E/M 2021 Changes

Target Audience: Pulmonary Providers

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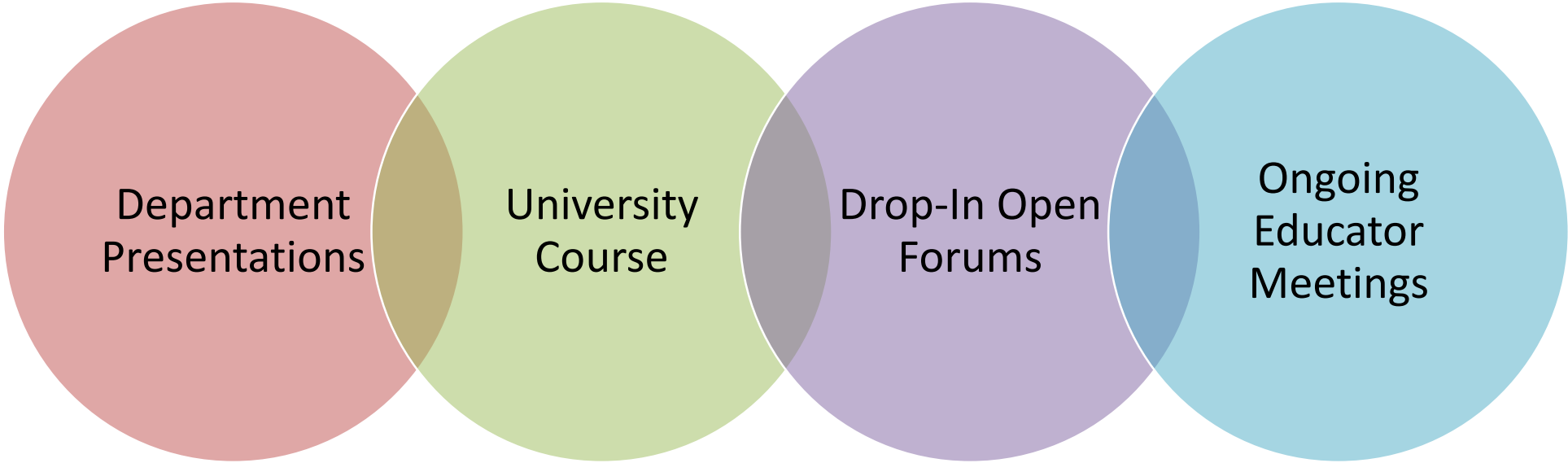
Available Trainings



Goals

- Summary of changes
  - Level of Service crosswalk
  - Estimated Payments
  - Affected Services
- Level of Service: Medical Decision Making
- Level of Service: Time Based
- Prolonged Service Codes

- Additional Information
  - Definitions

Introduction and Summary of Changes

Why the change?

Decrease administrative burden of documentation and coding

Decrease need for audits

Decrease unnecessary documentation in medical record not needed for patient care

Ensure payment for E/M services is resource based and has no direct goal for payment redistribution between specialties

Category	Subcategory	CPT Codes	Use Existing MDM Criteria	Use Revised MDM Criteria
Office or Other Outpatient Services	New Patient Established Patient	99202-99205 99211-99215		* *
Hospital Observation Services	Initial Care Subsequent Care Discharge	99218-99220 99224-99226 99217	* *	
Hospital Inpatient Services	Initial Care Subsequent Care Discharge	99221-99223 99231-99233 99238-99239	* *	
Observation or Inpatient Care	Admit and Discharge on Same DOS	99234-99236	*	
Consultations	Office or Other Outpatient Inpatient	99241-99245 99251-99255	* *	
Emergency Department Services	New or Established Patient	99281-99285	*	
Critical Care Services	Time Based Critical Care	99291-99292		
Nursing Facility Services	Initial Nursing Facility Care Subsequent Nursing Facility Care Nursing Facility Discharge Services Other Nursing Facility Services	99304-99306 99307-99310 99315-99316 99318	* * *	
Domiciliary, Rest Home, or Custodial Care Services	New Patient Established Patient	99324-99328 99334-99337	* *	
Home Services	New Patient Established Patient	99341-99345 99347-99350	* *	
Post Op Services	Post Operative services provided during Post-Op period	99024	No change to existing usage.	

