

## **Guidance on Level 4 and Level 5 Evaluation and Management (E&M) Services**

### **Determining the E&M Level:**

The level of an E&M service is determined based on **Medical Decision Making (MDM)** or **Total Time**. Best practice: when counseling and/or coordination on the same encounter date dominates the encounter, billing by time (including documentation in the record of time spent) may be appropriate.

#### **1. Medical Decision Making (MDM)**

MDM is categorized into four levels: straightforward, low, moderate, and high. To determine the appropriate level of service, two of the three following components must meet or exceed the required criteria:

- **Number and complexity of problems addressed**
- **Amount and/or complexity of data to be reviewed and analyzed**  
(includes reviewing medical records, diagnostic tests, and other relevant information that need to be obtained, ordered, reviewed, and/or analyzed)
- **Risk of complications and/or morbidity or mortality** associated with the patient's condition and treatment options.
- More information on MDM criteria can be found in the [tip sheet](#).

#### **2. Total Time**

The total time spent on the day of the encounter, including both face-to-face and non-face-to-face time, can also be used to determine the level of service. This includes activities such as reviewing records, ordering tests, and documenting the visit.

- Level 4: At least 30 minutes for an established patient/45 minutes for a new patient
- Level 5: At least 40 minutes for an established patient/60 minutes for a new patient

NOTE: Time cannot be used to level Emergency Medicine Services (99281-99285).

### **Medical History/Examination:**

A medically appropriate history and/or examination must still be documented to support the medical necessity of the service, though the level of service is not directly determined by these factors.

### **Tips for Accurate Documentation and Coding:**

1. **List the primary diagnosis code first** – This should be the condition, problem, or reason for the encounter that is chiefly responsible for the services provided by the physician.
2. **List additional codes** for coexisting conditions, if applicable. If the primary diagnosis is a symptom, use the most specific diagnosis code available.
3. **Use the highest level of specificity** for each diagnosis. This includes documenting how the patient condition may progress or worsen, as this is critical to meet the high-level documentation and coding requirements.
4. **Document complications and co-morbidities** to reflect the high level of medical decision making associated with the patient's care.

## Scenarios

**Scenario 1:** Established 60 y/o male with a history of poorly controlled type 1 diabetes, hypertension, hyperlipidemia, and obesity. He presents with blurred vision, frequent urination, and a 10-pound weight loss over the past month. Blood tests (fasting glucose, HbA1c, lipid panel, urinalysis) ordered and reviewed.

### Assessment/Plan:

- **Type 1 Diabetes Mellitus with Hyperglycemia** – Fasting glucose: 185 mg/dL, HbA1c: 9.2%. Continue Metformin 500 mg BID, add GLP-1 agonist for better glucose control. Educated patient on lifestyle modifications, increased physical activity, and weight loss.
- **Hypertension** – Blood pressure is slightly elevated at 135/85 mmHg. Continue Lisinopril 10 mg daily.
- **Hyperlipidemia** – Lipid panel shows borderline elevated LDL and triglycerides. Continue Atorvastatin 20 mg nightly.
- **Obesity Class 1** – BMI of 31.8.

**Total Provider Time:** 52 minutes spent examining patient, reviewing labs, educating patient.

**Originally Coded:** Frequency of micturition (R35.0), Type 1 Diabetes Mellitus w/o complication (E10.9), Hyperglycemia (R73.9) and Obesity, unspecified (E66.9)

**Revised Codes Supported:** Type 1 Diabetes Mellitus with hyperglycemia (E10.65), Hypertension (I10), Hyperlipidemia (E78.5), Obesity Class 1 (E66.811), BMI 31.0-31.9 (Z68.31)

### **Rationale:**

The diagnosis specificity was changed to **Type 1 Diabetes Mellitus with Hyperglycemia** to better convey the severity of the condition. The previously listed diagnosis of frequent urination (R35.0) was removed as it is a symptom of the diabetes. These changes help meet the criteria for Level 5 (99215) services, demonstrating the complexity of the case.

**Scenario 2:** 52 y/o male who was last seen in 2020. He is here for a follow up with a history of deceased donor renal transplant in 2019, complicated by chronic rejection, and now on hemodialysis. He has history of hypertension, and Heart Failure with reduced ejection fraction. He presents with shortness of breath and decreased urine output. Panels for potassium, creatinine, and BUN are ordered.

