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

<table>
<thead>
<tr>
<th>E/M code</th>
<th>Time (minutes)</th>
<th>MDM (Two out of three elements)</th>
<th>Number and complexity of problems addressed</th>
<th>Amount and/or complexity of data to review and analyze (Combination of two or combination of three in Category 1)</th>
<th>Risk of complications and/or morbidity or mortality of patient management (diagnostic testing or treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td></td>
<td></td>
<td></td>
<td>CATEGORY 1</td>
<td>CATEGORY 2</td>
</tr>
<tr>
<td>99211</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td></td>
<td></td>
<td></td>
<td>Minimal</td>
<td>Minimal or none</td>
</tr>
</tbody>
</table>
| 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  | 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 | • OTC drugs  
  • Minor surgery without risk factors  
  • PT/OT  
  • IV fluids without additives |
| 99213    | 20-29          |                                 | • 1 stable chronic illness  
  • 1 acute, uncomplicated illness or injury |            |            |            |
| **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) | • 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          |                                 |                                             | Category 2: Independent interpretation of tests  
  • Independent interpretation of a test performed by another physician/other qualified healthcare professional  
  • Discussion of management or test interpretation  
  with external physician/other qualified healthcare professional/appropriate source | Category 3: Discussion of management or test interpretation  
  • 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) |
## Medical Decision Making for Outpatient E/M Codes (effective January 2021)

<table>
<thead>
<tr>
<th>Level 5</th>
<th>High</th>
<th>Extensive</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>60-74</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>40-54</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

### High
- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- 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, or independent historian(s)
- 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
- 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

### 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 day 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.

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

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