THE UNIVERSITY OF CHICAGO | UChicago Medicine | Office of Corporate Compliance
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Tip Sheet: Outpatient Evaluation & Management Services (CPT codes 99202-99215)

:::::::::EFFECTIVE JANUARY 1, 2022

Instructions: This tip sheet pertains only to Office/Outpatient E/M codes 99202-99215 whether conducted in-person or via video. This tip sheet does not apply to telephone E/M which are billed with CPT 99441-99443. **For detailed Telehealth coding guidance, click here.** All other E/M services still use History, Exam, and Medical Decision Making to level services, including consultations, inpatient, observation, and ED services. **For guidance on all other E/M's (excluding outpatient E/M) click here.**

Office/Outpatient E/M Code Description (99201-99215)	Level	MDM	Time n/a for PCE
Office or other outpatient visit for the evaluation and management of a NEW patient which requires medically appropriate history and/or examination and [SF/ Low/Mod/High] level of medial decision making	• 99202 • 99203 • 99204 • 99205	• Straightforward • Low • Moderate • High	• 15-29 • 30-44 • 45-59 • 60-74
Office or other outpatient visit for the evaluation and management of a ESTABLISHED patient which requires medically appropriate history and/or examination and [SF/Low/Mod/High] level of medial decision making. Note– CPT 99211 may not require the presence of a physician or other qualified health care professional.	• 99211 • 99212 • 99213 • 99214 • 99215	• N/A • Straightforward • Low • Moderate • High	• N/A • 10-19 • 20-29 • 30-39 • 40-54

Selecting a Level of Service

Method of level selection is MDM or Time, except for Primary Care Exception services which may only use MDM as of Jan 1st, 2022.

- **All Services** *(except Primary Care Exception)*:
  1. The total Time for E/M services performed on the date of the encounter (n/a for PCE); ***or***
  2. The level of the Medical Decision Making as defined for each service.

"All Services" Includes resident non PCE services (Mod GC).

- **Primary Care Exception (Mod GE):** In qualified primary care centers, residents may be seen without the presence of a teaching physician.
  1. Only the level of Medical Decision Making may be used to level regular or video services.

History and/or Examination

Office or outpatient services include a medically appropriate history and/or physical examination, when performed. However, history/exam elements are not required for level selection of office or other outpatient services (see code list above). The nature and extent of the history and/or exam is determined by the treating physician/qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire). The provider should indicate that such information has been reviewed.

Selecting Level of Service Using Medical Decision Making (MDM)

The four level of MDM are straightforward, low, moderate, and high. MDM is defined by three elements:

1. The number and complexity of problem(s) that are addressed during the encounter;
2. The amount and/or complexity of data to be reviewed and analyzed; and
3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

Documentation of MDM

To support the level of MDM, the provider's note should include:

- A clear description of all problems managed, evaluated and/or treated on the date of service, as well as the severity and acuity of those problems.
- A description of the data ordered, reviewed or interpreted plus any relevant analysis (i.e., "Reviewed CBC from 10/20 and (insert analysis here)."
- If an assessment requiring an independent historian (e.g., parent, spouse, guardian) is obtained because the patient is unable to provide a complete or reliable history (i.e., due to developmental stage, dementia, or psychosis).
- Possible management options that were considered but ruled out, after shared medical decision making with the patient/ family. These considerations must be documented.
- Any social determinants of health and their impact on the provider's ability to diagnose or treat the patient.

Social Determinants of Health Examples

- **Illiteracy and low-level literacy —>** Low health literacy may require different or more extensive efforts with patient education (i.e. all verbal instruction because patient can't read written instructions)
- **Inadequate housing** —> Patient may lack refrigeration in their home so can't be prescribed cold storage medications, so you have to prescribe something else. May have mold infestation so have to intensify management of their asthma.
- **Extreme poverty or Low income** —> May not be able to afford medications or other over-the-counter type therapies/devices.
- **Disappearance and death of family member** —> May decide to defer addressing some medical issues to prioritize providing emotional support for bereavement.

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- **Child in welfare custody.** —> May have to spend extra time educating new foster parent on medical management or on how to provide support care for medical condition

Selecting Level of Service Using Time *(n/a for PCE)*

- Time increments for each code are in the table above.
- A face-to-face encounter with the physician/qualified health care professional (QHCP) is required.
- Note: The concept of time does not apply to code 99211.
- ***Time that may not be counted:***
  - ∗ Time spent on a Primary Care Exception service
  - ∗ Time spent on a previous or subsequent day
  - ∗ Activities performed by clinical staff (i.e., RNs, MAs)
  - ∗ When the E&M is warranted and separately identifiable, the time spent on separately reportable services (such as procedures, diagnostic tests, professional interpretation) cannot be combined with the E&M time.
  - ∗ Overlapping time spent between an NPP and Physician for the purpose of split-shared billing
  - ∗ Time spent on travel
  - ∗ Time spent on teaching that is general
- ***Time that may be counted***
  - ∗ Both face-to-face and non-face-to-face time personally spent by the Physician/QHCP or Teaching Physician on qualifying activities the day of the encounter,
  - ∗ Time the Teaching Physician is present when the resident is performing qualifying activities on the DOS

