limited or minor problem	Minimal or none	**MINIMAL RISK** *(Examples only):* • Rest/Gargles • Superficial dressings/bandages
LOW MDM **99203:** 30-44 minutes **99213:** 20-29 minutes	• 2 or more self-limited or minor problems; • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness **or** injury	**LIMITED:** *(Must meet at least **1 out of 2 categories**)* **Category 1:** Tests, documents, or independent historian(s) *Any combination of **2** of the following:* • Review of prior external note(s), each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; **Category 2:** Assessment requiring independent historian(s)	**LOW RISK** *(Examples only):* • Over-the-counter drugs • Physical Therapy
MODERATE MDM **99204:** 45-59 minutes **99214:** 30-39 minutes	• 1 or more chronic illnesses w/exacerbation; • 2 or more stable chronic illnesses; **or** • 1 undiagnosed new problem w/uncertain prognosis; **or** • 1 acute illness w/systemic symptoms; **or** • 1 acute complicated injury	**MODERATE:** (*Must meet 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) **Category 2:** Independent interpretation of tests performed by another qualified health care professional; **Category 3:** Discussion of management or test interpretation with external qualified health care professional/appropriate source	**MODERATE RISK** *(Examples only)* **:** • RX drug management • Decision regarding minor surgery w/ identified risk factors • Diagnosis/treatment significantly limited by Social Determinants of Health (SDoH)
HIGH MDM **99205:** 60-74 minutes **99215:** 40-54 minutes	• 1 or more chronic illnesses w/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	**EXTENSIVE:** (Must meet 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 test*; • Assessment requiring independent historian(s) **Category 2:** Independent interpretation of tests performed by another qualified health care professional; **Category 3:** Discussion of management or test interpretation with external qualified health care professional/appropriate source	**HIGH RISK (***Examples only):* • Therapy requiring intensive monitoring for toxicity • Decision regarding: emergency major surgery, hospitalization d/t poor prognosis
Total Encounter Time* *See code descriptions above for time ranges.	Total encounter time includes both face to face (F2F) and non-F2F time personally spent by the clinician or QHP on the day of the encounter. Activities counted towards total time, including relevant pre, intra and post-service work should be well-documented. Clinical staff time cannot be counted. Time spent performing separately reported services other than the E/M service is not counted toward the time.		

A new patient (9920X) is one who has not received any professional services from the qualified health care professional or another qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

See back side of coding tool for definitions of terms and prolonged service guidelines.

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American Medical Association (AMA) Definitions

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 expected duration of at least a year or until death of the patient. Conditions are treated as chronic whether or not stage or severity changes.
Acute, uncomplicated illness/injury	A recent or new short-term problem w/low risk of morbidity. Little to no risk of mortality, full recovery expected. *Examples: allergic rhinitis or a simple sprain.*
Chronic illness w/exacerbation	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. *Example: unstable hypertension.*
Undiagnosed new problem w/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 include a lump in the breast.*
Acute illness with systemic symptoms	An illness that causes systemic symptoms & has a high risk of morbidity w/o 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 include a head injury with brief loss of consciousness.*
Independent historian(s)	An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
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 clinician 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.
Chronic illness with severe exacerbation, or side effects	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. *Examples may include: Exacerbated COPD or T2DM requiring hospitalization to stabilize.*
Acute or chronic illness/injury 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 MI, PE, severe respiratory distress*
Drug therapy requiring intensive monitoring for toxicity	Monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. 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 a cytopenia 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.*
Appropriate source	For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.
PROLONGED SERVICES: +99417* Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services). *Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes.	

A reminder from the ICD10CM & cooperating parties: A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. Guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

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