CODING AND DOCUMENTATION MODULE:
TEACHING POINTS FOR CLINICAL EDUCATORS

This document, prepared by a working group of SGIM’s Clinical Practice Committee, is a stand alone reference for medical educators and complements the Power Point presentation available online.

Though the rules for documenting clinical service codes are seemingly arbitrary and at times awkward, understanding and employing the rules in outpatient and inpatient practice is essential for appropriate compensation.

RVUs (Relative Value Units) are the metric used to measure work in nearly all practice settings.

The content of this document represents the best synthesis of a varying of interpretations of the 1995 and 1997 Centers for Medicare and Medicaid Services’ (CMS) guidelines.

Local implementation of these guidelines should be consistent with our content but ultimately the local rules will apply in your setting. If they do not, you may have a legitimate basis for challenge.

These were updated and edited last on May 1, 2007.

Contributors:

John D. Goodson, MD Chair, Practice Management Subcommittee, Clinical Practice Committee
Christine Sinsky, MD Co-Chair Practice Management Subcommittee, Clinical Practice Committee
Davoren Chick, MD
Yvette Cua, MD
David C. Dugdale, MD
Jeannine Z. Engel, MD
Stephen K. Sigworth, MD
Thomas O. Staiger, MD
David C. Thomas, MD
I. Introduction and framing

1. Our clinical work is measured in Resourced-based Relative Value Units (RVUs). By convention, this is the “currency” of our profession.
2. Reimbursement for a clinical service is based on the summation:
   1. The face-to-face content or “work” of the clinical encounter (the W RVUs)
   2. The overhead costs or “practice expense” (the PE RVUs)
   3. The liability or “risk” (L RVUs).
3. The W RVUs represent about 52% of the total RVUs.
4. Medicare payment from the Centers for Medicare and Medicaid Services (CMS) is based on the multiplication of the total RVUs times a regional adjustment factor, the Geographic Practice Cost Index (GPCI).
5. The current (2007) geographic adjustments for work and practice expense RVUs are:

<table>
<thead>
<tr>
<th>Service code</th>
<th>W RVUs</th>
<th>PE RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manhattan</td>
<td>+6.5%</td>
<td>+30.0%</td>
</tr>
<tr>
<td>Atlanta</td>
<td>+1.0%</td>
<td>+9.1%</td>
</tr>
<tr>
<td>Omaha</td>
<td>-4.1%</td>
<td>-12.4%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>+4.1%</td>
<td>+15.8%</td>
</tr>
</tbody>
</table>

6. The actual Medicare payment per CPT code is then equal to the total RVUs multiplied times a Conversion Factor (CF) that is reassigned annually by CMS. The 2007 CF = $37.8975

1. Total RVUs = (W RVUs x W GPCI) + (PE RVUs x PE GPCI) + (L RVUs x L CPCI)

7. Though the system is determined and regulated by CMS, the profession advises CMS through the Resource-based relative Value Update Committee (RUC). The RUC is administered by the AMA under contract from CMS. SGIM participates under the aegis of the ACP.
8. This RBRVS system has been adopted by virtually all carriers and is the basis for incentive payment in most staff model practices.
9. There are nearly 9000 CPT codes with RVU values.
10. Outpatient generalists primarily use the Evaluation/Management (E/M) service codes, 99201-5 (new outpatient) and 99211-5 (established outpatient).
11. Hospitalists use 99217 (discharge next day from observation admission), 99218-99220 (observation with next day discharge), 99221-99223 (full inpatient admission), 99234-99236 (observation with same day discharge) and 99238-99239 (hospital discharge from full admission).
12. We will focus our teaching on 99203, 99204 and 99214 but explain when to go above or below these anchor service codes.

<table>
<thead>
<tr>
<th>Service code</th>
<th>W RVUs*</th>
<th>Total RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>1.34</td>
<td>2.56</td>
</tr>
<tr>
<td>99204</td>
<td>2.30</td>
<td>3.92</td>
</tr>
<tr>
<td>99205</td>
<td>3.00</td>
<td>4.93</td>
</tr>
<tr>
<td>99213</td>
<td>0.92</td>
<td>1.66</td>
</tr>
<tr>
<td>99214</td>
<td>1.42</td>
<td>2.52</td>
</tr>
<tr>
<td>99215</td>
<td>2.00</td>
<td>3.42</td>
</tr>
</tbody>
</table>
13. 2005 Medicare billing data for Internal Medicine

<table>
<thead>
<tr>
<th>Code</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>21,494</td>
<td>1.2%</td>
</tr>
<tr>
<td>99202</td>
<td>140,787</td>
<td>8.0%</td>
</tr>
<tr>
<td>99203</td>
<td>535,768</td>
<td>30.3%</td>
</tr>
<tr>
<td>99204</td>
<td>707,201</td>
<td>40.0%</td>
</tr>
<tr>
<td>99205</td>
<td>363,605</td>
<td>20.6%</td>
</tr>
</tbody>
</table>

1,768,855

<table>
<thead>
<tr>
<th>Code</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>2,894,138</td>
<td>5.1%</td>
</tr>
<tr>
<td>99212</td>
<td>3,450,716</td>
<td>6.0%</td>
</tr>
<tr>
<td>99213</td>
<td>31,694,634</td>
<td>55.5%</td>
</tr>
<tr>
<td>99214</td>
<td>16,709,719</td>
<td>29.2%</td>
</tr>
<tr>
<td>99215</td>
<td>2,385,989</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

57,135,196

14. Though work RVUs are based on face-to-face time, all services are “bundled” with the RVUs assigned to a given encounter.

15. “Bundled” services include the following:
   1. Review of material before the visit, the pre visit time.
2. Documentation of a visit, the intra visit time.
3. Follow-up lab and test result review after a visit, including non face-to-face (e.g. letter, phone or electronic) communication to the patient, the post visit time.
16. Chart audits are employed by carriers to ensure that the service codes selected for clinical services are justified by the documented content of a visit.

II.CMS guidelines

1. CMS specifies three information components for every service code:
   1. History,
   2. Physical Exam and
   3. Medical Decision Making (MDM).
2. Service code choice is based on the level of history, the level of the physical examination and the complexity of the MDM.
3. The level of history and physical examination is based on the number of elements documented.
4. The level of history is based on the number of documented elements in four areas
   1. Chief Complaint (CC)
   2. History of Present Illness (HPI)
   3. Review of Systems (ROS)
   4. Past Medical, Family, Social History (PFSH)
5. Chief Complaint: Brief reason for patient visit (symptom, problem, condition, diagnosis, physician recommended return) or patient’s described problem.
6. The CC as well as the ROS and the PFSH may be listed separately for all service codes or they may be included in the HPI documentation
7. History of Present Illness: Medicare recognizes 8 narrative descriptors of the patient’s complaints/problems:
   1. Location
   2. Quality
   3. Severity
   4. Duration
   5. Timing
   6. Context
   7. Modifying factors
   8. Associated signs/symptoms.
8. Review of Systems: Medicare recognizes 14 different organ systems:
   1. Constitutional symptoms
   2. Eyes
   3. Ears, Nose, Throat, Mouth
   4. Cardiovascular
   5. Respiratory
   6. Gastrointestinal
   7. Genitourinary
   8. Musculoskeletal
   9. Integumentary (skin and/or breast)
   10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

9. Past Medical, Family, Social History (PFSH)
   1. Patient’s past medical/surgical history, medications, allergies, immunizations
   2. Patient’s history of family illness
   3. Patient’s social history.