Level of Service Crosswalk

	Currently	Beginning 2021

Medical Decision Making (MDM)	Requires:
	• History
	  • History of Present Illness
	  • Review of Systems
	  • Past/Family/Social History)
	• Exam
	  • Review of Body Areas/Organ Systems
	• MDM
	  • Number of Diagnoses
	  • Data Points
	  • Risk
		Requires:
		• MDM
		  • Number of Diagnoses
		  • Data Points
		  • Risk
		• Elements of History and Exam to justify medical necessity

Time Based	• Counseling/Coordination of care must dominate (>50% of time) visit with patient and/or family • Only face-to-face time on date of encounter counts towards time *(Residents/Fellows cannot bill based on time)*	• Total time for E/M services provided *on date of encounter* • Includes both face-to-face time and non-face-to-face time *on date of encounter* *(Residents/Fellows cannot bill based on time)*

Estimated Payments

New Patients

Level	Current		Beginning 2021	
	Payment	Work RVU	Estimated Payment*	Work RVU
1	$45	0.48	n/a	n/a
2	$76	0.93	$130 (or $143 for primary care and non-procedural care)	0.93
3	$110	1.42		1.60
4	$167	2.43		2.60
5	$211	3.17	$211	3.50

Established Patients

Level	Current		Beginning 2021	
	Payment	Work RVU	Estimated Payment*	Work RVU
1	$22	n/a	$24	0.18
2	$45	0.48	$90 (or $133 for primary care and non-procedural care)	0.70
3	$74	0.97		1.30
4	$109	1.50		1.92
5	$148	2.11	$148	2.80

The Conversion Factor for 2021 is decreasing from $36.09 to $32.26 (a difference of $3.83 or ~10.5%).

Some specialties may see increased RVUs for 2021 to help offset this change in reimbursement.*

*pending CMS Final Rule, expected late Fall 2020: https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

Level of Service: Medical Decision Making

Medical Decision Making Table

- Guide to assist in selecting the level of MDM
- Used for office or other outpatient E/M services *only*
- Includes four levels of MDM ***(unchanged from current levels of MDM)***
  - Straightforward (Level 2)
  - Low (Level 3)
  - Moderate (Level 4)
  - High (Level 5)
- To qualify for a particular level of MDM, two of the three elements for that level of decision making must be met or exceeded **(*unchanged from current guidelines)***

MDM Table

CPT Code	Time (minutes)	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making (MDM)		
			Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A	N/A
99202 99212	**15-29** **10-19**	**Straight-forward**	**Minimal** • 1 self-limited or minor problem	**Minimal** or none	**Minimal** risk of morbidity from additional diagnostic testing or treatment

99203
 	
99213
	30-44
	
	20-29
		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 of 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 interpretations, see moderate or high)
					Low risk of morbidity from additional diagnostic testing or treatment

MDM Table (cont'd)

CPT Code	Time (minutes)	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	45-59
	30-39
		Moderate	**Moderate**
			• 1 or more chronic illness(es) 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 of the 3 categories)
				Category 1: Tests, Documents
				• Any combination of 3 of 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

MDM Table (cont'd)

CPT Code	Time (minutes)	Level of MDM (based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99205
99215
	60-74
	40-54
		High	**High**
			• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatments; 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
				• Any combination of 3 of 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

LOS by MDM Example

I had the pleasure of consulting on your patient, in the pulmonary clinic at Henry Ford Hospital, on 1/27/2020 for an initial evaluation of cough.
As you are aware, the patient is a 39-year-old male with hypertension and gout who presents for an evaluation of a cough. The patient was seen in the HFH-Detroit Emergency Department on 1/18/2020 with a 4-day history of an upper respiratory tract infection. His symptoms included fever, cough and sore throat.
He was asked to complete an azithromycin Z pack (which was given to him by a physician friend) and follow up with his PCP. The patient reports that he is doing much better since his emergency center visit. He did have episodes of cough with musculoskeletal pain, but this has resolved as well. His current cough is minimally productive and has gradually been dissipating.

HENT:
Head: Normocephalic and atraumatic.
Nose: Nose normal.
Mouth/Throat:
Pharynx: No oropharyngeal exudate.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: Normal heart sounds. No murmur. No friction rub. No gallop.
Pulmonary:
Effort: Pulmonary effort is normal. No accessory muscle usage or respiratory distress.
Breath sounds: Normal breath sounds. No stridor. No wheezing, rhonchi or rales

Impression:
Acute bronchitis, unspecified organism
Need for prophylactic vaccination and inoculation against influenza
Plan:
Acute bronchitis
The patient likely **had** acute bronchitis associated with influenza B. He had an exposure from his child, and his wife was diagnosed with it formally approximately 3 days ago. However, his clinical syndrome has completely resolved, and it is greater than 48 hr. since the onset of symptoms.
The patient received an influenza vaccine today

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

99203	**Low**	**Low**
		• **2** or more self-limited or minor problems;
		1 stable chronic illness;
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Test 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

Level of Service: Time Based

LOS by Time Example

Physician/other qualified health care professional time includes the following activities, *when performed before, during, or after the visit on the date of the encounter*:

- preparing to see the patient (eg, review of tests)
- 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 record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

