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2021 Evaluation and Management (E/M) Services Guidelines for Office and Other Outpatient Services

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Prepared by Peter Rossow, Director of Audit and Education

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What are E/M codes?

Formally named evaluation and management codes, E/M codes are essential to the medical billing process. A subset of current procedural terminology (CPT codes) used to represent specific encounters between physicians and patients, E/M codes (CPT code range 99201-99499) are used by commercial insurance providers, Medicare, and Medicaid to determine reimbursements. The codes represent three key factors that determine medical billing:

1. **Patient Type:** Identifies the patient as new or established.
2. **Setting of Service:** Identifies where the healthcare services were provided, such as an office or outpatient setting, hospital, or nursing facility.
3. **Level of Service Provided:** E/M codes reflect the complexity of the medical services provided. The more complex the service, the higher the code value.

What Changes Have Come to E/M Codes?

For the first time since it was introduced in 1992, the office/outpatient E/M CPT code set (99201-99215) has been extensively revised, including the addition of a new code to report incremental time associated with prolonged office or other outpatient services.

2021 Office/Outpatient E/M Coding Changes:

- New patient level 1 code (99201) was deleted, reducing the number of levels for new patient office/outpatient E/M visits to four (99202-99205). Established patients retained five levels of coding (99211-99215).
- History and physical examination are no longer determining factors in selecting the level of care. Clinically relevant history and examinations must still be documented when necessary, however.
- The level of service can be determined based on **medical decision-making** or **time** criteria.
    - While the inclusion of time as a definition of E/M service levels has been implicit before these adjustments, its inclusion as an explicit factor to determine the most appropriate level of E/M services is part of the new changes in 2021.

Documentation requirements for E/M visits were also revised to include two separate sets of reporting guidelines:

- One set for reporting office/outpatient E/M visits, and
- One set for reporting all other E/M visits that are not furnished in the office/outpatient setting.

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The table below highlights several major differences in reporting guidelines for E/M visits effective January 1, 2021.

	OFFICE/OUTPATIENT E/M VISITS (99202-99205, 99211-99215, G2212)	**ALL OTHER E/M VISITS (e.g., consultation, inpatient, observation, nursing home, emergency department visits)**
Which reporting guidelines apply to E/M services in 2021?	**New:** Code selection is based on medical decision making **OR** total time on the date of encounter.	**No change:** The 1995 and 1997 E/M documentation guidelines continue to apply to all other E/M services not furnished in the office or other outpatient setting.
Are history and physical examination (H&P) required elements?	**New:** History **and/or** examination is required **only** as medically appropriate for all levels of both new and established patient codes.	**No change:** The four categories of H&P (problem focused, expanded problem focused, detailed, and comprehensive) are **still applicable** in E/M code selection.
When using TIME for reporting, how is time used for code selection?	**New:** Code selection is based on **total face-to-face and non-face-to-face time** of the billing provider on the date of the encounter.	**No change:** Time may only be used for code selection when **counseling and/or coordination of care** dominates the service.
When using MDM for reporting, what MDM elements apply for code selection?	**New:** Both new and established patients require only **two out of three** MDM components.	**No change:** Code selection for new patients requires **three out of three** MDM components. Code selection for established patients requires **two out of three** MDM components.

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Guidelines for Reporting Office or Other Outpatient E/M Services

History and/or Examination

Office or other outpatient services include a *medically appropriate* history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or qualified healthcare professional (QHP) reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by electronic health record portal or questionnaire) that is reviewed by the reporting physician or other QHP. The extent of history and physical examination is not an element in selection of the level of office or other outpatient codes.

Time

Beginning in 2021, total time on the date of the encounter may be used instead of MDM for office/outpatient EM code selection. Time has been redefined from "typical face-to-face time" to the sum of both face-to-face and non-face-to-face services of the physician or QHP on the date of the encounter. Time may be used to select a code level for office/outpatient EM services whether or not counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M coding, time is defined by the service descriptors. For instance, the descriptor for 99213 states, "When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter." As that wording indicates, as long as the total time falls within the listed range, it is appropriate to choose 99213. The E/M services for which these guidelines apply require a face-to-face encounter with a physician or other qualified healthcare professional. If the physician or other qualified health care professional's time is spent supervising the clinical staff performing the face-to-face encounters, the code is 99211.

The following activities are considered physician or qualified health professional time and can be selected for E/M coding when performed:

- Preparing to see the patient, for example reviewing test results or charts
- Obtaining and/or reviewing separately-obtained 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 records
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination, when not separately reported

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

The table below highlights the changes in time reporting requirements for office/outpatient E/M codes. It may be beneficial to familiarize yourself with it and use it as a reference for coding office or other outpatient visits based on time.

