Current Procedural Terminology

All providers use CPT® codes to quantify their medical visit. These codes are also known as Evaluation and Management (E/M) codes. The fee/reimbursement corresponds with the chosen code: the higher the complexity, the higher the fee. Fees may vary for the same level of care according to location were the services are performed (hospital/office) and/or if the patient is NEW or ESTABLISHED. Each of the following **SEVEN** components are considered when choosing the correct code for a visit.

TIME: Face to face time spent with the patient may range between 5 to 60 minutes.

HISTORY: All coded visits must have a documented chief complaint (CC:) and a History of Present Illness (HPI:) Review of Systems and Past Medical, Family, and Social history (ROS PFSH) are not necessary in a Minimal or Focused visit.

PHYSICAL EXAMINATION:

Minimal exam doesn't require the doctor to be present (nurse simply checks blood pressure).

Focused exam includes a brief history and exam for single problem.

Expanded exam is limited to the affected body area or organ system.

Detailed exam is extended to the affected body area and other symptomatic or related organ systems.

Comprehensive - exam is a general multi-system exam or complete examination of a single organ system.

Elements of the physical examination include:

CONSTITUTIONAL (general appearance) & VITALS: BP supine • sitting • standing, Temp, Weight, Height, Pulse (regular irregular), Respiration (regular irregular), BMI, Waist circumference, O_2 %sat

BODY AREAS: Head-Neck, including the face, Chest, including breasts and axillae, Abdomen, Genitalia, groin, buttocks

ORGAN SYSTEMS: Cardiovascular, Musculoskeletal, Ophthalmologic, Otolaryngologic, Respiratory, Neurologic Hematologic/Lymphatic, Endocrine, Gastrointestinal, Each extremity Back including spine, Allergic/Immunologic, Genitourinary, Integumentary, Psychiatric

SEVERITY: How serious and what are the consequences of the presenting medical problem?

COMPLEXITY: Medical decisions are made by considering and DOCUMENTING the following issues:

- What is the most probable diagnosis?
- What are the possible diagnoses, treatment, and management options?
- What tests if any, should be ordered, reviewed, and interpreted?
- What is the risk or complication of the decision: low, moderate, or high?

Low Complexity Medical Decision Making, the problem will (1) be of low severity, urgency with a low risk of complications, (2) have a limited differential diagnosis and data, (3) have a straightforward diagnostic and treatment plan.

Moderate Complexity Medical Decision Making, the problem addressed will (1) be of moderate severity with a moderate risk of complications, (2) require review of a moderate amount of additional information with an extended differential diagnosis, (3) require complicated diagnostic and/or therapeutic intervention.

Highly Complex Medical Decision Making, the problem addressed will (1) be of high severity with a high risk of complications and clinical deterioration, (2) require review of an extensive amount of additional information with an extensive differential diagnosis, (3) require highly complex multiple diagnostic and/or therapeutic interventions, with a highly complex treatment plan.

For the purpose of documentation 2 of these 3 elements must either meet or exceed the requirement for medical decision making.

COUNSELING: Discussing lifestyle changes, personal or medical dilemmas, or adherence to treatment.

COORDINATION OF CARE: Discussion and planning with other health care professionals.

Templates and prompts help develop a pattern of questions and examination actions. Always "code" the patient visit using the point system to perfect your coding accuracy. The forms guide you when seeing patients in clinic or floors for accurate data collection, presentations, daily visit tasks, and handoffs. Have the patient fill out the ROS form before the visit to save time and improve data relaibility.

Clinic Established Patient

A patient arrives at registration 2 hours late. He asks for one week's worth of lisinopril and an appointment next week. The clerk runs it by you and you ask the nurse to check the blood pressure. The nurse relates the following vital signs: blood pressure 110/64 left arm, 112/66 right arm, weight of 144 lbs., pulse 66, respiratory rate 14. So, you...

99211...authorize a refill and request the patient reschedule an appointment for next week.

Decide to see the patient, ask "Why are you here?" He says, "I have hypertension and need a refill." Then...