List of qualifying activities:

- ⇒ Preparing to see the patient (eg, review of tests)
- ⇒ Obtaining/reviewing separately obtained history
- ⇒ Performing a medically appropriate examination and/or evaluation
- ⇒ Counseling/education of the patient/family
- ⇒ Ordering medications, tests, or procedures
- ⇒ Referring and communicating with other health care professional (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)

Split– Shared Time Requirements

- Time personally spent by the Physician and Non-Physician Practitioner (NPP) on the date of the service is summed to define total time. Only distinct time is summed.
- If the Physician and NPP see the patient together, or discuss the patient together, time is counted once.
  - Example 1: Physician & NPP jointly spend 15 mins on a split-shared visit with a patient. Time Allowed = 15 mins (not 30).
  - Example 2: NPP personally spends 15 mins of time related to the patient visit; Physician personally spends 10 minutes of time on the visit. Time Allowed = 25 (15 + 10).

⇒ Billing practitioner uses .**SPLITSHAREDNPPVISIT**

⇒ Non-billing practitioner may use **.TIMEATTEST**

Counting Time with Teaching Physicians & Housestaff (e.g., Residents & Fellows)

- **Primary Care Exception (PCE):** Time may **not** be used to level Primary Care Exception services as of Jan 1, 2022.
- **Non-Primary Care Exception:** Housestaff's time may not be counted. Count only the Teaching Physician's time, which may include time TP is present with resident while performing qualifying activities.
  - ⇒ Do not count time spent in educating the Housestaff (i.e., on teaching that is general and not limited to mgmt. for specific patient)

Time Documentation

- If time is used to select the E/M code, the provider (e.g. APP, Attending) must document total time in the note. Use the smart phrase below to capture total time.
- **.TIMEATTEST**—"I spent a total of *** minutes (excluding separately reportable procedure time) in care of this patient on @ED@.
- Teaching Physicians can use the Attestation Statements below to record total time.

* Housestaff in non-PCE settings do not have to record time since their time cannot be counted by the Teaching Physician.

Teaching Physican Attestation Statements

Teaching Physician alone —> **.ATTESTNOTPRESENTAMB**

I personally saw and physically examined the patient with {PATIENT COMPLEXITY:91025} level of risk. I agree with the housestaff's assessment and plan of care. I spent a total of *** minutes (excluding separately reportable procedure time) in care of this patient on @ED@.

Teaching Physician with Housestaff —> **.ATTESTPRESENTAMB**

I was present with the resident and participated during the history and physical exam of the patient with {PATIENT COMPLEXITY: 91025} level of risk. I agree with the housestaff's assessment and plan of care. I spent a total of *** minutes (excluding separately reportable procedure time) in care of this patient on @ED@.

Teaching Physician (PCE) —> .**ATTESTPRIMARYCAREEXCEPTION**

I discussed this service with the resident which included a review of the patient's medical history, findings on physical exam, diagnosis and treatment plan. I agree with the assessment and plan as written/with exception. *(Time no longer applies Jan 1st)*

See the **tip sheet of attestation statements** for further help.

EPIC Level of Service Calculator (Wizard)

- The EPIC Level of Service (LOS) calculator can provide a suggested office/outpatient E/M code based on MDM criteria or time the provider enters into the calculator.
- Caution: The calculator captures the approximate time the provider had the patient's chart open. This time may not accurately reflect the provider's actual face to face, and non face to face time on the service.
- See the OCC tip sheet for instructions on how to access and use the calculator (LINK).

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Calculating Medical Decision Making: Follow steps 1-4 to determine the level of MDM and CPT code.

(Note: definitions for key terms are in the appendices)

Step 1: Calculate Number and Complexity of Problems Addressed at the Encounter - Select all bulleted elements that apply. The furthest right column in which an element is selected represents the final complexity level. For example, if a patient has 1 stable chronic illness (Low) and 1 chronic illness with severe exacerbation and progression (High), the overall complexity level is High.

