Practice Management Center

Definitions for the medical decision-making elements terminology

The American Medical Association (AMA) has revised and updated the E/M services medical decision-making (MDM) terminology and definitions. Understanding the meaning of these terms and their definitions will assist the dermatologist or non-physician clinician (NPC) in consistently and accurately applying the MDM concepts when selecting the level of service for dermatology encounters. The table below should be used as a reference tool when reviewing the coding examples provided in the Derm Coding Consult (DCC) Application of 2021 E/M Coding Concepts and other E/M articles.

Diagnosis Complexity Categorization

This document provides many dermatology diagnoses as examples of conditions that will qualify under the "Complexity of Problems Addressed" categories. Please note that the conditions listed may qualify under multiple categories, depending on disease severity and patient presenting circumstances at the time of the encounter.

The examples provided do not constitute an exhaustive list. Placement of a condition in a category does not exclude it from other categories. The complexity of the problem addressed for each encounter is determined by the diagnosis AND the presence of additional patient comorbidity factors which may reduce or elevate the risk of the patient's presenting problem.

For example, there are patients who may present with psoriasis so minor that it would be considered a stable chronic illness, or potentially severe enough to be a chronic illness with severe exacerbation. A patient's actinic damage may manifest solely as rhytids (self-limited, minor problem) or with such severe actinic damage that it would be categorized as a chronic illness with exacerbation or progression.

The medical record must clearly reflect the level of complexity of the problem addressed during the encounter. Consider using the descriptive language included in the MDM table, to relay and support the complexity of the problem addressed or level risk of patient management or treatment options. For example, documentation of a chronic problem addressed during the encounter may be described as one at treatment goal (low complexity) or one that is exacerbated/not at treatment goal (moderate complexity). An example of the use of this descriptive language when describing the problem addressed is *chronic progressive dermatoheliosis from continuing sun exposure.*

Terminology	Definition
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. *Examples include any problem presented and addressed during an encounter including but not limited to: Acne, Actinic Keratosis, Allergic contact dermatitis, Alopecia, Atopic Dermatitis, Basal Cell Carcinoma (BCC), Irritant Dermatitis, Seborrheic Keratosis, Squamous Cell Carcinoma (SCC), Neoplasm Uncertain Behavior (NUB), Pigmented lesion, Pruritus, Psoriasis, Rash, etc.*
Problem addressed	A **problem is addressed or managed** when it is evaluated or treated at the encounter by the dermatologist or NPC reporting the service. *This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or the patient/parent/guardian/ surrogate's 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 dermatologist or NPC 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.* *For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.*
Minimal problem	A **problem** that may not require the presence of the dermatologist or NPC, but the service is provided under the supervision of a dermatologist or NPC. *Examples include dressing change during a nurse encounter (see 99211, 99281).*
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. The problem does not need to meet all three of these criteria but must be one that is **not likely to permanently alter the patient's health status**.

Self-limited or minor problem (continued)	For example: *The problem can either be one that runs a definite course **AND** is not likely to permanently alter health status **OR** one that is transient in nature **AND** not likely to permanently alter health status.* *Examples may include:* *Acrochordon, Angiofibroma; nonvenomous insect bite; Dry skin or Xerosis; Epidermal inclusion cyst; Lentigines; Lipoma; Melanocytic nevi; Post Inflammatory Hyperpigmentation; Scar; Seborrheic Keratosis; Telangiectasia; Pityriasis Rosea; Etc.* ** Any of the above-listed conditions may run a definite course in that they are evaluated, found not likely to permanently alter health status, and are therefore removed from the problem list. Just as well, these conditions could be found to either not run a definite course or be non-transient, and they would then not be placed in this category.*
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. **'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. *Examples, when at treatment goal may include:* *Acne; Actinic Keratoses; or Clinically Significant Actinic Damage; Actinic Cheilitis; Alopecia Areata; Atopic Dermatitis; Atypical Nevi; Bullous Pemphigoid; Chronic Urticaria; Dermatomyositis; Diffuse Actinic Damage; Disseminated superficial actinic porokeratosis (DSAP); Granuloma Annulare; History of skin cancer; Intertrigo, Keloid; Melasma; Notalgia Paresthetica; Onychomycosis, uncomplicated; Pemphigus Vulgaris; Psoriasis Vulgaris; Rosacea; Scleroderma;, Seborrheic Dermatitis; Sjogren Syndrome; Stasis ulcer; etc.*
Acute, uncomplicated illness or injury	A recent or new short-term problem with a 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 consistently with a definite and prescribed course is an acute uncomplicated illness. *Examples may include:* *Abrasion; Acne, short term (such as related to wearing a mask); Actinic Keratosis; Acute Urticaria, self-limited; Allergic Contact Dermatitis; Atypical Nevus; Cellulitis; Erythema nodosum, uncomplicated; Folliculitis, Impetigo; Inflamed or infected Epidermal Inclusion Cyst; Inflamed Seborrheic Keratosis; Irritant Dermatitis; Intertrigo; Melasma; Onychomycosis, uncomplicated; Tinea Corporis; Retinoid Dermatitis; Wound healing by second intent; Pityriasis rosea; etc.*