LOS by Time Example (cont'd)

- Can be included in time calculations
  - Only when performed by provider:
    - EPIC pre-charting
    - Waiting on hold for insurance authorizations
    - Filling out denial paperwork
    - Filling out forms (FMLA, insurance, worker's comp, prior authorizations, etc)

- Cannot be included in time calculations
  - Any part of the above activities that are performed by support staff
  - Time spent on any day other than the date of the encounter
  - Time that is included in other billed time-based services

Time: Office and Other Outpatient E/M Services: New Patient (Total Time on the Date of Encounter)

New Patient E/M Code	*Typical* Time (2020)	*Total* Time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15-29 minutes
99203	30 minutes	30-44 minutes
99204	45 minutes	45-59 minutes
99205	60 minutes	60-74 minutes

Established Patient E/M Code	*Typical* Time (2020)	*Total* Time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10-19 minutes
99213	15 minutes	20-29 minutes
99214	25 minutes	30-39 minutes
99215	40 minutes	40-54 minutes

Counseling and coordination of care statement will not be needed starting in 2021

LOS by Time Example

Patient is seen because of cough. She is somewhat of a vague historian as regards her cough but acknowledges the presence of refill walks though this is apparently laryngeal in nature. Follow-up endoscopies for laryngeal reflux have shown considerable improvement in the status of her lower of larynx. She has a not doing much with positional change in a matter of a BUN of improving reflux but feels content otherwise of she is doing things that move her in the correct direction.

She takes no controller is for her asthma for which he says has been present fatigue is. She is a lifelong murmur smoker of the week.
Spirometry in the clinic today is normal.
Chest x-rays were unrevealing.

History and Exam are appropriate to meet medical necessity.

Impression: Cough likely due to cough variant manifestation for have discussed.
Plan: Symbicort, with instructions to the pharmacist for substitution is sent. She is told that her cough will likely require 2 months of treatment before it contained me stated that this is not the cause. There are no other obvious precipitant. She is asked to stay on her omeprazole it half doses with plan by the ENT physicians, and to follow the 10 commencement of reflux management. She will return in a couple of months.

This visit lasted 25 minutes of which ~~more than 50% involved discussion and counseling~~ about the varied etiology is cough and how they interact common a difficult is to treat, but fortunately, she seems to be improving and I think we will be able to suppress removed her cough entirely with the program mentioned.

New Patient E/M Code	*Total* Time (2021)
99201	Code deleted
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Remember: Total time spent will include face-to-face time AND non-face-to-face time on the same date of the encounter.

LOS by Time Example 2: Shared Visits

-Our patient spends 10 minutes with the APP.

-The APP leaves the room; the Attending enters and spends 5 minutes with the patient.

-The APP spends 10 minutes completing charting after the patient checks out.

10 minutes with APP and patient
+ 5 minutes with Attending and patient
+ 10 minutes APP indirect care (charting)

= **25 minutes Total Billable Time**

-Our patient spends 10 minutes with the APP.

-The APP leaves the room; the Attending enters and spends 5 minutes with the patient.

-The APP joins the Attending and the patient for a final 10 minutes.

-The APP spends 10 minutes completing charting after the patient checks out.

10 minutes with APP and patient
+ 5 minutes with Attending and patient
+ 10 minutes with APP, Attending, patient
+ 10 minutes APP indirect care (charting)
= **35 minutes Total Billable Time**

Prolonged Services

Prolonged Services (99417)

- E/M Workgroup identified the need for a prolonged service code to capture services for a patient that required longer time on the date of the encounter
- Workgroup agreed with CMS that a shorter time was appropriate

- Shorter prolonged services code to capture each 15 minutes of critical provider work beyond the time captured by the office or other outpatient service E/M code
  - Used only when the office/other outpatient code is selected using time
  - For use ONLY with 99205, 99215
  - Prolonged services of less than 15-minute increments should not be reported
  - Includes with and without direct patient contact on same calendar date of encounter

- Minimum time threshold for Prolonged Service code
  - New patient = 75 minutes
  - Established patient = 55 minutes

Prolonged Services Times

TIMELINE (minutes)							
New Patient	**1-14**	**15-29**	**30-44**	**45-59**	**60-74**	**75-89**	**90-104**
	Do not use time (99202 by MDM)	99202	99203	99204	99205	99205 + 99417	99205 + 2 units 99417
Established Patient	**1-9**	**10-19**	**20-29**	**30-39**	**40-54**	**55-69**	**70-84**
	Do not use time (99212 by MDM)	99212	99213	99214	99215	99215 + 99417	99215 + 2 units 99417

Prolonged Service Example

History of Present Illness: Lung nodule and cough.
This new Patient complains of nonproductive cough which began in November 2019. She had cough and chest pain and her daughter who is a nurse listened to her lungs and felt they sounded "scratchy". She was given a course of steroids which helped but the cough never fully went away. She was also prescribed an albuterol MDI which she has not used as she would prefer not to use medications. She also notes that over the past couple years, she has increased shortness of breath when hiking in the summer and chest tightness when she exerts herself such as playing tennis. The current coughing and chest tightness can come on when she laughs a lot. Cough is dry. No hemoptysis. No fever/chills. She had a negative chest x-ray and ECG in the past but notes a coronary calcium CT scan from 2015 showed 2 small (2 mm and 3 mm) lung nodules which were never follow up with subsequent imaging.

