**2021 MDM Changes for E/M Outpatient**

**Definitions for MDM Elements – Office or Outpatient**

**(AMA 2019)**

**Acute, uncomplicated illness or injury:** A recent or new problem with low risk of morbidity/mortality and full recovery is expected without any functional impairment. This problem is usually minor BUT is not resolving with consistent best medical practice and the course of illness is considered acute and uncomplicated. Examples include simple sprain/strain, cystitis or allergic rhinitis.

**Acute illness with systemic symptoms:** Illness that causes systemic symptoms and can have a high risk of morbidity without treatment. Many systemic symptoms may be a single system. Examples include colitis, or pyelonephritis.

**Acute, complicated injury**: Injury which require treatment including an evaluation of body systems that are not part of the injured organ, can be extensive, and treatment options are varied/multiple with risk of associated morbidity. Examples include: Brief loss of consciousness – head injury.

**Chronic illness complicated by side effects, progression and exacerbation**: Chronic illness that is worsening, is poorly controlled, that requires treatment for side effects, care but does not require any hospital level of care.

**Undiagnosed new problem with an uncertain prognosis**: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. Examples include lump in the breast.

**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.

**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 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.

**Test:** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

**External:** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization. External physician or other qualified healthcare professional: An external physician or QHP is an individual who is not in the same group practice or is a different specialty or subspecialty. This includes: 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.

**QHP:** Qualified Health Care Professional

**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(s) is needed, the independent historian(s) requirement is met.

**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.

**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 (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

**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 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.

**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.

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

**Drug therapy requiring intensive monitoring for toxicity**: 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 test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a 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 does not qualify include: monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.