

# Problems Defined for Evaluation and Management Coding Medical Decision Making

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As everyone should know by now, the rules for determining the level of Evaluation and Management (E&M) services changed in 2021 to be based on either Medical Decision Making (MDM) or time. MDM has three basic components to be considered – Problems, Data, and Risk. When choosing a code level, a provider must appropriately document at least two of the three components. The last two months, the Data and Risk components have been discussed. This article will discuss the importance of and proper documentation of the “number and complexity of problem” component of MDM.

In the past, E&M coding guidelines defined the specific content for the patient history along with how to record the chief complaint(s) for a patient visit. With the 2021 changes in E&M coding, the patient history and the examination content are described as what is deemed medical necessary for any particular patient for the particular visit. While stating a chief complaint can still be important, the provider should clearly document the reason for the visit. The definition of “problem” became broader to include any or all of the following: Disease, Condition, Illness, Injury, Symptom, Sign, Finding, Complaint or Other issues noted at encounter. The reason for the visit is valid whether or not a diagnosis is established at the encounter as long as the “problem(s) are evaluated.

As previously stated, the provider should clearly document why the patient is being seen. When the patient has multiple problems, only the problems actually addressed during the encounter will be counted for MDM purposes. For instance, if a patient comes in for an IOP check but also has ARMD, dry eye syndrome, and cataracts and only the IOP is documented during the examination and nothing is evaluated regarding the cataracts, dry eye syndrome or ARMD, only the glaucoma problem would be counted for this visit. However, if the provider also evaluated the dry eye syndrome and cataracts, then three problems could be counted toward MDM.

The Problem component of MDM is divided into four different levels, each with a specific definition.

**Minimal:** 1 self-limiting or minor problem

(Runs a defined and prescribed course, is transient in nature and not likely to alter health status permanently)

**Low:** 2 or more self-limiting or minor problem OR 1 stable chronic problem OR 1 acute, uncomplicated illness or injury OR 1 stable, acute illness OR 1 acute, uncomplicated illness or injury requiring hospital and/or observation level of care

(Expected duration of 1 year or more and chronic: either stable – varies with goal for specific patient or unstable – not at patient goal and the risk or morbidity if condition is not treated)

**Moderate:** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment OR 2 or more stable, chronic illnesses OR 1 undiagnosed new problem with uncertain prognosis OR 1 acute illness with systemic symptoms OR 1 acute, complicated injury

(Acute complicated: Recent or new short-term problem, low risk of morbidity, treatment is considered but full recovery expected without treatment, or is typically a self-limiting condition but not resolving as expected)

**High:** 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment OR 1 acute or chronic illness or injury that poses a threat to life or bodily function

(Chronic illness that is getting worse, is poorly controlled, continue to progress when attempting to control, needs more supportive treatments, treatment for side effects)

Providers are responsible for appropriately documenting each patient problem and ensuring that problem was addressed (evaluated) during the specific encounter. Per CPT®, a Problem is addressed or managed when it is evaluated and or treated during visit by physician and includes any consideration of further testing or treatment that may not be chosen due to risk-benefit analysis or patient’s (parent/guardian/surrogate) choice. However, a problem is considered NOT addressed in cases when the provider only makes a note in record that problem managed by another professional without any documentation of additional assessment or care coordination and/or when a referral made without any evaluation or treatment considerations in the documentation. As in all things coding, appropriate and concise and complete documentation is a necessity in the event of an audit. Happy coding...