10. The CC, ROS, PFSH may be listed separately for all service codes or included in the HPI.

11. Medicare allows the level of physical examination to be determined in two different ways:
   1. Using body areas
   2. Using organ systems

12. PE: Body Areas
   1. Head (including face)
   2. Neck
   3. Chest (including breast/axillae)
   4. Abdomen
   5. Genitalia/groin/buttocks
   6. Back, including spine
   7-10 Each extremity

   1. Constitutional (i.e. vital signs, general appearance)
   2. Eyes
   3. Ears/nose/mouth/throat
   4. Cardiovascular
   5. Respiratory
   6. Gastrointestinal
   7. Genitourinary
   8. Musculoskeletal
   9. Skin
   10. Neurologic
   11. Psychiatric
   12. Hematologic/lymphatic/immunologic

14. Endocrine and allergy systems are not considered distinct for coding purposes. Thyroid falls under neck.

15. The complexity of Medical Decision Making (MDM) is base on three characteristics, Table 2:
   1. Number of diagnostic/treatment options
   2. Amount and complexity of data obtained, reviewed and analyzed
   3. Risk of complications associated with the presenting problems and the patient’s comorbidities and/or management options.

16. MDM: Number of diagnostic/treatment options
   1. Nature of the problem: Number of possible diagnoses, self limited vs. open ended, new vs. established.
   2. Status: Stable vs. unstable
3. Need for further evaluation: Number of possible management options, need for referral

17. MDM: **Amount and complexity of data reviewed**
   1. Review/order laboratory test(s)
   2. Review/order radiologic test(s)
   3. Review/order other diagnostic test(s)
   4. Decision to obtain old records or obtain patient history from someone other than the patient
   5. Review and summarize old records
   6. Discuss test results with the physician who performed the test
   7. Self-interpretation of a test, image, tracing or specimen (and documented, e.g. “I personally..”)

18. MDM: **Risk of complications**
   1. Complications associated with the presenting problem
   2. Comorbidities
   3. Diagnostic procedures and/or management options.
   4. Decisions (DNR choices)

19. CMS has published two editions of the Evaluation and Management documentation guidelines. The first was issued in 1995, with a subsequent publication in 1997. The main difference between the two revolves around the documentation of the physical exam. CMS allows the practitioner to follow either guideline.

20. General internists typically use the 1995 guidelines, as they are easier with regards to documentation of the general physical exam. Specialists often use the 1997 guideline due to the fact that the physical exam they perform and document is often limited to one organ system in great detail. The 1997 guidelines recognize the assessment of multiple medical problems within the HPI section.

21. Medicare expects local intermediaries to audit charts to ensure compliance with documentation and coding, but does not specifically instruct the intermediary how to complete this task. Each local intermediary interprets the guidelines and applies these interpretations as they see fit to the charts that they review.

22. Caveat: Familiarize yourself with your local Medicare intermediary to determine how they conduct chart audits and what coding requirements they may have.

### III. Audit tools

1. Physicians need to be certain that documentation in the medical record is sufficient to accurately justify the choice of service code
2. Most carriers and many practices retrospectively audit documentation
3. Table 1 is an example of an audit tool used as a checklist to compare with a patient record in order to determine the level of history, physical examination, and the complexity of medical decision making that the documentation supports. Physicians should organize their notes to make it easy for an auditor to recognize the work they do.
4. With all audit tools, the amount of detail for each of the three components will determine if your documentation is adequate. The requirements and critical contents areas vary by components, patient type, (new, established or consultation) and by location (inpatient, outpatient, nursing home, home, etc.).
5. For medical decision making, it is particularly important to note that only 2 of the 3 characteristics are required (“diagnoses, data, or risk”), regardless of the patient type or location of service.

IV. Planning documentation with each visit to sustain the appropriate code level

1. There are two ways to conceptualize proper documentation for coding:
   1. **Point counting (retrospective):** What service code is supported by the medical content of my note?
   2. **Diagnosis-driven approach (prospective):** Are all requirements documented to achieve the specific service code I have chosen to reflect the medical content of my note?

2. Most clinicians over time will have an “intuitive feel” (gestalt) for what documentation is needed for a specific code choice.

3. Most begin by understanding how points are counted in the auditing process so that they can determine the service code for a given note. It is important to understand how many points are necessary (and how much documentation is needed) to support a given coding level. The most important aspect of the diagnosis-driven approach is KNOWING precisely what elements are medically necessary to document for the problem/diagnosis, and therefore the medically appropriate service code that will generally result from the necessary documentation.

4. With experience, most physicians develop a sense of how clinical content drives service code selection and build the note to provide the documentation needed for that code.

5. The “Medical Necessity” of each specific clinical encounter becomes the “driving force” of service code selection in the **Diagnosis-driven approach**.

V. The New Outpatient family, 99203-99204

1. The focus will be on the codes most frequently used by GIM practitioners, 99203 and 99204. Codes above or below these levels will be used infrequently.

2. Steps for choosing service code:
   1. Step one: Is the patient new to the practice?
   2. Step two: What elements are recorded in the history and physical examination components of the note and how complex is the medical decision-making?
   3. Step three: Choose service code based on documentation

3. New patient has not been seen by your billing group in the last three years
   1. Billing group determined by Medicare specialty assignment
   2. Hospital = clinic = ER (if you or your group bill from ER)
   3. Consider ANY billing source, hospital consult, outpatient visit, etc. If an hospitalist is part of your group and they cared for the patient in hospital, then the service is an ESTABLISHED patient visit when they come to your outpatient practice to establish care, even though the patient is “new” to the practice.

4. The point counting approach to **99203 History**
   1. HPI: 4 element
   2. ROS: 2 elements,
3. PFSH: 1 element
5. 99203 HPI Elements (4/8): See II. 8
8. 99203 PE: (5/12) or “Detailed exam”: See II. 14. It is often safer to document 6/12 PE findings to provide the option of using the 1997 guidelines for a new patient without any specific complaints.
9. “Detailed exam” may be further defined and verified by local Medicare contractors.
10. 99203 Low Complexity MDM Characteristics, 2/3 required, Table 2:
    1. Diagnostic/treatment options
       a. 2 minor or self limited problems OR
       b. One new problem with no additional work-up
    2. Amount and complexity of data
       a. Obtaining history from someone other than pt OR
       b. Independent review of a specimen or tracing OR
       c. Review of old records
    3. Risk of complications
       a. Two or more self limited or minor problems OR
       b. One stable chronic illness OR
       c. An acute uncomplicated illness OR
       d. OTC drugs OR
       e. PT/OT
    4. Two of the above three elements are needed to reach low MDM
11. All three elements (History, Exam, MDM) must be met or exceeded to bill at this level
12. Working backwards, considering the elements: Most GIM docs will easily meet low MDM on a new patient, even if pt has a simple problem, they will recommend some OTC meds, or some PT. Unless a very simple problem, MDM will be met at this level.
13. Physical Exam will also meet the 5 system requirement most of the time: VS or general appearance, eyes, skin, psych (affect), neurological (alertness, orientation, gait) can all be documented from observation alone, without ever touching the patient with a stethoscope. Add CV, lungs and/or abdomen, and the 6 systems (1997 guidelines) are easily documented
14. All that is left is HPI/ROS and PFSH. Again, on a new pt, most GIM docs will at least review allergies and meds, if not PMH. Only one of these is needed to meet the single PFSH needed. All problems presenting will be new to the examiner on a new patient, therefore the history will most likely include the needed 4 elements and 2 ROS
15. For patients without any new complaints, the 1997 guidelines allow more than a 99202 by documenting the status of three chronic problems in lieu of the 4/8 modifiers of a CC for the HPI criteria.
16. In summary, the majority of General Internal Medicine Physicians seeing a new patient for (even) a simple problem will easily fulfill the documentation requirements for a Level 3 new patient visit.
17. Billing based on TIME can only be done if > 50% of the physician face to face time is spent counseling and/or care coordination. For 99203, the total face to face time is 30 minutes.
18. Counseling: Just about anything an internist talks about with the patient or any family member present...
   1. Planning tests
   2. Planning therapies
3. Reporting test results
4. Discussing prognosis
5. Discussing risk and benefits of tests and interventions
6. Giving instructions for a test or treatment
7. Discussing compliance
8. Discussing risk factor modification

19. **Coordinating care:** Just about anything that directly involves the physician…
   1. Calling a consultant to set up an evaluation
   2. Calling a home health agency to set up a service
   3. Setting up an interdisciplinary meeting
   4. Setting up transportation

20. The **diagnosis-driven** approach to 99203 serves as an alternative to point counting. Oftentimes, one can determine which CPT code to use within the first few minutes of meeting a patient.

