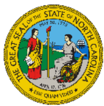

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Public Health

Clinical Record Review (CRR) Tool for Medical Decision Making (MDM) and Time-Based Coding

Use this CRR Tool to review records that are coded based on MDM or Time (see reverse for instructions). Revisions effective January 2025

Medical Decision-Making Coding			**Time-Based Coding**
1. Number and Complexity of Problem(s)	**2. Complexity of Data**	**3. Risk of Complications**	Total time for activities by treating physician/QHP on date of service.
Level 2: Minimal ☐ Self-limited/minor **(1)**	**Level 2: Minimal or None**	**Level 2: Minimal** risk of morbidity from additional diagnostic testing or treatment	
Level 3: Low ☐ Self-limited/minor **(≥ 2)** ☐ Stable/chronic illness **(1)** ☐ Acute uncomplicated injury/illness **(1)** ☐ Stable acute illness **(1)** ☐ Acute uncomplicated illness or injury requiring hospital inpatient or observation level of care **(1)**	**Level 3: Limited (must meet 1 of 2 categories)** **Category 1** (any combination of 2) ☐ Review of prior external note(s) from each unique source ☐ Review of results of each unique test ☐ Ordering of each unique test **Category 2** ☐ Assessment requiring an independent historian(s)	☐ **Level 3: Low** risk of morbidity from additional diagnostic testing or treatment **(examples only*)** • Minor surgery w/o risk factors* • Superficial dressings*	**New Patients:** 15 mins: 99202 30 mins: 99203 45 mins: 99204 60 mins: 99205
Level 4: Moderate ☐ Chronic illnesses with exacerbation, progression or side effects of treatment **(≥ 1)** ☐ Stable/chronic illnesses **(≥ 2)** ☐ Undiagnosed new problem with uncertain prognosis **(1)** ☐ Acute illness with systemic symptoms **(1)** ☐ Acute complicated injury **(1)**	**Level 4: Moderate (must meet 1 of 3 categories)** **Category 1** (any combination of 3) ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test ☐ Assessment requiring an independent historian **Category 2** ☐ Independent interpretation of a test by ordering provider or another provider **Category 3** ☐ Discussion of management or test interpretation with external provider/appropriate source	☐ **Level 4: Moderate** risk of morbidity from additional diagnostic testing or treatment **(examples only)** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by SDOH	**Established Patients:** 10 mins: 99212 20 mins: 99213 30 mins: 99214 40 mins: 99215 Report 99211 when all time is completed by supervised clinical staff.
Level 5: High ☐ Chronic illnesses with severe exacerbation, progression or side effects of treatment **(≥ 1)** ☐ Acute or chronic illness or injury that poses threat to life or bodily function **(1)**	**Level 5: Extensive (must meet 2 of 3 categories)** **Category 1** (any combination of 3) ☐ Review of prior external notes unique source ☐ Review of results of each unique test ☐ Ordering of each unique test ☐ Assessment requiring independent historian **Category 2** ☐ Independent interpretation of a test by ordering provider or another ordering provider **Category 3** ☐ Discussion of management or test interpretation with external provider/appropriate source	☐ **Level 5: High (examples only)** • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances	**Overall MDM Level/Code**: **RN:** 99211 **Minimal-2:** 99202/99212 **Low/Limited-3:** 99203/99213 **Moderate-4**: 99204/99214 **High/Extensive-5:** 99205/99215
Problem Level: 2 3 4 5	**Data Level:** 2 3 4 5	**Risk Level:** 2 3 4 5	**Overall Level:** 2 3 4 5

Patient name/ ID ______________________________ Chief Complaint(s) ____

Treating Clinician name _________________________ Date of visit _________________________ Carrier _______________________________

For all records (either MDM or Time-Based Coding):

Original code selected: __________________ **Reviewer agrees?** ☐ Yes ☐ No **Reviewed code:** ____________________

History documented? ☐ Yes ☐ No **Physical Exam documented** ☐ Yes ☐ No

Physician/QHP signed chart? ☐ Yes ☐ No

____ ____________________________

Reviewer name (print & sign) Date of review

Time-based- Prolonged services (if applicable)

Use with codes 99205 or 99215 only, when selected based on time. One (1) unit of service (UOS) equals 15 minutes. Minutes required for 1 UOS shown in table below. Use either 99417 OR G2212 based on payor; do not use both.

Units of 99417 ___________ Units of G2212 _______________

Primary Code	**AMA minutes reported**	**Primary Code**	**CMS minutes reported**
99205	75+	99205	89+
99215	55+	99215	69+

Instructions for using this tool: Prior to reviewing the provider note, complete the information on the top of page 2 (patient name/ID, chief complaint(s), treating clinician name, date of visit, carrier) and correlate to the CRR Tracking Tool. Review entire selected provider note, including the CPT code used, whether coding was based on MDM or Time, and if the patient was New or Established.

Time-based coding: Ensure the total time was documented. Use the far-right column of the tool to determine the visit level and corresponding CPT code based on the number of minutes documented. Circle the code level in Overall Level box. If Prolonged Time services were coded, see the text box above and note the number of units documented in the record, and corresponding code reported.

MDM-based coding: Determine the problem, data and risk levels using the criteria defined in each column. Circle code level for each column, and overall code level for the visit (based on 2 of 3 elements). Compare the provider code and the reviewer code and check the corresponding boxes on page 2.

For all selected visits, ensure that History, Physical Exam, and Provider/QHP signature(s) are documented and check the appropriate boxes on page 2. Sign and date the tool once the CRR is completed.