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care	A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting. *Examples may include:* *Acute cellulitis that failed to respond to oral antibiotics; Ramsey Hunt or Zoster ophthalmicus; Post-op observation for pain control; Post-op observation for patients at high risk of [non-life threatening] bleeding.*

Stable, acute illness	A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition. *Examples may include:* *Herpes zoster; Bullous impetigo; Tinea Perioral dermatitis; Acute urticaria; Chrondodermatitis nodularis helicis; Rhus dermatitis; Folliculitis; Angular chelitis; Acute paronychia; Intertrigo.*
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. *Examples may include:* *Acne, flaring; Alopecia areata; Atopic Dermatitis, flaring; Discoid Lupus Erythematosus (DLE) with new, active lesions; Side effect from medication to treat a chronic condition; Immunocompromised/ Immunosuppressed patient with skin cancer; Intertrigo, flaring; Psoriasis that has spread to other anatomic location(s); Psoriasis vulgaris with new flare, poor progression or not at treatment goal; Subacute lupus, flaring; Seborrheic dermatitis with flare; chronic urticaria (not at treatment goal); venous insufficiency with flaring of stasis dermatitis; actinic damage with cutaneous field cancerization, etc.*
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. *Examples may include:* *Changing pigmented lesion; New bleeding red papule; Atypical Nevus; Neoplasm of Uncertain Behavior (NUB); Rash concerning for autoimmune blistering disorder; Leg ulcer; etc.*

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, see the definitions for '**self- limited or minor**' or '**acute, uncomplicated illness or injury**.' Systemic symptoms may not be general but may be single system. *Examples may include:* *New onset acute Systemic lupus erythematosus; Cellulitis with fever and chills; Drug-induced exfoliative erythroderma; Erythema multiforme; Leukocytoclastic vasculitis with hematuria; Pemphigus vulgaris, flaring; Psoriasis with psoriatic arthritis; Tick bite with myalgias; Viral exanthema with systemic symptoms; Varicella Zoster with neuralgia Worsening pyoderma gangrenosum with abdominal symptoms.*
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. • *Severe fall in the examination room with head trauma* ● *Severe, extensive blistering (second degree) sunburn*

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 escalation in hospital level of care. *Examples may include:* *Acne fulminans flare after initiation of isotretinoin therapy; Pemphigus vulgaris with severe cutaneous and oral mucosal/esophageal exacerbation; Dermatomyositis with worsening muscle weakness; Systemic lupus erythematosus with acute diffuse purpuric eruption; Erythrodermic psoriasis with systemic symptoms.*
Acute or chronic illness or injury that poses a threat to life or bodily function	An **acute illness** with systemic symptoms, 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. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity. *Examples may include:* *Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS); Erythroderma with hypotension; Sezary Syndrome; Paraneoplastic pemphigus; Toxic epidermal necrolysis.*

We recognize that while the AMA Level of Medical Decision-Making Table is a valuable reference, and many diagnoses and presenting conditions fit well within the AMA's diagnostic schema. However, many diagnoses do not conform to the limited complexity categories within the revised E/M definitions the examples provided are not exhaustive in their representation of medical complexity. In such cases, an estimation of complexity level / problem risk based on the understanding of the disease process and patient specific factors is required.

Examples of conditions that do not align well with the five descriptors listed in available categories of problem addressed include malignancies that have a low to moderate risk of metastasis or bodily harm.