21. Choosing 99203 is appropriate when a patient with no medical problems presents with a simple medical issue that is self-limited and will either resolve on its own or with a non-prescribed pharmaceutical agent. Common scenarios include: acute viral URI, constipation, resolving UTI. Patient-centered questions pertaining to what precisely needs to be documented are described as follows;

22. **99203 History**
   1. Document Chief Complaint
   2. Document HPI - ensure to include 4+ elements describing the HPI
   3. Document ROS – problem pertinent, 2-9 system elements in addition to elements counted in the HPI
   4. Document PFSH – only requires one, but get in the habit of doing all 3.

23. **99203 Physical Exam**
   1. Document a detailed exam (5+ systems) of affected body area or organ system and other symptomatic or related systems.

24. **99203 Medical Decision Making**
   1. Document the new diagnosis and patient instructions on how to monitor disease progress which meets the required level
   2. Document Data reviewed
      a. If you reviewed data, document. Typically, there is no data reviewed, thus can omit this.
   3. Document Risk
      a. Offer an over-the-counter medication for symptom relief meets the required level.

25. The point counting approach to **99204 History**
   1. HPI: 4 elements
   2. ROS: 10 elements
   3. PFSH: All 3 elements


27. **99204 Systems to review (10/14):** See II. 9. It may be acceptable to state “remaining 10 organ ROS negative,” but this should be verified with the local intermediary.

28. **99204 PE Elements: (8/12):** See II. 14.

29. **99204 Moderate Medical Decision Making Characteristics(2/3):**
   1. In “presenting problems,” moderate MDM is met by
a. A new problem with or without additional workup planned OR
b. A patient establishing care with 3 or more chronic stable conditions

2. In “amount of data,” moderate MDM would be met if
   a. Several different tests are ordered (labs, x-ray and ECG), OR
   b. If one test is ordered and either history is taken from another person or old records are reviewed, OR
   b. If lab is ordered and personally reviewed.

3. In the “table of risk,” moderate MDM is met by
   a. One chronic illness with mild exacerbation or side effect OR
   b. An acute illness with systemic symptoms OR
   c. 2 or more stable chronic illnesses OR
   d. An undiagnosed new problem OR
   e. Any prescription drug management.

31. All three elements (History, Exam, Medical Decision Making) must be met or exceeded to bill at this level.

32. Working backwards through the elements, many new patients presenting to a GIM practice will have problems that meet moderate MDM. By definition, the problem will be new, and very often, will be managed with prescription medication, even for a short period of time.

33. The Physical Exam requirement of 8 organ systems is a bit harder to meet for some new patients. If the problem is relative focused, then the MD may not routinely examine 8 organ systems. If the problem is more complex, or diffuse (such as dizziness or SOB) then the requirement will done routinely.

34. The History requirement for the 99204 will be the element most often missing. While the 4 HPI elements are easy to fulfill, as are the PMH and SH (tobacco use or profession), many MDs may fail to routinely inquire about FH or complete a full 10 organ ROS on a new pt with a problem such as LBP, or dizziness even though they have fulfilled all of the other requirements for a 99204 service code, including moderate MDM.

35. In Summary, documenting a 99204 visit requires a full 10 organ ROS as well as the full PFSH and the 8 + organ exam. As always, medical necessity should drive all patient documentation for coding. Some physicians find a pre-appointment questionnaire which includes a full ROS to be a tool that benefits workflow. Documenting “complete ROS otherwise negative” or referring to a questionnaire may be sufficient to meet this criterion, verify with your local intermediary. “Non-contributory” is not sufficient to get credit for an area.

36. **Billing based on TIME** can only be done if > 50% of the physician face to face time is spent counseling and/or care coordination. For 99204, the total face to face time is 45 minutes.

37. **Counseling:** See V. 18; **Care coordination,** see V. 19.

38. Documentation requirements for billing based on time:
   1. Documentation of the total face-to-face visit time
   2. Documentation of either the actual # minutes spent counseling/coordinating care, OR the % of the total visit time spent on this
   3. Documenting specifics of what was discussed, e.g. “Patient counseled on risks of colonoscopy and prep involved,” or “Discussed results of breast biopsy and treatment options for breast cancer, including chemo/XRT.”

39. You do not need to satisfy ANY of the above key component criteria when billing based on time.
40. Using the **diagnosis-driven approach** for 99204 is again a relatively simple process. For example, if the patient has hypertension, osteoarthritis and allergies, surmised from their stated med list which may include a daily blood pressure pill and PRN NSAIDs and anti-histamines, deciding to code the visit a 99204 is appropriate before you begin the patient encounter. Quickly counting the diagnoses, based on med lists, easily and accurately predicts the subsequent service code, regardless of what the patient presents with. If the patient described above presents with an allergy exacerbation, the decision should be made to code a 99204. Patient-centered questions pertaining to medically necessary documentation for the expected code are described below.

41. **99204 History**
   1. Document Chief Complaint
   2. Document HPI - ensure to include 4+ elements describing the HPI or status of 3 chronic problems
   3. Document ROS – perform a complete ROS (10+)

42. **99204 Physical Exam**
   1. Document an extended exam of affected body area or organ system and other symptomatic or related systems (8+).

43. **99204 Medical Decision Making**
   1. Document diagnoses
      b. Document the new diagnosis and patient instructions on how to monitor disease progress which meets the required level
   2. Document Data reviewed.
      a. If you reviewed data, document. Typically, this includes any past labs/x-rays etc. This may not need to be done since you will meet the required level with diagnoses and risk.
      a. If you continue a prescription medication for hypertension you have satisfied the criteria for moderate risk.
      b. Alternatively, if you offer a prescription medication for symptom relief if indicated (i.e. for allergy exacerbation: nasal steroids) or chronic anti-histamines (from PRN to daily for example) will meet “moderate” risk criteria.

VI. **The Established Outpatient family, 99214**

1. The focus will be on 99214, which should be the most frequently used code by most GIM practitioners even though the 2004 Medicare data showed that 99213 was the most commonly used IM code.
2. An Established patient (or “return” patient) has received professional service from you or your billing group in the last 3 years.
3. Service can be from any location, hospital, clinic, ED and from any provider, MD or physician extender.
4. For Established patients, only 2 of 3 elements below must be met or exceeded to bill at 99214 level.
5. Medical necessity should ALWAYS drive medical care, and therefore, Medical Decision Making is usually one of the two elements counted. You will meet criteria with Hx and MDM or PE and MDM.

6. You can and SHOULD refer to previously documented elements such as PFSH, Medications, etc. You must specify the date of the reference note.

7. The **point counting approach to 99214** History
   1. HPI: 4 element OR follow up of 3 chronic medical problems,
   2. ROS: 2 elements
   3. PFSH: 1 element

10. 99214 PE: (5/12) systems or “Detailed exam”: See II. 14.
11. “Detailed exam” may be further defined and verified by local Medicare contractors though a 5-7 systems exam would generally meet criteria for a detailed exam.

