2017 Compliant EM Documentation & Coding

A documentation and coding workshop

Presented by

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NEW PATIENT SERVICES	
Straightforward or 10 min. counseling	99201
Straightforward or 20 min. counseling	99202
Low or 30 min. counseling	99203
Moderate or 45 min. counseling	99204
High or 60 min. counseling	99205
ESTABLISHED PATIENT SERVICES	
Non MD Visit	99211
Straightforward or 10 min. counseling	99212
Low or 15 min. counseling	99213
Moderate or 25 min. counseling	99214
High or 40 min. counseling	99215
CONSULTATION SERVICES	
Straightforward or 15 min. counseling	99241
Straightforward or 30 min. counseling	99242
Low or 40 min. counseling	99243
Moderate or 60 min. counseling	99244
High or 80 min. counseling	99245
NEW / EST PT PHYSICAL & EPSDT	
< 1 y 99381	99391
1-4 y 99382	99392
5-11y 99383	99393
12-17y 99384	99394
18-39y 99385	99395
40-64y 99386	99396
> 65y 99387	99397
SCREENING CODES	
IPPE Exam	G0402
AWV – Initial Visit	G0438
AWV – Subsequent Visit	G0439
Alcohol Screening – 15 minutes	G0442
Depression Screening – 15 minutes	G0444
Breast / Pelvic	G0101
Obtain Pap	Q0091
Tobacco Cessation w c/o 3-10 minutes	99406
Home Health Re-certification	G0179
Home Health Certification	G0180
Advance Care Planning – 30 minutes	99497
CCM Assessment	+G0506
Chronic Care Management	99490
CCM Without Patient	99487
TCM Moderate Risk – 14 days	99495
TCM High Risk – 7 days	99496
INJECTIONS	
Arthrocentesis - small joint	20600
Arthrocentesis - medium joint	20605
Arthrocentesis - large	20610
Carpal tunnel injection	20526
Trigger point – 1 or 2 muscles	20552
Trigger point – 1 ten origin	20551
Trigger point – 1 ten/lig	20550
Trigger point – 3 or > muscles	20553

RADIOLOGY	
Abdomen – 1 View	74000
Abdomen – 2 Views	74020
Ankle – 2 views	73600
Cervical Spine – 2 or 3 Views	72040
Chest – 1 View	71010
Chest – 2 Views	71020
Clavicle – Complete	73000
Coccyx/Sacrum – 2 views	72220
Elbow	73070
Femur - 2 Views	73550
Finger – Minimum 2 Views	73140
Foot - 2 Views	73620
Hand - 2 Views	73120
Hip - 2 Views	73510
Humerus - 2 views	73060
Knee –1 or 2 Views	73560
Lumbosacral Spine - 2-3 Views	72100
Nasal – 3 Views	70160
Radius and Ulna – 2 Views	73090
Ribs, Unilateral - 2 Views	71100
Shoulder - 2 Views	73030
Sinus - < 3 Views	70210
Sinus - 3 Views	70220
Skull - < 4 Views	70250
Thoracic Spine – 2 Views	72070
Tibia & Fibia - 2 Views	73590
Toe – 2 Views	73660
Wrist - 2 Views	73100
MEDICATIONS	
Admin. Therapeutic/Antibiotic	**96372**
IV; Hydration first hour	**96360**
each additional hour ___	**96361**
Ancef 500 mg	J0690
B-12 up to 1000 mcg	J3420
Bicillin 0.6 million	J0530
Bicillin CR 1.2 units	J0540
Celestone 3 mg	J0702
Decadron 1 mg	J1100
Depo Medrol 40 mg	J1030
Depo-Medrol 80 mg	J1040
Depo-Provera (**BC only**) 150 mg	J1055
Depo-Provera 50 mg	J1051
Depo-Testosterone 100 mg	J1070
Gentamicin 80 mg	J1580
Kenalog per 10 mg	J3301
Lincocin up to 300 mg	J2010
Phenergan up to 50 mg	J2550
Rocephin 250 mg x _____	J0696
Saline, normal 1000 cc	J7030
Supartz (MCR Q4083)	J7319
Toradol per 15 mg	J1885