	CPT CODE	REPORTING TIME PRIOR TO 2021	REPORTING TIME EFFECTIVE IN 2021
New Patient	**99201**	Typically, 10 minutes are spent face-to-face with the patient and/or family	*Deleted for 2021*
	99202	Typically, 20 minutes are spent face-to-face with the patient and/or family	15-29 minutes total time on day of encounter
	99203	Typically, 30 minutes are spent face-to-face with the patient and/or family	30-44 minutes total time on day of encounter
	99204	Typically, 45 minutes are spent face-to-face with the patient and/or family	45-59 minutes total time on day of encounter
	99205	Typically, 60 minutes are spent face-to-face with the patient and/or family	60-74 minutes total time on day of encounter
	+G2212	New for 2021	Each additional 15 minutes after 74 minutes on day of encounter
Established Patient	**99211**	Typically, 5 minutes are spent performing or supervising these services	Time does not apply
	99212	Typically, 10 minutes are spent face-to-face with the patient and/or family	10-19 minutes total time on day of encounter
	99213	Typically, 15 minutes are spent face-to-face with the patient and/or family	20-29 minutes total time on day of encounter
	99214	Typically, 25 minutes are spent face-to-face with the patient and/or family	30-39 minutes total time on day of encounter
	99215	Typically, 40 minutes are spent face-to-face with the patient and/or family	40-54 minutes total time on day of encounter
	+G2212	New for 2021	Each additional 15 minutes after 54 minutes on day of encounter

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How to Assign E/M Codes Based on Time

Total time includes all of the time the physician or qualified health professional spends on that visit on the date of service. That means it includes prepping for the visit (e.g. chart review) and anything done after the face-to-face portion of the visit (e.g. calling other clinicians and ordering tests or procedures). However, it does not include staff time or time spent by the physician or qualified health professional outside the date of the visit.

Language should be placed in the medical record making it clear how much time was spent performing activities related to the encounter. Here is a documentation template to use, if needed:

> *"A total of X minutes was spent on this visit performing face-to-face, pre and post encounter activities including reviewing previous notes, counseling the patient on _____, ordering tests (_____), adjusting meds, and documenting the findings in the note."*

Examples of Using Time for Code Selection Beginning in 2021:

The following clinical scenarios provide examples of using time for reporting an office visit for an established patient with a new 2-cm lump on the lower back.

Scenario A: On the day of the visit, Dr. Smith spends 5 minutes reviewing a patient's chart while clinical staff gowns the patient and takes vitals. Dr. Smith then spends 15 minutes updating the patient's history and performing a brief examination of the patient's back. Based on a review of the chart and the H&P, Dr. Smith determines the lump is a lipoma that does not require treatment. After the patient leaves the office, Dr. Smith spends 5 minutes completing the notes about the visit in the patient's chart. Dr. Smith spent a total of 25 minutes in face-to-face and non-face-to-face E/M services related to this patient encounter on the day of the visit. If time were used for code selection, Dr. Smith would report CPT code 99213 (i.e., 20-29 minutes total time), even though the presenting problem was minor and required no treatment.

Scenario B: On the day of the visit, Dr. Smith spends 5 minutes reviewing a patient's chart while clinical staff gowns the patient and takes vitals. In this scenario, the patient is obese and has limited mobility. It takes Dr. Smith a few extra minutes to position the patient for an examination of the lower back and then reposition him to sitting. The patient also has limited English proficiency and his son who came with the patient helps with translation. This results in Dr. Smith spending 20 minutes face-to-face with the patient. Based on a review of the chart and the H&P, Dr. Smith determines the lump is a lipoma that does not require treatment. After the patient leaves the office, Dr. Smith spends 5 minutes completing the notes about the visit in the patient's chart. In this scenario, Dr. Smith spent a total of 30 minutes in face-to-face and non-face-to-face E/M services related to this patient encounter on the day of the visit. If time were used for code selection, Dr. Smith would report CPT code 99214 (i.e., 30-39 minutes total time), even though the presenting problem was minor and required no treatment.

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Medical Decision Making (MDM)

MDM consists of establishing the patient's diagnosis, assessing the status of the patient's condition, and selecting a management option if necessary. The following three elements/categories make up MDM for office and other outpatient services:

1. The number and complexity of problem(s) that are addressed during the encounter

One element used in selecting the level of office or other outpatient service is the number and complexity of the problems that are addressed at an 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/underlying diseases, in and of themselves, are not considered in selecting the 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 number of possible diagnoses and/or the number of management options to consider is based on:

- The number and types of **problems addressed** during the encounter
- The complexity of establishing a diagnosis
- The management decisions made by the physician

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.