12. 99214 Moderate Medical Decision Making Characteristics(2/3):
    1. In “presenting problems,” moderate MDM is met by
       a. 2 existing, poorly controlled problems, OR
       b. 3 chronic stable problems, OR
       c. 1 stable and 1 poorly controlled problems OR
       d. 1 new problem with or without additional workup planned.
    2. In “amount of data,” moderate MDM is met if
       a. Several different tests are ordered (labs, x-ray and ECG) OR
       b. If any one test is ordered and either history is taken from another person OR old records are reviewed OR
       c. If lab is ordered and personally reviewed.
    3. In the “table of risk,” moderate MDM is met by
       a. One chronic illness with mild exacerbation or side effect OR
       b. An acute illness with systemic symptoms OR
       c. 2 or more stable chronic illnesses OR
       d. An undiagnosed new problem OR
       e. **Prescription drug management**, including a decision to continue or alter an existing medication.

13. **ONLY TWO of the THREE elements (History, PE, MDM) must be met or exceeded to code for 99214**.
14. Working backwards through the elements, most established GIM patients will require Moderate MDM due to:

   1. Prescription drug management: This does not just require NEW meds, but refilling meds, ordering labs to monitor for side effects, or documenting side effects or medical compliance. All of this is MANAGEMENT of prescription drugs.
   2. OR 2 or more STABLE chronic illnesses. Yes, STABLE
   3. OR 1 chronic illness with progression or side effect of treatment.
   AND
   4. Presenting Problems: 3 stable chronic illnesses OR 1+ stable chronic illness and 1+ unstable or uncontrolled illness OR 1+ new problem with or without additional workup.
15. If any single test is ordered, any of the following allow for moderate MDM independent review of x-ray or ECG, reviewing of old records or recording history from someone other than the patient.

16. Note the inconsistency in the coding rubric. While 2 stable chronic illnesses meet criteria for Moderate MDM in the table of risk, it requires 3 stable chronic illnesses in the presenting problems subcategory. Just one of the many inconsistencies.

17. The minority of established patients that will NOT meet criteria for moderate MDM will be acute problems only such as URI, rash, or sty which only require OTC meds or watchful waiting as the intervention.

18. Physical Exam- 5 organ systems can easily be met on patients with one or more chronic illnesses such as HTN or DM. OR this will be the element that is not counted.

19. History- If a specific problem, then 4 HPI elements will be routinely done, otherwise, simply stating that the patient is following up for 3 chronic medical problems is sufficient provided you note the status of each. 2 ROS is also easily met in all patients with a new problem, or chronic problems- usually related to expected symptoms of their chronic diseases: CP, SOB, DOE in pt with heart disease. The single PFSH element is fulfilled by documenting medications or allergies.

20. In Summary, the key to documenting a 99214 visit in GIM is knowing when you have used Moderate Medical Decision Making. If you manage prescription medication and 3 chronic medical problems for a patient, then this IS a 99214 visit. A single new illness, with prescription drug management ALSO meets moderate MDM criteria. Then, be sure to document either 5 organ system exam OR 4+ HPI, 2 ROS and 1 PFSH.

21. Billing based on TIME only can be done if > 50% of the physician face to face time is spent counseling and/or care coordination. For 99214, the total face to face time is 25 minutes.

22. Counseling: See V. 18; Care coordination, see V. 19.

23. The diagnosis-driven approach to 99214, again, serves as an alternative to point counting. Choosing 99214 is appropriate when a patient with a few stable medical problems presents for follow-up of chronic disease, has a minor exacerbation of a chronic disease, or has a new problem.

24. If the patient visit requires the management of multiple chronic diseases such as hypertension, osteoarthritis and seasonal allergies, the visit can be coded a 99214 regardless of patient presentation.

25. Using the prior common scenario of stable hypertension and osteoarthritis with allergy exacerbation, the note can be coded at 99214. Patient-centered questions pertaining to what precisely needs to be documented are described below.

26. 99214 History
   1. Document Chief Complaint
   2. Document HPI
      a. Be sure to include 4+ elements describing the HPI
   3. Document ROS
      a. Perform problem pertinent + 2-9 additional
   4. Document PFSH
      a. Requires just one (typically past medical history which is always obtained).

27. 99214 Physical Exam
   1. Document a detailed exam, an extended exam of affected body area or organ system and other symptomatic or related systems, generally 5-7 systems.

28. 99214 Medical Decision Making
1. Document diagnoses
   b. Document the new diagnosis and patient instructions on how to monitor disease progress which meets the required level

2. Document Data reviewed
   a. Document data reviewed but this may not need to be done since you will meet the required level with diagnoses and risk.

3. Document Risk
   a. Prescription medication for symptom relief if indicated (for allergy exacerbation, nasal steroids, chronic anti-histamines (from PRN to Daily for example) which gives you “moderate” risk and meets the required level.

29. ONLY TWO of the THREE elements (History, PE, MDM) must be met or exceeded to code for 99214.

VII. Cases

New patient:

Case 1: 99202

CC/ID: 35 year old man with back pain.
HPI: Onset 1 week ago of mild, right sided lower back pain.
ROS: Denies neurologic symptoms.
PFSH: Has history of similar episode 3 years ago that resolved with rest.
EXAM: Weight 85 kg, BP 110/60 P90. He is uncomfortable with movement
MS: ROM of lower back 60 degrees flexion, limited by pain, paraspinal muscle spasm and tenderness R>L. NEURO: anterior tibialis and gastrocnemius strength 5/5 bilaterally.

A/P: Diagnosis is musculoskeletal low back pain-no red flags for cauda equina syndrome found. Treat with ibuprofen 200-400 mg TID. F/u in 2-3 weeks.

History: Expanded problem focused (brief HPI [3 descriptors], 1 system ROS, 1 element PFSH)
Exam: Expanded problem focused (3 systems)
Decision making: Low complexity (1 new problem with no work-up, no data, non-prescription meds)

For new patient, lowest level determines code, so this is 99202.

Case 2: 99203

CC/ID: 35 year old man with back pain.
HPI: Onset 1 week ago of severe, intermittent, right sided non-radiating lower back pain. Associated with vague discomfort in the RLQ with movement.
ROS: Denies weight loss, fever, bowel, or bladder symptoms.
PFSH: Has history of similar episode 3 years ago that resolved with rest. Does not recall any imaging studies. No current medications.
EXAM: Weight 85 kg, BP 110/60 P90. He is uncomfortable with movement
LYMPH: no neck, chest, or inguinal nodes. ABD: No liver, spleen, or mass palpable. MS: ROM of lower back 60 degrees flexion, limited by pain, paraspinous muscle spasm and tenderness R>L. GU: testicles normal. NEURO: anterior tibialis and gastrocnemius strength 5/5 bilaterally.

A/P: Diagnosis is musculoskeletal low back pain-no red flags for cauda equina syndrome found. Treat with ibuprofen 600 mg TID and cyclobenzaprine 10 mg TID for spasm. F/u in 2-3 weeks.

History:  Detailed (extended HPI [5 descriptors], 3 system ROS, 1 element of PFSH)
Exam: Detailed (6 systems)
Decision making: Moderate complexity (1 new problem with work-up, no data, prescription meds)

For new patient, lowest level determines code, so this is 99203.

**Case 3: 99204**

CC/ID: 65 year old man with back pain.
HPI: Onset 1 week ago of moderate, right sided non-radiating lower back pain. No change with movement.
ROS: Denies fever, bowel, or bladder symptoms. Reports fatigue for a month. No chest pain, dyspnea, leg paresthesia, rash, enlarged lymph nodes. Reports anxiety about pain severity. History of allergy to ibuprofen (swelling)

EXAM: Weight 90 kg, BP 110/60 P90 Uncomfortable with movement
HEENT: not jaundiced; no oral lesions
LYMPH: no neck, axillary, or inguinal nodes
LUNG: dull to percussion right base, with decreased breath sounds
COR: no murmur or gallop
ABD: tender RUQ and LLQ, with healed prostatectomy scar
GU: no testicular mass. Prostate absent.
MS: Paraspinous muscle spasm and tenderness R>L; also at L4 spinous process
NEURO: 4/5 strength at anterior tibialis muscle, right.