LABORATORY	
Finger Stick	**36416**
Venipuncture	**36415**
B-12	82607
BMP	80048
BUN	84520
Calcium	82565
Carbon Dioxide	82374
CBC w auto differential	85025
CBC w/o auto differential	85027
Chloride	82435
CMP	80053
CPK	82550
Creatinine	82565
Flu A&B	87804
GGT	82977
Glucose - FDA device	82962
Glucose, w/o regent strip	82947
Glucose, regent strip	82948
Hepatic Function Panel	80076
Hgb	85018
HgbA1C	83036
HgbA1C – FDA device	83037
Influenza	87804
KOH	87220
Lipid Panel	80061
Liver Panel	80076
Micro albumin	82043
Occult Blood – Single Card	82272
Occult Blood – Triple Card	82270
Pap Smear	88142
Potassium	84132
Pregnancy, urine	81025
PSA	84153
PT / INR	85610
Renal Panel	80069
Sed Rate	85651
Sodium	84295
Strep A	87880
Strep culture	87081
Strep, rapid	86403
T4, free	84439
TB, Intradermal	86580
Thyroxine, total	84436
TSH	84443
U/A auto w/o scope	81003
U/A auto w/scope	81001
U/A non-auto w/o micro	81002
U/A non-auto w/scope	81000
Urine colony count	87086
Urine Culture	87088
Wet Mount	87210

OFFICE PROCEDURES	
EKG	93000
Audiometry	92551
Cerumen Removal	69210
Hearing Screening	92551
Nebulizer	94640
- Duo Neb	J7620
Nebulizer demonstration	94664
Spirometry – Pre/Post	94060
Spirometry – Single	94010
Tympanometry	92567
FOREIGN BODY REMOVAL	
FB removal – ear	69200
FB removal – eye, cornea	65220
FB removal – eye, embedded	65210
FB removal – eye, superficial	65205
FB removal – nose	30300
FB removal - skin, simple	10120
SKIN PROCEDURES	
Biopsy	11100
Biopsy, each additional x ___	11101
Destroy pre-malignant lesion	17000
Destroy Pre-mal les, 2-14 each ___	17003
Skin tag removal 1-15	11200
VACCINES	
Admin thru 18 w counseling any route	**90460**
Each additional vaccine/toxoid	**90461**
Admin any age, injection	**90471**
Each additional vac: _____	**90472**
Admin any age intranasal or oral	**90473**
Each additional vac: _____	**90474**
DT < 7	90702
DTP	90701
DtaP < 7	90700
Flu – 3 and > (G0008 MCR)	90658
Flu 6-35 months	90657
Hepatitis – adult (G0010 MCR)	90746
Hepatitis – child	90744
HIB – PRP-T – 4 dose	90648
HIB HbOC – 4 dose	90645
HIB – PRP-OMP – 3 dose	90647
HPV	90650
IPV	90713
Meningococcal	90734
MMR	90707
Pediarix	90723
Pneumonia – adult (G0009 MCR)	90732
Prevnar	90669
Proquad	90710
Rota Teq - Oral	90680
TD > 7	90718
Varicella	90716

Evaluation & Management Coding Summary – Outpatient and Office

Code	Minutes	History	Examination	Decision-Making
New/Consultation Patient Visits (3 out of 3)				
99201 99241 99251	10 15 20	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 – (1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99202 99242 99252	20 30 40	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99203 99243 99253	30 40 55	*Detailed* • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low **OTC, Short-term Meds, Minor Surgery**
99204 99244 99254	45 60 80	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • **10 ROS** • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate **Long term Rx or Major Surgery**
99205 99245 99255	60 80 110	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Established Patient Visits (2 out of 3)				
99211	N/A	N/A	N/A	N/A
99212	10	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal 1 • Data – Minimal or None 1 • Risk – Minimal 1 1 stable problem
99213	15	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited 2 • Data – Limited 2 • Risk – Low 2 **2 stable problems** **1 unstable problem**
99214	25	*Detailed* • CC • **4 HPI or status of 3 chronic conditions** • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 **3 stable problems on meds** **1 stable and 1 unstable on meds** **2 unstable problems on meds** **New problem requiring major surg**
99215	40	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive 4 • Data – Extensive 4 • Risk – High 4 Very sick patient with extensive data review and high risk

