Coding for Clinicians
Are you Ready???

By

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Coding Office Visits

- Each visit is dependent on history/physical and Medical Decision Making
  - Consequently not every patient at the same level of care
- All three key factors are needed for a new patient, initial admission/observation, out-patient/inpatient consult or ER visit.
- Only two of three key factors are needed for established visits, subsequent hospital visits.
- Key factors change with categories
  - **99202**: Expanded history/physical, MDM straightforward
  - **99212**: Problem focused history/physical, MDM straightforward
  - **99203**: Detailed history/physical, MDM low
  - **99213**: Expanded history/physical, MDM low

Chief Complaint and HPI

- Office visits, Consultations, All Admissions, Subsequent care and ER visits must have a chief complaint
  - If using chronic conditions the status of each condition must be summarized in the medical record
  - This includes current medications, patients present condition and treatment plan and compliance
  - **Coding Tip: Preventive Care DOES NOT HAVE A CHIEF COMPLAINT!**
- HPI must be obtained and documented by the physician
  - If ancillary staff document the HPI, the provider has to note his/her actual review and interaction by adding further information to the HPI.

History of Present Illness

- **Timing**: Indication of when something occurs, i.e.: number of occurrences or freq. of s/s. (1 time, constant, intermittent)
- **Quality**: A description of discomfort (sharp, dull, stabbing, acute, chronic, improving)
- **Severity**: A measurement of discomfort, sensation or pain. Comparison to previous pain. Non-verbal signals of discomfort (wincing, pacing, doubled over) The extent of process (e.g. grading and staging carcinomas).
- **Context**: A description of where the pt. is and what the patient is doing when the s/s begin. (occurred at, during, while, fell from porch)
- **Location**: Where on the body are the s/s's located
- **Duration**: From what starting point did the s/s's begin (6 months, 3 months, yesterday)
- **Assoc. S/S's**: What other, positive or negative s/s does the pt. have at presentation (nausea with vomiting, head inj: no LOC, pain in right arm and shoulder etc)
- **Modifying Factors**: What has the pt/physician attempted to do to obtain relief/or treat

Let's start with a history

- There are four parts to a history
  - Chief Complaint
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past Medical, Family and Social History (PMFSH)
- There are four types of history
  - **Problem Focused**
  - **Expanded Problem Focused**
  - **Detailed**
  - **Comprehensive**

What's in a history?

- Four types of history
  - Problem Focused: (201/212/231/241/251/281)
    - HPI = 1-3
    - ROS = 0
    - PMFSH = 0
  - Expanded Problem Focused: (202/213/232/242/252/282)
    - HPI = 1-3
    - ROS = 1
    - PMFSH = 0
  - Detailed: (203/214/218/221/233/234/243/253/283)
    - HPI = 4+
    - ROS = 2-9
    - PMFSH = 1 (pertinent)
  - Comprehensive: (204/205/215/219/220/222/223/244/245/254/255/235/236/284/285)
    - HPI = 4+
    - ROS = 10+ (or some with statement: Remainder of systems negative)
    - PMFSH = 3 for those that require all three key factors/ 2 for all others

History (cont)

- **Interval History**: Est. visit/subs hosp. care
  - ROS and PFSH documentation not required if you:
    - Refer to initial history or interval history for ROS and PMFSH
    - Document date of initial/interval history
  - Example
    - History obtained on 2/23/98. I have reviewed the data; no changes are noted.

- **Unobtainable History**
  - Qualifies for a "comprehensive" PMFSH and ROS
  - Example:
    - Patient non-communicative (comatose, urgent or emergent situation)" EG: Due to acute critical illness, ROS and PMFSH unobtainable at this time.
    - Poor historian: EG: Grandmother brought in child and is unable to speak English and no interpreter present so ROS and PMFSH unobtainable.