### Assessment/Plan:

- **Acute on Chronic Heart Failure with reduced ejection fraction** – Symptoms of shortness of breath and edema consistent with exacerbation of heart failure. Increase furosemide to 40mg PO daily. Add ACE inhibitor. Follow up in 1 week to assess response.
- **Hypertension** – Elevated blood pressure today. Add Lisinopril 25mg PO at bedtime.

- **End Stage Renal Disease** – The patient's renal function continues to decline, contributing to fluid retention and difficulty controlling blood pressure. Continue dialysis 3/week. Monitor renal function closely.
- **Discussed with Nephrologist** – Discuss with Dr. Jones optimal dialysis management and potential adjustments.

**Originally Coded:** Shortness of breath (R06.2), Acute on chronic Heart Failure with reduced ejection fraction (I50.23), and End Stage Renal Disease (N18.6).

**Revised Codes Supported:** Hypertensive heart and chronic kidney disease with End Stage Renal Disease (I13.2), Acute on chronic Heart Failure with reduced ejection fraction (I50.23), End Stage Renal Disease (N18.6), Kidney transplant rejection (T86.11), and Dependence on renal dialysis (Z99.2).

**Rationale:** Shortness of breath (R06.2) was removed as it is a symptom of Heart Failure with reduced ejection fraction. The more specific diagnosis of I13.2 (Hypertensive heart and CKD with ESRD) was added to better reflect the patient's severity of illness. Additionally, documentation of the discussion with the Nephrologist supports the high complexity of the case, which is required for Level 5 (99205) billing.

**Scenario 3:** 8-week-old female with atrial septal defect and ventricular septal defect who was recently admitted for 45 days found to have significant tracheomalacia and moderate L bronchomalacia requiring High Flow Nasal Cannula. Presents for post discharge follow up.

Assessment/Plan:

- **Dependence on Supplemental Oxygen** - Patient on High Flow Nasal Cannula 1L/kg 21%
- **Congenital Tracheomalacia, congenital bronchomalacia** - PO continues to improve on Similac. I will increase nutrition by increasing volume of feeds given decrease in weight.
  - Similac 360 24kcal RTF with iron 75 cc q3hr PO
  - Vitamin D daily
  - Glycerin suppository daily
  - Simethicone PRN
- **Atrial Septal Defect, Ventricular Septal Defect** - Echo performed today shows moderately enlarged Left Atrium with large Atrial Septal Defect (9-10 mm, left to right flow), mild-moderate Right Ventricle dilation, and 2 small muscular Ventricular Septal Defects. Follow up with cardiology in 1 month.
- **Discussion with Parent:** Discussed long-term care plan with mother.

**Total Provider Time:** 45 minutes spent examining patient, reviewing admission notes, discussion with mother.

**Originally Coded:** Septal (heart) defect NOS (Q21.9)

**Revised Codes Supported:** Atrial Septal Defect, unspecified (Q21.10), Ventricular Septal Defect (Q21.0), Congenital Tracheomalacia (Q32.0), Congenital Bronchomalacia (Q32.2), Dependence on Supplemental Oxygen (Z99.81)

**Rationale:** The more specific diagnosis of Q21.10 (Atrial Septal Defect, unspecified) was added. Additional diagnoses documented were added to better reflect the patient's severity of illness. These changes help meet the criteria for Level 5 (99215) services, demonstrating the complexity of the case.

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### **Additional Resources**

As we move forward with ensuring the accuracy of our billing and coding practices, your attention to the specificity of diagnosis codes and thorough documentation will be critical to mitigating the risk of down-coding. Ensuring that each case reflects the full complexity of the patient's condition will help protect against potential coding issues and streamline the reimbursement process.

For further guidance or clarification:

**Compliance and Billing Support:** For any questions regarding compliance or billing, or if you receive any communication from payers about increased scrutiny, please forward it to [compliance@med.cornell.edu](mailto:compliance@med.cornell.edu) and [mcomanagedcarecontracting@med.cornell.edu](mailto:mcomanagedcarecontracting@med.cornell.edu)

Thank you for your commitment to high-quality care and accurate billing.