LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: 99202 - 99215 OFFICE/CLINIC BASED SERVICES

Note: The following is a modification of the original AMA MDM Chart. This chart has been modified to provide more general terms and also include more specifications from the guidelines.

Code	Level of Service (Based on 2 out of 3 Elements of MDM) -OR- Time	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management *NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!*
99211	Services at this level are provided by ancillary staff. *NOTE: Ancillary staff and providers must be employed by the same TAX ID number to meet supervision requirements			
99202 **99212**	**Straightforward - or-** 99202: 15 - 29 | 99212: 10 - 19 99242: 20	**Minimal** • **1** negligible or meager problem addressed	**Minimal or none** Minimal infers the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up PRN

99203
99213
	Low
	-or-
	Time:
	99203: 30 - 44
	99213: 20 - 29
	99243: 30
		Low
		• **2** or more negligible or meager problem addressed;
		• **or**
		• **1** stable chronic problem addressed;
		or
		• **1** acute, direct or well-defined problem addressed or injury;
		or
		• 1 stable, acute illness;
		or
		• 1 acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents (Work commonly associated with E&M services)
			• **Documentation noting 2 of the following were performed:**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  ○ Example: Review of admission to the ED or IP since previous visit
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  ○ Example: PCP reviews testing ordered and performed by the cardiologist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  ○ Example: If the 26 component is NOT billed by the provider- the order can be allowed. However, the order and independent interpretation could NOT be combined.
			• **or**
			Category 2: Encounter including an additional historian(s)
			*****Documentation: Who is the historian, information historian provided, and best practices- why historian was required*
				Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Medications NOT requiring prescriptive authority
				• DME
				• Physical Therapy
				• Consult/Referral without elaboration

99204
99214
	Moderate
	-or-
	Time:
	99204: 45 - 59
	99214: 30 - 39
	99244: 40
		Moderate
		• **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment;
		or
		• **2** (or+) stable chronic problems addressed;
		or
		• **1** new problem undiagnosed potentially high risk;
		or
		• **1** acute complaint with unanticipated symptoms;
		or
		• **1** acute complex 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**: **(REFER TO EXAMPLES ABOVE):**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			  ○ Example: Provider request Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed.
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
			  ○ Example: Provider makes the decision to send the patient to the ED. The provider calls the ED provider to discuss
				Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority
				• Decision or consideration of a minor* procedure with documented patient or procedure risk factors.
				• Decision or consideration of a major* procedure without documented patient or procedure risk factors.
				• Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient
				• Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option
				*AMA: Minor and Major are at the discretion of the provider as documented
				*CMS: Minor 0-10 global | Major 90 day global

99205
99215
	High
	-or-
	Time:
	99205: 60 - 74
	99215: 40 - 54
	99245: 55
		High
		• **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment;
		or
		• **1** acute or chronic problem or injury that places danger/ risk to life or bodily function
			Extensive (REFER TO EXAMPLES ABOVE):
			(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**:
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
				Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Long/short term *intensive* monitoring to prevent toxicity (NOT monitoring efficacy)
				• Decision or consideration of a major* procedure with documented patient or procedure risk factors.
				• Decision or consideration of an major* surgery performed with minimal delay/immediate
				• Decision or consideration for hospitalization or alternative levels of care
				• Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery
				• Administration of controlled substance via IM, IV, or SubQ
				*AMA: Minor and Major are at the discretion of the provider as documented
				*CMS: Minor 0-10 global | Major 90 day global

For a copy of this MDM chart, contact NAMAS by email at namas@namas.co or at 877-418-5564

LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: INPATIENT PLACE OF SERVICE

Note: The following is a modification of the original AMA MDM Chart. This chart has been modified to provide more general terms and also include more specifications from the guidelines.