ROS and PMFSH

- ROS and PMFSH
  - ROS and PMFSH can be obtained by staff or parents (if a form is filled out by them).
- Physicians have to document that they reviewed by adding to/agreeing with the information written by staff or review of forms filled out by parents with the physicians signature.
- The most common lack of documentation is the ROS.
  - Templates are IDEAL BUT
    - Watch that you do not do more than what is “medically necessary” just because there is a box to check!
    - Stating: ROS is negative is not sufficient. Need to specify which systems are negative
    - Be sure to state all systems that are positive as well as negatives
    - Can make the statement: 10 of 14 systems obtained, remainder of systems negative.

Review of Systems

- Review of systems
  - Allergic/Immunologic
  - Cardiovascular
  - Constitutional
  - Ears, Nose, Mouth, Throat
  - Endocrine
  - Eyes
  - Gastrointestinal
  - Genitourinary
  - Hematologic/lymphatic
  - Integumentary
  - Musculoskeletal
  - Neurologic
  - Psychiatric
  - Respiratory

- Problem Focused
  - Not applicable

- Expanded Problem Focused
  - 1 system

- Detailed
  - 2 – 9 systems

- Comprehensive
  - 10 + systems or all others negative

Past Medical Family and Social History

- Past-Medical, Family and Social History (PMFSH)
  - Elements
    - Past History
    - Family History
    - Social History

- Problem Focused
  - Not applicable
- Expanded Problem Focused
  - Not applicable
- Detailed
  - 1 element
- Comprehensive
  - 3 elements for initial visit/consult
  - 2 elements for est. visit

Problem Focused History

- **99201 and 99212**
- Only requires 1 to 3 History of Present Illness (HPI)
  - Child presents today with an injury to their left foot while they played foot ball yesterday. Foot swollen and bruised, used ice and tylenol
- Hx: 5 HPI: Location, context, duration, assoc. S&S, modifying factor
- No further information is required for this history

Expanded Problem Focused History

- **99202 and 99213**
- Requires 1 to 3 HPI and 1 ROS
  - Example:
    - Patient c/o left ear hurting and a sore throat, not eating as well and no fever and no cough or V&D.
      - Chief Complaint: ear hurting
      - HPI: location (left ear); assoc. sign and symptom- sore throat
      - ROS: Respiratory: no cough; General: no fever; GI: no V&D
    - HX: 2 HPI and 2 ROS

Detailed History

- 99203/99214/99218/99221/99243
  - Requires 4+ HPI; 2 to 9 ROS and 1 of PMFSH
    - Example: Patient presents today with c/o sore throat, also has had a fever for 2 days. Mom states has been using Motrin. Patient states sore throat has gotten worse in the last 24 hours. No rash, no nausea, vomiting or diarrhea. No other family members ill
      - Chief Complaint: sore throat
      - HPI:
        - » Associated sign and symptoms: fever
        - » Duration: 2 days
        - » Modifying factor: Motrin
        - » Quality: gotten worse
      - ROS: Skin and GI
      - Family History: no other ill members

Another detailed history

- Pt presents today c/o both ears hurting (chief complaint), presents crying and holding both ears (assoc. S&S) and (severity). Mom also states he has a cough (ROS) but no fever (ROS). She had some old ear gtts so used those (modifying factor) but he seems to be getting worse (Quality). He does get ear infections “a lot” (PMH).
  - 4 HPI; 2 ROS; PMH
-

Comprehensive History

- **99204/99205; 99215; 99244/99245**
- **Requires 4+ HPI, 10+ROS, 2 of PMFSH or all 3 for New Patient**
  - Example: 15 year old presents with c/o a severe headache, has had it for more than 3 days, also has had nausea and vomited X 1. Pain on scale of 10 of 10. No blurred vision, no dizziness, no Diarrhea, no resp. issues, last period normal, remainder of systems negative. Has had no ill exposures and no family members with migranes.
    - C/O: headache
    - HPI:
      - Duration (3 days)
      - Associated sign and symptom (nausea)
      - Timing (vomited X 1)
      - Severity (scale of 10 of 10 in pain)
    - ROS:
      - Eyes, Neuro, GI, Resp, GU, + remainder of systems negative (10 or more)
    - PMFSH
      - Social history (no ill exposures)
      - Family history (no migranes)