AMA does not provide a distinct category for to place these malignancies in this resource. Moreover, the AMA does not provide specific examples or diagnoses for any of the problem addressed MDM element categories. The AMA does state that *clinically relevant problems addressed at the moderate level include either multiple problems or significantly ill* (patient).

Based on this guidance, if in the dermatologist's judgement, the presenting problem or malignancy is equal to a significant illness based on the patient's risk of morbidity or mortality, it would be considered a problem addressed at the moderate risk level. In the case of moderate risk malignancies map, estimation of risk can be assessed as equivalent to the Undiagnosed New Problem with uncertain prognosis category.

Problems addressed not included in the AMA descriptor categories	**Cutaneous malignancy:** The following are examples of where specific tumor types may be categorized. However, these are only examples as a specific diagnosis is not exclusive to a particular level of problem addressed. ***It is critical to note that the level of risk of almost any cutaneous malignancy is fluid and the factors associated with that cutaneous malignancy such as tumor type, body location, histology, etc. must be taken into consideration when determining the level of risk and complexity associated with the problem addressed.*** *Examples at the low level of risk may include:* *Melanoma in-situ; low risk NMSC; Superficial Basal Cell Carcinoma (BCC/ Squamous Cell Carcinoma (SCC); Squamous Cell Carcinoma In-Situ (SCCIS); Small nodular BCC or Well Differentiated SCC (SCCIS) – All in low-risk areas.* *Examples at the moderate level of risk may include:* *Malignancies that have a low to moderate risk of metastasis or bodily harm including; T1a Melanoma; BWH T2a SCC; High Risk Subtype Basal Cell Carcinoma in Moderate to High-Risk Anatomic Area not obviously impairing anatomic function; Atypical Fibroxanthoma (AFX).* *Examples at the high level of risk may include:* *BCC/SCC threatening impairment of anatomic function; AJCC8 T3/T4 SCC; BWH T2B/T3 SCC; Metastatic SCC or Melanoma; New invasive T1b or higher; Melanoma; Advanced regional Melanoma; Merkel Cell Carcinoma.*
Test	**Tests** are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. For the purposes of data reviewed and analyzed, pulse oximetry is not a test. The determination between single or multiple unique tests is defined by the CPT code. Defined panels of tests, e.g., Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC) each count as one individual test. Cholesterol (82465), and triglycerides (84478) would each be counted as individual tests when they are not performed as part of the lipid panel.

Test (continued)	*Examples may include review of:* *Skin biopsy report not generated by the treating practitioner; CBC; differential, platelet; CMP; Chest X-ray; LDH level when ordered as a single test; CT scan; MRI, Lipid panel; Pregnancy test; Prothrombin Time Test/International Normalized Ratio (PT/INR); Medication Blood Level.*
	Ordering a test(s) includes both the order and the analysis of the test result. As such, the review of the ordered test result(s) is part of the encounter at which the test is ordered and is counted only once under data reviewed element. Tests ordered are presumed to be analyzed when the results are reported, even if the analysis is performed post-encounter. Therefore, when they are ordered during an encounter, they are counted as part of that encounter. *Ordering a test may include those considered, but not selected after shared decision making, such as NOT ordering a chest X-ray for a melanoma diagnosis.* *All considerations must be documented in the medical record including tests that may normally be performed, but due to the risk for a specific patient are not ordered.*
	Any service for which the professional component is separately reported by the physician or other QHP 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. *An example may include when a dermatologist or QHP reports the pathology code 88305. The ordering and reviewing of the histopathology report cannot be counted toward the E/M data element.*
	Tests that are ordered outside of an encounter may be counted as part of the data element during the encounter in which they are analyzed. *This may include analyzing the results of the tests that are ordered outside of the face-to-face encounter.* *When the ordering of the test does not occur during an E/M encounter, analyzing the test results can be counted as a single test during the encounter at which the result is reviewed.*
	When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. *For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed.*

