Medical Decision Making for Outpatient E/M Codes
(effective January 2021)

MGMA

E/M code	Time *(minutes)*	MDM *(Two out of three elements)*	Number and complexity of problems addressed	Amount and/or complexity of data to review and analyze *(Combination of two or combination of three in Category 1)*			Risk of complications and/or morbidity or mortality of patient management *(diagnostic testing or treatment)*
				CATEGORY 1	**CATEGORY 2**	**CATEGORY 3**	
Level 1							
99211	0	N/A	N/A	N/A			N/A
Level 2			**Minimal**	**Minimal or none**			**Minimal risk**
99202	15-29	**Straightforward**	• 1 self-limited or minor problem	**Minimal or no complexity and/or data reviewed**			• Rest • Gargles • Bandages • Superficial dressings
99212	10-19						
Level 3			**Low**	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)*			**Low risk**
99203	30-44	**Low**	• 2 or more self-limited or minor problems **or** • 1 stable chronic illness **or** • 1 acute, uncomplicated illness or injury	**Category 1: Tests and documents** At least 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	**Category 2: Assessment requiring an independent historian(s)**	**N/A**	• OTC drugs • Minor surgery without risk factors • PT/OT • IV fluids without additives
99213	20-29						
Level 4			**Moderate**	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)*			**Moderate risk**
99204	45-59	**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	**Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: • Review of prior external note(s) from each 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** • Independent interpretation of a test performed by another physician/other qualified healthcare professional	**Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• Prescription drug management • Decision regarding minor surgery with identified risk factors • Decision regarding elective major surgery without risk factors • Diagnosis or treatment significantly limited by social determinants of health (SDoH) [e.g., socioeconomic status, geographic location, education, employment, transportation access)
99214	30-39						

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Level 5			High	Extensive *(Must meet the requirements of at least 2 out of 3 categories)*			High risk
99205	60-74	**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	**Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: • Review of prior external note(s) from each source • Review of the result(s) of each test • Ordering of each test • Assessment requiring an independent historian(s)	**Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified healthcare professional	**Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source	• 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
99215	40-54						

Time-based coding elements* *(when performed and documented)*

- Reviewing patient's record prior to visit
- Performing a medically appropriate history and examination
- Ordering prescription medications, tests, or procedures
- Independently interpreting results
- Communicating results to the patient/family/caregiver
- Obtaining/reviewing separately obtained history from someone other than patient
- Counseling/educating the patient/family/caregiver
- Referring and communicating with another healthcare provider(s) when not separately reported during the visit
- Documenting clinical information in the patient's electronic health record
- Coordination of care for the patient

* **Time-based coding is based on total time spent on the date of the encounter.**

Important notes:

- E/M code 99201 is deleted in 2021 due to low utilization.
- Documentation of history and exam will not be counted as an element, but medical necessity must be established by documenting risk and MDM relevant to management of patient's condition.
- Interpretation of tests or discussion of management with another qualified healthcare professional is considered only when not separately reported.

For more information on these changes, consult the American Medical Association's E/M office revisions for level of MDM (effective Jan. 1, 2021).