ADHD Comprehensive History

- 9 year old presents for evaluation of ADHD **(chief complaint),** Mom states has been acting up in class **(associated S & S**), seems he has been this way for years **(duration),** can't seem to concentrate when reading **(context),** occasionally will be able to sit through an entire movie if it is something he is really interested in **(timing). (4 HPI**) He does not complain of any visual problems, no hearing problems, no headaches, mom has never noticed any type of tics or outbursts, he is loud but can be quiet as well, has not had frequent illness's like URI's or abdominal pain. Denies any cardiac, GU or MS issues, some allergy's in the fall, no particular rashes or skin problems. Dad was "hyper" when he was young and still is somewhat. Pt is in 4th grade doing fair. **(10 ROS, FH, SH)**

Physical

- Four Types of Physical
  - Problem focused: 1 organ system
    - Exam limited to affected body area or organ system
  - Expanded problem focused: 2-7
    - Limited exam of affected body area or system and 1-6 symptomatic or related systems
  - Detailed problem focused: Ext. 2-7
    - Extended exam of affected body area(s) or system(s) and other symptomatic or related organ system(s).
  - Comprehensive problem focused: 8+ or complete.
    - General Multi-system or complete single organ system exam
      - Must be “system(s)”, don’t count body areas

Physical

- Difference between a 99213 (established patient) and a 99214 (established patient) in the physical
- 99213
  - Expanded problem focused exam: 2 to 6 brief systems
    - General: alert and active
    - Ears: left clear, right fluid
    - Nose: clear drainage
    - Resp: clear
    - Card: no murmur
  - 4 systems documented (ENT is only one system)

Physical

- Detailed examination: requires 1 system in detail and 1 to 6 others in brief
- 99214
  - General: Fussing on Mom's lap with flaring nostrils
  - ENT: clear runny nose, ears clear
  - Resp: Resp. rate 30, substernal retractions, in obvious distress. Rales and rhonchi bilaterally. Will do neb and re-eval.
  - Heart: Heart Rate rapid but normal
  - Re-eval: improved but still having wheezing. Resp rate 20 will repeat neb
  - Re-eval: much improved, no further wheezing. Resp rate normal.
- 4 systems with 1 in detail (respiratory) and three others that are brief.
- A detailed respiratory system will have the respiratory rate, assessment of respiratory effort, auscultation findings and usually a re-evaluation of the respiratory system.
- A detailed abdominal exam would have how the abdomen looks in general, palpation of liver, spleen, masses, area of pain, degree of pain, bowel sounds etc.

Medical Decision Making

- Most subjective part of coding
- Based on three factors
  - Risk
    - Presenting problem(s)
    - Diagnostic Procedure(s) ordered
    - Management Options Selected
  - Number of Diagnoses and/or Management Options
  - Amount and/or Complexity of Data to be reviewed
- Two of three must match or exceed for a given level

Risk of Complications

Level of Risk	Presenting Problems	Diagnostic procedures	Management options
Minimal	**1 self limited**	**Lab test-veni punct.**	**Bandages / rest / drsg**
Low	**2 or more self limited 1 stable chronic illness Acute uncomp. Illness or inj.**	**Superficial needle bx Lab test- art punc Single x-ray Physiologic tests**	**OTC drugs Minor surgery OT**
Moderate	**1 or more chronic illness with mild exacerbation 2 or more stable Acute illness with systemic sympt. Acute comp. inj. Undiag. New prob. With uncertain prog.**	**Multiple x-rays Deep needle bx LP, joint asp. CT, MRI Cardio imaging**	**Minor surgery with risks Elective major surgery Prescription Drugs Closed tx of fx**
High	**1 or more chronic with severe exacerbation Acute illness with threat to life/limb Abrupt change in neurologic status**	**Discography Myelography arthrogram**	**Elective major surgery with risks/ER major surgery Parenteral controlled substance/Drug therapy with intensive monitoring DNR**