Code	Level of Service (Based on 2 out of 3 Elements of MDM) -OR- Time	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management *NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!*
	No IP Services fall under "minimal". There are other services that fall under SF, but they also fall under Low Level of Complexity as well. The same requirements are required with the exception of 99252 which has a time value of 35 minutes. Refer to the Low Complexity guidelines below.			
99252	**Straightforward** **- or-** **35 Minutes**	**Minimal** • **1** negligible or meager problem addressed	**Minimal or none** Minimal infers the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Will Follow up on patient tomorrow | Patient awaiting Discharge

99221
99231
99234
99253
	Low
	- or -
	99221 = 40 minutes
	99231 = 25 minutes
	99234 = 45 minutes
	99253 = 45 minutes
		Low
		• **2** or more negligible or meager problem addressed;
		• **or**
		• **1** stable chronic problem addressed;
		or
		• **1** acute, direct or well-defined problem addressed or injury;
		or
		• 1 stable, acute illness;
		or
		• 1 acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents (Work commonly associated with E&M services)
			• **Documentation noting 2 of the following were performed:**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  ○ Example: Review of previous admission IP
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  ○ Example: Cardiology reviews testing ordered by the hospitalist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  ○ Example: If the 26 component is NOT billed by the provider- the order can be allowed. However, the order and independent interpretation could NOT be combined.
			• **or**
			Category 2: Encounter including an additional historian(s)
			*****Documentation: Who is the historian, information historian provided, and best practices- why historian was required*
				Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Medications NOT requiring prescriptive authority
				• DME
				• Physical Therapy
				• Consult/Referral without elaboration
				• Awaiting discharge without further treatment plan

99222
99232
99235
99254
	Moderate
	- or -
	99222 = 55 minutes
	99232 = 35 minutes
	99235 = 70 minutes
	99254 = 60 minutes
		Moderate
		• **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment;
		or
		• **2** (or+) stable chronic problems addressed;
		or
		• **1** new problem undiagnosed potentially high risk;
		or
		• **1** acute complaint with unanticipated symptoms;
		or
		• **1** acute complex 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**: (**REFER TO EXAMPLES ABOVE):**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			  ○ Example: Provider requests Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed. The need for independent interpretation (medical necessity) should be included
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
			  ○ Example: Provider request consult and calls requesting services and discuss the patient with the on call provider
				Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority
				• Decision or consideration of a minor* procedure with documented patient or procedure risk factors.
				• Decision or consideration of a major* procedure without documented patient or procedure risk factors.
				• Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient
				• Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option
				• Leaving AMA without high complexity risk documented

99223
99233
99236
99255
	High
	- or -
	99223 = 75 minutes
	99233 = 50 minutes
	99236 = 85 minutes
	99255 = 80 minutes
		High
		• **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment;
		or
		• **1** acute or chronic problem or injury that places danger/ risk to life or bodily function
			Extensive (REFER TO EXAMPLES ABOVE):
			(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**:
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
				Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Long/short term *intensive* monitoring to prevent toxicity (NOT monitoring efficacy)
				• Decision or consideration of a major* procedure with documented patient or procedure risk factors.
				• Decision or consideration of an major* surgery performed with minimal delay/immediate
				• Decision or consideration for hospitalization or alternative levels of care
				• Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery
				• Administration of controlled substance via IM, IV, or SubQ

*AMA: Minor and Major are at the discretion of the provider as documented

*CMS: Minor 0-10 global | Major 90 day global

For a copy of this MDM chart, contact NAMAS by email at namas@namas.co or at 877-418-5564

namas national alliance of medical auditing specialists

Medical Decision Making (MDM) Level Tool: EMERGENCY DEPARTMENT SERVICES

EFFECTIVE FOR USE: JANUARY 1, 2023

Note: The following is the a modification of the original AMA MDM Chart. This chart has been modified to be specific to the ED, add examples to the chart, as well as provide more general terms from the guidelines.

