

YOU MUST MEET OR EXCEED 2 OUT OF THE 3 SECTIONS (DX, DATA, RISK) TO DETERMINE THE FINAL MDM							
NUMBER & COMPLEXITY OF PROBLEMS ADDRESSED	DATA	RISK	MDM (2 of 3)	CLINIC/OP CONSULT	IP/OBS/ED/SAME DAY ADMIT DC	SNF/NF	HOME/DOMICILIARY/CUSTODIAL CARE/ALF
N/A	N/A	N/A	N/A	99211	99281		
MINIMAL • 1 SELF-LIMITED MINOR PROBLEM	MINIMAL OR NONE • REVIEW PRIOR NOTES • REVIEW TEST RESULTS • ORDER TESTS	MINIMAL RISK • REST • GARGLES • SUPERFICIAL DRESSINGS	STRAIGHTFORWARD	99202 (15-29 MIN) 99212 (10-19 MIN) 99242 (20 MIN)	99221 (40 MIN) INITIAL IP/OBS 99231 (25 MIN) SUBSQ IP/OBS 99234 (45 MIN) SAME DAY ADMIT/DC 99252 (35 MIN) CONSULT IP/OBS 99282 ED	99304 (25 MIN) 99307 (10 MIN)	99341 (15 MIN) 99347 (20 MIN)
LOW • 2 OR MORE SELF LIMITED MINOR PROBLEMS • 1 STABLE CHRONIC ILLNESS • 1 ACUTE UNCOMPLICATED ILLNESS OR INJURY • 1 STABLE ACUTE ILLNESS • 1 ACUTE UNCOMPLICATED ILLNESS OR INJURY REQUIRING HOSPITAL IP OR OBS LEVEL OF CARE	LIMITED (MUST HIT 1 OUT OF THE 2 CATEGORIES) CATEGORY 1 ANY COMBINATION OF 2 BELOW • REVIEW PRIOR NOTES • REVIEW TEST RESULTS • ORDER TESTS OR CATEGORY 2 • HX OBTAINED FROM INDEPENDENT HISTORIAN	LOW RISK • OTC DRUGS • MINOR SURGERY W/NO IDENTIFIED RISK FACTORS • PT/OT • IV FLUIDS	LOW	99203 (30-44 MIN) 99213 (20-29 MIN) 99243 (30 MIN)	99221 (40 MIN) INITIAL IP/OBS 99231 (25 MIN) SUBSQ IP/OBS 99234 (45 MIN) SAME DAY ADMIT/DC 99253 (45 MIN) CONSULT IP/OBS 99283 ED	99304 (25 MIN) 99308 (15 MIN)	99342 (30 MIN) 99348 (30 MIN)
MODERATE • 1 OR MORE CHRONIC ILLNESSES W/EXACERBATION, PROGRESSION OR SIDE EFFECTS OF TX • 2 OR MORE STABLE CHRONIC ILLNESSES • 1 UNDIAGNOSED NEW PROBLEM W/UNCERTAIN PROGNOSIS • 1 ACUTE COMPLICATED INJURY • 1 ACUTE ILLNESS WITH SYSTEMIC SYMPTOM	MODERATE (MUST HIT 1 OUT OF THE 3 CATEGORIES) CATEGORY 1 ANY COMBINATION OF 3 BELOW • REVIEW PRIOR NOTES • REVIEW TEST RESULTS • ORDER TESTS • INDEPENDENT HISTORIAN OR CATEGORY 2 • INDEPENDENT INTERP OF TEST OR CATEGORY 3 • DISCUSSION OF MANAGEMENT OR TEST (NOT SEPARATELY REPORTED)	MODERATE RISK • RX MANAGEMENT • MINOR SURGERY W/IDENTIFIED RISK FACTORS • ELECTIVE SURGERY W/NO IDENTIFIED RISK FACTORS • DIAGNOSIS OR TX SIGNIFICANTLY LIMITED BY SOCIAL DETERMINANTS OF HEALTH	MOD	99204 (45-59 MIN) 99214 (30-39 MIN) 99244 (40 MIN)	99222 (55 MIN) INITIAL IP/OBS 99232 (35 MIN) SUBSQ IP/OBS 99235 (70 MIN) SAME DAY ADMIT/DC 99254 (60 MIN) CONSULT IP/OBS 99284 ED	99305 (35 MIN) 99309 (30 MIN)	99344 (60 MIN) 99349 (40 MIN)
HIGH • 1 OR MORE CHRONIC ILLNESSES WITH SEVERE EXACERBATION, PROGRESSION OR SIDE EFFECTS OF TX • 1 ACUTE OR CHRONIC ILLNESS WITH EXACERBATION THAT POSES A THREAT TO LIFE OF BODILY FUNCTION	EXTENSIVE (MUST HIT 2 OUT OF THE 3 CATEGORIES) CATEGORY 1 ANY COMBINATION OF 3 BELOW • REVIEW PRIOR NOTES • REVIEW TEST RESULTS • ORDER TESTS • INDEPENDENT HISTORIAN OR CATEGORY 2 • INDEPENDENT INTERP OF TEST OR CATEGORY 3 • DISCUSSION OF MANAGEMENT OR TEST (NOT SEPARATELY REPORTED)	HIGH RISK • DRUG THERAPY REQUIRING MONITORING FOR TOXICITY • ELECTIVE MAJOR SURGERY WITH IDENTIFIED RISK FACTORS • EMERGENCY MAJOR SURGERY • DECISION REGARDING HOSPITALIZATION OR ESCALATION OF HOSPITAL LEVEL CARE • DNAR OR DEESCALATE CARE DUE TO POOR PROGNOSIS • IV NARCOTICS BELOW FOR NF CARE ONLY • Multiple morbidities requiring intensive management: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.	HIGH	99205 (60-74 MIN) 99215 (40-54 MIN) 99245 (55 MIN)	99223 (75 MIN) INITIAL IP/OBS 99233 (50 MIN) SUBSQ IP/OBS 99236 (85 MIN) SAME DAY ADMIT/DC 99255 (80 MIN) CONSULT IP/OBS 99285 ED	99306 (45 MIN) 99310 (45 MIN)	99345 (75 MIN) 99350 (60 MIN)