HPI: [ ] Location [ ] Duration [ ] Severity [ ] Timing [ ] Context [ ] Other Signs and Symptoms [ ] Modifying Factors [ ] Quality
ROS: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych Allergy Endocrine or [ ] All other systems reviewed were negative (10)
Exam: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych

Table of Risk

Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
MIN (L-1/2)	• 1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • EKG/ EEG • Urinalysis • Ultrasound (echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW (L-3)	• 2 or more self-limited or minor problems • 1 stable chronic illness (eg, well controlled hypertension or non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (eg, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (eg, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (eg, barium enema) • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives • *Short-term antibiotics*
MODERATE (L-4)	• 1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment • 2 or more stable chronic illnesses • Undiagnosed new problem w/ uncertain prognosis (eg, lump in breast) • Acute illness with systemic symptoms (eg, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (eg, head injury w/ brief loss of consciousness)	• Physiologic tests under stress (eg, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies w/ no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies w/contrast, no identified risk factors (eg, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (eg, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic) w/no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation w/o manipulation
HIGH (L-5)	• 1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure • Abrupt change in neurologic status (eg, seizure, TIA, weakness, or sensory loss)	• Cardiovascular imaging studies w/contrast with identified risk factors • Cardiac eletrophysiological tests • Diagnostic endoscopies w/identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) w/identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Calculation of Data Points		Documenting Data Points
1	Review and/or order of clinical lab tests (80000)	To obtain data points, the note must clearly indicate "independent review," "decision to obtain old records," Discussed test with performing physician," "Relevant findings from the review of old records revealed:" – You must be specific.
1	Review and/or order tests in radiology section of CPT (70000)	
1	Review and/or order tests in medicine section of CPT (90000)	
1	Discussion of tests results w/performing physician	
2	Independent review of image, tracing or specimen	
1	Decision to obtain old records/history from someone other than patient	
2	Relevant findings from review of old records	
	Total	

Calculation of Diagnosis Points		High MDM when not High Risk
1	Self-limited – Max of 2	For a level 5 visit on a patient that is not "High Risk" in the office or a level 3 visit in the hospital that is not "High Risk" you need 4 data points and a new problem that requires additional work up.
1	Established Stable	
2	Established Worsening	
3	New - No Workup – Max of 1	
4	New - With Workup	
	Total	

Primary Care Form - 97 Guidelines

PATIENT'S NAME: _____ o **M** o **F / DOB** ___/___/___ **TODAY'S DATE:** ____/____/____

Chief Complaint and HPI Information:			**Problems With Current Meds:** o Yes o No	
			See Medication Sheet: o **See NPI Sheet:** o	
			Drug Allergies: o Yes o No	
			Smoker: o Yes o No	
			Alcohol: o Yes o No	
Flex/Colon:	Stress Test:	LMP:	Pap Smear:	Pelvic:
Last Heath Exam:	Chest X-ray:	DEXA:	Occult Blood:	Other:
Headaches o Yes o No	Blurred Vision o Yes o No	Change/Bowel Habits o Yes o No	SOB o Yes o No	Chest Pain o Yes o No
Insomnia o Yes o No	Swelling o Yes o No	Fatigue o Yes o No	Dizzy Spells o Yes o No	Increased B/P o Yes o No

o Vitals: (3) Wt _____ Ht _____ T _____ R_____ P_____ o Reg o IR BP: Sitting R___/___ L___/____