She works as a teacher and does note that her school had asbestos and construction over the summer and when they came back to school in the fall, there was a lot of dust left behind. She smoked a pack a week from age 15-18 and had secondhand smoke exposure in her home as both her parents smoked. She denies other triggers to the cough including cold air, humidity, strong odors. No other complaints today.

SOCIAL HISTORY:
Patient reports that she quit smoking about 32 years ago. Her smoking use included cigarettes. She has a 0.45 pack-year smoking history. She has never used smokeless tobacco. She reports previous alcohol use. She reports that she does not use drugs.

REVIEW OF SYSTEMS:
A complete review of systems was done today. Please see HPI for pertinent negatives and positives. All remaining systems negative.

PHYSICAL EXAMINATION:
HEENT: Head: Normal, Normocephalic, atraumatic. Mucous membranes moist and no pharyngeal exudates or erythema.
LYMPHATICS: No cervical, supraclavicular, or submandibular lymphadenopathy.
LUNGS: No accessory muscle use. Lungs are clear to auscultation bilaterally. No crackles or wheezes. Normal symmetry and expansion of chest. Trachea midline.
CARDIAC: regular rate and rhythm, S1, S2 normal, no S3 or S4, no click and no rub. No murmurs appreciated.

DATA REVIEW:
Pulmonary Function Testing: Independently interpreted by me.
FEV1: 2.63 (94 % predicted), FVC: 3.44 (97 % predicted), FEV1/FVC: 76% consistent with no obstruction.

IMPRESSION:
1. Total coronary calcium score = 0.
2. Two 2 to 3 mm pulmonary nodules within the right lung.

ASSESSMENT:
1. Lung nodule
2. Pulmonary nodule/lesion, solitary
3. Cough

History and Exam are appropriate to meet medical necessity.

PLAN:
1. Pulmonary nodules. 2 and 3 mm on 2015 coronary calcium scoring CT scan. Patient will follow up with a low dose CT chest.
2. Chronic cough. Likely reactive airway disease verses asthma; however, in setting of normal spirometry I discussed returning for a methacholine challenge test (MCT) verses empiric treatment with an inhaled corticosteroid (ICS). She would prefer to not use any inhalers and her main concern is the lung nodules; therefore, I have ordered a MCT and if she changes her mind, she can call and schedule this.
3. Immunization status: Flu shot declined.

More than half of the 60 minutes of face-to-face time I spent with the patient was devoted to discussion of the diagnosis, treatment options, and counseling and an additional 15 minutes reviewing chest-x-rays, ECG and CT scans.

TIMELINE (minutes)							
New Patient	1-14	15-29	30-44	45-59	60-74	75-89	90-104
	Do not use time (99202 by MDM)	99202	99203	99204	99205	99205 + 99417	99205 + 2 units 99417
Established Patient	1-9	10-19	20-29	30-39	40-54	55-69	70-84
	Do not use time (99212 by MDM)	99212	99213	99214	99215	99215 + 99417	99215 + 2 units 99417

Remember: Total time spent will include face-to-face time AND non-face-to-face time on the same date of the encounter.

Questions?

To request education for your group or department on the 2021 E/M changes, please email codinganddocumentationed@hfhs.org.

More information can be found on our website on OneHenry at:
https://onehenry.hfhs.org/departments/documentationandcodingeducation/Pages/EM-2021.aspx

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Definitions

Problem Complexity Definitions

- ***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.

American Medical Association, CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Problem Complexity Definitions (cont'd)

- ***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 (eg, 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.
- ***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.

American Medical Association, CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Problem Complexity Definitions (cont'd)

- ***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.
- ***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 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.

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Complexity of Data Definitions

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- ***External:*** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
- ***External physician or other qualified healthcare professional:*** An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.
- ***Independent historian(s):*** 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(s) is needed, the independent historian(s) requirement is met.
- ***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 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.
- ***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.

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Complexity of Data Definitions (cont'd)

- ***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. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.
- ***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 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.
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Risk of Complications Definitions

- ***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.
- ***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 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. 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.

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