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: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management ***NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!***
99281	Services at this level are provided by ancillary staff. *NOTE: Ancillary staff and providers would need to be employed by the same TAX ID number due to supervision rules			
99282	**Straightforward** Time-based services are NOT allowed in this place of service	**Minimal** • **1** negligible or meager problem addressed	**None**	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up with PCP without elaboration
99283	**Low** Time-based services are NOT allowed in this place of service	**Low** • **2** or more negligible or meager problem addressed; • **or** • **1** stable chronic problem addressed; **or** • **1** acute, direct or well-defined problem addressed or injury; **or** • 1 stable, acute illness; **or** • 1 acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit	**Limited** *(Must meet the requirements of **at least 1 of the 2 categories**)* **Category 1: Tests and documents (Work commonly associated with E&M services)** • **Documentation noting 2 of the following were performed:** • Evaluate external records from an external provider (may not divide per test/per CPT); ○ Example in ED: previous admissions to the IP or ED • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; ○ Example in ED: previous labs/imaging/diagnostics from other dates of service • ordering imaging, lab, psychometric, physiologic data testing per CPT (standing orders MUST be documented) ○ Example in ED: Most test the ED physician does not bill the TC component. If the TC is not billed by the provider- the order can be allowed. However, the order and independent interpretation could **NOT** be combined **or** **Category 2: Encounter including an additional historian(s):** *(In Moderate & High, this moves to Category 1)* ○ Documentation: Who is the historian, information historian provided, and best practices- why historian was required	**Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Medications NOT requiring prescriptive authority • DME such as a splint • Consult/Referral without elaboration • Leaving AMA without elaboration
99284	**Moderate** Time-based services are NOT allowed in this place of service	**Moderate** • **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment; **or** • **2** (or+) stable chronic problems addressed; **or** • **1** new problem undiagnosed potentially high risk; **or** • **1** acute complaint with unanticipated symptoms; **or** • **1** acute complex 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 (REFER TO EXAMPLES ABOVE):** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); ○ Example: ED provider request Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed. **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed) ○ Example in ED: ED provider Discuss an patient admission with the hospitalist	**Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority • Decision or consideration of a minor* procedure with documented patient or procedure risk factors. • Decision or consideration of a major* procedure without patient or procedure risk factors. • Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient • Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global
99285	**High** Time-based services are NOT allowed in this place of service	**High** • **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment; **or** • **1** acute or chronic problem or injury that places danger/ risk to life or bodily function	**Extensive (REFER TO EXAMPLES ABOVE):** *(Must meet the requirements of **at least 2 out of 3 categories**)* • **Any combination of 3 from the following**: **Category 1: Tests, documents, or independent historian(s)** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)	**Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Long/short term *intensive* monitoring- for high risk meds or the consideration of to prevent toxicity (NOT monitoring efficacy) • Decision or consideration of a major* procedure with documented patient or procedure risk factors. • Decision or consideration of an major* surgery performed with minimal delay/immediate • Decision or consideration for hospitalization • Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery • Administration of controlled substance via IM, IV, or SubQ *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global

For a copy of this MDM chart, contact NAMAS by email at namas@namas.co or at 877-418-5564

Vignettes for 2021 Documentation Guidelines

***NOTE* Vignettes are recommendations only and documentation criteria is required to support the appropriate level of service.**

2 — Minimal Complexity & Risk Encounter

Patient present post global/surgical and is recovering well and is discharged from care to follow up as needed in the future.

Patient presents with common cold and is told to return if symptoms worsen and provided reassurances.

3 — Low Complexity & Risk Encounter

Patient with chronic stable problem presents and medication is refilled.

Patient presents with ear pain which is diagnosed as OM. No systemic symptoms are noted. The patient is prescribed an antibiotic.

Patient is seen and the decision is made to perform a minor procedure. However an additional chronic problem is also addressed and OTC anti-inflammatory recommended.

4 — Moderate Complexity & Risk Encounter

Patient w/chronic problem placed on a new RX medication last visit. This visit, it is noted they are not at treatment goals, continue current plan.

Patient presents with a new problem-workup for diagnose is required, but the suspected problem will have substantial duration and PT's function will be limited. The PT is provided RX for pain management

Patient presents with acute onset of respiratory complaints. The patient, diagnosed with URI is having labored breathing. Patient is given an antibiotic.

5 — High Complexity & Risk Encounter

Patient presents for follow up of DM. Sugars today are 565 and the provider makes the decision to send the patient to the ED. The patient refuses. The provider documents that they recommended advanced care, but the patient refused. The documentation also included the risks to the patient for not receiving advanced care in their condition.

Patient presents w/asthma exacerbation & possible URI, PT is retracting/audible wheezes. O2 provided, first nebulizer, minimal improvement, second nebulizer, air flow returns. RX provided, and emergency protocols revisited. ED visit avoided- and should be documented- if it was considered.

ABOUT THESE VIGNETTES:

It is important to understand the ***DOCUMENTATION matters***

These vignettes have been designed to offer examples of patient care, utilizing Column 1 and Column 3 of the MDM chart, it requires that the documentation include the complexity and risk associated with these categories to support the level of service.

Each example in the vignette has been selected to try and provide the most common scenarios regardless of specialty.

In order to make the most out of these vignettes, consider a challenge-

Take these vignettes and the AMA MDM chart, and analyze the condition to the MDM chart. Identify why each, utilizing Column 1 & 3 support the levels identified above.

Have a question?

Contact us: namas@namas.co
1-877-418-5564