Element	• 1 self-limited or minor problem *(runs a prescribed course, is transient in nature, and is not likely to permanently alter health status)*	• 2 or more self-limited or minor problem • 1 stable chronic illness *(ie, well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia)* • 1 acute, uncomplicated illness or injury *(i.e. cystitis, allergic rhinitis, or a simple sprain)*	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment *(requires supportive care or attention to side effects, but not hospitalization)* • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 acute illness with systemic symptoms *(ie, pyelonephritis, pneumonitis, or colitis)* • 1 acute complicated injury *(ie, head injury with brief loss of consciousness)*	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment *(significant risk of morbidity; may require hospitalization)* • 1 acute or chronic illness or injury that poses a threat to life or bodily function, i.e.: * *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*
Complexity Level	**Minimal**	**Low**	**Moderate**	**High**

Step 2: Calculate Amount and/or Complexity of Data to be Reviewed and Analyzed—Select all of the elements that apply to the service. To reach a certain complexity level, one must meet the required number of elements for the level as described below. Data includes 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 inter-professional communications that are not separately reported. It includes interpretation of tests that are not separately reported.

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. Do not count the order and performance or interpretation when it will be separately reported by the provider reporting the E/M.

Complexity Level **Must meet category requirements specified here** →	**Minimal** **MINIMAL OR NO DATA**	**Limited** **MEET CATEGORY 1 BELOW**	**Moderate** **MEET 1 OF 3 CATEGORIES BELOW**	**Extensive** **MEET 2 OF 3 CATEGORIES BELOW**
CATEGORY 1 **1.** Review of prior external note(s) from each unique source* **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test* (order of test includes review of results) **4.** Assessment requiring an Independent historian *Each unique test, order, or document may be counted		**Category 1:** Meet any combination of 2 from items 1-3 **Or** Meet item 4 (independent historian)	**Category 1:** Meet any combination of 3 from items 1-4	**Category 1:** Meet any combination of 3 from items 1-4
CATEGORY 2: **i**ndependent interpretation of tests—*performed by another physician/other qualified healthcare professional (not separately reported)*			**Category 2:** Independent interpretation of test	**Category 2:** Independent interpretation of test
CATEGORY 3: Discussion of management or test interpretation—*with external physician/other qualified health care professional/ appropriate source (not separately reported)*			**Category 3:** Discussion mgmt., or test interpretation (external)	**Category 3:** Discussion mgmt., or test interpretation (external)

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Step 3: Calculate Risk of Complications and/or Morbidity or Mortality of Patient Management Decisions Made at the Visit Associated with the Patient's Problems, the Diagnostic Procedure(s), and Treatment(s) - Select the risk level associated with the patient's problems, diagnostic procedures and treatments. This risk is distinct from the risk associated with the condition.

This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Description	Minimal risk of morbidity from additional diagnostic testing or treatment Examples only • Rest • Gargles • Elastic bandages • Superficial dressings	Low risk of morbidity from additional diagnostic testing or treatment Examples only • OTC drugs • Minor surgery w/no identified risk factors • Physical/Occ therapy	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	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 deescalate care because of poor prognosis
Risk Level	**Minimal**	**Low**	**Moderate**	**High**

Step 4: Calculating Level of Medical Decision Making - Select the corresponding complexity level below that was calculated for Elements 1-3. To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded. If a column has 2 or 3 selections, draw a line down the column and select the code. Otherwise, draw a line down the column with the center selection and select the code.

ELEMENTS	**COMPLEXITY LEVEL**				
1. Number and Complexity of Problems Addressed	N/A	Minimal	Low	Moderate	High
2. Amount and/or Complexity of Data to be Reviewed and Analyzed	N/A	Minimal or None	Limited	Moderate	Extensive
3. Risk of Complications and/or Morbidity or Mortality of Patient Management	N/A	Minimal Risk	Low Risk	Moderate Risk	High Risk
LEVEL of MDM	**N/A** **99211**	**Straightforward** **99202 (New)** **99212 (Est)**	**Low** **99203 (New)** **99213 (Est)**	**Moderate** **99204 (New)** **99214 (Est)**	**High** **99205 (New)** **99215 (Est)**

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APPENDICES

I. Definitions for the elements of medical decision making for office or other outpatient services

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.

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.

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, 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.

Analyzed (3-9-21): The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

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.

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.

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.

Combination of Data Elements (NEW): 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. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

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Drug therapy requiring intensive monitoring for toxicity (Updated 3-9-21): 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. Examples may include monitoring for 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 do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Discussion (3-9-21): 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)

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care 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) (Updated 3-9-21): 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. 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 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.

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.

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.

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.

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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.

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk (Updated, 3-9-21 and see above): 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. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

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.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

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.

Surgery (minor or major, elective, emergency, procedure or patient risk) (3-9-21):

> **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.

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Test (Updated 3-9-21): 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 tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a 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. An example may be a lump in the breast.

Unique (3-9-21): 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.

II. Resources

A. AMA CPT E/M Code and Guideline Changes: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

B. MLN Booklet Evaluation and Management Services Guide, ICN 006764 January 2020: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

C. CMS CY20 Physician Fee Schedule Final rule: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-11-6-PFS