Examination Detail	*Pertinent Positives and Negatives*
CONST: o Well-developed, well-nourished, no acute distress.	
RESP: o Respiration even and un-labored. o Lung fields – no flatness, dullness or hyperresonance. o Clear /equal no adventitious sounds bilaterally.	
CARD: o RRR, w/no murmurs-rubs-gallops. o No Bruits throughout. o Pedal pulses within normal limits bilat.	
Female G/U: (7 of the following 11) **G0101** o Breasts symmetrical. No masses, lumps, tenderness, dimpling or nipple discharge. o Rectal exam exhibits even sphincter tone, no hemorrhoids or masses. **Pelvic** o No external lesions. Normal hair distribution. o Urethral meatus pink, no lesions or discharge. o Urethra intact, no tenderness, masses, inflammation or discharge. o Bladder without tenderness or masses, no incontinence. o Vaginal mucosa moist and pink, without lesions or discharge. o Cervix pink, no lesions, odor, or discharge. o Uterus midline, non-tender, firm and smooth. o No adnexal masses, nodules or tenderness. o Anus and perineum intact. ___ No lesions, rashes, fissures, fistulas or external hemorrhoids. Wet Prep _____ Hemoccult **Pos. Neg.**	
ABDOMEN: o No masses, no tenderness, bowel sounds active X 4 quad. o Liver and spleen are without tenderness or enlargement.	
GI/GU: o Prostate (normal) o Rectal (normal) o Genitalia (normal)	
MUSCULO: o Joints with full ROM, no pain, crepitus or contracture. o No muscle atrophy/weakness.	
NEURO/PSYCH: o Alert and oriented X 3. o No mood disorders noted, calm affect.	
SKIN: o No rashes, lesions or ulcers. o Warm and dry, normal tugor.	

Assessment / Plan:

F/U: _____ **o Days o Weeks o Months o Years oPRN**

o Counseling: Total Face to Face Time: _____ minutes / Total Time Counseling: _____ minutes. ***(Must be>Than 50% of Total Face to Face Time)***

Topics Discussed:

99201 (10m), 99212 (10m)= 1chk 99202(20m), 99213 (15m) = 6 chks 99203 (30m), 99214 (25m) = 12chks 99204(45m), 99205(60m) , 99215 (40m) = 2 chks from 9 area

Welcome to Medicare (G0402)

1) Review medical and social history.
2) Review risk factors for depression and mood disorders.
3) Review functional ability and level of safety.
4) Height, Weight, BP, VA, BMI.
5) End-of-life planning, if needed.
6) Education, counseling and referrals based on above.
7) Education, counseling, and referrals for other listed services.

Initial AWV (G0438)

1) Health Risk Assessment
2) Establishment of an individual's medical and family history.
3) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
4) Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5) Detection of any cognitive impairment that the individual may have.
6) Review of the individual's potential (risk factors) for depression,
7) Review of the individual's functional ability and level of safety, based on direct observation
8) Establishment of the following:
   -A written screening schedule, such as a checklist, for the next 5 to 10 years
   -A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended.
9) Furnishing of personalized health advice to the individual and a referral, as appropriate.
10) Any other element determined appropriate through the National Coverage Determination process.

Subsequent AWV (G0439)

1) Health Risk Assessment
2) An update of the individual's medical and family history.
3) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing personalized prevention plan services.
4) Measurement of an individual's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5) Detection of any cognitive impairment, as that term is defined in this section, that the individual may have.
6) An update to both of the following:
   -The written screening schedule for the individual as that schedule was developed at the first AWV providing personalized prevention plan services. CMS-1503-FC 761
   -The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first AWV providing personalized prevention plan services.
7) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.
8) Any other element determined through the NCD process.