A/P: Diagnosis most likely musculoskeletal low back pain with radiculopathy, but needs more workup including UA, PSA and lumbar spine MR. Treat with ibuprofen 600 mg TID and cyclobenzaprine 10 mg TID for spasm, pending workup with f/u tomorrow after MR.

History: Comprehensive (extended HPI [5 descriptors], 10 system ROS, 3 elements of PFSH)
Exam: Comprehensive (10 systems)
Medical Decision Making: Moderate complexity (1 new problem with work-up, no data, prescription meds)
For new patient, lowest level determines code, so this is 99204.

**Case 4: 99205**

CC/ID: 65 year old man with back pain.
HPI: Onset 1 week ago of severe, right sided non-radiating lower back pain. No change with movement.
ROS: Denies fever, bowel, or bladder symptoms. Reports fatigue for a month. No chest pain, dyspnea, leg paresthesia, rash, enlarged lymph nodes. Reports anxiety about pain severity. History of allergy to ibuprofen (swelling)

EXAM: Weight 90 kg, BP 110/60 P90 Uncomfortable with movement
HEENT: not jaundiced; no oral lesions
LYMPH: no neck, axillary, or inguinal nodes
LUNG: dull to percussion right base, with decreased breath sounds
COR: no murmur or gallop
ABD: tender RUQ and LLQ, with healed prostatectomy scar
GU: no testicular mass. Prostate absent.
MS: Paraspinous muscle spasm and tenderness R>L; also at L4 spinous process
NEURO: 4/5 strength at anterior tibialis muscle, right.

A/P: Diagnosis may be musculoskeletal low back pain with radiculopathy, but needs more workup including UA, PSA and lumbar spine MR to evaluate for possible cancer. Plan: Oxycodone 5-10 mg QID prn pending workup with f/u tomorrow after MR.

**History: Comprehensive (extended HPI [5 descriptors], 10 system ROS, 3 elements of PFSH)**
**Exam: Comprehensive (10 systems)**
**Medical Decision Making: High complexity (1 new problem with work-up, no data, medication requiring intensive monitoring and also life-threatening diagnosis)**

For new patient, lowest level determines code, so this is 99205.

**Established patient:**

**Case 5A: 99213**

CC/ID: 35 year old man with back pain.
HPI: Onset 1 week ago of severe, right sided non-radiating lower back pain.
ROS: Denies fever, bowel, or bladder symptoms
PFSH: No current medications.

EXAM: BP 110/60 P90, uncomfortable with movement. MS: paraspinous muscle spasm and tenderness R>L, ROM of lower back 60 degrees flexion, limited by pain

A/P: Diagnosis is musculoskeletal low back pain. Plan rest and F/u in 2-3 weeks.
History: Detailed (extended HPI [4 descriptors], 3 system ROS, 1 element of PFSH)
Exam: Expanded problem focused (2 systems)
Decision making: Straightforward (1 new problem with work-up, no data or meds)

For an established patient this is a service code 99213.

Case 5B: 99213

CC/ID: 35 year old man with back pain.
HPI: Onset 1 week ago of severe, right sided non-radiating lower back pain.
ROS: Denies fever
PFSH: No current medications.
EXAM: BP 110/60 P90, uncomfortable with movement. MS: paraspinous muscle spasm and tenderness R>L, ROM of lower back 60 degrees flexion, limited by pain

A/P: Diagnosis is musculoskeletal low back pain-no red flags for cauda equina syndrome found. Treat with ibuprofen 600 mg TID and cyclobenzaprine 10 mg TID for spasm. F/u in 2-3 weeks.

History: Expanded problem focused (extended HPI [4 descriptors], 1 system ROS, 1 element of PFSH)
Exam: Expanded problem focused (2 systems)
Decision making: Moderate complexity (1 new problem with work-up, no data, prescription meds)

For an established patient this is a service code 99213.

Case 6: 99214

CC/ID: 35 year old man with back pain.
HPI: Onset 1 week ago of severe, right sided non-radiating lower back pain.
ROS: Denies fever, bowel, or bladder symptoms
PFSH: No current medications.
EXAM: BP 110/60 P90, uncomfortable with movement. MS: paraspinous muscle spasm and tenderness R>L, ROM of lower back 60 degrees flexion, limited by pain

A/P: Diagnosis is musculoskeletal low back pain-no red flags for cauda equina syndrome found. Treat with ibuprofen 600 mg TID and cyclobenzaprine 10 mg TID for spasm. F/u in 2-3 weeks.

History: Detailed (extended HPI [4 descriptors], 3 system ROS, 1 element of PFSH)
Exam: Expanded problem focused (2 systems)
Decision making: Moderate complexity (1 new problem with work-up, no data, prescription meds)

For an established patient this is service code 99214.

Case 7: 99215

CC/ID: 65 year old man with back pain.
HPI: Onset 1 week ago of severe, right sided non-radiating lower back pain. No change with movement.
ROS: Denies fever, bowel, or bladder symptoms. Reports fatigue for a month. No chest pain, dyspnea, leg paresthesia, rash, enlarged lymph nodes. Reports anxiety about pain severity. History of allergy to ibuprofen (swelling)
PFSH: No current medications. History of prostate cancer and renal stones.
Cigarettes: 30 pack years

EXAM: Weight 90 kg, BP 110/60 P90 Uncomfortable with movement
HEENT: not jaundiced; no oral lesions
LYMPH: no neck, axillary, or inguinal nodes
LUNG: dull to percussion right base, with decreased breath sounds
COR: no murmur or gallop
ABD: tender RUQ and LLQ, with healed prostatectomy scar
GU: no testicular mass. Prostate absent.
MS: Paraspinal muscle spasm and tenderness R>L; also at L4 spinous process
NEURO: 4/5 strength at anterior tibialis muscle, right.

A/P: Diagnosis may be musculoskeletal low back pain with radiculopathy, but needs more workup including UA, PSA, and lumbar spine MR to evaluate for possible cancer. Plan: Oxycodone 5-10 mg QID prn pending workup with f/u tomorrow after MR.

History: Comprehensive (extended HPI [5 descriptors], 10 system ROS, 2 elements of PFSH)
Exam: Comprehensive (10 systems)
Medical Decision Making: High complexity (1 new problem with work-up, no data, medication requiring intensive monitoring and also life-threatening diagnosis)

For an established patient this is service code 99215.

VIII. Coding when seeing patients in a teaching setting:

1. Background: Resident salaries are funded in large part by Medicare dollars, thus care provided by residents to Medicare beneficiaries has already been paid for by CMS. For an attending physician to also bill for this care, he/she must carefully follow the rules of oversight and documentation that indicates their participation in this care.
2. GC and GE are MEDICARE modifiers, which indicate that the billing physician has seen the patient in conjunction with a resident physician in an approved graduate medical education (GME) program. It includes interns, residents and fellows in their post-graduate training.
3. Only specific lower E&M service codes, and the “Welcome to Medicare” exam can be billed using the GE modifier:
   1. New outpatient family: 99201, 99202, 99203
   2. Established outpatient family: 99211, 99212, 99213
   3. Welcome to Medicare: G0344
4. GC is the modifier used for billing Medicare when a resident is involved in the patient’s care and the teaching physician does not operate under the Primary Care Exception, described later.
5. While these modifiers apply only to Medicare (and Medicaid, depending on your state of residence), most Teaching Hospital compliance offices will recommend that you apply these modifiers to ALL patients that you see with residents. This should be verified with your local compliance personnel.

6. **GE Modifier:** The Primary Care Exception billing for outpatient training
   1. The GE Modifier can only be used in approved training programs in general internal medicine, family medicine, geriatrics, pediatrics, OB/GYN, and certain psychiatry programs that provide comprehensive, longitudinal care to their patients.
   2. GE Modifier: The Primary Care Exception
   3. The clinic must be located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital.
   4. This requirement is not met when a resident is assigned to a physician’s office or makes home visits.
   5. GE Modifier: The Primary Care Exception
   6. The resident must be following a panel of patients who consider the clinic and the resident to be the continuing source of their health care.
   7. The resident must have completed 6 months of an approved residency.