99212...you refill the lisinopril and ask him to schedule another appointment for nest week. Dx: HTN

CC	HPI	ROS	PFSHx	Exam	Complexity
					(Low) Moderate High
					$39

99213...you shake hands, you document the patient is a man in his 50's with a good grip, an appropriate affect and his eyes track you during the introduction. He is able to hear you without difficulty,has a normal respiratory effort, clears his throat 3 or 4 times. You ask about hoarseness, runny nose, cough, and sneezing. Dx: HTN/Viral URI

CC	HPI	ROS	PFSHx	Exam	Complexity
					(Low) Moderate High
					$63

99214.... you ask how long he has been on lisinopril and if he has SOB, PND, GERD, rash, a dry cough or tickle in his throat? He acknowledges cough and tickle were barely noticeable for 2 weeks and medication was started 4 weeks ago. You ask about his job and family. Examine heart, lungs, neck, oropharynx, skin, order CMP-lipids, ask the patient to stop the lisinopril and schedule an appointment next week. Dx: HTN/ ACE allergy

CC	HPI	ROS	PFSHx	Exam	Complexity
					Low (Moderate) High
					$96

99215.... after explaining your thoughts that the cough is due to lisinopril and you think it should be stopped, you ask the patient why lisinopril was started. The patient tells you the medication was started to "protect his heart." He then reaches into a briefcase and pulls out labs and several bottles of medication for you to see. Lisinopril 10 mg qam, metoprolol 25 mg bid, atorvastatin 20 hs, plavix 75 qam, aspirin 81 qam. You ask if there is CAD in the family. He tells you his father and brother died before age 60 of CAD and he was a 2ppd smoker for 30 years but quit 4 weeks ago after hospitalization for a stent. The lisinopril bottle is empty but the others have another two weeks or so left. "This pill is to be taken once daily how did you run out?" "Once daily, I was taking it twice a day." He responds with an apologetic grin. You examine heart, lungs, neck oropharynx, skin,order old records, blood work, change the lisinopril to losartan and schedule an appointment for next week. Dx: HTN/ ACE allergy/CAD

CC	HPI	ROS	PFSHx	Exam	Complexity
					Low Moderate (High)
					$133

ROS

Sweats chills fevers LOC Δ appetite Δ weight
Depression anxiety Δ memory Δ sleep tired dizzy
Headaches Δ vision ears throat sinus Δ voice epistaxis
Chest pain-pressure palpitations DOE PND edema
Orthopnea SOB wheezing cough sputum hemoptisis
Food intolerance pain dysphagia dyspepsia bloating
Dysphagia nausea vomiting hemorrhoids blood Δ BM
Nocturia dysuria incontin frequency blood Δ libido
LMP G: P: A: monogamous high risk
Joint muscle pain stiffness weakness numb cramps
Skin lesions rashes ulcer bruising Δ nails Δ hair

	Focused	Expanded	Detailed	Compreh
CC	+	+	+	+
HPI	1-3	≥4	≥4	≥4
ROS	1-3	3-8	≥9	≥9
PFSHx		1	1-3	3
Exam	1-5	6-12	12-18	≥19
Complexity/Dx	1	2	systemic	severe
Minutes	10	15	25	40

Eyes	**Neck**	**GU**	**GI**
Vision ≥20/40 OU	Palpation	Scrotum	Scars
Conjunctivae	Thyroid	Penis	Bowel sounds
Lids	**Resp**	Prostate	Consistency
PERRLA	Effort	Fem Genitals	Tender • Mass
Fundi	Breath sounds	Urethra	Liver • spleen
lens • disc	Percussion	Bladder	Hernia
ENT- Mouth	Fremitus	Cervix	Ano-rectal
Ears external	**CV**	Uterus	Occult blood
TM EAC right	Palpate PMI	Adnexa	**Mus/Skel**
TM EAC left	thrill	**Skin**	Gait >50 ft
Hearing R = L	Heart sounds	Inspection	Digits nails
Speach clear	No murmur	Palpation	Upper Extrem
Nose	Carotids	Lymph	ROM
mucosa•septum	Aorta	Neck	Strength • Tone
turbinates	Femorals	Axillae	Lower Extrem
Teeth • gums	Pedal pulses	Groin	ROM
lips	Varicose veins	**Neuro**	Strength • Tone
Oropharynx	Edema	CN II-XII	**Psych**
mucosa•palates	**Chest**	DTR	Year Season
tongue•tonsils	Inspect breasts	Sensation	Affect • Insight
glands•pharynx	Palpate breasts	Cerebellar	3 step command
Counseling >50% face time		Lifestyle	Diagnosis
		Medications	Testing