Risk Table

- Minimal (straightforward):
  - 1 self limited (splinter)simple sprain
  - Bandages, rest
- Low:
  - 2 self limited- diaper rash/runny nose
  - 1 stable chronic- asthma, well controlled
  - Acute problem-URI/Bronchitis/Pharyngitis
  - OTC drugs/x-ray/art. Lab/
- Moderate:
  - Asthma exacerbation/comp fx /2 or more chronic stable problems
  - Prescription drugs/CT/MRI/closed fx tx
- High:
  - Severe exacerbation of chronic cond
  - Threat to life or limb

Two out of three elements must be met or exceeded for a given level of Medical Decision Making			
Risk of complications	**Number of DX and/or mgmt options**	**Amount and / or complexity of data to be reviewed**	**Level of MDM**
Minimal	**(PTS / ITEMS)** **1 pt Minimal** **1 self limited** **1 est. problem**	**1 pt Order and / or review lab** **1 pt Order and / or review radiology test**	
Low	**2 pts Low** **2 self limited / minor** **2 est. problems** **1 est. worsening** **1 stable chronic**	**1 pt Order and / or review other tests- EKG / PFT** **2 pts Direct visualization and independent review of image/tracing or spec.**	
Moderate	**3 pts Moderate** **1 new prob. w/o add. work up** **3 established problems** **2 est. problems, one worsening**	**1 pt Decision to obtain old records and / or history other than pt** **2 pts. Review & summarize old records and / or obtain hx other than pt**	
High	**4 pts High** **1 new problem w/add work up** **4 established problems** **2 established prob. worsening** **Total Points_____**	**2 pts. Discuss case with other health care provider** **Total Points_____**	
Minimal	**1 pt Minimal**	**< 1 pt Minimal**	**Straightforward**
Low	**2 pts Low**	**2 pt Low**	**Low**
Moderate	**3 pts Moderate**	**3 pts Moderate**	**Moderate**
High	**4 pts High**	**4 pts High**	**High**

Diagnosis Table

- Point system:
  - 1 point: straightforward/2 pts low/3 pts mod and 4 pts high
    - STFD: resolved OM (no further tx); rash (no tx) basically an illness or inj without any treatment, just watch
    - Low: Recurrent OM (RX); asthma stable; URI/Fever (no tx);
    - Moderate: Strep (new problem); Asthma exacerbation and hypoxia; Fever and Pneumonia; Abd. pain and vomiting (or just abd pain new problem); new ADHD no further w/u;
    - High: Abd pain with further testing not done in office; asthma exacerbation with hypoxia and tachypnea ; Respiratory distress (adm to hosp); New onset of diabetes with further w/u; New ADHD dx with fur. w/u

What History is This?

- 3 year old here for evaluation of cough for two days. Mom felt she heard wheezing today. Did not notice any fever.

Answers

- **CC: Cough**
- **Associated SS: wheezing**
- **Duration: 2 days**
- **ROS: 1 (constitutional-fever)**
- **PFSH: 0**
  - **2HPI**
  - **1ROS**

- **Expanded Problem Focused History**

What History is this?

- CC of Headache and nausea. Woke during the night X 3 nights with severe headache. Very fatigued due to not sleeping with headache, throat feels okay. LMP 2nd or 3rd wk in Sept. HA usually left parietal; no problem with vision. Eating less than normal. Using Ibuprophen 400 mg with some help. No family hx of migraines. Spoke privately with patient-denies drugs, etoh and tobacco. Denies any type of abuse, wears hair in pony tail but has tried it down with no difference.
- **CC: Headache and nausea**
- **Context: woke during night**
- **Timing: woke during night X 3**
- **Quality: Severe headache**
- **Assoc. S & S: fatigue**
- **Location: left parietal**
- **Modifying factor: ibuprophen 400 mg**
- **ROS: ENT, GU, Constitutional, Eyes**
- **PMFSH: Family and Social history**
  - **HPI-6**
  - **ROS-4**
  - **PMFSH-2-F and S**
- **Detailed history: if had added statement: Remainder of systems negative, this would have been a comprehensive history as long as 10 were reviewed.**

How About this One!