7. **GE Modifier: The Primary Care Exception:** The teaching physician (billing physician) must
   1. Assume management responsibilities for those beneficiaries seen by the residents.
   2. Not supervise more than four residents at any given time.
   3. Directs the care from such proximity as to constitute immediate availability.
   4. Have no other responsibilities at the time of which the service for which payment is sought (e.g. not seeing own patients or student’s patients).
   5. Review the case with the resident during the workup while the patient is in the clinic or immediately after the resident saw the patient.
   6. Ensure that the services are appropriate.

8. The teaching physician can bill both GE and GC in the same session, e.g. he/she can have interns (in their first 6 months) and residents in the same clinic session.

9. Commercial insurers: Most commercial insurers do not recognize the GE/GC modifiers, and these will drop off during charge entry.

10. The Annual Preventative Services Codes (99381-99387 and 99391-99397) can be billed using GE modifier at some institutions for commercial insurers, but you must check with your hospital compliance office. Medicare preventive service codes cannot be used with the GE modifier.
    1. The billing physician must document that they discussed the history, exam and medical decision making with the resident physician and approved the resident’s documented note. The billing physician’s documentation can be hand written or electronic. No patient specific information needs to be added to the attestation.

11. **GC Modifier**
    The GC modifier is used when the attending physician is billing for a service that he/she provided in conjunction with a resident physician.

12. **GC Modifier:**
1. The billing physician is expected to evaluate the patient independently, OR be present and observe the resident physician during their evaluation of the patient.
2. For a procedure, the billing physician is expected to be present for the KEY components of the procedure.
3. The GC modifier can be used for all E&M, preventative, G codes and procedures.
4. The billing physician must documentation that they evaluated the patient, reviewed and approved the resident’s documented note, and add key elements in a minimum of 1/3 categories: History, exam or medical decision making.
5. Patient specific information MUST be added if the attestation is being done electronically.
6. If the attestation is hand written by the billing physician, then it is adequate to document as follows: “I have seen and evaluated the patient on morning rounds. I have discussed and agree with Dr. Resident’s interval history, exam, assessment and plan with no changes or additions.”

13. Medical Students
1. Medical students of all levels are NOT considered residents by CMS, even when acting in that capacity on the hospital ward.
2. The billing physician can only attest to the ROS, PFSH of a note by the Medical Student
3. A resident co-signing a Medical Student note DOES NOT make it an MD note.

14. Nurse Practitioners
1. NPs are considered the same as Medical Students, unless they have their own UPIN and are billing CMS as an independent provider.

IX Multiple services on the same day
1. The default logic of CMS is that one service is delivered at a time.
2. CMS considers the decision to perform a procedure and advice regarding post-procedure care bundled in the procedure code, and not a separate E/M service.
3. A patient who comes to the office only to have a skin tag removed. The physician would submit the CPT code for skin tag removal (11200), but no separate E/M code for advising about the procedure and post-operative care.
4. Modifier -25 should be used if the “…provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure” Office of Evaluation and Inspections.
5. For concurrent procedural and E/M Care use the -25 modifier for reimbursement for both services: Use of –25 modifier
   1. Procedural services + unrelated E/M care: -25 modifier
   2. A patient presents with hypertension and requests 3 skin tags be removed. The proper coding would be:
      a. 99213-25 (for hypertension management)
      b. 11200 (for removal of skin tag)
6. For concurrent procedural and E/M Care use the -25 (and possibly -57) modifier for reimbursement for both services: Use of –25 modifier
   1. Procedure + related E/M care, but above and beyond usual pre- and postoperative care: -25 modifier
   2. A patient who presents with fever, malaise, and a red, swollen knee.
      a. The physician performs an extensive evaluation with a wide differential diagnosis.
      b. The physician orders lab and performs an arthrocentesis as part of the workup.
      c. The clinical work exceeds that which is usually associated with an arthrocentesis.
      d. If the E/M documentation supports a level 4 visit the billing would be: 99214-25 (for E/M of fever, malaise, joint paint) and 20610 (arthrocentesis large joint)
      e. Some intermediaries use the -57 modifier in this situation

7. Common office procedures for general internists

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>WRVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>17000</td>
<td>Destruction of premalignant lesion</td>
<td>0.62</td>
</tr>
<tr>
<td>17110</td>
<td>Cryotherapy of warts</td>
<td>0.67</td>
</tr>
<tr>
<td>20610</td>
<td>Large joint arthrocentesis</td>
<td>0.79</td>
</tr>
<tr>
<td>49080</td>
<td>Paracentesis</td>
<td>1.35</td>
</tr>
<tr>
<td>11200</td>
<td>Skin tag removal (up to 14)</td>
<td>0.79</td>
</tr>
<tr>
<td>58100</td>
<td>Endometrial biopsy (?waiver if asx)</td>
<td>1.53</td>
</tr>
<tr>
<td>57500</td>
<td>Endocervical polypectomy</td>
<td>1.20</td>
</tr>
<tr>
<td>69210</td>
<td>Ear irrigation</td>
<td>0.61</td>
</tr>
<tr>
<td>20620</td>
<td>Arthrocentesis</td>
<td>0.69</td>
</tr>
</tbody>
</table>

X. Home Health Plan Certification

1. Service codes G0179-G0180 are used to initiate and recertify Home Health Care Plans for Medicare patients.
2. The most common scenario is certifying care plans initiated by a physician and submitted by a home health agency.
   1. Physicians certify plans submitted by a home health agency by signing them and returning them to the agency
   2. The documentation required for billing includes a brief summary of the care plan and diagnoses, as well as the beginning and ending dates of the care plan.
   3. Face to face patient contact is NOT required to use these codes.
   4. These codes can be submitted no more than every 60 days
3. Commercial payers may require a different CPT code, so be sure to inquire with the practice administrator about which code is appropriate.
XI. Care Plan Oversight, Table 3

1. Care plan oversight (CPO) codes allow a physician to charge for non face-to-face coordination of care for patients with complex care plans.
   1. Typical work includes: generating care plans, reviewing medical data and patient status reports, adjusting the care plan, and communicating the plan of care with other health care professionals, family, or caregivers.
   2. This can be billed once per calendar month by only one physician.
   3. The physician must have seen the patient within the preceding 6 months.
   4. Documentation must be dated and timed, and include details of the provided service.

2. We recommend using a CPO log to capture this information and that the log be included in the patient record.

3. Choose either the Medicare codes for CPO (HCPCS codes G0181 and G0182 only for 30 minutes or more) or the non-Medicare codes for CPO (99374-99380, and 99339-99340) depending on the setting in which the patient resides (home vs. hospice vs. nursing facility) and the time involved in CPO. (Table 3) Be aware that Medicare will not pay for CPO < 30 minutes (i.e. G0181 or G1082).

XII. Consultation: Outpatient Consults 99241-99245
Inpatient Consults 99251-99255

1. Consultation
   1. With a consult, the requesting physician or ANP seeks “patient management advice from another physician/NPP, regardless of subspecialty, BUT with expertise in a specific medical area beyond the requesting professional’s knowledge.”
   2. The key to billing a consult is that an opinion is requested.

2. Consultation definitions
   1. The consultant may be in the same subspecialty as the requestor.
   2. The consultant may initiate treatment or perform a procedure.
   3. The consultant may have seen the patient before, eg: pre-op clearance of your regular patient if specifically requested by the surgeon and not done as part of your routine practice.
   4. If the patient has been seen as consult before, a consult can be reported again if one of these exists:
      a. Consult is to evaluate a new condition
      b. The requesting physician re-consults the physician for the same condition and the consulting physician is not providing ongoing management of that condition.
   5. Check with local carriers on restrictions on requesting physicians – ie residents may not be accepted since they do not have UPIN numbers.

