

Medical Decision-Making in Evaluation and Management Coding: Practical Applications and Key Clarifications

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PRACTICE POINTS

- Evaluation and management coding is now based on medical decision-making (MDM), requiring 2 of 3 categories (complexity, data, risk) and strict adherence to medical necessity.
- Moderate MDM includes problems not at target, shared decision-making for prescription therapy (not simple refills), relevant social determinants of health, and independent test interpretation.
- Common errors include misclassifying refills, overlooking the data category, and improperly reporting procedural decisions, especially same-day minor procedures.

Recent updates to evaluation and management coding emphasize medical decision-making (MDM) as the primary determinant of visit level, though clinicians still face challenges in application. Medical decision-making is established by meeting criteria in 2 of 3 domains: problem complexity, data, and risk. In this article, key clarifications are discussed, including inadequately controlled conditions as moderate complexity; distinction between prescription drug management and simple refills; inclusion of relevant social determinants of health; and classification of independent test interpretation under data. Additional nuances in procedural decision-making and common clinical scenarios also are reviewed to support accurate coding and documentation.

The new coding guidelines for evaluation and management services have simplified coding by focusing on medical decision-making (MDM), but practicing clinicians often have questions about how to

apply the rules. This article will focus on common mistakes and nuances clarified in communications from the American Medical Association. As before, the highest level of service in 2 of 3 categories—complexity, data, and risk—determine the level of service. Only medically necessary services should be reported, and all reported codes should accurately reflect the services provided.

Key Clarifications to MDM Criteria

Important clarifications that came after the initial distribution of the new coding rules include the following:

- An established problem not at treatment target requiring ongoing MDM counts as moderate complexity in column 1.
- Under the category of risk, prescription drug therapy includes discussion of risks, benefits, and alternatives with a decision to start, stop, or continue a prescription medication; this differs from a simple refill that does not require evaluation, discussion, and shared decision-making.
- Social determinants of health that are medically appropriate to address during the visit are considered moderate under the category of risk. These include issues that directly affect patient management (eg, transportation access, medication affordability, cultural norms, restrictions) and other factors influencing health and well-being (eg, income, education, occupation, environmental change, unemployment, working conditions, social support) when they impact the patient's condition and inform treatment decisions.
- Independent interpretation of a laboratory test counts as moderate under the category of data; an example

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The author has no relevant financial disclosures to report.

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Cutis. 2026 June;117(6):178-179. doi:10.12788/cutis.1402

would be a biopsy reported as “consistent with lupus erythematosus” in a patient with a heliotrope rash and shawl sign, which may require clinicopathologic correlation and reinterpretation as “diagnostic of dermatomyositis.”

- The decision to perform a 0- or 10-day global procedure on the same date of service as the visit is already bundled in payment for the procedure and should not be reported as a separate service; however, if scheduled for a future date of service, it counts as low under the risk category if the patient has no unique risk factors or moderate if the patient does have unique risk factors that weigh into MDM. In contrast, the decision to perform a 90-day global procedure is reportable even on the same date of service (with modifier 57) and counts as moderate risk without unique risk factors and high with such factors.

Application of MDM Coding in Common Dermatology Encounters

Let’s look at some common scenarios and how they should be coded.

A patient presents with a new lesion of concern. On physical examination, it is a stuck-on keratotic papule with no inflammation, and you reassure them that it is merely a benign seborrheic keratosis. This encounter would be coded as straightforward MDM (level 2, new or established), reflecting the evaluation of a single minor problem.

A patient returns with localized eczema and is doing very well with triamcinolone cream applied as needed, and you simply refill the prescription. This encounter represents low-level MDM (level 3, established), reflecting a single stable problem managed with a simple prescription refill.

A patient presents with psoriasis that has had some response to topical therapy but is clearly not at target, and the patient now reports axial joint stiffness that is much worse in the morning and takes more than 30 minutes to resolve. You discuss risks, benefits, and alternatives; note that the patient already had recent screening for tuberculosis and other infectious diseases; and prescribe a T-helper 17 biologic because of the axial arthritis. This encounter represents moderate-level MDM (level 4, established), reflecting both a problem not at target and a new problem of uncertain prognosis under complexity, as well as shared decision-making to initiate prescription drug therapy under risk. Although review or ordering of 3 laboratory tests would also meet moderate criteria under data, only 2 of the 3 domains are required to establish the level of service.

A patient presents with a severe flare of eczema that requires treatment with cyclosporine. This encounter represents high-level MDM (level 5, established), reflecting

a severe exacerbation of an existing condition requiring a high-risk medication with at least quarterly laboratory monitoring and uncertainty regarding long-term therapy needs.

Application of Moderate and High MDM in Dermatology

Many dermatology patients present with multiple problems, and the visit often falls into the moderate category for column 1 (complexity) of MDM (level 4, new or established). Under complexity, moderate could be 2 stable problems, one worsening problem, one new problem of uncertain prognosis, or one problem improved but not at target. Remember that moderate MDM also must be established in a second category, such as risk. Under the risk category, moderate could include prescription drug therapy, addressing a relevant social determinant of health, the decision to perform a 0- or 10-day global procedure not performed on the same date of service with unique patient risk factors, or the decision to perform a 90-day global procedure in a patient with no unique risk factors.

Don’t forget the data category, as it often is relevant to determining the correct level of service. Moderate under the data category includes review or ordering of 3 laboratory tests (a complete metabolic panel is a single laboratory test, and a complete blood count is a single laboratory test), independent interpretation of a laboratory test, or a phone call to another provider caring for the patient with a medically necessary discussion of management (eg, severe eczema in a patient on a calcium-channel blocker—you call the primary care physician advising that calcium-channel blockers are the most common cause of eczematous drug eruption and advise a change in therapy). If 2 of the above categories were necessary (eg, order 3 laboratory tests and call the primary care physician), that would count as high MDM under the data category. Remember, 2 categories are required to establish the level of service.

Other examples of high MDM (level 5, new or established) include a new diagnosis with major risk to life or limb plus one of the following: high-risk medication requiring at least quarterly drug monitoring, the decision to perform a 90-day global surgery with documented additional patient risk factors, or the decision to admit to the hospital (eg, new invasive melanoma with excision and decision to perform adjacent tissue transfer in a patient who takes aspirin).

Final Thoughts

Physicians should perform medically necessary services that are in the best interest of their patients. Current coding rules focus on the complexity, risk, and data associated with MDM.