

Review of Risk When Determining Level of Evaluation and Management Coding

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When the Evaluation and Management (E&M) Coding guidelines changed in 2021, the elements for history and examination were changed to include what the provider considered medically necessary and clinically appropriate to address the patient issues. The choice of E&M code level is determined by either Medical Decision Making (MDM) or Time. The MDM has three components – Problems, Data and Risk. This article will discuss the determination of the Risk component.

To be exact, the Risk Component is the “Risk of Complications and/or Morbidity or Mortality of Patient Management”. CPT® clearly states this risk is separate from the risk of the patient problem(s). “The probability and/or consequences of an event” where the nature of the event(s) being considered impacts how high or low the risk category is considered to be by the provider for any specific patient. Per the [AMA clarifications](#):

“For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.”

Providers must keep in mind the need to clearly document their thought process regarding risks specific to a particular patient. Without this documentation, an auditor cannot understand the provider’s thought process in this regard. Any risk of complications, morbidity, and/or mortality of patient management decisions made at the visit for that patient should be related to the patient’s problem(s) addressed during the visit, the diagnostic procedure(s), and any treatment(s). Any particular management option that was considered but not chosen should be documented and would count toward the risk element of MDM. CPT® does not specifically define low, medium or high risk. Instead, providers must use their knowledge of how risk is commonly applied within their specialty and/or the use of published, evidence-based medicine guidelines.

Morbidity is defined in CPT® as “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 those of us in eyecare, morbidity involves any limitations to what would otherwise be considered the normal vision and function of the eye.

The one section in the MDM Risk category that can be misunderstood is Prescription Drug Management. Providers must understand that prescription drug management involves more than just listing a medication. The [AMA](#), for example, states the following:

“Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided. Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as ‘stable hypertension, continue valsartan 10 milligrams, will refill for 4 months until the next follow up visit.’ Simply stating that the medication list was reviewed will not meet the definition of prescription management.” And, “There is no ‘blanket’ guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the service to be performed including medicine management (***prescription or OTC***) based on a specific patient’s risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or an anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management.”¹

Further from [CGS](#):

“Prescription drug management does not require a new drug, a new dosage, or a discontinuation of a current prescription. The medical record will show the physician work to determine the medical necessity of the prescription drugs. An encounter documented as only a prescription refill without documentation of a problem addressed would not suffice. The AMA defines a problem addressed in part as ‘A problem is addressed or managed when it is evaluated or treated at the encounter by the

physician or other qualified health care professional reporting the service.' You can also count prescription medications considered but not given [assuming supportive documentation is present]. There could be patient choice, possible drug interactions, etc. Prescription drug management does not include drugs injected during the current or subsequent encounter."

From [Noridian](#):

Documentation for prescription drug management would need to show the work and/or risk involved by the billing provider when managing a prescription.

- Is the prescription something that could be harmful to the patient's health?
 - Will it interact with other drugs the patient is taking?
 - Is the prescription a non-complex drug for a patient with no allergies or complications? Example – a patient taking anticoagulants.
 - Did the patient have a stroke and is there a risk they may sustain a subsequent hemorrhage?
- Additional considerations for prescription drugs that may support risk management when included in the documentation:
- Ability of a patient to self-administer the medication. Education to the patient on performing injectables or ability to open a pill bottle and take a pill out.
 - Caregiver or family member at home to monitor the effects of the drug.
 - Any concern about the patient's understanding with taking their medication.

Adding new or deleting drug(s) should include narrative in the medical note to explain why the change was made.

Providers must take the time necessary to properly document their thought process for each individual patient and patient problem(s) to ensure that the element of risk of morbidity and mortality are being properly applied. This action will aid in the success in any audit or appeal situation that may be encountered. Happy Coding...