Here are some important points to keep in mind when documenting the number of diagnoses or management options.
You should document:

- An assessment, clinical impression, or diagnosis for each encounter, which may be explicitly stated or implied in documented decisions for management plans and/or further evaluation:
    - For a presenting problem with an established diagnosis, the record should reflect whether the problem is:
        - Improved, well controlled, resolving, or resolved

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        - Inadequately controlled, worsening, or failing to change as expected
    - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" diagnosis
- The initiation of, or changes in, treatment, which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications
- If referrals are made, consultations requested, or advice sought, to whom or where the referral or consultation is made or from whom advice is requested.

2. 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:

- Test, documents, orders, or independent historian(s). (each unique test, order, or document is counted to meet a threshold number).
- Independent interpretation of tests.
- Discussion of management or test interpretation with external physician or QHP.

Here are some important points to keep in mind when documenting amount and/or complexity of data to be reviewed. You should document:

- The type of service, if a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter.
- The review of laboratory, radiology, and/or other diagnostic tests. A simple notation such as "WBC elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, document the review by initialing and dating the report that contains the test results.
- A decision to obtain old records or additional history from the family, caretaker, or other source to supplement information obtained from the patient.
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient. You should document that there is no relevant information

beyond that already obtained, as appropriate. A notation of "Old records reviewed" or "Additional history obtained from family" without elaboration is not sufficient.
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

3. The risk of complications and/or morbidity or mortality of patient management decisions made at the visit.

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).

The risk of complications, morbidity, and/or mortality of patient management decisions is based on the risks associated with:
- **Presenting problem(s) –**
  - The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.
- **Diagnostic procedure(s) –**
  - The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.
- **Possible management options –**
  - The assessment of risk of possible management options includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal
- Low
- Moderate
- High

The highest level of risk in any one category determines the overall risk.

Four types/levels of MDM are recognized:

- Straightforward
- Low
- Moderate
- High

The concept of the level of MDM does not apply to 99211

Here are some important points to keep in mind when documenting level of risk. You should document:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality.
- The specific procedure or procedure type, if a surgical or invasive diagnostic procedure is performed, ordered, planned, or scheduled at the time of the E/M encounter.
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis. This point may be implied.

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The Levels of MDM in the following table is a guide to assist in selecting the level of MDM for reporting an office or other outpatient E/M services code. The table includes the four levels of MDM and the three elements of MDM. To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. Following this table are definitions for the elements of MDM for other office and outpatient services.

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CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: 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.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			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)
				Low risk of morbidity from additional diagnostic testing or treatment

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 problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			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)
				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

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
			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)
				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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Definitions for the Elements of MDM for Other Office or Other Outpatient Services

Term	Description	Examples
Appropriate Source	An appropriate source includes professional who are not health care professionals but may be involved in the management of the patient. It does not include discussion with family or informal caregivers	• Lawyer • Parole Officer • Case Manager • Teacher
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	• Cystitis • Allergic rhinitis 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 definition for ***self-limited or minor problems*** or ***acute, uncomplicated illness or injury.*** Systemic symptoms may not be general but may be single system.	• Pyelonephritis • Pneumonitis • 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	• Head injury with brief loss of consciousness

	extensive, or the treatment options are multiple and/or associated with risk and mortality.	
Acute or chronic illness or injury that poses a threat to life or bodily function	An acute illness with systemic symptoms, and 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.	• 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 • Abrupt change in neurologic status
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.	No examples given by CPT guidelines
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.	No examples given by CPT guidelines
Discussion	Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not	

	qualify as an interactive exchange. 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 (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).	
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	• Monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. • Short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing dialysis. **DOES NOT QUALIFY:** • Monitoring glucose level during insulin therapy (unless severe hypoglycemia is a current, significant concern) Annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold

External	External records, communications and/or test results are from an external physician, QHP, facility, or health care organization.	
External physician/QHP	An external physician or QHP who is not in the same group practice or is of a different specialty or subspecialty.	
Independent Historian	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. 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. 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 QHP 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.	
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.	
Minimal Problem	A problem that may not require the presence of the physician or other qualified healthcare professional, but the service is provided under the physician's or QHP supervision (see 99211).	No examples given by CPT 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 QHP 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 assessment or care coordination documented does not qualify as being addressed. Referral without evaluation or consideration of treatment does not qualify as being addressed or managed by the physician or QHP.	
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 QHP 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 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.	
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	• Cold • Insect Bite • Tinea Corporis

Stable, chronic illness	A problem with an expected duration of at least one year or until death of the patient. For the purposes of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, 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 their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.	• Well-controlled hypertension • Non-insulin dependent diabetes • Cataract • Benign prostatic hyperplasia **NOT stable:** • Asymptomatic but consistently high blood pressure, with a treatment goal of better control
Surgery	**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 (eg, 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.	
Test	Test are imaging, laboratory, psychometric, or physiologic data. 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.	• A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test.
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.	• Lump in breast
Unique	A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, 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.	