Outpatient Consult Converter			
Commercial	Medicare Office or Observation		Medicare ER
Code	New	Established	ER
99241	99201	99212	99281
99242	99202	99212	99282
99243	99203	99213	99283
99244	99204	99214	99284
99245	99205	99215	99285

*ONLY IF DETAILED HX/EXAM IS DOCUMENTED

Inpatient Consult Converter		
Commercial	Medicare	Nursing Home
Code	Code	Code
99251	99221*	99304*
99252	99221*	99304*
99253	99221	99304
99254	99222	99305
99255	99223	99306

Evaluation & Management Coding Summary – Hospital Services

Code	Minutes	History	Examination	Decision-Making
Initial Hospital Visits 3 out of 3				
99221	30	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99222	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99223	70	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Subsequent Hospital Visits 2 out of 3				
99231	15	Problem Focused • CC • 1HPI	*Problem Focused* *1995 – (1)* *1997 – (1 check)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99232	25	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99233	35	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Hospital Discharge				
99238	30	Hospital Discharge		
99239	> 30	Hospital Discharge > 30 minutes – **{Must document time}**		

Definitions	
99221	Admission – Low Risk
99222	Admission – Moderate Risk
99223	Admission – High Risk
99231	Patient is responding well
99232	Pt is responding inadequately to therapy / developed a minor complication
99233	Pt is unstable or has developed a significant complication / significant new problem

HPI: [ ] Location [ ] Duration [ ] Severity [ ] Timing [ ] Context [ ] Other Signs and Symptoms [ ] Modifying Factors [ ] Quality
ROS: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych Allergy Endocrine or [ ] All other systems reviewed were negative (10)
Exam: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych

Evaluation & Management Coding Summary – Observation / Admission

Code	Minutes	History	Examination	Decision-Making
Observation/Hospital Discharge Same Day - 3 out of 3				
99234	40	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99235	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99236	55	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Observation - 3 out of 3 (first day of a multiple day observation service)				
99218	30	Detailed / Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99219	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99220	70	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Subsequent Observation Care Visits - 2 out of 3 (day(s) after first till day before discharge)				
99224	15	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99225	25	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99226	35	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 extended)* *1997 – (12 checks)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Observation Discharge (final day of observation)				
99217	N/A	Observation care discharge on date other than initial observation day		

Evaluation & Management Coding Summary – Emergency Department Services

Emergency Department Services 3 of 3				
99281	N/A	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal 1 • Data – Minimal or None 1 • Risk – Minimal 1
99282	N/A	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited 2 • Data – Limited 2 • Risk – Low 2
99283	N/A	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 4)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 The presenting problem(s) are of moderate severity
99284	N/A	*Detailed* • CC • **4 HPI or status of 3 chronic conditions** • 2 ROS • Medical or Family or Social History	*Detailed* *1995 – (5-7 – extended)* *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 The presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function
99285	N/A	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or 1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive 4 • Data – Extensive 4 • Risk – High 4 The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function

Critical Care Services		
Less than 30 minutes	Appropriate E/M Code	**Provision of Critical Care Services** This is a *47 y/o white m* with *severe sepsis*. For the record I spent *60 minutes* in constant attention with this *critically ill / injured patient*. The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. I provided critical care services requiring my direct and personal management as noted below:
30-74 minutes	99291 x 1	
75-104 minutes	99291 x 1 and 99292 x 1	
105-134 minutes	99291 x 1 and 99292 x 2	
135-164 minutes	99291 x 1 and 99292 x 3	
165-194 minutes	99291 x 1 and 99292 x 4	
195-224 minutes	**99291 x 1 abd 99292 x 5**	

Evaluation & Management Coding Summary – Preventive Medicine

Preventive Medicine Service		
Code	Age	**Preventive Medicine Services – New Patient**
99381	Under 1	If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier "-25" should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided.
99382	1-4	
99383	5-11	
99384	12-17	
99385	18-39	
99386	40-64	
99387	Over 65	
Code	Age	**Preventive Medicine Services – Established**
99391	Under 1	If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier "-25" should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided.
99392	1-4	
99393	5-11	
99394	12-17	
99395	18-39	
99396	40-64	
99397	Over 65	
Code	Minutes	**Counseling and/or Risk Factor Reduction Intervention**
99401	15	Preventive medicine counseling and/or risk factor reduction intervention(s)
99402	30	Preventive medicine counseling and/or risk factor reduction intervention(s)
99403	45	Preventive medicine counseling and/or risk factor reduction intervention(s)
99404	60	Preventive medicine counseling and/or risk factor reduction intervention(s)
99408	30	Alcohol and/or substance (other than tobacco) abuse structured screening
99409	60	Alcohol and/or substance (other than tobacco) abuse structured screening