- **Recurrent bronchitis, cough even after meds, start antibiotic**
- **Obtain CBC**
- **Chest x-ray ? Pneumonia by my interp, awaiting radiology reading**

Answers

- **Risk: Mod (Rx Med)**
- **DX: Mod (2 est. prob, one worsening)**
- **Data: High (1 pt. labs, 1 pt. x-ray, 2 pts. interp -total 6 pts.)**

- **2 of 3 have to match:**
- **Moderate Risk and Moderate diagnosis equals Moderate Complexity Decision Making**

What Level is this?

- f/u of otitis media. Per Mom, still complaining of ear pain and now complains of sore throat off and on for more than 2 days. Sometimes this sore throat is so bad cannot swallow. Mom using Motrin, ear gtts. and finished antibiotics two days ago. Fever occasionally, no Vomiting or diarrhea. This is the 4th otitis in 5 months.
- Exam: Ht: 36in., Wt: 22lb T: 99.2, not ill appearing. Ears: TMS slight fluid rt. > lt. Nose: clear Throat: Red with pustules Neck: no lymphadenopathy. Chest Clear to auscultation, no wheeze or rhonchi. Abd. Soft, no masses or splenomegaly
- MDM: Strep test +, Zithromax , Reviewed old records and will need to monitor ear infections. Motrin as needed. Recheck in 10 days.
- DX: Otitis Media/ Strep Pharyngitis

1st Example

- **f/u of otitis media. Per Mom, still complaining of ear pain and now complains of sore throat off and on for more than 2 days. Sometimes this sore throat is so bad cannot swallow. Mom using Motrin, ear gtts. and finished antibiotics two days ago. Fever occasionally, no Vomiting or diarrhea. This is the 4th otitis in 5 months.**
  - **CC: Otitis Media**
  - **HPI: Assoc. S/S, Timing, Modifying factors, Duration, quality**
  - **ROS: Constitutional, GI**
  - **PMFSH: Medical (4+ HPI,2 ROS, 1 PMH: DETAILED HISTORY)**
  - **Exam: 2-7 systems: Ht: 36in., Wt: 22lb T: 99.2, Ears: TMS slight fluid rt. > lt. Nose: clear Throat: Red with pustules, Neck: no lymphadenopathy. Chest: Clear to auscultation, no wheeze or rhonchi. Abd: Soft, no masses or splenomegaly (EXPANDED PROBLEM FOCUSED:2-7 brief systems)**
  - **MDM: Strep test +, Zithromax , Reviewed old records and will need to monitor ear infections. Motrin as needed. Recheck in 10 days.**
  - **DX: Otitis Media/ Strep Pharyngitis (Risk: Moderate/Dx:Mod/Data:5 pt.)**
- **99214: 2 of 3: History and MDM**

What level is this?

- Mom comes in to talk about Susie's depression. Susie's grades are good but she does complain that she is tired all the time, cries a lot. Mom has tried to talk with her about what is wrong, always says nothing. Has a boyfriend and they seem ok. She is popular in school. This has been going on for over a month.
- No exam
- MDM: Will bring Susie in for a complete evaluation.
- Total time: 30 min/most of visit spent in counseling about depression.

4th Example

- **Mom comes in to talk about Susie's depression. Mom feels she is depressed. Susie's grades are good but she does complain that she is tired all the time, cries a lot. Mom has tried to talk with her about what is wrong, always says nothing. Normal periods. Has a boyfriend and they seem ok. She is popular in school. This has been going on for over a month.**
- **No exam**
- **MDM: Will bring Susie in for a complete evaluation.**
- **Total time: 30 min/most of visit spent in counseling about depression.**

CC: depression

- **Assoc. S&S: tired and cries a lot ; Duration: a month**
- **ROS: GU**
- **Social History**

No Exam

MDM:

Risk: acute illness (straightforward)

DX: New problem with further workup (high)

Data: none

MDM: straightforward

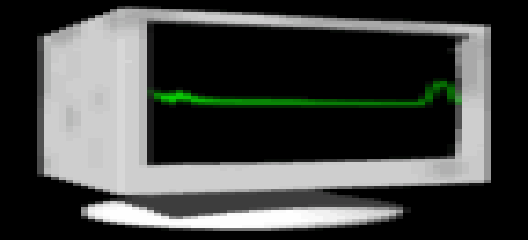
99212: But time was documented HOWEVER it does not state that >50% was spent in counseling. If it had then visit would equal 99214.