CC must be so listed. HPI should include: location, severity, quality, duration, modifying factors and associated symptoms. There are 58 exam elements - vital Signs havel 3 value points. Non-indented exam elements equal 1 point. ALL indented = 1 pt. PFSHx has 3 components. COMPLEXITY of Medical Decision Making is related to the : severity, urgency, risk of clinical deterioration and complications - Minimal • Straightforward • Low • Moderate • High
Each patient encounter is classified as: Minimal • Focused • Expanded • Detailed • Comprehensive

ICD-10

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is a revision of the ICD-9-CM system which physicians and other providers currently use to code all diagnoses, symptoms, and procedures recorded in hospitals and physician practices.

The ICD-10-CM revision has more than 68,000 diagnostic codes, compared to the 13,000 found in ICD-9-CM. The revision also includes twice as many categories, and is more specific in identifying treatment. For example, ICD-10 provides codes to distinguish between a left or right leg; ICD-9 does not.

The U.S. Department of Health and Human Services had set implementation October 1, 2014. However, on April 1, 2014, Pres. Obama signed into law H.R. 3402 which prevented H.H.S. from establishing ICD-10 as the standard code set before October 1, 2015.

ICD 10					
Abdominal pain	R10.9	Dehydration	E86.0	Migraine	G43.909
Acne	L70.0	Depression	F32.9	Neuropathy	G58.9
Allergic rhinitis	J30.9	Dermatitis contact	L25.9	Obesity	E66.9
Anemia	D64.9	DM I	E10.9	Osteoporosis	M81.0
Anxiety	F41.1	contrld DM II	E11.9	Otitis Media	H66.90
Arthropathy	M12.9	uncontrld DM II	E11.65	Palpitations	R00.2
Asthma	J45.909	Diarrhea	R19.7	Periph Vas Dis	I73.9
Atrial Fib	I48.91	Degen Disc Lumbar	M51.36	Pharyngitis	J02.9
Acute Bronchitis	J20.9	Edema	R60.9	Pneumonia	J18.9
Bursitis	M71.50	Gastritis	K29.00	Psoriasis	L40.8
Carpal Tunn Syn	G56.00	GERD	K21.9	Sinusitis	J32.9
Cellulitis	L03.90	GI Bleed	K92.2	Sciatica	M54.30
Cerumen Plug	H61.23	Gout	M10.9	Spinal Stenosis	M48.00
Chest pain	R07.9	Headache	G44.209	Strep throat	J03.00
CKD III	N18.3	Hemorrhoids	K64.8	Stroke	I63,40
CKD IV	N18.4	Hyperlipidema	E78.5	Syncope	R55
Claudication	I70.219	Hypertension	I10	Tendonitis	M77.9
Cong hrt failure	I50.9	Hypercholesterol	E78.0	Upper respir inf	J06.9
Conjunctivitis	H10.9	Hypothyroid	E03.9	Urinay tract Inf	N39.0
Constipation	K59.00	Hyperthyroid	E05.80	Vaginitis	N76.0
Costochondritis	M94.0	Incontinence	R32	Vertigo	H81.49
Cor art disease	414.01	Insomnia	G47.00	Vestibulitis	H81.93
Colitis	K52.89	Low back pain	M54.5	Warts viral	B07.9
COPD	J44.9	Menopause	N95.9	Weakness	R53.81

Office visits					TIme	Inpatient visits				
Hx	Ex	Dx	New	Established		New	Established	Hx	Ex	Dx
				99211	5					
F	F	S	99201	99212	10					
F	F	L		99213	15		99231	F	F	L
E	E	S	99202		20					
D	D	M		99214	25		99232	E	E	M
D	D	L	99203		30	99221		D	D	L
C	C	H		99215	35		99233	D	D	H
					40					
C	C	M	99204		45					
					50	99222		C	C	M
C	C	H	99205		60					
					70	99223		C	C	H