3. Referral definition
4. Referral = transfer of care
   1. A physician or ANP requests that another physician or ANP take over the responsibility for managing the patient’s complete care for the specific condition, and does not expect to continue treating or caring for the patient for that condition.
2. The requesting provider is not asking for advice to personally treat the patient and does not plan on managing this specific condition.
3. This patient should be billed as New or Established.

5. Documentation requirements for billing a consultation
   1. The requesting physician or ANP must document in the patient’s chart that a consult is being requested and the reason for it.
   2. This can be a written order, consult form, or an entry in progress note plan.
   3. The requestor can verbally request the consult – ie phone call or face-to-face discussion, but must still document the conversation in the patient’s chart.
   4. It is the requesting physician that determines if a referral is a consult or a transfer of care.

6. Consultant: 3 R’s:
   1. **Request**
      a. Document name of the individual (not name of medical group or specialty) requesting physician or ANP and reason for consult
      b. If patient self refers or family member and not provider requests consult, the patient visit should be billed as New or Established, i.e. consult was not requested by a physician.
      c. If second opinion or third party payer requests consult, the patient visit should be billed as New or Established.
   2. **Render**
      a. Document their findings, advice, and (if applicable) any services that may have been ordered or performed.
      b. A consultant can initiate diagnostic and/or therapeutic services to help formulate an opinion.
   3. **Reply**
      a. Written report of findings and recommendations must be sent back to requesting physician or ANP.
      b. If chart is shared between requesting and consulting physician or ANP, consultant progress note is sufficient documentation.
      c. If chart is not shared, consultant must send a letter (or copy of their progress note) of findings and recommendations back to requesting physician/NPP.

7. In summary, the pitfalls to achieving documentation compliance
   1. Inability in determining if request is a consult vs. transfer of care
   2. Inability in determining the individual requesting the consult
   3. Investing extra work into generating letter of reply.

8. Example of opening statement of consultant reply: “Mr. X is a 49 y/o male ’Am.asked to see (patient name) by Dr. Y for advice re: treatment of dizziness…”, not “for management of…”

9. Focus will be on most common codes for GIM – 99243, 99244; 99253, 99254. Codes above and below will be used less frequently.
1. Requirements for each coding level are identical to “New outpatient” coding grids with the exception of coding based on time.
2. Most consults we see actually require medical decision-making at a level 4, however, due to the ROS 10 + PFSH 3, many may end up as a level 3.

10. The point counting approach to 99243, 99253 History:
   1. HPI: 4 elements
   2. ROS: 2 elements
   3. PFSH: 1 element


14. The point counting approach to 99243, 99253 PE: 5 systems or “Detailed exam”
   1. Organ systems for exam (12): See II. 14

15. Detailed exam must be defined and verified by local Medicare contractors.

16. The point counting approach to 99243, 99253 Low Medical Decision Making
   1. 2 minor or self limited problems, one new problem with no additional work-up meet criteria for low MDM in “presenting problems”
   2. Obtaining history from someone other than pt, independent review of a specimen or tracing, reviewing old records would each meet criteria for low MDM in “amount of data”
   3. Two or more self limited or minor problems or symptoms, one stable chronic illness, acute uncomplicated illness; treatment options such as OTC drugs, PT/OT all meet criteria for low MDM in the “table of risk”
   4. Two of the above three elements are needed to reach low MDM

17. All three elements (History, Exam, Decision making) must be met or exceeded to bill at this level

18. Billing based on TIME only can be done if > 50% of the physician face to face time is spent counseling or coordinating care. For 99243 and 99253, the total face to face time is 40 and 55 minutes respectively

19. Working backwards, considering the elements: Most GIM docs not only meet, but exceed low MDM on a consult, even if pt has a simple problem, they will recommend some OTC meds, or some PT. Unless a very simple problem, MDM will be met at this level.

20. Physical Exam will also meet the 5 system requirement most of the time: VS or general appearance, eyes, skin, psych (affect) can all be documented from observation alone, without ever touching the patient with a stethoscope. Add CV, lungs and/or abdomen, and the 5 systems are easily documented

21. All that is left is HPI/ROS and PFSH.

22. On a consult, most GIM docs will at least review allergies and meds, if not PMH. Only one of these is needed to meet the single PFSH needed.

23. With the exception of doing a pre-op consult on an established patient, all problems presenting will be new to the examiner, therefore the history will most likely include the needed 4 elements and 2 ROS

24. In summary, the majority of General Internal Medicine Physicians seeing a consult for (even) a simple problem will easily fulfill the documentation requirements for a Level 3 consultation visit. As always, medical necessity should drive all of your patient documentation and billing.

25. The diagnosis-driven approach to 99243, 99253
1. Use these codes when you are asked to consult for only one simple problem, usually self-limited, where no prescription meds are subsequently recommended (ie: viral URI or constipation). These codes are not as commonly used due to the simplicity of the problem that is being addressed. The typical complex medical patient requiring a consultation will usually be billed at a higher level.

26. Craft your note to meet the requirements of these codes:

1. History  
   a. CC  
   b. HPI: 4 elements  
   c. ROS: Problem pertinent + 2-9 additional  
   d. 1 of 3 PMFSH

2. Exam  
   a. Extended exam of affected body area or organ system and other symptomatic or related systems.

3. Medical Decision Making (2 of 3, usually the last two if only addressing one diagnosis)  
   a. Established/possible diagnoses = 2  
   b. Data reviewed/ordered = 2 (usually labs/radiology)  
   c. Low risk = Over the counter meds

27. The point counting approach to 99244, 99254 History:  
   1. HPI: 4 elements  
   2. ROS: 10 elements  
   3. PFSH: All 3 elements


30. 99244, 99254 PE Elements (8/12): See II. 14

31. Comprehensive exam must be defined and verified by local Medicare contractors

32. 99244, 99254: Moderate Medical Decision Making (2/3 required)
   1. In “presenting problems,” moderate MDM is met by a new problem with or without additional workup planned.
   2. In “amount of data,” moderate MDM would be met if tests were ordered in each of these categories: labs, xray and other, like ECG; if one test is ordered and history is taken from another person, or old records are reviewed; or if lab is ordered and ECG is personally reviewed.
   3. In the “table of risk,” moderate MDM is met by one chronic illness with mild exacerbation or side effect; an acute illness with systemic symptoms; 2 or more stable chronic illnesses; an undiagnosed new problem; or prescription drug management.

33. All three elements (History, Exam, Decision making) must be met or exceeded to bill at this level

34. Billing based on TIME only can be done if > 50% of the physician face to face time is spent counseling and/or coordinating care. For 99244 and 99254, the total face to face time is 60 and 80 minutes respectively.

35. Working backwards through the elements, many consult patients that present to a GIM clinic will have problems that meet moderate MDM. With the exception of doing a pre-op consult on an
established patient, the problem(s) will be new, and very often, will be managed with prescription medication, even for a short period of time, thus moderate MDM will be met.

36. The Physical Exam requirement of 8 organ systems is a bit harder to meet for some consults. If the problem is relative focused, then the MD may not routinely examine 8 organ systems. If the problem is more complex, or diffuse (such as dizziness or SOB) then the requirement will be filled routinely.

37. The History requirement for the 99244 and 99254 will be the element most often missing. While the 4 HPI elements are easy to fulfill, as are the PMH and SH (tobacco use or profession), many MDs may fail to routinely inquire about FH or complete a full 10 organ ROS on a consult with a problem such as LBP, or dizziness even though they have fulfilled all of the other requirements for a level 4 visit, including Moderate MDM.