Test (continued)	Tests that have overlapping elements are not unique, even if some of their individual components are identified with distinct CPT codes. *For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count.*
Analyzed	Is the process of using test data as part of the MDM. *The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment.*
Unique source	A **unique source** is defined as a physician or QHP in a distinct group or different specialty or subspecialty, or a unique entity. Please check directly with the private payer and seek clarification on how they will apply this policy. *Review of all materials from any unique source counts as one element toward MDM.*
Combination of data elements	A combination of different data elements does not require each item type or category to be represented. A unique test ordered, plus a note reviewed from an external source and an independent historian would be a combination of three elements. *This may include a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, which allows these elements to be summed: External records, Skin biopsy result, PT/INR, Caregiver/Power of Attorney/Historian/ Parent/Guardian/Witness, Test result, and/or Independent interpretation of test.*
External	**External** records, communications, and/or test results are from an external physicians, NPC, facility, or health care organization not affiliated with the practice. *Data to be reviewed can also include information obtained from multiple sources or interprofessional communication that is not separately reported e.g., medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.*

External physician or other qualified health care professional	An **external physician or other qualified health care professional** is an individual who is not in the same group practice or is of a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as in a hospital, nursing facility, or home health care agency. Though Medicare recognizes sub-specialty credentialing, private payers do not. Please check directly with the private payer and seek clarification on how they will apply this policy. *This may include review of external records, communications, and/or test results from a physician, NPC, facility, or health care organization not affiliated with the dermatology practice or are from a different specialty or subspecialty.* *Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., 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 (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).* • *Referral or consult from any specialty other than dermatology within the same practice group* • *Referral from any outside group, including dermatology*
Independent historian(s)	An individual, other than the patient or physician (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 the dermatologist or NPC determines that 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.

Independent historian(s) (continued)	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. *Translators are not considered an independent historian, as they only translate the patient words and are not adding to the history being obtained.*
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 dermatologist or NPC is reporting the service or has previously reported the service for the patient. A test that is ordered and independently interpreted may count both as a test ordered and interpreted. Documentation of the interpretation test result must be documented in the patient medical record. *This includes the interpretation and/or reporting of results of tests not ordered by the dermatologist or NPC, review of slides as part of a request for consultation by another physician.* • *Independent assessment of pathology slides from an external referral with your own interpretation documented in the chart* • *Review of a CT scan or MRI (the images) prior to performing surgery with your own interpretation documented in the chart*
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). It does not include discussion with family or informal caregivers. *This includes lawyer, parole officer, case manager, teacher.* For the purpose of documents reviewed, documents from an appropriate source may be counted.
Risk	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. The term “risk” as used in the definition of this element relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management. 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).

Risk (continued)	*The risk of patient management criteria applies to the patient **management decisions** made by the reporting physician or other QHP as part of the reported encounter.* *This may include patient management decisions made during the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).* *It also includes the possible management options selected and those considered but not selected, after sharing the MDM with the patient and/or family.*
Parenteral controlled substances	The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.
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. 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.
Social Determinants of Health (SDOH)	Economic and social conditions that influence the health of people and communities. *Examples may include:* *food or housing insecurity, lack of reliable transportation to medical appointments, homelessness, financial insecurity, etc.*
Drug therapy requiring intensive monitoring	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 less than quarterly. The monitoring may be by a lab test, a physiologic monitoring for test, or imaging. Monitoring by history or examination does not qualify. Monitoring for toxicity affects the level of medical decision making in an encounter in which it is considered in the management of the patient.

Drug therapy requiring intensive monitoring (continued)	*This may include:* • *Psoriasis patient on methotrexate or cyclosporine with labs drawn and analyzed four times per year* • *Patient with elevated lipids on an oral retinoid requiring monitoring four times per year or more* • *Pemphigus patient treated with cyclophosphamide* *Quantitative human chorionic gonadotropin (hCG) levels during isotretinoin therapy does **NOT** qualify.*
Surgery (minor or major elective, emergency, procedure, or patient risk)	**Minor or Major:** The AMA classifies 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.* **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 (e.g., 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 *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.* ***Minor surgeries** can include:* *Skin biopsy; Excision, Destruction; Shave removal; Simple, intermediate, or complex linear repairs; Uncomplicated Mohs surgery.* ***Major surgeries** can include:* *Complex or extensive excision, Complex Mohs surgery, Flap reconstruction, Graft reconstruction.* ** CMS classifies minor and major procedures based on the global surgical package relative to number of post-operative days assigned to the CPT code. (Minor; 0-10 days post-operative period and Major; 90- day post-operative period.)* **Check with your private payers for guidance regarding their classification of minor versus major procedures.**