One More

- HX: c/o cough, no fever. Appetite good
- PX: General, ENT, Resp, Card
- MDM: URI-symptomatic symptoms
- As Mom was leaving she brook out in tears, stated her and her husband were getting a divorce and she didn't know how to talk to the kids
- Talked at length in counseling about how to talk to the children, getting counseling herself
- Total time in visit: 35 min with >25 min spent in last part of visit counseling her divorce situation.

OH By the way…

- Well care is well care, there is NO chief complaint
- Chief complaint can be in the sick portion of the well visit service
- Bill both well care and sick care when there is a significant issue that has to be addressed during the well care visit.
- Medicare now will cover preventive care for their patients yearly
- Use the 25modifier as appropriate on the sick visit
  - Follows Bright Futures from the AAP and the Coalition for Immunizations
  - Still may have a co-pay for the office portion
- Have to have two separate notes!!!
- New patient codes: 99381-99387: specific to age
- Established patient codes: 99391-99397: specific to age



Critical Care

- **99291**: Initial 30-74 minutes of critical care on a given date
  - 99292: each additional 30 minutes beyond the first 74 minutes
- Can be done in the physician's office where age is not a factor
- Critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.
- CC is usually provided **but not always** in a critical care area.
- CC can be provided daily
- CC and other E&M services may be provided on the same patient on the same date by the same physician

Newborn Care

- **99460**: Initial hospital/birthing center care, per day, for the E/M of the normal newborn infant
  - Includes maternal and/or fetal and newborn history
  - Newborn physical examination
  - Ordering of diagnostic tests and treatments
  - Meetings with the family
  - Documentation in the medical record
- **99461**: Initial care, per day, for the E/M of the normal newborn infant seen in other than hospital or birthing center
- **99462**: Subsequent hospital care, per day, for evaluation and management of normal newborn
- **99463**: Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
- ICD-9 code = V30.XX
- ICD-10 code = Z38.0

Can you bill for an office visit and a procedure on the same day?

YES YOU CAN

- Bill a visit when the patient presents for problems and a procedure is **"needed"** to help determine a definitive diagnosis
  - Incision and drainage of an abscess
- Do NOT bill for a visit when the patient presents and the procedure has already been determined to be done at this visit at a previous visit.
  - Removal of wart (diagnosed week prior and told to come back for removal)
- You will need to use modifier 25 on the VISIT only.
- Don't forget to use different diagnosis for visit and procedure.
- **REMEMBER: you have to make a separate notation for the procedure**
  - **How procedure was performed**
  - **Results**
  - **How tolerated**

Minor Procedures

- **20600:** Arthrocentesis: bursa or small joint ($44)
- **20605**: ", intermediate joint ($61)
- **20610**: ", large joint ($56)
- **10060:** I & D abscess, simple ($86)
- **11730:** Avulsion of nail plate, partial or complete, simple, single ($73)
  - **11732**: each additional nail plate
- **11740**: Evacuation of subungual hematoma ($37)
- **17250**: Chemical cauterization of granulation tissue ($78)
- **10120**: FB subq tissue via simple incision ($114.75)
  - Includes removal of splinters when physician has to go beneath the skin to remove splinter
- **28190**: FB-foot ($196.76)
- **30300**: FB-nose ($180.76)
- **11200**: Skin tag removal; up to 15 lesions ($65.75)
- **41010**: Incision in the lingual frenulum to free the tongue ($161)
- Application of splints:
  - Short arm splint (forearm to hand): static-**29125 ($49)** dynamic-**29126 ($58)**
  - Finger splint: static- **29130** ($30.75) dynamic-**29131 ($39.25)**
  - Short leg splint (calf to foot): **29515 ($54.50)**
  - **A4570**: Splint **S8450-S9452**: Splint, prefabricated for finger, wrist, ankle or elbow
- Strapping
  - Shoulder: **29240 ($43)**
  - Elbow or wrist: **29260 ($39)**
- **24640:** nursemaid elbow (10 day post op) ($107.75)