38. In Summary, the catch to documenting a 99244 or 99254 visit is documenting a full 10 organ ROS as well as the full PFSH and the 8 + organ exam. As always, medical necessity should drive all of your patient documentation and billing. Some physicians find a pre-appointment questionnaire which includes a full ROS to be a tool that benefits workflow. Documenting “complete ROS otherwise negative” may be sufficient to meet this criterion, check with your local intermediary.

39. The diagnosis-driven approach to 99244, 99254
   1. These codes are the most commonly used codes for the complex medical patient. The patient typically has one or more chronic illness with at least a mild exacerbation and will require prescription drug management as part of the therapeutic recommendations.
   2. Craft your note to meet the requirement of these codes:
      1. History
         a. CC
         b. HPI: 4 elements
         c. ROS: 10 or more
         d. 3 of 3 PFSH
      2. Exam
         a. Complete single organ system exam or general 8-12 system exam (the latter is typically documented).
      3. Medical Decision Making (2 of 3, usually the last two if only addressing one diagnosis)
         a. Established/possible diagnoses of three or more
            1. The condition for which you are consulted AND
            2. Comments on other stable diseases which were considered during the patient evaluation (such as diabetes, hypertension, or coronary artery disease).
         b. Data reviewed/ordered of 3 or more
            1. Labs/radiology/ECG OR
            2. Discussion with consulting MD to obtain further history and discuss therapeutic recommendations
         c. Risk
            1. Prescription drug management.
43. This note will not require subsequent review as it was written with the code **99244/99** in mind.
44. Subsequent visits – if consultant sees patient back for further visits, even if still finalizing recommendations, outpatient follow-up codes 99212-99215 or inpatient follow-up codes 99231-99233 should be used.
45. Peri-operative care

1. If an outpatient pre-op consultation was billed and the patient is followed in the hospital either pre- or post-op, you cannot bill the initial inpatient visit as a consult again, but instead should use 99231-99233 subsequent visit codes.
2. If you are consulted post-op on your continuity outpatient and have not done a pre-op consult, you can bill for a consult now, even if you know the patient as long as all other criteria are met.
### Table 1. History and Exam Criteria (Point counting)

#### Outpatient Established

(need 2 of 3 components)

<table>
<thead>
<tr>
<th></th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI</td>
<td>1</td>
<td>1</td>
<td>4 (or 3 chronic*)</td>
<td>4 (or 3 chronic*)</td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Past/Family/Social History</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Exam # of systems (per 95 audit tool)</td>
<td>0</td>
<td>2-7</td>
<td>2-7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Data</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Billing by time (min)</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

#### Outpatient New (also outpatient/inpatient consults)

(need 3 of 3 components)

<table>
<thead>
<tr>
<th></th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4 (or 3 chronic*)</td>
<td>4 (or 3 chronic*)</td>
</tr>
<tr>
<td>ROS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Past/Family/Social History</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Exam # of systems (per 95 audit tool)</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Data</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Risk</td>
<td>minimal</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
<tr>
<td>Billing by time (min): Outpt new</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Outpt consult</td>
<td>15</td>
<td>30</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Inpt consult</td>
<td>20</td>
<td>40</td>
<td>55</td>
<td>80</td>
</tr>
</tbody>
</table>

### HISTORY

**HPI:** location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms; (*the status of three chronic conditions counts as the equivalent of 4 or more elements of the HPI), Section II, 8.

**ROS:** constitutional (fever, weight loss), eye, ENT, cardiovascular, respiratory, GI, GU, musculoskeletal, skin/breast, neurological, psychiatric, endocrine, hematologic/lymph, allergic/immunologic (ok with most carriers to say “complete ROS o/w negative”), Section II, 9

**PFSH:** past, family, and social history (1 pt max. for each PFSH sub-element), Section II, 10.
EXAM

Systems: Constitutional (i.e., 3 vitals), eyes, ENT, Cardiovascular, Respiratory, GI, GU, Heme/lymph, musculoskeletal, skin, neurologic, psychiatric

TIME

Billed time based on face-to-face time (not counseling time; not including time outside exam room coordinating care)
### Table 2. Medical Decision Making Criteria

Determine # of points for Diagnoses and Data and select level of risk, then refer to coding grids for service code determination.

**Dx:** Number of Diagnostic or Treatment Options: (common qualifiers in bold)

<table>
<thead>
<tr>
<th>Dx:</th>
<th>Number of Diagnostic or Treatment Options</th>
<th>Self-limited or minor problem</th>
<th>Established problem – stable</th>
<th>Established problem – worse</th>
<th>New problem, no W/U</th>
<th>New problem, further W/U</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>____ x 1 = ____</td>
<td>____ x 1 = ____</td>
<td>____ x 2 = ____</td>
<td>____ x 3 = ____</td>
<td>____ x 4 = ____</td>
<td></td>
</tr>
</tbody>
</table>

**Data:** Amount and Complexity of Data:

<table>
<thead>
<tr>
<th>Data:</th>
<th>Amount and Complexity of Data:</th>
<th>Lab: (any blood or urine test ordered)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X-ray: (any radiologic test ordered)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other test: (i.e. ECG, PFTs, echocardiogram)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss test results w/ performing MD:</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision to review old records or obtain hx from someone other than pt:</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Actually review old records or obtain hx from someone other than pt:</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss case w/ another health care provider:</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent review of test (i.e., ECG, x-ray):</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk:** Risk of Complications (risk is determined by the highest level in any of these 3 categories)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Presenting problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal risk:</td>
<td>1 minor</td>
<td>lab, CXR, ECG</td>
<td>rest, gargles</td>
</tr>
<tr>
<td>Low risk:</td>
<td>2 minor problems</td>
<td>PFTs</td>
<td>physical therapy</td>
</tr>
<tr>
<td>or 1 stable chronic illness</td>
<td>UGI</td>
<td>OTC meds</td>
<td></td>
</tr>
<tr>
<td>or 1 acute (UTI, allergic rhinitis, sprain)</td>
<td>skin biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate risk:</td>
<td>1 chronic condition with mild progression or tx side effect</td>
<td>stress test</td>
<td>prescription drug</td>
</tr>
<tr>
<td>2 or more stable problems</td>
<td>endoscopy, no RF</td>
<td>management</td>
<td></td>
</tr>
<tr>
<td>1 acute illness with systemic sx</td>
<td>LP</td>
<td>surgery (elective/minor)</td>
<td></td>
</tr>
<tr>
<td>High risk:</td>
<td>1 chronic condition w/ severe progression or side effects of tx acute Illness that could pose threat to life or function (MI, PE, severe RA) abrupt change in neurologic status</td>
<td>c. cath with RF</td>
<td>major surgery</td>
</tr>
<tr>
<td></td>
<td>endoscopy with RF</td>
<td>parenteral narcotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EP</td>
<td>drug Tx requiring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>intensive monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>do not resuscitate order</td>
<td></td>
</tr>
</tbody>
</table>

Dx= Diagnoses; Tx= Treatment; W/U= Work-up; UGI=Upper Gastrointestinal Radiographs; CXR= Chest Radiograph; ECG=Electrocardiogram, PFT=Pulmonary Function Tests; OTC=Over the counter; Sx=symptoms; LP=Lumbar puncture; c. cath=cardiac catheterization; RF=Risk factors; EP=Electrophysiologic testing
Table 3: Care Plan Oversight Codes

<table>
<thead>
<tr>
<th>Site of service</th>
<th>Code for 15-29 minutes</th>
<th>Code for 30 minutes or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home, with home health agency</td>
<td>99374</td>
<td>99375 or G0181</td>
</tr>
<tr>
<td>Hospice</td>
<td>99377</td>
<td>99378 or G0182</td>
</tr>
<tr>
<td>Nursing facility</td>
<td>99379</td>
<td>99380</td>
</tr>
<tr>
<td>Home or assisted living, without home health agency</td>
<td>99339</td>
<td>99340</td>
</tr>
</tbody>
</table>