Top Sugery Codes and Global Periods

CPT	PROCEDURE	GLOBAL
10060	DRAINAGE OF SKIN ABSCESS	10
11055	PARING OR CUTTING OF LESIONS	0
11100	BIOPSY OF SKIN LESION	0
11200	REMOVAL OF SKIN TAGS	10
11400	REMOVAL OF SKIN LESION	10
11750	REMOVAL OF NAIL BED	10
12031	INTERMEDIATE REPAIR/CLOSURE	10
16000	TREAT 1ST DEGREE BURN	0
17000	DESTROY BENIGN/PREMAL LESION	10
17110	DESTRUCTION OF FLAT WARTS	10
17340	CRYOTHERAPY OF SKIN	10
20550	INJECTION TENDON SHEATH	0
20610	DRAIN/INJECT JOINT/BURSA	0
45330	SIGMOIDOSCOPY, DIAGNOSTIC	0
55250	VASECTOMY	90
57410	PELVIC EXAMINATION UNDER ANESTH.	0
57452	COLPOSCOPY OF CERVIX	0
57454	COLPOSCOPY OF CERVIX / BIOPSY	0
57505	ENDOCERVICAL CURETTAGE	10
58100	BIOPSY OF UTERUS LINING	0
59025	FETAL NON-STRESS TEST	0
69210	REMOVE IMPACTED EAR WAX	0

CPT	PROCEDURE	GLOBAL
59025	FETAL NON-STRESS TEST	0
59400	OBSTETRICAL CARE	0
76827	ECHO EXAM OF FETAL HEART	0
88150	CYTOPATHOLOGY, PAP SMEAR	0
76805	ECHO EXAM OF PREGNANT UTERUS	0
76815	ECHO EXAM OF PREGNANT UTERUS	0
81002	URINALYSIS NONAUTO W/O SCOPE	0
81000	URINALYSIS, NONAUTO, W/SCOPE	0
59425	ANTEPARTUM CARE ONLY	0
57410	PELVIC EXAMINATION	0
88156	TBS SMEAR (BETHESDA SYSTEM)	0
59426	ANTEPARTUM CARE ONLY	0
87210	SMEAR, STAIN & INTERPRET	0
87110	CULTURE, CHLAMYDIA	0
80055	OBSTETRIC PANEL	0
76700	ECHO EXAM OF ABDOMEN	0
76830	ECHO EXAM, TRANSVAGINAL	0
76816	ECHO EXAM FOLLOWUP OR REPEAT	0
81003	URINALYSIS, AUTO, W/O SCOPE	0
87070	CULTURE SPECIMEN, BACTERIA	0
81025	URINE PREGNANCY TEST	0

2013 Modifiers

Surgery Only

22
23
26
47
50 – bilateral
51
52
53
54
55
56
58 - staged
59 - separate
62
63
66
73
74
76
77
78 - related
79 - unrelated
80
81
82

E&M MODIFIERS ONLY

24 – unrelated E/M
25 – minor (same day)
57 – major (day of or day before)