Even More Procedures

- Fracture Care (have 90 day post op period)
  - **23500**: Clavicle fx **($164)** **25500**: Radial Fx **($204)**
    26750: distal phalangeal fx **($139)**
  - **26720**: Proximal or middle phalanx, finger or thumb fx
  - **28490**: Great Toe Fx **($111)** **28470**: Metatarsal Fx
    28510: Fx phalanx or phalanges other than great toe **($93)**
- **93000**: Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report **($13.50)**
- **93005**: tracing only, without interp and report **($7.50)**
- **93010**: interpretation and report only **($6)**

LEVEL OF SERVICE GUIDE

OFFICE/OUTPATIENT SERVICES, NEW PATIENT

KEY COMPONENTS		Level I	Level II	Level III	Level IV	Level V
		99201	99202	99203	99204	99205
HISTORY*	Problem-Focused	X				
	Expanded Problem-Focused		X			
	Detailed			X		
	Comprehensive				X	X
EXAMINATION*	Problem-Focused	X				
	Expanded Problem-Focused		X			
	Detailed			X		
	Comprehensive				X	X
MEDICAL* DECISION MAKING	Straightforward	X	X			
	Low			X		
	Moderate				X	
	High					X
CONTRIBUTORY COMPONENTS						
PROBLEM SEVERITY	Minimal Minor / self-limited	X				
	Low		X			
	Moderate		X	X	X	
	High				X	X
TIME**	Face to Face	10 Min	20 Min	30 Min	45 Min	60 min

* LOS (level of service) determination requires ALL THREE KEY COMPONENTS

** Time becomes a contributory component ONLY IF counseling and/or coordination of care represents >50% of visit.

LEVEL OF SERVICE GUIDE

OFFICE/OUTPATIENT ESTABLISHED PATIENT VISITS

KEY COMPONENTS		Level I	Level II	Level III	Level IV	Level V
		99211	99212	99213	99214	99215
HISTORY*	Problem-Focused	**nurse visit**	X			
	Expanded Problem-Focused			X		
	Detailed				X	
	Comprehensive					X
EXAMINATION*	Problem-Focused		X			
	Expanded Problem-Focused			X		
	Detailed				X	
	Comprehensive					X
MEDICAL DECISION MAKING	Straightforward		X			
	Low			X		
	Moderate				X	
	High					X
CONTRIBUTORY COMPONENTS						
PROBLEM SEVERITY (presenting problem)	Minimal Minor / self-limited	X	X			
	Low			X		
	Moderate			X	X	X
	High				X	X
TIME**	Face to Face		10 Min	15 Min	25 Min	40 min

* LOS (level of service) determination requires ALL THREE KEY COMPONENTS

** Time becomes a contributory component ONLY IF counseling and/or coordination of care represents >50% of visit.

LEVEL OF SERVICE GUIDE

OFFICE/OUTPATIENT CONSULTATIONS; New or Established Patient

KEY COMPONENTS		Level I	Level II	Level III	Level IV	Level V
		99241	99242	99243	99244	99245
HISTORY*	Problem-Focused	X				
	Expanded Problem-Focused		X			
	Detailed			X		
	Comprehensive				X	X
EXAMINATION*	Problem-Focused	X				
	Expanded Problem-Focused		X			
	Detailed			X		
	Comprehensive				X	X
MEDICAL DECISION MAKING	Straightforward	X	X			
	Low			X		
	Moderate				X	
	High					X
CONTRIUTORY COMPONENTS						
PROBLEM SEVERITY	Minimal Minor / self-limited	X				
	Low		X			
	Moderate			X		
	High				X	X
TIME**	Face to Face	15 Min	30 Min	40 Min	60 Min	80 min

* LOS (level of service) determination requires ALL THREE KEY COMPONENTS

** Time becomes a contributory component ONLY IF counseling and/or coordination of care represents >50% of visit.