Home visits					TIme	Nursing Facility				
Hx	Ex	Dx	New	Established		New	Established	Hx	Ex	Dx
					5					
					10					
F	F	S		99347	15		99307	F	F	S
F	F	S	99341		20					
E	E	L		99348	25		99308	E	E	L
E	E	L	99342		30	99304		D	D	L
					35		99309	D	D	M
D	D	M		99349	40	99305		C	C	M
D	D	M	99343		45		99310	C	C	H
					50	99306		C	C	H
C	C	M	99344	99350	60	Hx = History	Ex = Exam			
					70	Dx = Diagnosis or				
C	C	H	99345		75	management options				

	History	Exam
S=Straightforward 1 diagnosis/no data/ minimal risk	F=Focused 1-3	1-5
L=Low complexity 1 diagnosis/limited data/low complication risk	E=Expanded 4-8	6-11
M=Moderate complexity ≥2 diagnosis/moderate data & risk	D=Detailed ≥9	12-18
H=High complexity systemic/extensive data/high complication risk	C=Comprehensive ≥9	≥19

	CC	HPI	ROS	PFSH	Exam	Dx/Mgt	Data	Risk
F=Focused	Yes	1-3	None	None	1-5	≤2	None	Minimal
E=Expanded	Yes	1-3	Pertinent	None	6-11	2-3	Limited	Low
D=Detailed	Yes	≥4	2-9	Pertinent	12-18	Mutlple	Multiple	Moderate
C=Comprehensive	Yes	≥4	Complete	Complete	≥19	Extensive	Extensive	High

Unacceptable Decision Making**: "**No change" or "CPM" must state what/why: "DM controlled continue Lantus."
Acceptable Decision Making: Reviewing old medications or treatments. Writing new prescriptions. Complex drug management 3 or more prescriptions, changing doses, changes to complex medications like insulin.
Reviewing test results. Discussing test results. Ordering tests or X-ray. Personally reviewing the Ekg, path slide , X-ray. Reviewing consults or speaking with consultant.
Risk: Low if its self limited (URI) or stable (HTN). Moderate if exacerbation (asthma) or Acute (UTI). High if there is chance for significant mortality or morbidity.

Coding Card

						Decision making			
Level	CC	HPI	ROS	PFSH	Exam	Dx	Data	Severity Risk	Min
Min - 1	+	1-3	-	-	-	1	-	Minimal	5-10
Foc - 2	+	1-3	-	-	1-5	1	Single	Low	10-20
Exp - 3	+	1-3	2-4	1-2	6-11	1	Limited	Moderate	15-30
Det - 4	+	≥4	4-9	1-2	12-20	2	Multiple	High	25-45
Com - 5	+	≥4	≥40	3	>30	Sys	Extensive	High	35-60

◇ **Minimal** - straightforward follow up; doctor does not need to be present. (flu shot)

◇ **Focused -**single diagnosis, no testing, minimal risk. (blood pressure check)

◇ **Expanded** - two problems or stable chronic problem, limited testing, low risk. (diabetes)

◇ **Detailed** - acute systemic illness or 2 chronic illness(es) with exacerbation. (asthma)

◇ **Comprehensive** - acute/chronic illness threatening function. (pulmonary edema)

Complexity of Decision Making effort for treatment or diagnosis

Straightforward • Low • Moderate • High

"No Change or CPM" Unacceptable Decision Making**: S**tate what you are doing and why: "DM controlled will continue Lantus and check A1C in 3 months."

Acceptable Decision Making: Reviewing old medications or treatments. Writing new prescriptions. Complex drug management 3 or more prescriptions, changing doses, changes to complex medications like insulin.
Ordering lab tests or imaging. Reviewing test results. Discussing test results.
Personally reviewing the EKG, slides, X-ray.
Reviewing consults or discussing with consultant or allied health provider.

Severity/Risk of complications for the condition, treatment, diagnostic procedure**:**
Minimal
Low if its self limited (URI) or stable (HTN).
Moderate if exacerbation (asthma) or Acute (UTI).
High if there is chance for significant mortality or morbidity.

Data amount of data in arriving at at diagnosis

Diagnosis (focal-systemic) number of diagnosis or management options