Medical Decision Making (MDM) Grid

Code	Time ** <small>minimum time must be met or exceeded</small>	Level of MDM <small>(Based on 2 out of 3 Elements of MDM)</small>	Elements of Medical Decision Making		
			Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Patient Management Risk
99252 Inpatient Consult	35-44 minutes	Straightforward Complexity	Minimal <input type="checkbox"/> 1 self-limited or minor problem	Low Minimal or none	Minimal risk of morbidity or mortality with the management/treatment considered or planned
99221 Initial Inpatient or Observation Care	40-54 minutes	Low Complexity	Low <input type="checkbox"/> 2 or more self-limited or minor problems; or <input type="checkbox"/> 1 stable, chronic illness; or <input type="checkbox"/> 1 acute, uncomplicated illness or injury or <input type="checkbox"/> 1 stable, acute illness or <input type="checkbox"/> 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Minimal / Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents Any combination of 2 from the following: <input type="checkbox"/> Review of prior external note(s) from each unique source*; <input type="checkbox"/> Review of the result(s) of each unique test*; <input type="checkbox"/> Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Minimal or low risk of morbidity or mortality with the management/treatment considered or planned <i>Examples only:</i> <input type="checkbox"/> OTC treatment <input type="checkbox"/> Minor surgery without identified patient or procedure risk factors <input type="checkbox"/> Physical / Occupational Therapy <input type="checkbox"/> IV fluids without additives <input type="checkbox"/> Other low-risk testing or treatment
99231 Subsequent Inpatient or Observation Care	25-34 minutes				
99234 Inpatient or Observation Same-Day Admit & Discharge	45-69 minutes				
99253 Inpatient Consult	45-59 minutes				
99222 Initial Inpatient or Observation Care	55-74 minutes	Moderate Complexity	Moderate <input type="checkbox"/> 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or <input type="checkbox"/> 2 or more stable, chronic illnesses; or <input type="checkbox"/> 1 undiagnosed new problem with uncertain prognosis; or <input type="checkbox"/> 1 acute illness with systemic symptoms; or <input type="checkbox"/> 1 acute complicated injury	Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: <input type="checkbox"/> Review of prior external note(s) from each unique source*; <input type="checkbox"/> Review of the result(s) of each unique test*; <input type="checkbox"/> Ordering of each unique test*; <input type="checkbox"/> Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests <input type="checkbox"/> 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 <input type="checkbox"/> Discussion of management or test interpretation with external physician/other qualified health care professional or appropriate source (not separately reported)	Moderate risk of morbidity or mortality with the management/treatment considered or planned <i>Examples only:</i> <input type="checkbox"/> Prescription drug management <input type="checkbox"/> Decision regarding minor surgery with identified patient or procedure risk factors <input type="checkbox"/> Decision regarding elective surgery without identified patient or procedure risk factors <input type="checkbox"/> Diagnosis or treatment significantly limited by social determinants of health <input type="checkbox"/> Other moderate-risk testing or treatment
99232 Subsequent Inpatient or Observation Care	35-49 minutes				
99235 Inpatient or Observation Same-Day Admit & Discharge	70-84 minutes				
99254 Inpatient Consult	60-79 minutes				
99223 Initial Inpatient or Observation Care	Min 75 minutes				
99233 Subsequent Inpatient or Observation Care	Min 50 minutes	High Complexity	High <input type="checkbox"/> 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment; or <input type="checkbox"/> 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: <input type="checkbox"/> Review of prior external note(s) from each unique source*; <input type="checkbox"/> Review of the result(s) of each unique test*; <input type="checkbox"/> Ordering of each unique test*; <input type="checkbox"/> Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests <input type="checkbox"/> 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 <input type="checkbox"/> Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity or mortality with the management/treatment considered or planned. <i>Examples only:</i> <input type="checkbox"/> Drug therapy requiring intensive monitoring for toxicity <input type="checkbox"/> Decision regarding hospitalization <input type="checkbox"/> Decision regarding emergency major surgery <input type="checkbox"/> Decision regarding elective surgery with identified patient or procedure risk factors <input type="checkbox"/> Decision not to resuscitate or to de-escalate care because of poor prognosis <input type="checkbox"/> Parenteral controlled substances (the controlled substance must be listed in the FDA schedule of parenteral controlled substances AND given by injection or infusion) <input type="checkbox"/> Other high-risk testing or treatment
99236 Inpatient or Observation Same-Day Admit & Discharge	Min 85 minutes				
99255 Inpatient Consult	Min 80 minutes				