E&M Credit Cards

NEW PATIENT VISITS (3 OF 3)		
New Patient - History	**Exam**	**MDM**
99203 or 99243	**'97-12 checks**	**Low**
Cc, 4 HPI, 2 ROS, M Hx	**'95-5-7 extended**	
99204 or 99244	'97-2 from 9	**Moderate**
Cc, 4 HPI, 10 ROS, M, F, S Hx	'95-8 OS	
99205 or 99245	**'97-2 from 9**	**High**
Cc, 4 HPI, 10 ROS, M, F, S Hx	**'95-8 OS**	
ESTABLISHED VISITS (2 OF 3 – MDM Should be 1 of the 2)		
Follow-Up Patient History	**Exam**	**MDM**
99213 can also be billed on time – 15 min	**'97-6 checks**	**Low**
Cc, 1 HPI, 1 ROS	**'95-2-4**	
99214 can also be billed on time – 25 min	'97-12 checks	**Moderate**
Cc, 4 HPI (***status of 3***), 2 ROS, Meds	'95-5-7 extended	
99215 can also be billed on time – 40 min	**'97-2 from 9**	**High**
Cc, 4 HPI, (*status of 3)* 10 ROS, M, F, S Hx	**'95-8 OS**	

E/M BILLING TIPS

E/M ONLY MODIFIERS
24 – Unrelated E/M in global period
25 – Separately Identifiable E/M service same day as minor surgery
57 – E/M day before or day of major surgery

EXAM - (8): CONST, EYE, ENT, CV, RESP, LYMPH, MUSK, GI, GU, SKIN, NEURO, PSYCH. L = limited and D = detailed
Extended: Document 3 relevant findings regarding 5-7 parts of body.
ROS - (10): list one, then "all other systems reviewed negative"
Counseling: I spent _____ min. face to face. Greater than 50% of that time was counseling regarding the following: (list topics discussed)

EXTRA CMS CODING – 25 on E/M
G0101 – Pelvic and Breast Exam (CMS)
Q0091 – Obtain Pap (CMS)
G0402/G0403 – Welcome to Medicare (CMS)
G0438 – Initial AWV
G0439 – Subsequent AWV
99406: 3-10 minutes of Tobacco Cessation Counseling
99407: > 10 minutes of Tobacco Cessation Counseling

DETAILED HISTORY:
CC: Patient here today for follow-up of multiple complex conditions:

STATUS OF CHRONIC CONDITIONS
HTN – Stable on current meds
DM – Stable on current meds
OA – Stable on current meds

ROS:
CV: Denies chest pain or discomfort
Resp: Denies SOB

SOCIAL HISTORY
Patient continues to smoke

Constitutional	[ ] Vital signs listed above. [ ] Well developed, well nourished and in no acute distress. [ ] Alert and oriented X's 3. [ ] No mood disorders noted, calm affect.
Eyes	[ ] Sclera white, conjunctiva clear. [ ] Lids are without lag. [ ] PERRLA. [ ] Pupils and irises are equal and round without defect.
ENMT	[ ] TMs intact and clear, normal canals, grossly normal hearing. [ ] Gums pink, good dentition. [ ] Oropharanx clear and moist without erythema. [ ] Full range of motion
Respiratory	[ ] Chest symmetrical, respirations non-labored. [ ] No dullness or flatness. [ ] Clear bilaterally to auscultation. [ ] Non-tender to palpitation.
Cardiovascular	[ ] No lifts, heaves, or thrills felt on palpation. S1and S2. [ ] Regular Rate and Rhythm w/o murmurs, rubs or gallops. [ ] Pedal pulses +2 throughout. [ ] No peripheral edema.
Gastrointestinal	[ ] Soft, non-tender, non-distended, [ ] No hepatosplemomegaly. [ ] Normal bowel sounds. [ ] No masses noted.
Skin	[ ] Normal temperature. [ ] Normal tone and turgor. [ ] No rashes, lesions, or ulcers. [ ] Warm and dry to touch.
Musculoskeletal	[ ] No digital cyanosis or ischemia. [ ] Normal strength and tone all extremities. [ ] No atrophy or weakness. [ ] Joints with full range of motion. [ ] No misalignment, defects, or deformities
Neurological	[ ] Recent and remote memory intact. [ ] Cranial nerves II-XII grossly intact with normal sensation, reflexes, coordination, muscle strength and tone. [ ] Speech smooth and clear. [ ] Aware of current events