**** Time-Based Documentation and Level Selection:**

Document total time on the date of the encounter. A statement should include a brief statement validating the total time spent, as well as carving out ancillary services. ALL time is included as long as it is directly related to the care of the patient. This includes time spent face-to-face with the patient, family/caregiver, as well as non-face-to-face time, which even includes time spent off of the patient's unit/floor. This is the provider's personal time only, not teaching or performing billable procedures. Do not count the time of any separately reported service as prolonged services time.

The following is a list of activities that can be used when defining total time: Preparing to see the patient (e.g., review of tests); Obtaining and/or reviewing a separately obtained history; Obtaining and/or reviewing a separately obtained history; Ordering medications, tests, or procedures; Ordering medications, tests, or procedures; Ordering medications, tests, or procedures; Documentation; Independent interpretation of results; Care coordination. TIP: CMS is looking for a time statement — the total time spent and all the activities that were performed to get to that time.

Inpatient Services Documentation Tips

Problem Addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service.

A problem noted to be under the management of another healthcare provider is not considered “addressed” or managed by the provider reporting the service unless they document their own additional assessment or care coordination.

In the inpatient or observation setting, the problem addressed reflects the patient’s status on the encounter date. This problem may be different from the problem that caused the admission or continued inpatient/observation stay.

Complexity of Presenting Problems:

- Chronic: A problem with an expected duration of at least 1 year or until death
- Stable: A patient at their treatment goals
- Exacerbated: Worsening, progressing, poorly controlled, not at treatment goals
- Multiple: 2+ Chronic problems, can also include stable problems
- Severe Exacerbation: A chronic problem documented as severely exacerbated
- Acute: A problem that runs a definite and prescribed course
- Uncomplicated: require hospital care low risk of morbidity w/treatment and full recovery
- Stable, acute illness: new or recent that treatment is initiated but not resolved
- Acute w/systemic symptoms: illness with onset of symptoms beyond general symptoms
- Acute w/threat: Exacerbation, progression, or acute threat to life or bodily function

Order/Review Tests: 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. A unique test is defined by the CPT code set. When multiple results for the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

Document: Each test ordered and reviewed as part of the work of each encounter.

Discussion: This requires an interactive exchange, must be direct and not through intermediaries (e.g., clinical staff or trainees). Residents and APPs working in conjunction with supervising physicians are exempt. Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.

Document: Healthcare providers involved, how the discussion was held, and the nature of the conversation for the patient.

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 provider has or will be reporting the service. A form of interpretation should be documented.

Document: Visualization, interpretation, and the need for the independent interpretation (medical necessity)

Independent historian(s): An individual (e.g., 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 (e.g., 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. It does not include translation services.

Document: Identity of historian, relationship to patient, and indications for using historian.

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 the purpose 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.

Document: Within the treatment plan, be sure to include the risk of patient management, all treatments considered, and differential diagnosis.